Inter-relationships between environmental factors, personal experiences and behaviour following childbirth: a longitudinal study

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INTER-RELATIONSHIPS BETWEEN ENVIRONMENTAL FACTORS, PERSONAL EXPERIENCES AND BEHAVIOUR FOLLOWING CHILDBIRTH: A LONGITUDINAL STUDY

A thesis submitted in fulfilment of the requirements for the award of the degree of

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For Susan
who introduced me to
the joys and agonies of
parenting a premature baby
ABSTRACT

Using reciprocal determinism as a model an examination of the inter­relationships between environmental factors, personal experiences and behaviour following childbirth was undertaken. Three different samples of women were studied. Each group had given birth under different environmental conditions. The first sample gave birth in a hospital which practiced routines that led to separation of the mother and child; the second comprised women who gave birth to a premature infant; and the third was of young low socio-economic status mothers. The women were interviewed while still in the hospital, in the home when the children were three months old, and again when they were eighteen months old.

Background biographical data were recorded and home environments assessed in order to determine the past and current environments of these mothers and their children.

A schedule for observing mother-infant interactive behaviours was developed for each home visit. Behaviours were recorded for ten minutes on each occasion. Factor analysis of this data produced seven factors for each age period. Social contacts with another adult proved to be important to mothers when the children were three months old. At the eighteen months visit the children's increased independent activity produced several child behaviour factors. Loving, playing and child-care behaviours also proved important.

Interview data provided information on the mothers' personal experiences on each occasion. Content analysis scales were used to assess their
affective reactions to this psychosocial event. There were marked differences in the three samples' personal reactions to the birth. For mothers of healthy infants giving birth was a time of warm feelings and increased intimacy. The mothers who experienced routines leading to separation expressed significantly more angry and lonely feelings relating to the medical procedures and hospital shortly after birth. Mothers of premature infants found that their birth experience was gained at great emotional cost. Their warm feelings increased as the likelihood of the child's survival improved, but their worries only diminished slowly. The young working class women had difficulty in expressing feelings. They tended to somatise their stresses and their affective responses resembled those of people who have been described as alexithymic. They were difficult to locate for follow up visits.

Warm and loving behaviours were associated with positive emotions in the mothers, and women performing routine caretaking behaviours expressed more negative feelings. At three months leaving the baby lying down was related to recollections of lonely feelings in the hospital, and at eighteen months, hostility was related to some of the behaviours of mother and child.

The patterns of interacting environmental factors, personal experiences and behaviour showed that reciprocal determinism is a valuable model for the study of psychosocial events. The complexity of the results preclude presentation in this abstract of all the interactions observed, but the foregoing are examples of some of the relationships discovered. As well as observing different interactive patterns for each sample of mothers it was also evident that each woman responded as an individual, interpreting her own experience, integrating it into her ongoing and developing family pattern, and making decisions about her own and her family's future.
CHAPTER ONE

A MODEL FOR EXAMINATION OF PSYCHOSOCIAL INTERACTIONS

1.1 ELEMENTS OF THE MODEL

A sophisticated psychological approach to analysing psychosocial events has been proposed by Bandura (1977(b), 1978). He has suggested reciprocal determinism as a basic analytical principle to aid in the understanding of ".... psychosocial phenomena at the level of interpersonal development, interpersonal transactions and interactive functioning of organisational and social systems" (Bandura, 1978, p.344). This approach recognises the bidirectional nature of the influence of behaviours, cognitions and the external environment. Bandura points out that although behaviour is influenced by the environment, the environment is partly of the person's own making. That is, the environment influences behaviour but it is also moulded and adapted by the individual. The influence is, therefore, bidirectional. He has chosen to present a model with three elements:

1. Behavioural influences (represented as B).
2. Personal influences (represented as P) covering internal personal factors. This includes both cognitive structures and other internal functions that are used for perceiving, evaluating and regulating behaviour.
3. Environmental influences (represented as E). This element refers only to the external environment.
Schematically the model can be represented as follows:

```
      P
    /    \
B « » E
```

There is not much argument about the significance of behaviour and the role it plays in human affairs. Most would agree that people react and behave in response to stimuli and while, in one sense, they are externally controlled, in another sense they are also controlling. Humans adapt the environment to their needs as well as adapting to the environment.

There is greater difficulty in defining and accepting the scope, role and interaction of E (environmental events) and P (internal personal events). Bandura (1978) appears to be talking about a real external environment which can impinge upon individual perception and reaction, as he says:

"To contend that mind creates reality fails to acknowledge that environmental influences partly determine what people attend to, perceive, and think." (p.345)

The interaction between the E and P factors is spelled out further when he says:

"Cognitive factors partly determine which external events will be observed, how they will be perceived, whether they have any lasting effects, what valence and efficacy they have, and how the information they convey will be organised for future use." (p.345)

Therefore, the external environment is attended to and is perceived in the light of the individual's own capacity and needs. When Bandura mentions "valence" he is allowing for the affective component of experience.
However, he seems to imply that valence (or affect) is post-cognitive and comes only after recognition of the stimulus and cognitive awareness.

Zajonc (1980) argued most persuasively for the separation of affect and cognition. He pointed to differences between judgments based on affect and those based on perceptual and cognitive processes and concluded that:

".... affect and cognition are under the control of separate and partially independent systems that can influence each other in a variety of ways, and that both constitute independent sources of the effects in information processing." (p.151)

Therefore, affect can be pre-cognitive and can influence perceptions and decisions. Zajonc believed that it was still too early to write a model for affect and the various ways that it interacted with cognitions. Because of this it is difficult to see exactly how Bandura's model of reciprocal interaction could be modified to cope with affect as a separate interacting force. Further research is required before the affective/cognitive components of P can be fitted separately into the model, but emotion is certainly an important part of human reactions.

Emotions and cognitions are inextricably interwoven and in the past, social learning theorists have tended to emphasise cognitions. In some psychosocial events, such as mothering, emotion is a very important part of the process of adaptation and it is, therefore, important not to ignore affect in this system.

Bandura's analysis based on reciprocal determinism avoids some of the pitfalls inherent in other approaches. It is obvious that considering only the person and the behaviour ignores much vital information from the
environment and the role it plays. For example, most adults could walk along a narrow path, but if that path were at the edge of a ledge on a twenty storey building they would refuse.

It is equally limiting to consider just the interaction of the person and the environment when predicting behaviour. Man's behaviour can alter and create specific environments. For example, a tired mother woken during the night when she uses appropriate and skilful behaviour can soothe a crying infant, put it to sleep and return to her own bed. She has changed a demanding stressful situation to one of calm and rest.

Nor is it appropriate to place too much emphasis on behaviour as a sole determinant of future environments. There are many occasions when an individual is relatively powerless to achieve certain goals. For example, continued job-seeking activity by a young unemployed person will not necessarily secure work during a depression.

Therefore, as "Bandura states, "..... behaviour, internal personal factors, and environmental influences all operate as interlocking determinants of each other". (1978, p.346)

1.2 FINDING A STARTING POINT FOR RESEARCH USING THIS MODEL

In this type of interactional process there can be no ultimate cause of behaviour and it is arbitrary at which point the analysis of the interlocking system begins.
Interchanges between the person, behaviour and the environment in everyday life are ongoing and exert concurrent influences. That is, the same event can be a stimulus, a response, or an environmental reinforcer depending upon where in the sequence the observation begins. For example, giving birth to a child may be a stimulus to mothering behaviour; it may be viewed as an irresistible response to internal physiological stimuli; or it may be a reinforcer which the woman perceives as a reward for and fulfilment of her female role.

1.3 SPECIFYING CONDITIONAL PROBABILITIES OF THE INTERACTING FACTORS AS A TOOL FOR RESEARCH

Bandura has suggested that to analyse interchanges one should be able to examine how each is conditional upon the other. He suggests that "the methodology best suited for this purpose specifies the conditional probabilities that the interacting factors will affect the likelihood of the occurrence of each other in an on-going sequence" (Bandura, 1977(b), pp.197-198). Previous research into psychological aspects of childbirth and childrearing enables the identification of some key elements in the process.

Thus, one could specify that a difficult childbirth, such as a premature birth, would make it probable that the mother would react to the child with increased anxiety. Having had this increase in anxiety she may then behave differently in routine caretaking behaviours. In addition, as it is a dyadic relationship, the infant would probably react to the mother's anxiety and tension and in turn become tense and tearful. The sequences, therefore, are ongoing and conditional upon one another. Such a system appears to be ideal for analysing the adaptation, reactions, and behaviours of new
mothers and their infants. The following research is based on this model of examining psychosocial phenomena.

1.4 THE NEED FOR LONGITUDINAL RESEARCH

The conditional probabilities governing interaction are not momentary. Anticipation of long term consequences will change perception of an event and will alter reciprocal contingencies. As Bandura says:

"Therefore, in analyzing how the behaviour of one person affects the counter-reactions of another, one must consider, in addition to immediate effects of each action, the anticipated changes in mutual consequences over time, predictive cues, and the socially structured constraints on behaviour of roles and circumstances." (1977(b), p.199)

It becomes important, therefore, to study psychosocial events longitudinally when using this system. Examples are frequently seen in mothering behaviour when a parent rebukes a child. The immediate effect may be a crying child and an emotional distance between mother and child, but the long term pay-off for the mother may be an improved relationship with a child who has come to understand acceptable social interactions. In this situation the conditional probabilities of the scolding behaviour would be quite different if viewed only momentarily without considering the long term goals of the mother. Consider another example: If a mother has been known to physically abuse an infant it may be predicted that in a given interaction the mother will once more abuse the child. However, the long term probability may be influenced by social constraints and the knowledge that further abuse will incur the interventions of the law and welfare agencies.
In summary then, the use of reciprocal determinism as an analytic principle will require:

1. an examination of the bidirectional influences of behaviour (B), internal personal factors (P), and the environment (E);

2. a specification of the conditional probability of the interacting factors in the ongoing sequence of events under examination;

3. a recognition that this is an interlocking system and the starting or finishing point of the examination is arbitrary because there will be important events preceding the initiation of the examination, and interactions will continue after observation has finished;

4. a longitudinal study to examine not just the immediate effects of the interaction but also the changes in bidirectional consequences over time.
CHAPTER TWO

RECIPROCAL DETERMINISM APPLIED TO A PARTICULAR PSYCHOSOCIAL EVENT: CHILDBIRTH

Mothering behaviour and the development of the mother-child relationship has been the subject of much investigation in recent years. Many of the research programmes have been limited by their failure to recognise the bidirectional influences of B, P, and E. There has been a tendency to isolate one pattern of events and regard this as a cause of subsequent behaviours. For example, early and extended contact between mother and child has been correlated with increased or improved mothering behaviours. The early and extended contact is an environmental factor (E) and the patterns of mothering are behavioural factors (B). In this case, there has been no measurement of the internal factors within the mother (P). In other instances the behaviour of the mother has been examined in conjunction with the response of the infant. The mother's provision of a stimulating environment for the infant is a behaviour (B) creating a specific type of E. The responses of the infant (B) are then studied. Once again the internal events (P) are not directly studied and the infant's cognitions are inferred from the observed behaviours.

Literature abounds with expositions of maternal emotions (P) with little examination of the behaviours (B) promoted by such affective responses. In some ways it is strange that psychologists have tended to leave the internal, cognitive and emotional side of mothering to the realm of fiction.
Understanding of mothering behaviours and the interaction between the mother and the child is of considerable importance yet it has often been studied in a fragmented way. It provides an important psychosocial event which is ideally suited to research using reciprocal determinism as the analytical principle. The data on the effect of different birth experiences and subsequent mothering permit the formulation of some conditional probabilities about specific factors interacting reciprocally in the postpartum months.

Because of the interlocking nature of the elements in any psychosocial system the starting point for research will be arbitrary. However, when studying mothering behaviour and the development of the mother-child relationship the birth itself seems one logical place to begin.

2.1 **E FACTORS - ENVIRONMENTAL**

By starting with the birth itself it is relatively easy to identify differences between groups of women and their experiences of childbirth. Some examples follow:

1. Separation of mother and infant immediately postpartum creates an environmental deprivation. Limited contact between mother and infant in the early days following delivery has been shown to produce changes in mothering behaviours (Klaus and Kennell, 1976).
2. Giving birth to a premature infant introduces the woman to motherhood in a crisis situation. The environment is usually perceived as life-threatening for the infant.
3. Young, unmarried women from low socio-economic groups frequently lack the supporting environment which can help a middle class woman make the transition to motherhood. Limited experiences and inadequate resources (financial and emotional) may hinder mothering behaviours (Rutter, 1979).

Although the foregoing examples have specified different E conditions it is obvious that the effects of each will be exacerbated or mitigated by varying P (cognitive and internal factors) and B (behavioural) events within the individual mother. For example, the mother who is separated from her infant who interprets this separation as a time when she must regain strength and prepare for the task of mothering is reacting quite differently, and creating a different perceived environment, to the mother who feels loneliness and loss and who argues with the nursing staff to have more contact with her baby. There will always be some individual differences among women experiencing any one set of E conditions, but women giving birth under basically similar E conditions will, in the main, have comparable reactions. The conditional probability which can be formulated from this E effect is:

**HYPOTHESIS 1**: Different birth environmental conditions (E) will produce differences in maternal internal personal experiences (P) and behaviours (B). [E changes P and B]

2.2 **P FACTORS - INTERNAL PERSONAL**

The internal factors (P) at the time of the birth will vary a great deal among individual women. Personal construct psychology has demonstrated
the unique nature of the individual's interpretation of the world (Bannister and Fransella, 1980). Although there may be some affective similarity between people reacting to crises (Viney, 1980; Viney and Westbrook, 1980; Viney and Westbrook, 1981), there will also be quite marked differences in the way each person interprets and copes with that event (Bardwick, 1967; Breen, 1975; Fjeld and Landfield, 1961; Gottschalk and Gleser, 1969; Osgood, Suci and Tannenbaum, 1957).

Westbrook (1975) examined the experiences of women during a childbearing year. She found significant differences in people's affective experience of the events of pregnancy, labour, hospitalisation and being at home. She also found differences in patterns of experience which were associated with social class membership, parity of the birth and a woman's perception of her marital relationship.

It is possible to formulate some conditional probabilities based on a woman's construction of the event as she experiences it.

**HYPOTHESIS 2:** Objectively similar birth environments (E) may be interpreted (P) and reacted to (B) differently according to the individual's personal needs, and past experience or learning. [P changes E and B]

**HYPOTHESIS 3:** A birth experience (E) which has a high emotional cost (P) will produce differences in mothering behaviour (B). [E changes P and B]

**HYPOTHESIS 4:** Personal constructs (P) of the experience of childbirth and childrearing will change over time as a result of events (E) and responses (B and P). [P is changed by E, B and P]
2.3 B FACTORS - BEHAVIOURAL

Observation of early mother-infant interactions has provided information on behaviours commonly displayed after childbirth. Klaus and Kennell (1976) cite their own research findings and those of Rubin demonstrating an orderly progression of touching behaviour displayed by mothers shortly after birth. They concluded that they had evidence "... that human mothers engage in a species-specific sequence of behaviours when first meeting their infants, even though the speed of this sequence is modified by environmental and cultural conditions". (pp.69-70)

Marton, Minde and Ogilvie (1981) found evidence from their research into mothering behaviour in the premature nursery to enable them to state that they had:

"noted differences in maternal responsivity to .... early social signals, and these differences can be related to specific maternal characteristics, such as the general activity level of the mother." (p.202)

They discuss their findings in a way similar to the reciprocal determinism approach. They go on to conclude:

"It appears that a mother enters the nursery with a predetermined set that influences her interactional style. The nature of her background and personal history influences the intensity with which a mother will interact with her infant and the degree to which she will be responsive. The specific events surrounding the birth seem to play a less direct role." (p.202)

Ainsworth, Bell and Stayton (1971) have been able to quantify differences in behaviours of both mothers and infants. These complex findings showed several different patterns of mothering behaviour and infant reactions.
Some mothers were sensitive to their babies' signals and they tended to be accessible, co-operative and accepting. Their infants tended to regard mother as a secure base. Other mothers were inconsistently sensitive and their infants sometimes used the mother as a secure base and at other times explored independently avoiding the mother. A third group were classed as insensitive. Their infants showed both minimal distress in the separation episodes and proximity-avoiding behaviour in reunion episodes during the observations. It is apparent, therefore, that it has been possible to identify an orderly and consistent pattern of behaviours displayed by mothers in relation to both newborn and older infants.

Although behaviours may be modified by life experiences and the changing needs of both mother and infant, it is likely that such changes occur slowly within each mother. Mothering behaviours are the end product of a lifetime of observing others. Each woman has first been a grateful consumer or victim of her own mother's behaviours, then an observer of society, and eventually a mother herself. Her life experiences are fitted into her own persona and together these produce her mothering behaviours. With such a solid and comprehensive base some mothering behaviours will be consistent over time. Thus Hypothesis 5 can be stated:

**HYPOTHESIS 5:** Although some mothering behaviours (B) will change as the mother adapts to her new role there will be other behaviours (B) which will show consistencies over time. \([B = \overline{B}]\)

Clarke-Stewart (1973) studied relations between mothers and infants over a nine month period. She found changes over time in the behaviours of both the infants and mothers - there was an increasing interest in the physical
environment and a decreasing amount of interpersonal interaction. Relationships were found between childrens' competence and the mothers' care. The different environmental conditions created by the changes in the growing child demand different behaviours from the mother. Also, the environment the mother creates for the child influences the infant's development.

**HYPOTHESIS 6**: Particular patterns of behavioural interactions (B) and affect (P) will change in response to the input of the child changing the environmental (E) conditions. [E changes B and P]

Thus it can be seen that past research has indicated that behavioural (B) factors have been both influenced by the past and are instrumental in influencing future development of the mother-infant relationship. Observations of the conditional probabilities of the effect of behaviours on E and P for both mother and child have already been attempted, even though such observations were couched in different terminology.
CHAPTER THREE

PRIOR APPROACHES TO THE STUDY OF CHILDBIRTH

As well as interacting reciprocally the role of each of the three factors may change over time. For example, what was an environmental variable (such as pressure to breastfeed) may become internalised within an individual's personal value system (the belief that breastfeeding is best for the infant). This makes it difficult to summarise past research findings relevant to birth and early childrearing neatly under different yet discreet E, B, or P headings. Previous attempts to study this psychosocial event have usually produced information about selected factors only. As the starting point for this research was the birth environment, the literature will be presented under three main headings. First I will describe those findings relating to instances where the mother and infant have been separated because of hospital practice and allowed only routine contact for feedings. Then I will describe findings about the effect of prematurity on the mothering process and development of attachment. Finally research with low socio-economic status mothers will be examined. Young women with inadequate financial, educational and social backgrounds have been frequently studied and mothering difficulties related to these factors.

The information already available enables the specification of conditional probabilities, or bidirectional relationships, around each different birth event. Hypotheses can also be developed relevant to the longitudinal effects of these birth events. However, past research has frequently been designed in such a way that it is not always possible to develop hypotheses integrating each of the three elements B, P and E.
3.1 LIMITED CONTACT - ROUTINES LEADING TO SEPARATION

Although the history of rooming in is relatively long (O'Connor et al., 1980) it is only recently that a strong research movement has grown up to examine differences between separated mothers and those allowed rooming in. More recently a spate of research has developed to compare the effects of early and extended contact with the routine or separated experience of birth. An important research programme was reported by Klaus, Jerauld, Kreger, McAlpine, Steffa and Kennell (1972). Twenty-eight women were randomly allocated to one of two groups. All were primiparous and had normal full-term infants. The average age of the women in each group was 18. Twenty-six were black, only 9 were married and all came from low socio-economic suburbs, had poor education and had low status occupations. Their hospital stay was between three and four days. One group of women was given their nude infant for an hour soon after birth (within two hours) and had five extra hours contact on each of the next three days of life. The other group had a brief glimpse of the infant at birth, a brief contact six to eight hours later and then 20-30 minutes contact at four hourly intervals for routine feeding.

At about 28 days the mothers returned to the hospital. They were asked about their reaction to the infant crying and whether they had been out and left the baby. They were also observed during a standard medical examination of the baby. In addition, a feeding session was videotaped and analysed at one second intervals by 'blind' raters. The measures obtained related to close trunk contact, fondling behaviours, and holding the infant in the 'en face' position.
If fondling, looking, touching, soothing and being with the infant during a medical examination can be equated with 'good mothering' then it could be concluded that when the infant was one month old extended contact mothers were better mothers. Kontos (1977) also found more overall attachment behaviours in early contact mothers.

This group was followed up for long term effects. At one year they were filmed and observed for over an hour. The observation included a physical examination of the child. (Kennell, Jerauld, Wolfe, Chesler, Kreger, McAlpine, Steffa and Klaus, 1974). At this time the extended contact mothers were still showing differences in behaviour when compared with the non contact mothers. They spent more time soothing the infant and at the table-side assisting the physician during the examination.

Other studies have found comparable results - although direct comparisons are not always possible because of differences in observation techniques used. O'Connor, Vietze, Sandler, Sherrod and Altmeier (1980) found less parenting inadequacy in extended contact families. Seashore, Leifer, Barnett, and Leiderman (1973) found primiparous separated mothers were lower in self confidence.

De Chateau (1980) found significant correlations between extra contact and the mean duration of breastfeeding, maternal attitudes to some aspects of child-rearing (e.g. toilet, changing) and psychomotor development of the infants at one year of age. He also found that extra time with the infant made a greater difference in mothers of male infants.

Whiten (1977) found significant differences between normal delivery mothers and separated mothers. The separated mothers were medically
normal when they left the unit but had been separated for various minor medical reasons. Differences were noted in such things as early crying behaviour and turn taking in interactions. However, the differences disappeared by the time the infants were twelve months old. Other studies tend to find comparable results. Although direct comparisons are not always possible because of differences in observation techniques and criterion behaviours chosen for study. O'Connor et al (cited by de Chateau, 1980) have followed for up to 2 years a large number of primiparous mothers randomly assigned either extra contact or hospital routine care. All came from low income families. About 300 families have been involved in this study, and abuse, abandonment, neglect and failure to thrive have been observed more commonly in routine care infants.

From this evidence it is possible to postulate:

**HYPOTHESIS 7: Separation of mother and infant during the lying in period will influence both mothering behaviours and maternal affect.** [E changes P and E]

The studies mentioned so far have observed primiparous mothers and it is interesting to examine the results de Chateau (1980) found when he compared primiparous and multiparous mothers. Twenty-two healthy primiparous women with normal pregnancies and deliveries were given extra skin-to-skin contact and suckling with their infants during the first postpartum hour for a period of 20 minutes. A control group of 20 primiparous mothers and infants was given routine care, as was a second control group of 20 multiparous mothers and infants. He looked at such things as holding, encompassing and looking 'en face' 36 hours after
delivery. The extra contact primiparous group behaved much more like the multiparae than did the other primiparous group. By three months of age the extra contact group spent more time kissing and looking face to face with their infants and the infants smiled more and cried less frequently. By one year after delivery these mothers showed more close body contact with their infants during observation of a routine physical examination. This group also tended to breastfeed longer, continue night feeding longer and experience less problems with night feeding as compared to controls.

These results would indicate that perhaps one of the mechanisms operating in the extended contact situation is that the mother is able to learn about her infant and is better able to produce those behaviours which may have been learned from the rearing of older children by multiparous mothers. Thoman, Turner, Leiderman, (1970) also reported that multiparous women were more sensitive to their infants' cues.

There is additional evidence in support of the possibility of maximising mothering behaviours from an investigation reported by Svejda, Campos and Emde (1980). They found no differences between extended contact mothers and routine care mothers. They did point out that their samples were basically middle class, had twelve or more years of education, were married and had received prenatal education. Moreover, most husbands were available during labour and delivery. If one can interpret their attendance at prenatal classes as an indication that they were prepared to spend time and effort in learning about childbirth and improving their mothering skills, then it is probable that these mothers had 'maximised' their birth experience and preparation for mothering. This involvement may be due to educational/socio-economic factors.
It seems obvious that there is a learning, or experiential component to mothering behaviours. It is possible then to hypothesise that as the mother gains more experience with the infant her affect, confidence and behaviour will change. Hypothesis 4, given earlier, related to changes in personal constructs about childrearing. Therefore, at this point I will only specify behaviour changes.

**HYPOTHESIS 8: Over time, with increasing experience, women's behavioural responses to their infants will change.** [B is changed by E and P]

### 3.2 PREMATURE BIRTH

Mothers of premature infants usually are separated from the baby more than those women who experience traditional childbirth procedures. In addition to the separation they are also likely to fear for the survival of the child. Kaplan and Mason (1960) argue that mothers of premature infants have four tasks - (1) prepare for the loss of the child; (2) acknowledge her own failure to deliver a full-term child; (3) resume a relationship with the infant if it survives; and (4) understand how a premature baby differs from a full-term infant.

Cramer (1976) has discussed the woman's guilt feelings and how they interfere with the establishment of a loving relationship. Therefore, it is likely that just the fact of giving birth to a premature infant will interfere with bonding.

Although past research has indicated a relationship between poor infant development and prematurity, and also between marital disruption and
premature birth, such studies tended not to make allowances for the effects of socio-economic status and social support networks. Recently Heimann, Calame, Marchand, Plancherel and Prod'hom (1981) found no relationship between socio-economic factors and low birth weight. They did find though that the families with premature infants had significantly more disturbances in their family relationships and they stressed the importance of subjective, i.e. psychological factors as the cause of difficulties in the mother-child relationship.

In addition the mother is likely to have experienced a number of medical interventions during the last few months or the pregnancy and at the time of birth. This poses an additional hazard to the development of a loving relationship between mother and child. In 1980 Robson and Kumar attempted to examine the onset of maternal affections. Primiparous women were interviewed on the seventh day after delivery and they were asked to recall their initial reactions to the child. None reported dislike but 43 (forty per cent) said that they had felt indifference. The study was not concerned with premature infants and the effect found tended to disappear - by day seven only four mothers said that they were still indifferent. These women would have had more frequent contact under more positive circumstances, than the mothers of premature infants. Analysis of the birth experience showed that greater indifference to the infant was associated with pethidine, a forewater amniotomy and pain during the birth. More mothers of premature infants would have experienced such interventions that would a group of mothers giving birth to full term infants. Therefore I hypothesised that:

**HYPOTHESIS 9:** Mothers of premature babies will have greater difficulty in developing an emotional attachment to their infant initially and will continue to be slower to do so. [E changes P]
Minde, Trehub, Corter, Boukydis, Celhoffer and Marton (1978) examined mother-child relationships in the premature nursery. Mothers were observed with their premature babies in an intensive care nursery. The behaviours recorded included talking, holding, feeding, smiling, and looking 'en face'. These were sampled over a number of visits. The results showed that the mothers could be divided into three groups based on 'activity' - viz., high, medium, and low activity. These groups differed significantly in a number of ways. It was found that highly interacting mothers visited and telephoned the nursery more, and also stimulated their infants more at home. Mothers who stimulated their infants little while in the nursery also visited and phoned less, and stimulated them little at home.

This provides evidence of the same type of consistency in behaviours discussed earlier in relation to mothers of full term infants. However, there is also evidence to suggest a disruption occurring in the development of mothering behaviours. Klaus, Kennell, Plumb and Zuehlke (1970) noted that there was usually a regular progression of touching behaviour in mothers left with their naked infants. It began with fingertip touching of the extremeties, then massaging or stroking and palm contact of the trunk of the infant. Observations of mothers with clothed infants showed similar progressions of behaviour but this sequence was performed more slowly. With mothers of premature infants the progression was slowed even further. At the time of the third visit some mothers were still not using their palms in touching the infant.

HYPOTHESIS 10: Mothers of premature infants will not demonstrate bonding behaviours until after the trauma of the birth, whereas other mothers will show bonding soon after birth. [E changes B]
3.3 LOW SOCIO-ECONOMIC STATUS MOTHERS

Family support and personal resources have also been shown to be important for the psychological well-being of mother and child (Hunter, Kilstrom, Kraybill and Loda, 1978; Paykel, Emms, Fletcher and Rassaby, 1980; Wolkind, Kruk and Chaves, 1976). It is obviously more difficult for a young, unmarried mother with few social supports to cope with an infant than a woman who has had some experience with child raising and has multiple support systems. It is indeed unfortunate that a large proportion of those who may most need childbirth education, and in particular, support after the child is born, are not attending available classes. Hunter et al, (1978) have described parents who had battered their infants as socially isolated with poor support systems, having had major life stresses during pregnancy, and having apathetic or childish-dependent personality styles.

Rutter (1979) writes of intergenerational cycles of disadvantage, basing this notion on various studies which have shown that parents from psychologically disadvantaged backgrounds in turn provide a similar psychologically deprived interactional relationship with their offspring. He concluded that:

"The parents of children in care ..... had failed to move out of stress situations. Two factors seemed crucial - they bore children in their teens and they married (or cohabited with) someone from a similarly disadvantaged background." (p.294)

Therefore, I hypothesised that:

HYPOTHESIS 11: Young women from disadvantaged backgrounds will have less positive reactions to childbirth and will exhibit deprived interactional relationships with their infants. [E changes P and B]
Kempe and Kempe (1978) also discussed the intergenerational cycles of abuse. While agreeing with that proposition they also argued that psychological disadvantage occurs in all classes.

"The most consistent feature of the histories of abusive families is the repetition, from one generation to the next, of a pattern of abuse, neglect and parental loss or deprivation ... When the parent is absent in the emotional sense, the child can suffer from a deprivation that can go unrecognised. It is found in all social classes and can be seen in those children of the well-to-do who spend their lives with a succession of indifferent nursemaids and in a series of boarding schools and camps." (p.24)

Social class is not then the sole determinant of abuse. Coletta (1981) argued that social support networks were important to the mother and that it is when young mothers are isolated from such supportive networks that the infants are at greater risk of rejection. This leads to:

HYPOTHESIS 12: Women isolated from social support networks will have less positive relationships with their infants. [E changes P]

The importance of psychological factors in attachment as opposed to environmental was also proposed by Wise and Grossman (1980) who believed that the ego strength of the adolescent mothers they studied and the infants' behavioural individuality were the factors most strongly promoting attachment.
CHAPTER FOUR

METHOD

Many factors are involved in the development of a family system. Two sources of variation in mother-child interactions have been ignored because of the already complex nature of the study. These are the role of the father and the infant. I decided to examine only mother-infant relationships, even though I recognised that the father has a most important role to play in the network of social interaction in the family system (Belsky, 1979; McKee and O'Brien, 1982; Parke and Sawin, 1977). I also decided to disregard most infant variables in spite of the research indicating that children show individual differences at birth (Kroner, 1971) and that parents respond to differences between children (Lamb, 1978; Lytton, 1977; Osofsky, 1976). Those infant variables reported in the subsequent research are derived from the mothers' perceptions of the infant and reflect her phenomenological view of the child.

The patterns of development of a first-born child may not always be smooth (Ounsted and Hendrick, 1977), but parental behaviours differ depending on the ordinal position and sex of the child (Cohen and Beckwith, 1977; de Chateau, 1980; Rheingold and Cook, 1975). Because of the confounding effects of behaviours relating to ordinal position I decided to interview only primiparous women.
The aim of the research was to examine the development of mothering and the experiences of primiparous women from a reciprocal determinism perspective. To do this, identification of the three elements involved in the bi-directional influence pattern (B, P, and E) important to the birth experience was first necessary. Then it would be possible to examine the conditional probabilities of the interacting factors at key times and longitudinally.

Because of the interlocking and ongoing nature of interactions between mother and child the research was designed to examine the inter-relationships on three key occasions and the sequential patterns occurring between these occasions. The occasions were:

1. Shortly after giving birth, while the mother was still hospitalised.
2. When the child was three months old. This is a time when children are beginning to attend to the outside world. To ensure equivalence of development the premature infants were seen when they were three months from their estimated due date. The average age of the children at this visit was 3.1 months.
3. When the children were aged eighteen months. At this period they have become toddlers, are exploring the world and developing greater independence from the mother. The average age of the children at this visit was 17.7 months.

The measurements at each time are shown in Table 1.
At each interview/observation it was necessary to adapt the order of measurements taken. This was done in order to cope with specific problems occurring at the time of the visit. For example, if the infant was awake but ready for sleep when I arrived the mother/infant behaviour observation was completed first. If the infant was sleeping and the mother reluctant to wake the child then all other data were obtained first. Also, although a semi-structured interview format had been designed, if the mother spontaneously provided information required then the answers were recorded and those questions omitted from the interview.
4.1 ASSESSMENT OF ENVIRONMENTAL FACTORS

The first decision I made related to isolating markedly different environmental conditions. I decided that three groups of women could be easily identified in relation to these differences.

The first group were women who represented the 'average' Australian primiparous mother, who gave birth under conditions that had been standard practice in this country for many years. These were middle class primiparous women who attended a hospital where the child was shown briefly to the mother soon after the birth and was then taken to a nursery. The mother remained in the maternity ward and saw the infant only for routine feeding.

The second group were women who gave birth to a premature infant. Usually this event is associated with traumatic birth experiences and separation from the infant.

A third group were of low socio-economic status. These were younger than the average mother, had poorer education and most were unmarried. It proved possible to locate three different hospitals with these populations who were willing to allow access to their patients.

In addition to selecting for such obviously different environmental conditions I decided to obtain information about other possible relevant E factors. This was done using a semi-structured interview. The full text of the interview is given in Appendix 1.1.
4.1.1 **Background Information**

Prior environmental experiences of the women were considered likely to have some bearing on their reaction to pregnancy and birth. Questions were included to tap those areas considered important.

Early termination of pregnancy was an important area to tap apart from selecting the mothers with premature babies. Reaction of women to infants whose survival is at risk has been discussed by Klaus and Kennell (1976). There may be some hesitancy to care for such infants. Also, the initial affective reaction may be guilt when the birth is premature (Cramer, 1978). The degree of prematurity provides a rough gauge of the attractiveness and the likelihood of survival of infants.

Socio-economic status has been shown to be related to mothering beliefs and behaviours. Baldwin (1977), after studying a mixed urban and rural community for more than eight years, concluded that child abuse occurred at the rate of one per thousand children aged under four. The families of the abused children were studied and the characteristics found were:

"... large family size, youthfulness, low social class, instability and gross psychiatric, medical and social pathology described." (p.102)

The women of low socio-economic status included in this study were young and were only just beginning their families so that large family size would not be found.
Socio-economic status measures were taken of residential suburb, occupation of woman and occupation status of husband (if married or living in a stable relationship). Educational level is also a measure of acculturation and status. Schooling levels and types of school attended (State or Private; co-educational or unisex) were assessed.

Time since the woman last worked was also measured. A long period of unemployment could create economic problems for one new mother while, on the other hand, an interrupted career may mean sacrifices for another.

Country of origin was recorded for both mother and father of the infant. It was thought that different socio-cultural expectations may be created by ethnicity. Apart from expectations and prejudices created by cultural background there may be additional pressures built up by conflicting beliefs about the roles of mother and father in the developing family. Oakley (1979) found that new mothers sometimes became less satisfied with the father's role and this resentment was expressed both directly and indirectly leading to the politics of baby care erupting into the emotional side of the marriage.

Childbirth education is an important feature of modern society. Classes are conducted at most Australian hospitals. From the woman's point of view the gathering of information could be expected to dilute fears of the unknown task before her. Although antenatal education for parenthood has been suggested as a valuable form of preventative psychiatry (Cook, 1970) there have been conflicting reports of its effectiveness (Doering and Entwisle 1975; Astbury, 1980). The attendance of the husband at both classes and the birth can provide the new mother with support. The value
of such support at this time has been discussed by Kitzinger (1978 (a) and (b)), and Raphael (1975). In spite of the value of sharing this experience, Oakley (1979) found that although 75 per cent of women in her study had seen a filmed birth, only 55 per cent had discussed birth with someone.

Information on child care helps the mother formulate plans for relating to and coping with the new infant. This factor was, therefore, also included. Social expectations have resulted from psychoanalytic writings, medical care-givers' advice, social sciences, the legal system, and educational institutions (Rapaport, Rapaport, Strelitz and Kew, 1977). Hence, information on child care resources and plans for the future was gathered.

The relationship of the woman to her own mother has been shown to be related to adaptation to motherhood (Breen, 1975). The influences of intergenerational cycles of disadvantage has been reviewed by Rutter (1979). From the research evidence reported it is apparent that coming from an unhappy home or a disrupted background is likely to lead to women producing illegitimate children, to becoming teenager mothers, to making unhappy marriages and to divorce. Frommer and O'Shea (1973 (a) and (b)) have related early disruption to problems with childrearing and within the marriage. They also found an increase in depression when comparing them to a non-separated group. Wolkind, Kruk and Chaves (1976) concluded that separation from parents experienced during childhood was associated with unmarried status, teenage pregnancy, having had psychiatric treatment, housing problems and a high score on the Malaise Inventory. Therefore, questions were designed to gauge the early environment of the women in this study. They were questioned on separation from the parents and early family trauma. Although not ideal, retrospective reports of early
separation were the only possible way to obtain this information. Recent research has shown that adults asked about separations in childhood gave answers that were reliable to reports of separations related to death of a parent and the break-up of the parental marriage (Finlay-Jones, Scott, Duncan-Jones, Byrne and Henderson, 1981).

4.1.2 The Interview After Birth

The women were approached while still hospitalised after the birth of the child. Their co-operation was sought and the nature of the study, including the times of the follow-up visits was explained.

The interviewer explained that the purpose of the research was to study the development of families, that information would be confidential, and that two follow-up visits would be required. Very few women refused to co-operate at this stage although, as can be seen later, promises of assistance with the research did not always lead to involvement with the project at all three stages of data collection.

Background information to provide both demographic data and an assessment of other environmental factors, was obtained using the interview schedule given in Appendix 1.1 and coding of responses, where appropriate, is also provided there. Although this information was collected to obtain a broad picture of each woman's past and current environment it is obvious that some of these E elements will have been internalised via social learning, and become internal (P) elements in the form of attitudes and beliefs. For example, attitudes to breastfeeding have followed fashions over the years. Young women will have observed and
listened to the beliefs, attitudes and practices of family and friends for many years before making decisions about plans for feeding their own infant.

4.1.3 The Environment at Three Months

Observations of mother-infant interactions within the laboratory situation allow a great degree of standardisation of the investigation procedures. The strange situation behaviour observation has allowed comparisons to be made between children, and over different investigations. It has been argued, however, that the behaviours observed within the child's own environment may be a better indicator of that infant's repertoire and reactions (Bronfenbrenner, 1974; Belsky, 1980). Accordingly, I decided to do follow-up interviews in the home. This has other practical advantages - the lower socio-economic group mothers were less likely to be able to arrange transport to the laboratory. It also allowed the researcher to make observations of the home environment.

Systematic approaches to the assessment of places have been suggested but most of these are still in the early stages of development (Craik 1971). The HOME Scale has been developed (Bradley & Caldwell, 1976) for assessment of home environments. However it measures both behaviours and environment. I decided to make extensive notes of the environment at each visit rather than try to assess according to a predetermined scale. It also seemed likely that the co-operation of the mothers would have been reduced by the recording of the information necessary to use the HOME Scale. Experimental mortality rate was a problem (Appendices 9.1 and 9.2) so that I made every effort to maintain rapport with mothers. Although I
may have allowed some subjective error doing the assessment this way it
allowed for great flexibility in reporting the 'colour' of the home. As a
clinician the researcher was aware of the relative 'attractiveness' of
different environments and mother-infant dyads so observations were
recorded with constant regard to potential bias.

Each environment was classified into one of six categories (Appendix 7.6)
based on its likely effect on the child. These were as follows:

1. World revolved around child (stimulating toys and house
gearied to the child and its needs).
2. Very good environment (toys available and adaptation of
the house and routines to suit the child).
3. Good (some adaptation but restrictions existed within a
relatively positive framework).
4. Barely adequate (some provision, but a lack of
understanding of a child's needs was evident, or there
were gaps in the equipment or stimulation that would be
expected to be provided for a normal infant).
5. Poor (a home where there were few toys and little
provision was made to meet the special needs of the
child).
6. Very poor (no toys, no adaptation of the home to meet
the needs of the child or the environment was extremely
limiting and non-stimulating).

At this visit the questions asked by Klaus, et al (1972) of mothers being
seen when the infant was one month old were asked. They are given in
Section 4.3.5. Although they relate to the mother's behaviour they also provide an early estimate of the infant's environment.

4.1.4 The Environment at Eighteen Months

Once again the environment was assessed using descriptive observation. However, as the infant was now much more active and mobile it seemed appropriate to question the mother on the child's development as this would affect her own environment. Other influences might be important which could not be directly observed. Accordingly, as part of the interview at this time each mother was given a series of questions if these were not spontaneously answered during the recording of the content analysis material. The areas probed were the following:

Infant Development

1. Estimated vocabulary
2. Age at which the child crawled
3. Age at which the child was able to stand
4. Age at which the child walked
5. Preferred games
6. Mother's estimate of the infant's response to strangers and other significant adults.
7. Mother's impression of the infant's state of health
8. Mother's impression of the infant's temperament
9. An estimate of how the mother thought her infant would cope with school when the time arrived (many Australian mothers send the children to either playgroup or kindergarten at about this age).
Family Development

1. Changes in life style since the child was born.
2. Satisfaction with relationship with husband and time available to spend with him at this time.
3. Social life possible now.
4. Work outside the home. They were questioned as to whether this was happening, was possible, or was desired by them.
5. Economic adjustments necessary since the birth of the infant.

(These responses were difficult to classify and are reported in the text in discussions relating to each group of women.)

4.1.5 Treatment of Material on the Background and Environment of the Women and Children

Many of these variables were descriptive of the samples of women and their environmental circumstances. Some tables are, therefore, summaries. Where appropriate, tests of significance have been calculated. Details of statistical analyses applied to environmental data are given in the Appendices.

The growing child has an increasingly important impact on the psychosocial system. Many variables are relevant to this, such as sex of child, developmental milestones, vocabulary, and mother's estimates of the child's response to strangers and to school. The child variables have been presented together in Appendix 8. Details of statistical analyses applied to these variables are in the Appendices.
4.2 ASSESSMENT OF THE INTERNAL PERSONAL FACTORS

Interview material provided some information on internal personal factors (for example, the mother's initial reaction to her child). In the past social learning theorists have concentrated on cold cognitions but I decided that emotional reactions to mothering were very important and chose two measures to tap into these internal factors.

The first was the Malaise Inventory (Rutter, Tizard and Whitmore, 1970), the second used content analysis. Both techniques are fully described below.

4.2.1 The Malaise Inventory

This inventory was derived from the Cornell Medical Index (Brodman, Erdmann, Lorge, Gershenson, Wolff and Broadbent, 1952; Brodman, Erdmann, Lorge, Gershenson, Wolff and Caples, 1952; Brodman, Erdmann, Lorge, Wolff and Broadbent, 1949; Brodman, Erdmann, Lorge, Wolff and Broadbent, 1951). It is a check list of a variety of symptoms which are mainly somatic complaints (Appendix 1.2). A high score on the Malaise Inventory has been shown to be related to disturbance in families (Rutter, 1976) and to be related to mothers who experience disruptive separations in childhood (Wolkind, Kruk and Chaves, 1976).

The items on the scale are not obviously related to emotions. However, there are some questions that would be expected to be scored by women suffering from depression or anxiety. There are also some questions which tapped into problems related to the last few weeks of pregnancy. For
example, "Do you usually have great difficulty in falling asleep or staying asleep?". When asked shortly after birth this was often answered by a recall of the size of the foetus, the discomfort and the need for frequent micturition. Eighteen months later the question, "Do you often have backache?" was sometimes answered in the affirmative with a remark about the weight of the child and how it was more difficult to carry a young child around. The women were informed that this was a Health Questionnaire, and the questions were read aloud. This was done in order to ensure that each respondent fully understood what was being asked. Each question was checked Yes or No, and the score is simply the total number of 'Yes' answers.

The Malaise Inventory was presented on each of the three occasions.

4.2.2 Content Analysis

The history of the development of content analysis and the value of using such an approach has been most adequately spelled out by Viney (in press). She described nine steps in the development of a content analysis scale.

1. A precise description of the psychological state must be made before assessment.
2. The unit of content to be analysed must be defined.
3. The content of the verbal cues from which the measurements will be taken must be specified in detail.
4. Cues to indicate the intensity of the state should be specified if such intensity is to be scored.
5. Differential weights applied to such cues must be specified.
6. As research participants will produce transcripts of differing lengths there must be a mechanism provided for correcting for length - a correction factor.

7. A scoring system must be set up so that a score (or set of subscores in multidimensional scales) can be derived.

8. Application of the scales to different samples and over time should be examined.

9. Normative data, when appropriate, should be collected from specified samples of people and situations.

The technique of content analysis makes possible the phenomenological assessment of the meaning of experiences. Standardised affect scales are applied to statements (verbal or written) made by individuals. Thus, the individual's own perceptions hold the key to the assessment. Verbal reports given to standard instructions are recorded. These verbal samples are transcribed, divided into clauses, and scored according to the predetermined scales. They have the advantage of tapping the actual experience of the subject while overcoming the tendency of the respondent to make responses to 'please' the interviewer. They also allow the subject to decide what aspects of experience are important and to state them.

To date scales are available to measure a number of different mental states or emotions. Provided the available scales cover a wide variety of states it becomes possible, using this approach, to accurately measure the individual's perception of an event without prescribing limitations. Use of standard questionnaires, personality tests and attitude scales limits the respondent to those areas the experimenter decides are important. The use of content analysis allows the subject to range over a variety of issues and to freely express those concepts and emotions which are of importance to her.
Test-retest problems are eliminated. The re-application of the content analysis technique produces no error due to practice effect, as the individual freely expresses perceptions at the time the verbal sample is taken. There can be no practice effect because the subject talks about things which are of concern at the time of the interview. The unstructured approach from the client's point of view works to the advantage of the researcher.

The states measured by scales currently available include:

1. Anxiety - The subscales are Death, Mutilation, Separation, Guilt, Shame, Diffuse. These scales were developed by Gottschalk and Gleser (1969) and scoring is given in Gottschalk, Winget and Gleser (1969).

2. Cognitive Anxiety. This scale was produced by Viney and Westbrook (1976).


5. Sociality Scales - The subscales are Helping, Intimacy, Influencing and Sharing (Viney and Westbrook, 1979).


The scales that have been developed have been applied to a wide range of respondents and psychosocial events and Australian 'norms' are available.
These comparative scores have been developed by Viney and Westbrook (1980) and by Westbrook (Viney 1980) and are presented in Appendices 14.1 and 14.2. The sample presented in Appendix 14.1 included males and females aged 18 to 64 years and all had successfully completed high school. Males made up 42 per cent of the sample. It contained over 75 per cent Australian-born respondents with 15-20 per cent born in other English-speaking countries. This English language sampling was necessary because of the heavy reliance the use of content analysis places on effective verbal communication. The second comparison group were ninety-two Australian women in the childbearing year studied by Westbrook (Viney, 1980). The available scores provide valuable comparative figures for research purposes. These scales and results have been extensively used in this work and comparative statistics given in the appropriate appendices.

The Total Anxiety Scale score is obtained by scoring on a number of subscales tapping different facets of anxiety (Gottschalk, Winget and Gleser, 1969). These include fears about dying (Death Anxiety - "I really felt if I breathed on her she'd just crumple and turn into dust"), fears about physical injury and damage (Mutilation Anxiety - "He was bruised and so on from the forceps"), feelings of loneliness and loss of love (Separation Anxiety - "I used to feel after he was born that he virtually had been stolen from me in some way"), concern about adverse criticism and moral disapproval (Guilt Anxiety - "I wondered if my working had brought on the early birth"), concern about embarrassment, humiliation and feelings of inadequacy (Shame Anxiety - "And I still feel I'm trying to be good enough for them. And this way I've failed them in having a premature baby"), and vague worries (Diffuse Anxiety - "I just get upset when I think about it all").
The Total Anxiety Scale does not tap one important kind of anxiety - that which occurs when people are unable to make sense of the events in which they are involved. The Cognitive Anxiety Scale has been developed for this purpose (Viney and Westbrook, 1976). Statements are scored on this scale when the respondents refer to experiences as being new to them, when they are puzzled and do not understand them, and when they are overwhelmed. ("It all happened so quickly and I just didn't know what to do.")

Hostility is another important reaction to life events. Three scales have been developed to measure this (Gottschalk, Winget and Gleser, 1969). They measure Hostility Out, Hostility In and Ambivalent Hostility. Hostility Out is scored when respondents express anger towards others, whether directly or indirectly ("I'll feel sorry for his school teacher because he is very rough."). However, anger can also be turned in on the respondents themselves and be expressed as self-criticism and depression. Hostility In scores correlate highly and consistently with similar ratings of depression and fatigue (Gottschalk, 1979 quoted in Viney and Westbrook, 1980). Hostility In appeared in statements like - "When I first saw him and his face was wrinkled and all that I was a bit depressed." Ambivalent Hostility assesses anger which is not expressed directly, but is expressed as anger attracted to the self from others. ("When I didn't want to breastfeed one of the nurses got pretty cross.") Using Hostility scales an indication of the Frustration experienced can be obtained by combining the Hostility Out and Hostility In scores.

Perceived power, particularly in the hospital setting and belief in one's competency in developing mothering skills, is most important. To measure this a pair of scales was used. The Origin and Pawn Scales (Westbrook and
Viney, 1980) measure how respondents perceive themselves in relation to their environment - whether they attribute their own behaviour to themselves or to forces beyond their control. For the Origin Scale such statements as "I kept on pushing until he was born" would be scored and on the Pawn Scales such statements as "I just didn't seem to be able to breastfeed" would score. Origin and Pawn scores have been shown to be independent (Westbrook and Viney, 1980).

The Sociality Scale (Viney and Westbrook, 1979) focuses on interpersonal relationships. Four subscales are available and contribute to the total score. The four relate to four different kinds of relationships: Solidarity, or helping relationships ("And later on he was rubbing my back and cleaning my face ...."); Intimacy, or attracting relationships ("Having Jenny has brought us very close."); Influence relationships ("He told me to stop pushing."); and Shared relationships where the nature of the interaction is not clear from the transcript ("She was wide awake and just looked at me."). The Sociality Scale and its focus on relationships made it a most valuable tool in this research.

The Positive Affect Scale (Westbrook, 1976) measures the positive aspects of experience. It is scored each time any positive feeling is expressed ("I felt really great."); "All the nurses have been kind to me."; "I cuddled him."). It was particularly developed in relation to research on women during a childbearing year (Westbrook, 1975).

An advantage of the Positive Affect Scale is that it can be combined with Total Anxiety to yield an index of psychological cost in relation to an event (Westbrook and Viney, 1977). The rationale used for developing this ratio
was that it represented a balance between the respondents' negative and positive experiences and, therefore, provided an indication of their sense of well-being.

Although the content analysis scales are applied to verbal material provided in response to relatively unstructured or open-ended stimuli, it is possible to apply strict criteria for measuring the affect. Training and practice with this technique produces high inter-rater reliability. Prior to scoring a random sample of 20 transcripts was selected to establish interscorer reliability. For most scales it was possible to obtain reliability coefficients of .8 or better. Lower values were obtained for Guilt, Shame and Diffuse Anxiety. During scoring I experienced some difficulty in distinguishing between the Guilt and Shame scales and this undoubtedly accounts for the lower reliability coefficients obtained on these scales. Pearson product moment correlation coefficients of the independent scorings are given below:

<table>
<thead>
<tr>
<th>Anxiety Type</th>
<th>Correlation Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death Anxiety</td>
<td>1.00</td>
</tr>
<tr>
<td>Mutilation Anxiety</td>
<td>.88</td>
</tr>
<tr>
<td>Separation Anxiety</td>
<td>.86</td>
</tr>
<tr>
<td>Guilt Anxiety</td>
<td>.66</td>
</tr>
<tr>
<td>Shame Anxiety</td>
<td>.76</td>
</tr>
<tr>
<td>Diffuse Anxiety</td>
<td>.75</td>
</tr>
<tr>
<td>Total Anxiety</td>
<td>.83</td>
</tr>
<tr>
<td>Cognitive Anxiety</td>
<td>.89</td>
</tr>
<tr>
<td>Hostility Out</td>
<td>.90</td>
</tr>
</tbody>
</table>
Because of the bulk of material Positive Affect, Origin and Pawn were scored by an experienced rater for whom acceptable inter-rater reliabilities have been reported (Viney, 1980).

I decided that as well as examining the affect scores in the usual way it would be of value to also look at the direction or source of some of the affect. By careful scrutiny of the transcripts, and having regard to the context in which the affect was expressed, it was possible to score emotion expressed in different directions. For Anxiety and Hostility the areas related to the mother herself; to the infant; and to the hospital, medical staff or medical procedures. Anxiety examples were as follows: Mother Anxiety - "I had a blood show at five o'clock, but I didn't go into labour at all. I just kept losing water."; Infant Anxiety - "I just worried whether he'd be alright."; Medical Anxiety - "I went down to the labour ward and I was really terrified that, because I was being induced."

Hostility examples were as follows: Mother Hostility - "I'm more disappointed in the way I reacted."; Infant Hostility - "Well when I first
saw her she was all covered in yuk."; Medical Hostility - "They don't really tell you very much in the Nursery."

With Positive Affect important foci were the infant, the father of the child, and the medical staff or hospital. Examples were: Infant Positive Affect - "He was just beautiful."; Father Positive Affect - "I really appreciated Ted being there because I thought he sort of helped."; Medical Positive Affect - "And, you know, they just sort of discuss your history and everything ..... They're very helpful."

As content analysis assumes that the relative magnitude of any one affect at any period of time can be validly estimated from the speech of an individual it was necessary to devise an open-ended or broad stimulus as a prompt for each interview. Restrictions by limiting the topics to be discussed, or by the use of closed-ended questions too frequently would interfere with the free flow of speech (and, therefore, affect) from the individual.

Because the assumption is that the speech will reflect emotion at the time of the interview it was not necessary to interview using the same stimulus at each stage. This allowed greater freedom for obtaining extra information, prevented test-retest difficulties, and made the establishment of rapport much easier. Accordingly, three different prompts were used which were appropriate to the situation and to the development of the mother-infant relationship (See 4.2.3; 4.2.4; and 4.2.5).
4.2.3 Content Analysis of Interview Material After Birth

It was necessary to use an open form of questioning to elicit answers suitable for analysis. Consideration was given to the types of social pressures and cultural expectations of a joyful mother that might lead to positive answers to questions about the infant during the lying in period. Robson and Moss (1970) have reported that not all women described their infant positively. Although they report they recorded the subjects' responses verbatim to 'selected questions' they do not give details of the semi-structured questionnaire that they administered. Their interview was conducted on the seventh day after delivery. Macfarlane (1977) reported on a study done by Kempe and associates on mothers' greeting and reaction to the newborn infant. The responses were filmed at the time of birth. Some of the mothers showed distinct distaste and disgust.

Doering and Entwisle (1975) reported on research on a sample of 269 women of whom 39 per cent were primiparous. They posed the question "What did he (she) look like?" as being neutral enough to allow a variety of responses. In an earlier pilot study they found that the question "How did you feel about the baby?" produced only socially acceptable positive replies. They believed the more neutral question " .... proved to be very effective in eliciting negative material, i.e. mothers described the baby as ugly, 'with hair sticking up all over', 'horrible - covered with scratches from her long fingernails', etc." (p.829). Accordingly, I decided to use an adaptation of the same form of questioning.
After permission to audiotape was obtained the women were asked: "What does your baby look like now, and what did he (she) look like when you first saw him (her)?"

The next question asked was: "Will you tell me about the labour and the birth?" Once again free response was allowed. However, because of the need to gather specific information some prompts were used if these areas had not been covered spontaneously. These areas were:

1. How did you know it was time to go to hospital?
2. How long were you in labour? Stage 1? Stage 2?
3. What was your labour like? Any stitches or other difficulties?
4. What was your husband's role? (If present at birth.)
5. How are you feeding the baby?
6. What does your husband think of the baby?
7. What does your family think of the baby? (If necessary, probes were also used about the reaction of the grandparents.)
8. When did you first see the baby and for how long?
9. How long do you spend with him/her each day?

The audiotapes were transcribed, clausled and scored according to the criteria specified for each of the scales. Unfortunately, technical difficulties occasionally prevented transcription of the full record. There were often extraneous background noises which obliterated the mother's
voice from time to time. It is remarkable how piercing the cry of a newborn baby is, and how clearly a tape recorder picks up that cry. On other occasions, battery failure produced rather scrambled recordings. When I could not transcribe words, I made an estimate of the number of words missed so that the correction factor could be accurately calculated. When large sections of an interview were not available for transcription (such as those occasions when the batteries failed) it became necessary to use only the portion which was audible.

4.2.4 Content Analysis of Interview Material at Three Months

Although it was necessary to obtain a transcript from the mothers at three months, it was obvious that the same form of questioning could not be reused. It was decided to use the projective picture prompt used by Westbrook (1975) to elicit responses (see below). This picture shows a woman holding an infant and surrounded by seven smaller pictures representing scenes commonly occurring during pregnancy, childbirth and early childrearing. One shows the woman with another person; another shows her either coming to or from the doctor's office; two pictures portray labour (one showing the woman alone in the labour ward, the other showing the birth with several figures around); two pictures refer to hospitalisation (one shows the baby with the mother and the other shows two figures); the other picture and the main picture show the mother at home. Both of these include the infant and one includes one other person. The stimulus picture is shown on page 50.
This picture was presented with the following statement:

"This woman has recently given birth to her first child. She's sitting here with the baby thinking back over all the things that have happened to her in the past few months. In these bubble pictures around her you can see some of the things she is remembering. The pictures aren't in the order in which things happened. What I would like you to do is to tell me a story about her and what she is remembering. You might just like to tell my about what your own experiences were or you might like to make it a story about this woman."

The advantages of the projective picture were that it allowed women to express any negative feelings they wished without necessarily 'owning' these feelings. Once again, it allowed for the production of what might be called 'socially unacceptable' responses as such responses could be attributed to the woman in the picture rather than to the respondent. Westbrook (1975) found that this stimulus picture produced a richness of memories and affect.

4.2.5 Content Analysis of Interview Material at Eighteen Months

The production of material for analysis at this time was elicited by a semi-structured interview. Because of the great individual differences among maturing children and the social stereotypes of appropriate play and behaviours for different sex children, it was decided not to use a picture prompt at this time. The women remaining in the study for the eighteen months follow-up had developed a good rapport with me and were pleased to co-operate. At this time I decided that it was important to measure, not just their affect at the time of the visit, but also their reactions to the adaptations and changes that had become necessary in their lives following the birth of the child. In particular, I felt the coping mechanisms used to deal with the demands of a growing child and the mother's perception of
the skills and temperament of the child were also important. Accordingly, I decided that an open ended question would be used to start the interview. They were asked: "How have things been since the birth of your baby?" Because of the need for specific information several prompts were used as required. These have been discussed in Section 4.1.4.

4.2.6 Treatment of Results of Content Analysis Material and Malaise Inventory

The affect scores were obtained in accordance with the standardised instructions for each scale (Gottschalk, Winget and Gleser, 1969; Viney and Westbrook, 1976; Viney and Westbrook, 1979; Westbrook, 1976; Westbrook and Viney, 1980).

In order to assess the differences between groups of women means and standard deviations were calculated for each source separately. In addition, comparisons were made with standard population scores which are available (Appendix 14). This sample has been called the 'Wollongong' sample. Comparisons were made using t-tests for independent means. These data are reported in Appendices 10 to 12.

To assess the significance of changes in affect between birth, three months and eighteen months, paired t-tests were calculated for women experiencing separation and premature birth. Unfortunately by eighteen months only one working class mother remained in the study. Therefore, only changes between birth and three months were compared for that group. These data are reported in Appendix 13.
Because of the discrepancy in capacity to express affect between the different groups of women I decided to collate lists of affect not being expressed at each interview. These lists are presented in Appendix 13.

The scores for the Malaise Inventory were calculated for each group of women separately at each visit. Comparisons were made using t-tests for independent means. Results for the birth interview are reported in Appendix 10.7, for the three month interview in Appendix 11.7, and for the eighteen month interview in Appendix 12.7.

4.3 ASSESSMENT OF BEHAVIOURAL FACTORS

It was not possible to arrange to observe mother and infant during the lying-in period at all hospitals. Therefore, the problem of developing observational criteria for assessing interaction related only to the three month and eighteen month visit.

Strict criteria have been developed for use in the laboratory (Ainsworth, Bell and Stayton, 1971). These conditions have the advantage that they can be applied to a number of different infants and the results compared. Standardised comparative findings allow for the testing of theories, models of development and also facilitate diagnoses.

Apart from the practical difficulties of getting lower socio-economic mothers and infants to a central laboratory, questions have been raised about the ecological validity of such investigations (Bronfenbrenner, 1974). The problems of generalising from the laboratory situation to the infant's home environment are obvious. Belsky (1980) set out to examine
the differences between mother-infant interaction during free play in the home and in the laboratory. He found that maternal functioning, but not infant functioning, was greatly affected by the location. Mothers interacted more with their infants in the laboratory than when at home. He concluded that:

"... serious questions can and should be raised regarding laboratory research that attempts to generalise its results to real world settings on the presumption that behaviour observed in the laboratory is representative of that observed under more naturalistic conditions." (P.45)

Rinkoff and Corter (1980) found differences in ten month old infants' reaction to separation from mother when comparing home and laboratory settings. However, Klein and Durfee (1979) found differences in infant behaviours when at home compared with those in the laboratory, but they went on to argue that such differences were caused by the mothers' behaviours (in turn related to experimental instruction) and that when they statistically controlled for the amount of maternal interaction, the differences between home and laboratory tended to disappear. They concluded:

"... no simple statement can be made regarding the representativeness of laboratory measures. This will depend on the group(s) being observed, the precise nature of the laboratory situation employed, the kind of comparison of interest, and the particular measures used." (p.1063)

This controversy combined with a recognition of the value of examining the infant's environment and the easier access to the mothers when in their own home led me to decide to do the follow-up interviews in the home. Once that decision was made it became necessary to devise assessment techniques to measure both the environment and the mother-infant interaction.
Subtle differences do occur - for example, Rheingold and Cook (1975) showed that parents provided different toys for girls and boys. Family behaviour associated with routines of daily living has been suggested as an assessment of the home environment (Steinglass, 1980). One of the more comprehensive and relevant measures is the HOME Scale (Bradley and Caldwell, 1976). This is a scale that assesses the quality of stimulation available to the child in the home. It has six subscales: (1) Emotional and Verbal Responsivity of Mother, (2) Avoidance of Restriction and Punishment, (3) Organisation of the Environment, (4) Provision of appropriate Play Materials, (5) Maternal involvement with Child, and (6) Opportunities for variety in Daily Stimulation. This scale measures some behavioural interactions but is primarily a measure of the child's environment.

4.3.1 Observation Schedule

As one aim of the research was to observe behaviour and record the inter-relationships between E, B and P factors I decided that a scale that measured behavioural interactions alone would be preferable to the combinations assessed in the HOME Scale. The research reported by Richards and Bernal (1972) detailing strict behavioural observations of mother-infant interaction provided a good model on which to build. They approached the problem from an ethological point of view. They assumed the existence of a two-way behavioural interaction between the mother and the child and sought to provide relatively independent measures of the elements each participant brought to this interaction. A strict behavioural observation eliminates the problems inherent in the situation where an investigator interprets, or a parent provides information according to recall
or the demand characteristics of their cultural interpretations. The possibility of accurate recall of behaviour by the parents is doubtful and cultural expectations about mothering are so strong that answers are likely to be coloured.

Because the infants at eighteen months would be older than those included in the Richards and Bernal study it was necessary to adapt the schedule to suit each occasion and to select behaviours which were likely to occur at each visit. Full details of the categories of behaviour and their description are given in Appendices 15.1 and 16.1. The adaptations at the eighteen months visit were made specifically to cope with the more mobile and active child behaviours.

The categories are of three types: (1) mother-infant behaviours; (2) infant state or vocalisations; and (3) infant position. The most obvious differences between the two schedules relate to the mobility and independence of the child and the role played by the infant in any interactions. This made it necessary to assess more complex behaviours of the child at eighteen months than at three months.

Another difference from the Richards and Bernal schedule was the differentiation between touching the infant on a clothed part of the body and on the bare skin. The Australian climate permits infants to be lightly clad for many months and it appeared that caresses to the bare skin were more sensual than those to clothed parts of the body.

Recording was done on duplicated sheets. Categories of behaviours were listed and columns were drawn representing thirty-second intervals. An
electronic interval timer was used which provided a sound pulse in the observer's ear every thirty seconds. Observations were made for ten minutes at each visit. This means that there are twenty columns recording whether each behaviour occurred in any thirty second interval while the observation was in progress.

Once the schedules were developed videotapes were made at the University creche of mothercraft nurses interacting with infants left in their care. The tapes were used to practice scoring and to establish my inter-rater reliability with other observers. Using them it proved possible to obtain high inter-rater agreement for ratings on all categories.

The experience gained in videotaping observations at the creche led me to decide against using video for the investigations for several reasons. The camera required the use of a fixed tripod and this prevented free movement during the observation period. Also the porta-pac video made a slight noise while recording and this, combined with the effect of the large lens 'eye' staring at the children, sometimes distracted them and prevented natural interactions.

Instructions were standardised and at each visit the mother was told:

"I am going to observe you both for ten minutes. I want you to behave as naturally as possible. The observation sheet is very flexible so please feel free to do whatever you would do normally."

4.3.2 Treatment of Results of Behavioural Observations

The behaviours were checked according to the schedules listed in Appendices 15 and 16. Full descriptions of the behavioural categories used
at three months are in Appendix 15.1 and those for eighteen months are in Appendix 16.1. It had been anticipated that there would be differences between the three groups of women, so t-tests for independent means were calculated for all behaviour categories. However, only one significant difference was found. This was for the behaviour 'Mother Looks Away from Infant' at three months (Appendix 15.2). Because of this, and because the numbers of subjects had dropped, I decided to combine the results for all three groups of women.

A principal components factor analysis was calculated and seven factors were extracted. The factors were rotated using the Varimax routine and factor score coefficients (based on standard scores) were obtained. Factor loadings are given in Appendices 15.4 and 16.4.

As a further check individual behaviour scores were calculated and Analysis of Variance was calculated between the three groups of mothers for the behaviour scales. At three months the only significant difference was on Factor 1 'Mother Socialising' (Appendix 15.5) which loads on 'Mother Looks Away From Infant'. This result was not surprising as this was the behaviour that was significantly different between mothers who were separated and mothers of premature infants. At eighteen months only Factor 4 'Mother Carrying Child' showed any significant difference between groups (Appendix 16.5).

To check on consistency of mothering behaviours Pearson Product Moment Correlations were calculated between Behaviour Scales at three months and Behaviour Scales at eighteen months for the combined groups of women who were available for interview at the later time (Appendix 18.4).
4.3.3 Observation Material Showing Stimulation of the Child

Because of the importance of maternal stimulation in the child's environment two extra tables were included which were developed from the observation schedules at three months and eighteen months. They describe the mother's input into interactions at these times and, hence, give an extra indication of the child's environment. These are in Appendix 7 and are:

7.9.1 Behaviours stimulating the infant at three months. This included kissing, touching, talking to and smiling at the infant.

7.9.2 Verbalising to others as opposed to speaking to the infant during the observation at three months.

7.10.1 Behaviours stimulating the infant at eighteen months. This included touching, talking, playing with and smiling at the child.

7.10.2 Verbalising to others as opposed to speaking to the infant during the observation at eighteen months.

4.3.4 Relationships Between Internal Personal Experience and Behaviour

Reciprocal determinism is based on the notion of mutual interaction between behaviour, events and internal factors. Sources of influence are interdependent and not deterministic in the sense of one necessarily
causing another. Therefore, correlation of the sources of influence is the ideal measurement to fit this approach. Behaviour factors were correlated with affect (Appendices 17 and 18).

4.3.5 Self Report Questions About Mothering

Two simple questions were used by Klaus et al (1972) in their interviews with mothers and infants. They report typical behaviours in response to the infant's crying and the mother's absences from the infant. These were adapted to suit Australian terminology and scored slightly differently to fit in with our family patterns (Appendices 7.7 and 7.8). The questions and answer categories I used were as follows:

1. When the baby cries, has been fed, the nappy is dry, what do you do?
- Always let him/her cry it out
- Tend to let him/her cry it out
- Tend to pick him/her up
- Always pick him/her up.

2. Have you been out since the infant was born? How did you feel?
- Yes and felt good
- Yes and thought about infant while out
- Yes and worried about infant while out
- Yes and did not want to leave infant
- Yes leaves only with mother (child's grandmother) and doesn't worry
- Yes leaves only with mother and worries
- No. Would not leave child at all.
4.4 CASE STUDIES

To demonstrate the interlocking nature and reciprocal determinism in each woman's adjustment process, and as an aid to making the statistical data more human, a case study is presented of a mother from the sample experiencing hospital routines leading to separation, one mother of a premature baby and two young working class mothers. These are in Chapters 6.6, 8.6 and 10.6.
"The time immediately after birth is treated by many hospitals not as a special period in which important psycho-biological needs of the mother are served by the staff, and in which she takes care of and gets to know her baby, but primarily as one during which both mother and child are medically screened and processed and must pass tests before they can be pronounced 'not at risk' and discharged back into society." Kitzinger (1978(b)), p.190.

5.1 THE HOSPITAL AND ENVIRONMENT

The hospital had been a district hospital for many years. It grew up with the early settlement and served local residents from convict days. Over the years its services and facilities had increased. While its history is long it had the disadvantage of growing and having to work with and around old-fashioned buildings. Buildings had been added as the need arose, and sometimes these additions were done in a way that was most economical—that is, some buildings in spite of being there for many years, looked make-shift. The maternity ward was one of those which appeared to be temporary and 'tacked onto' the rest of the hospital. It was built of fibrous cement and timber, had long narrow corridors and the office and nurses station was small by modern standards. Most wards had four beds in them. One ward had fifteen beds. It was to this ward that many of the public patients were sent.
At the time of the first contact with the hospital they were planning to introduce rooming in for those mothers who wished it. Up until then they had a traditional approach to nursery care. Infants were brought to their mothers for regular feedings during the day, were left for half to one and a half hours, and were then returned to the nursery. They remained in the nursery overnight. The unit had a 'Father's Night' one day each week. On this day only fathers were allowed to visit and at that time the infants were left in the ward so that the child's father might touch and cuddle it. As many women had only a short stay in hospital — four to five days — many fathers would only get a chance to be close to their infant when it came home from hospital.

The introduction of rooming in was delayed until hand basins were fitted along the corridor at regular intervals. The Administration decided that this was a necessity if the infants were to remain in the wards. The plumbing arrangements for this were difficult and lengthy and it took almost twelve months to have this work planned, approved and completed. However, it was eventually done and rooming in was introduced just before a government decision was made to change this hospital from a district hospital to a rehabilitation hospital.

One of the most telling indices of the hospital hierarchy's attitude was a sign prominently displayed at the nurses' station in the ward. It said: "Doctor ring bell and wait here for Sister". It seemed that even the doctors were to be regimented.

For a set period each day the blinds were drawn and the women were expected to rest. There never seemed to be many women visiting each
other in this hospital - they were more likely to be in their beds. Oakley (1980) has discussed the medicalisation of maternity cases. She had pointed out that reproduction is normal and that 97 per cent of the female population are able to deliver babies safely and without problems. In spite of this it has become routine to use technological, pharmacological and clinical procedures during as many stages of the reproductive process as possible.

If one can generalise from the ward atmosphere, the controls and interventions of the hospital staff and argue that such interventions place the woman in the 'sick' role, then the women in this group were 'sicker' than those in the other groups.

5.2 THE MOTHERS WITH ROUTINE SEPARATIONS

Sixty women were interviewed. All had recently given birth in a hospital which could be classed as serving a middle class population. Names of primiparous women were given to me by the nursing staff. I approached them while they were in the ward.

5.2.1 Country of Origin

Most of the women in this group were Australian born (80 per cent). The next highest frequency was in the category for women born in Great Britain (13.3 per cent). Percentages for married women in Australia aged between 15 and 44 are 72.9 per cent Australian born and 9.6 per cent born in the United Kingdom and Ireland (Australian Bureau of Statistics, 1979). In the sample only 5 per cent came from Latin countries and none were Asian
(Appendix 2.1). In this case the women interviewed would represent older traditional Australian values and backgrounds rather than the new culture which is more a mixture of both European and Asian migrants. Of course, a large number of migrant women were in the hospital following the birth of a child during the period of the investigation. However, it was not practicable to interview most because of their poor understanding of the English language.

5.2.2 **Relationships With Parents**

The majority (83.3 per cent) came from families where both their parents were still living. Only 15 per cent had lost either mother or father (5 per cent had lost their mother and 10 per cent had lost their father). One woman was unique. She reported that she did not know whether her parents were alive (Appendix 2.2).

Only 78.3 per cent were not separated from their parents before the age of 13 (Appendix 2.3). This shows a higher rate of separation than for mothers with premature births. Some family break-up was obvious. Fifteen per cent had been separated from their fathers before the age of 13, and 3 per cent had been separated from both parents. Occasionally this was the result of migration where father migrated to Australia first and left the family in the old country until he had established himself. In other instances it was the result of death or divorce. In those cases where they were separated from their mother it was usually another member of the family (such as grandmother or aunt) who took over the mothering role.

Eight women (13.3 per cent) reported trauma in their early life. This was usually associated with divorce, marriage breakdown or migration. The
majority (86.7 per cent) felt that their lives had been relatively uneventful. Perusal of the transcripts shows that in those cases where the parents were living in or near Sydney and were not estranged there were two main reactions to the birth. The most common one was a mixture of pride and excitement, but occasionally they reported a feeling of separation and wanting to have the child at home so they could be close to it.

Pride and Excitement

"Yes, I think Dad's really thrilled. And Mum too. She came over last night and she said, 'Now watch what you eat when you go home'." (Barbara)

"She said she's beautiful. She loved her." (Helen)

"They think she's beautiful. Because we haven't had a granddaughter for a while in the family. They've all been boys. So everyone is tickled pink. They all think she is lovely." (Maureen)

"They're as proud as punch. They think she is beautiful. She was the first grandchild. And they wanted a girl. We all did. It's too good to be true." (Diana)

"My family think he's marvellous, snapping cameras. The camera was down at the window each night that they've been." (Jenny)

Separation

"(Mum) says he's beautiful, very sweet. They're dying for a nurse. Just looking at him through a window is not very good." (Thelma)

"They all say how beautiful she is and they can't wait until I get home so they can get a closer look." (Michelle)

Overall these women painted a picture of solidarity with their parents and in-laws. Support for them in their parenting role and a shared joy in the birth of the child came from both their husbands and the extended family.
They did not mention anxieties caused by parents or their family's limitations in the same way as the mothers of premature babies sometimes did.

5.2.3 Educational and Occupational History

Almost 77 per cent had been educated in State high schools. The rest went to Roman Catholic schools. Most of the women (55 per cent) attended State co-educational schools (Appendix 3.1). Twenty six women (43.3 per cent) had extra training after completing School Certificate, which is regarded as the basic educational standard to achieve. Thirteen (21.7 per cent) had completed, or were still completing, tertiary education. As a group the women experiencing separation were not as well educated as those giving birth prematurely but had more education than the working class women (Appendix 3.2).

The mean occupation status ranking for this group was 5.05 (Appendix 3.3). Nearly half had occupations which ranked in the lowest category (Congalton, 1969). This ranking includes such occupations as office machine operators, public servants and receptionists. There was a significant difference between groups on occupation status. The same picture emerged for suburb status (Appendix 3.4). These women were between the other two groups in both occupation and suburb status.

About 70 per cent had kept working for at least part of their pregnancy, but the average time between finishing working and the birth of the child was 10.72 months. There were eight women who had not worked in the last two years prior to the birth (Appendix 3.5). There were fewer women in
this group who regarded their work as a career than there were among the mothers of the premature infants. The typical picture was of a young woman who had a basic education plus a few skills (such as typing and office work) who married, kept on working for a time to help financially and then, during her pregnancy gave up her job.

5.2.4 Marriage Related Factors

Nearly all the women were married (93.3 per cent - Appendix 4.1). Of those classified as 'single' one had been in a long term relationship which broke down during her pregnancy. One was a young woman who appeared to be acting as a mother's delegate and producing an infant for her own mother, but this child developed a terminal illness and died shortly after the three month visit. The third was a trainee teacher with strong peer and family support. However, she and the fourth single mother had moved by the time of the eighteen month follow-up.

All those who were married rated their marriage as happy all or most of the time (Appendix 4.2). For those who rated the marriage as happy most of the time (33.3 per cent) it seemed to be a realistic appraisal of two people living together rather than description of a lack of satisfaction in the union. They pointed out that all people had minor differences of opinion, but that things were good most of the time.

Subjects were asked about the number of stepchildren they had in their care. This information was obtained because I felt that caring for other children may have changed their behaviours to what was ostensibly a first child. Only two had stepchildren. One was interviewed at all three times,
and the other had initially given an incorrect address and could not be located at three months. Judy, who remained in the study, greatly valued her pregnancy, labour and the infant. She discussed her husband's reluctance to have more children and wanted to maximise her experiences as she knew she would have no other infants of her own. After the birth she said:

"The important thing about it was that it was my baby. I wanted to have a baby for the last three years and Geoff wasn't keen to start off with you know."

By three months she was reminiscing about the birth and regretting the little effort she had to expend to give birth.

"The labour was so short with David. There wasn't any pain. In fact I was a bit upset there wasn't because I didn't feel anything while I was laying on the table giving birth to him. ..... I would have actually (liked more pain). Because then I would have - it would have meant something more to me. Because there wasn't much pain. You know."

Most women wanted two or more children. Six did not know how many they would like to have. The average for this group was 2.41. Only eight (13.3 per cent) wanted as many as four children (Appendix 4.4).

5.2.5 Husband Related Factors

Like both other groups, most of the husbands were Australian born (Appendix 5.1). Almost 80 per cent were born in this country. Their occupational status was slightly lower than the fathers of the premature infants. The mean rating was 4.96 (Appendix 5.2). The mode ranking was 5. Occupations which rate 5 on the scale are such jobs as: insurance clerks, electrical fitters, foremen and mechanics.
Just under half of the men had decided they would not go to prenatal classes (Appendix 5.3). This compares with 40 per cent for fathers of the premature babies and 77.78 per cent for the working class fathers. There were, however, no significant differences between groups.

Even though only half attended prenatal classes most husbands wished to be present at the birth. Only 8 (14.28 per cent) planned to be there but missed and 38 (67.86 per cent) were able to stay with their wives during the labour and birth (Appendix 5.4).

Stella described most fully the richness of the shared experience. She said:

"At first he was there to hold my hand when I was getting contractions. And later on he was rubbing my back and cleaning my face down, but it got to the stage where his hand was distracting me from it. I was too busy concentrating on his hand and he just held my hip and that helped me. But I knew he was there. Just his presence was enough for me at the later stages of it. I'm glad he was there, talking to me. .... I seen her head as she just come out. And after that I had to push again. So I shut my eyes again to push and then all of a sudden she was on my tummy. And I was nursing her fully. And I was holding her back and touching her hair and her legs and holding her hand. And my husband, Bob, held her first. He held her first. They wrapped her up and gave her to her Dad. And he was quite happy. He was all chuffed. He was all tickled pink. I thought that was great. He'll tell his daughter, 'I was the first one to hold you'. Gee it was lovely. And he started to cry - bubbling. And actually a tear fell on my face. That was, I don't know, I kind of felt it was my own tear."

The majority of women felt that their husband's presence helped. In fact he didn't have to do anything. For most 'just being there' was stated as being worthwhile. A few women elaborated on the husband's role in the delivery room. Like the mothers of premature babies they appreciated his presence and looked to him for reassurance, comfort and information. However, for this group of women the reassurance was not about the child
or its physical condition. It centred more on support they themselves needed during the labour.

**Comfort and Reassurance Descriptions**

"I think if he hadn't been there I would have been more scared. I think because he was there and he kept talking to me he reassured me that everything would be alright." (Carol)

"He was really good. He was just with me all the time and he rubbed my back. And he just was encouraging and just knowing he was there, and I just knew that he was beside me in the labour." (Deborah)

"He was really good. He sponged me all down and rubbed my back and told me that it was alright." (Catherine)

"He rubbed my forehead for me and gave me his hand to squeeze and just kept talking to me. And he gave me the mask - helped me with the mask." (Diana)

"He could comfort you and make sure everything was all right. And rub your back and use the mask and things, which was good. I wouldn't have liked him not to be there." (Marilyn)

"Just him being there was a help, plus also he kept telling me to relax, helping me physically you know. Holding me up when I was pushing, reminding me how to breathe. All those sort of things." (Elizabeth)

One woman mentioned her husband being 'strict' with her. She appreciated this control. She said:

"Stephen was there all the time and he was a real good help. He was very strict with me, and when I was starting to break down a bit he was, sort of, 'Stop that, there's no need for it'." (Rosemary)

Another also spoke of her husband's control. Shirley said:

"I really appreciated Ted being there because I thought he sort of helped. I thought it was as if I couldn't do without him there because he was talking to me all the time. Even though the doctors and nurses were telling me, 'Oh come on you can do it'. With him telling me it sort of helped a lot. I took more notice of him." (Shirley)
Although one got the impression of togetherness and an appreciation of the shared labour there were only two women who specifically mentioned how happy the husband was to be present.

"Well I don't think he was all that keen to be there in the first place but I told him that I needed him. And he's pleased he was there now." (Beverley)

"I thought he was a great help and he loved it. He said he wouldn't have missed it for the world." (Margaret)

The husband of another woman discussed his presence at the birth during the home visit when the baby was three months old and summarised his reaction by saying, "I don't know whether it brought us closer together, but it sure didn't do no harm".

Narelle had very limited support which culminated in an initial rejection of her child. She described her husband's behaviour as follows:

"He was in and out because he's got a weak stomach and if it got too much for him he just went outside for a while."

She reacted badly to her child. She said:

"I didn't even want to look at her when she was born either .... I didn't really want to see her. I just wanted her to be all beautiful. Come out all neat in a package."

She described her husband's reaction to the child:

"He wasn't very impressed with all the blood on her face."

Ann, whose husband wasn't present, explained that:

"We discussed it before when they said he could. And, like I know he's got a weak stomach and I'm more worried, you know, say if he fainted or something like that. So I didn't want him there for that to happen."
She had her revenge. She went on:

"Well he could have come in straight away after everything was cleaned up and I was cleaned up. But they asked him not to come in. They asked me whether I wanted him and I said, 'no'. I just wanted the baby to myself. It was very selfish, but there it is."

He waited about fifteen minutes to see his wife and child.

Many of the women were pleased to describe their husband's pride and delight with the child they had produced.

"He thinks she's beautiful. The perfect human being. He held her for the first time last night and examined her properly and he just sat here all night nursing her." (Michelle)

"He thinks she's gorgeous. He's always down there staring through the window." (Wendy)

"He's crazy about him. Of course he wants to get him home." (Clare)

"I heard some nurses talking yesterday about him and saying that they'd never seen a prouder Dad than him. He goes down with his little card and stands there for ten minutes at a time watching her." (Sue)

The sense of separation that is hinted at in the last three comments about the fathers was not unusual. A number of women were much more explicit in their expressions of the father longing to be close to his child. Most women, though, while apparently regretting the separation did not openly criticise the hospital.

"It's a shame though because he only had a little nurse. He's come up tonight to have another. But he doesn't know her that well yet." (Marie)

"It was Fathers' Night last night and he came down. And they left her with us for about an hour. So he nursed her then. But he nursed her as soon as she was born. He was just about dying to have Fathers' Night. (Marilyn)
"He saw him last night because some days the fathers get to see them - just the father, myself and the baby. And he was tickled pink. He nursed him all of the time. You see, I've already seen him and Peter hadn't seen him before." (Sandra)

"He was really happy. But the trouble is he hasn't nursed him yet. So he's sort of hoping for it. ..... He sort of wants to get into contact with him you know. Oh, he's as proud as anything. He really is." (Noeline)

One woman went into great detail about how she felt about it:

"There was one thing I was disappointed in and that was last night. Well, I had the baby on Tuesday afternoon and, you know, Graham was there all the time and got to nurse it straight away. And then last night he could only see it from outside the window. And I just thought, 'Well, O.K., Sunday comes along, you know, and he can handle it then.' But he was just dying to love it himself. You could see it. I mean just, sort of, I just thought, they're detaching him from it. I just thought, why leave it to Sundays only. I still think if he'd been able to pick it up then it would be just that continuity of it and all. It would have been more worthwhile. That, I guess, is what I found disappointing - last night anyway. He could have just had that build up - that same feeling which I've built up. I felt, if only he had just been able to pick it up when he came to see her last night." (Joy)

The mothers' transcripts clearly show their reaction and it would be interesting to interview the fathers about their perception of the event. A father undergoes a series of separations during the birth process. He is inevitably separated from his wife, even if only briefly, while she is inducted into the hospital system. He is quite likely to be unsure of his role within the institution - after all he is not about to give birth. Even if he wished to be with his wife he may be requested to leave the labour ward while the 'professionals' get on with the job. One husband experienced a feeling of total redundancy when a Caesarean was decided upon. His wife described it:

"And it was just the fact that all of a sudden everything happened. You know, people just came from everywhere. And my poor husband didn't know what to do. You know, he
was lost. I could just see him standing in the corner thinking, you know, 'what's happening?' And I know that it was a real shock to him. And only because I've done a certain amount of nursing and that. You know, I wasn't worried. But I knew he was uptight about it, cause you know he was more worried and that. Oh, he's been good, you know. But I just knew he was, you know, he felt lost. He stood in the corner and kind of thought, 'Well, what am I supposed to do type of thing'.

(Tess)

Brown (1982) discussed the detachment of fathers in the labour ward. She found that many of the fathers she spoke to experienced feelings of peripherality or redundancy. Even in cases where the hospital staff attempted frequent communication with and inclusion of the father, many still felt like an intruder. For the fathers from this sample the period of redundancy was extended until mother and child were discharged from the hospital.

It is obvious that the promotion of mother–child bonding has recently been increasingly emphasised while the father's relationship with his child is still frequently regarded as secondary. Apart from the intuitive belief that early intimacy between father and child is advantageous it has been shown (Macfarlane, 1977) that fathers allowed to handle the infants and change their nappies prior to discharge from hospital, later spent more time with the infant than did a control group without this early experience.

It seems strange that the parents of infants in intensive care units (such as those discussed shortly) have more access to the child and feel less separation than do the parents of healthy full term infants. Klaus and Kennell (1976) and Blake, Stewart and Turcan (1975) have shown it is advantageous for fathers to visit their infants in the intensive care nursery. The same privileges should be routinely available for fathers of full term infants.
5.2.6 Childbirth Related Factors

There was a significant difference between the groups of mothers on age. This group were, on the average, 23.45 years old at the time of the birth (Appendix 6.1). They were, therefore, younger than the mothers of the premature babies and older than the working class women. They had fewer prior pregnancies than women giving birth prematurely, as fifty-five reported no earlier pregnancy (Appendix 6.2). All of them said that they had not had any earlier elective abortions (Appendix 6.3). This was significantly less than the women giving birth prematurely. It may not be an accurate representation of the true situation however, because of the nature of the circumstances surrounding a pre-term birth. It is likely that all mothers in the group giving birth prematurely had already discussed their medical history with hospital staff and would be, therefore, more likely to accurately report past abortions to the researcher. The women with routine care, having normal pregnancies and deliveries could afford to keep past abortions secret if they wished.

The estimated mean gestation period for this sample of women was approximately 40 weeks (Appendix 6.4). Analysis of variance showed a significant difference between groups. This was because of the much shorter gestation periods for the next sample of mothers.

At the three month visit the women were asked about experiencing postnatal 'blues'. Almost half (46.7 per cent) said they had not (Appendix 6.5). Only one woman reported that she had needed medication and professional help to cope with her difficulties. There were no significant differences between groups.
5.2.7 Childbirth Education

This group had the highest rate of attendance at prenatal classes (63.3 per cent). Only 35 per cent had decided not to attend classes (Appendix 7.1). There was not the same picture of interrupted plans to attend as there was for the next group of women. Only one woman planned to attend classes but didn't. As the mean gestation period was 39.78 weeks, it is likely that there was not much energy behind her intention. A few of the women spoke about using their training during the labour and birth. Some examples follow:

"When I went to the prep room I started to get very severe pains you know. But it was really Mrs Ross teaching us to breathe and everything. It took the worst part away." (Meg)

"He (husband) was helping all the time because he learned at the classes, massage and, you know, a bit of enflourage. And he helped me with my breathing because he knew what I was supposed to be doing." (Shirley)

"They kept telling me to relax and do my exercise in breathing. And I was doing panting and all that." (Pam)

"He (husband) talked to me the whole time and held my hand and rubbed my back and told me when to breathe, and kept talking about the classes and the different breathing - should I breathe through my stomach or my chest." (Debbie)

"I used the mask as well for breathing and that helped a lot. But I went to prenatal classes and did the exercises and learned the proper breathing and everything. I think that was a lot of help too." (Joan)

Some were surprised that there was not as much discomfort as they had anticipated and others, while recognising the reality of labour, spoke of the great satisfaction they felt in their own 'work' during the second stage of labour.
"It wasn't as bad as I thought it would be because you hear a lot of stories and things like that. People with their own labour - and you tend to think you're going to be like them. And it wasn't really. I was quite good in fact. I took it." (Stella)

"I was only in labour for about two and a half hours and the pain wasn't that bad, and the actual birth wasn't that bad. I didn't scream or cry out like some people." (Judy)

"I was really surprised. I think I expected the worst you know. So that never came until right at the end. But that was only because I wanted to push and they wouldn't let me push. But it was really good. I was surprised." (Debbie)

It was notable that none mentioned a painless labour. On the other hand, none reported experiencing the unpleasant shock that Kitzinger (1978, (a) ) discussed. She pointed out that mothers who imagined the labour will be painless are unprepared for the powerful sensations and the force of uterine contractions. The shock of this discovery can lead to panic and she believed that those women may be worse off than those who had no childbirth instruction at all.

5.2.8 Childrearing Factors

When questioned about sources of information on child care only eleven (18.3 per cent) replied that they did not know how to care for a child yet. This contrasts with the one third of the mothers of premature infants who replied in this way. No young working class mother admitted a lack of knowledge. The most common source of information was 'experience with other infants'. Twenty-two women gave this as their prime source of information (Appendix 7.2). They mentioned both siblings and friends' infants in talking about gaining this experience. There was a difference between the three groups in their intention to rely on their own mothers for information. Appendix 7.2 shows that three (5.0 per cent) from this
sample, none from the sample with premature deliveries and three (21.4 per cent) from the working class sample intended to learn from their mothers. This reply was not related to youth or dependency in the women who experienced routine separations. The three women from this group who replied in this way were competent and had worked for a number of years. One was a teacher, another was in the Army and the third had worked as a Traffic Controller. One of the three had been to childbirth education. It is most likely that the youth of the young working class women, combined with their inexperience, would lead to their decision to rely on their own mothers for help with their infants.

Fashions in feeding infants have changed over the years. There have also been big differences across cultures. Bain (1948) reported variations between States in the United States. She found that between 10 per cent and 72 per cent of women planned to bottle-feed. She also cited figures for Great Britain where, in 1944, 80 per cent of British babies leaving hospital were breastfed. Duration of breastfeeding is one of the factors which seems to be consistently longer in studies of the effect of early and extended contact between mother and child (Klaus and Kennell, 1976; de Chateau, 1980). The routine care mothers have not had the separation which is imposed on some parents of very ill infants but they have had only a limited contact with the child during the lying-in period.

Forty-nine (81.67 per cent) of them intended to breastfeed at birth. This is very close to the British figures cited above. However, the mean duration of feeding was only 3.64 months (Appendix 7.5). Ounsted and Hendrik (1977) found that only 33.5 per cent of the primiparous mothers they studied (N=209) were still breastfeeding at two months. By eighteen
months only seven of the twenty-five women interviewed reported that they managed to feed for six months or longer. Nine of them had managed to feed for only one month or less (Appendix 7.5). For some, discontinuing breastfeeding was forced on them by circumstances such as their own illness or an early return to full time or part time work. Three expressed regret at not having been able to feed for a longer period. Sally said that with a future child she would not wean as quickly. She had weaned her daughter at six weeks because she thought she was not gaining enough weight. She said:

"I think it's the bond between mother and child. Although I think Amanda and I are fairly close but ..... I don't know. It seems I weaned Amanda off and wished that I hadn't because I never felt as close to her as I did when I was feeding her."

Plans to breastfeed tended to be associated with decisions that demand feeding was preferable to feeding on a schedule. Twelve women were undecided about which they would choose. Those who chose a schedule were more likely to talk about getting into housekeeping routines when they left hospital.

"She's on a schedule in here. I think I'll probably keep going on a schedule when I get home. I want to get into a routine." (Fiona)

"I'd like to try and have a bit of a routine I think." (Jenny)

Most of those who didn't know whether to demand feed or not wanted the hospital staff to advise them.

The mothers with routine separation from their babies tended to have good to excellent environments for the children when the homes were rated during the home visits (Appendix 7.6). However, one third provided a barely adequate environment.
During these visits some mothers set about showing off their child's skills under the disguise of playing with them. They would try to get the child to smile, sing, play ball, or speak. Most women were involved in interactions at some time during the visit that could be classed as 'teaching' (Clarke-Stewart, 1978).

It is difficult to know whether they were sensitive to the child's needs and skills or whether their wishes had prompted the child to select particular types of play. There were instances of the mothers saying how musical the child was and then playing with musical toys or singing to the infant; others where the mother described how ball games were the favourite and then playing ball with the child; and even a couple of women who explained that the child liked to help in the house and they continued with their housework.

Klaus et al (1972) compared early and extended contact mothers with those receiving routine ward care. They found that the early and extended contact mothers were more likely to pick up the infant when it cried and less likely to leave the infant and go out. The same questions they asked were put to the women at three months (Appendices 7.7 and 7.8). Only one of the thirty women said that if her baby cried after it had been fed and the nappy was dry that she would let it cry it out. Twenty-six (86.7 per cent) said they would tend to pick the infant up, or always picked it up. Most who 'tended to pick up' wanted to elaborate on their answer. They said that they could tell different types of crying and that this would be part of the information they would use in making a decision about picking up the infant. The responses of the three groups of women were fairly similar but there was a trend for the young working class mothers to say less frequently that they would pick up the child.
In response to the question about going out since the child was born there were some differences between the groups of mothers but most of them did not want to leave the infant, or left it only with the child's grandmother (Appendix 7.8).

5.3 THE CHILDREN FROM THIS SAMPLE OF MOTHERS

5.3.1 Sex of the Children

There were slightly more than half of the infants female. There were two sets of twins (Appendix 8.1). The masculinity rate of this group is not representative of Australian births (Australian Bureau of Statistics, 1980). Although different, it was not very deviant and is unlikely to affect the results.

5.3.2 Age Crawling, Standing and Walking

All groups of infants were roughly comparable on the reported age they crawled (Appendix 8.2). For infants with routine separations the average age was 7.04 months. There were no significant differences in the average age they stood, and for these infants it was 9.48 months (Appendix 8.3). However, there was a tendency for them to be slightly earlier in standing when compared with the premature infants. This tendency towards earlier development for the infants also occurred in walking (Appendix 8.4). Their average age for walking was 11.52 months. These ages are much younger than one would expect. It is probable that the mothers' estimates were based on the first appearance of the skills rather than on mastery. Even allowing for this, as children usually develop mastery fairly quickly, they do
seem to be generous. Bayley (1935) reported a median age for prewalking progression at 9.2 months. Prewalking progression was tested by placing the child in a prone position with a toy in front of him or her and out of reach. The child was credited with the skill if any forward progress was made from this position. Routine separation mothers are estimating forward progress to begin about two months earlier than Bayley, i.e. 7.04 months (Appendix 8.2). The median age of standing alone in the Bayley study was 12.5 months, but 'pulls to standing position' appeared as early as 10.5 months. These mothers reported a mean age for standing at 9.48 months (Appendix 8.3) even comparing with the 'pulls to stand' item, these children are performing well.

Either parental generosity or precocious development is needed to explain the differences in age at walking. Bayley's criterion for walking alone was being able to take three steps alone. The median age for this was 12.5 months. These mothers' mean estimate was 11.52 months (Appendix 8.4). Bayley's item 'walks with help' which tested the child walking with only slight support, developed at a median age of 11.5 months. This was almost exactly the age that mothers with routine separations reported walking as being established. This tends to confirm the theory that they have been generous in their estimates.

5.3.3 Vocabulary at Eighteen Months of Age

The routine separation children were very similar to the premature children in their reported vocabulary. There was a wide distribution of scores, with the estimated vocabulary varying between three words and almost one hundred. The average vocabulary was 25.32 and this was not significantly
different from the premature infants. The standard deviation was large - 26.03 words (Appendix 8.5). Bee (1975) states that early language begins at about one year and develops rapidly during the second year of life, and that by age two, children have a vocabulary of about fifty words. Bayley (1935) reported that the infants she studied were able to talk (the criterion was saying two words) at an average age of 12.9 months (standard deviation 3.7 months). However, seven per cent of her sample were only reaching this standard by fifteen months of age. The infants in this study showed approximately the same pattern of development in both the number of words spoken and the range of ability within the sample.

All mothers spent about the same amount of time initiating conversation with the infant at eighteen months (Appendix 7.10) and the infants' vocalisations were similar on all the observed behaviours, except that children from the separated group vocalised to themselves less than the premature children.

5.3.4 Temperament Ratings

The picture painted of a typical child was that it was initially shy with strangers but later warmed up (Appendix 8.8) and that it was easygoing and friendly (Appendix 8.10). Most mothers also felt that their child would take well to going to school (Appendix 8.9). The infants who were reported as being shy with adults, or selectively shy with adults, created some problems for their mothers. Jenny's child had some reluctance to be nursed by grandparents. She said:

"Sometimes it worries me that he's, well I think he's not very sociable. I'd like to think that maybe a second child would accept other people a little bit more readily than he does. Grandparents tend to rush I think. And they don't see him every week or regularly like that."
Most mothers who rated their children as quick tempered when frustrated were not disapproving of this. There seemed to be a pride in the child's determination. The exception was Karen. She expressed a lot of hostility during the visit at eighteen months. She felt that when her son went to school the teachers would have trouble, and she herself appeared to be having trouble at that time in relating to him sympathetically. She complained about him depriving her of sleep, and in his hearing said:

"I'll feel sorry for his school teacher because he is very rough. He's got to climb all over you. He's got to bring you things and throw them at you and, you know, he's just different to his cousin. She's real quiet and she walks around and he's got to run everywhere. You know, he's just got to completely boss her all the time, and she's so quiet and he's so bloody noisy."

This statement can be contrasted with Deirdre's description of her son playing with another child:

"He's a leader in other ways too. He's so determined. Showing her how to climb. If she's got something he wants he won't give in until he's got it."

5.4 SUMMARY

Clearly, environmental conditions surrounding the birth and also the past history of the women combined to produce attitudes, expectations and reactions to the birth and to childrearing. The internal and emotional reactions discussed in the next chapter also demonstrate the interaction of key elements and supports a reciprocal determinism approach.
CHAPTER SIX

INTERNAL PERSONAL EXPERIENCES FOLLOWING ROUTINE SEPARATIONS AFTER BIRTH

6.1 INITIAL REACTION TO THE CHILD

Mothers' reported initial reactions to the baby varies in different studies. There is no doubt that some mothers do not react positively (Macfarlane, 1977; Robson and Moss, 1970). Oakley (1979) found only 30 per cent were proud or euphoric, and 70 per cent of her subjects reported disinterest. Doering and Entwisle (1975) concluded that women who have more positive first reactions towards their infants continued to have a closer bond in the immediate postpartum period (indicated by choosing rooming-in and breastfeeding). These women also breastfed longer. They interviewed 269 women and found that 24.53 per cent had an initial negative reaction and 61.34 per cent had a positive reaction. There were 14.13 per cent responses classified as neutral. The mothers who had routine separations answers to the question "What does your baby look like now, and what was he/she like when you first saw him?" were classified into five categories. The response frequency and percentage of the sample are shown in Table 2.

Just under half of the women produced statements that showed purely positive initial reactions. This was less than found by Doering and Entwisle. The women who produced positive or mixed statements were more likely to be available for follow-up visits. They made up 84 per cent of the sample at eighteen months.
Table 2: Separated mothers' initial response to the baby
and the retention figures for these women

<table>
<thead>
<tr>
<th>Category</th>
<th>Birth N (%)</th>
<th>Available at Eighteen Months N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purely positive</td>
<td>27 (45.00)</td>
<td>13 (52.00)</td>
</tr>
<tr>
<td>Mixed positive and negative</td>
<td>17 (28.33)</td>
<td>8 (32.00)</td>
</tr>
<tr>
<td>Not their child</td>
<td>3 (5.00)</td>
<td>0</td>
</tr>
<tr>
<td>Not motherly</td>
<td>3 (5.00)</td>
<td>1 (4.00)</td>
</tr>
<tr>
<td>Negative - then and now statements</td>
<td>6 (10.00)</td>
<td>3 (12.00)</td>
</tr>
<tr>
<td>Purely Negative</td>
<td>4 (6.67)</td>
<td>0</td>
</tr>
</tbody>
</table>

The mixed positive and negative statements usually included some discussion about how beautiful the child was, plus a description of a perceived flaw.

"She's beautiful. She was crying. She was a purply-blue colour and she's also nice." (Theresa)

"Beautiful, fat, red-faced and dead to the world. He had a tube up his nose which was irritating him and he didn't like that." (Meg)

The mixed statements frequently were indicative of some concern for the child or its appearance, but were based on fact rather than a fantasied flaw in the infant. From observations in the home at eighteen months it was obvious that many of those with initial mixed reactions had adapted well to parenthood. Pam after the birth described her son:
"He was bright blue and he was covered in blood ..... and the colour was unbelievable, and it was really bright blue, and he was just beautiful, and he just sort of lay there. And I just stared at him."

At the eighteen month visit she described her life and adaptation as follows:

"We're pretty satisfied with the way things are. I was offered a part time job for six weeks last Christmas, but I refused because we didn't really need the money and I didn't want to leave him. I enjoy being with him and would rather stay at home. Actually I'm trying to have another baby."

The feeling that the child was not theirs, or a lack of motherly feeling, puzzled the women. Some seemed guilty about their lack of feeling and at a loss to understand why this had happened.

"When I first saw her ..... it didn't hit me that she was mine. It was just sort of like a baby. You know, as soon as I saw her I knew that she was ours, but I didn't feel like I thought I'd feel. But as soon as I saw her the next morning I knew that she was mine and I didn't have to look at the name tag or anything." (Debbie)

"You know that the baby is there but I haven't really sort of cuddled you know. It's not really a part of me just yet you know. I don't feel like, 'Oh, you're my wonderful little baby and I love you' and all that sort of thing. I'm a bit surprised that I wasn't (motherly)." (Shirley)

"I'd say she was beautiful now. Well she's not beautiful physically, but I have more feeling now than what I did when she was first born. You know when she was first born I just thought she looked like a picture in a book, but now since I've been with her I've sort of grown attached to her." (Caroline)

It was surprising that as many as ten expressed initial negative reactions. Of course, the media representations and cultural myths about attractive babies may have contributed to their disgust. Marion's interview was interrupted by visitors but she began her description the same way on two consecutive days.
"Well when I first saw her she was covered in yuk." (Day 1)

"Well she was covered in blood actually." (Day 2)

A number of the negative reactions were descriptions of physical imperfections. Examples are:

"His face was swollen and his jaw. His nose was swollen and his eyes were clenched." (Kelly)

"She's had a temperature, she's just been sleeping all the time and pulls faces all the time and scratches herself. And she's always hiccuping or burping and sneezing." (Evelyn)

"He was a forceps birth so you know ...... his eyes were all real puffy and his head was a bit pointed." (Julie)

In spite of the initial negative impression of the baby six of the women were like the mothers of premature infants and gave 'then and now' statements. The phenomenon of developing attachment from neutral to powerful positive feelings over the first few days has been noted by Klaus and Kennell (1976).

"I thought she was fairly ugly when she was born. She had a misshapen head but she is improving a lot now. I think she is quite nice now." (Marie)

"I thought she looked like a little monkey when she was first born. But she's improved a lot." (Wendy)

I thought he had hair and he was very ugly but I didn't see him for about nearly twenty four hours later. That was the next time I saw him. I thought he looked real cute you know." (Felicia)

None of the four who had purely negative statements were available for any of the follow-up visits. Marion's husband rang the day after the hospital interview and refused further contact.

Unfortunately, some of the women's recollections were hazy about their first sight of their infant and it was not possible to accurately record the
length of the initial contact or the exact time between the birth and the
next time the mother saw her baby.

Five were unsure; four had no initial contact (those were nearly all women
who had Caesearians); five reported a brief glimpse; thirty-seven said they
held the infant for a few minutes; eight thought they had been left with the
infant for between ten and thirty minutes; and only one had been with the
baby for nearly an hour. This last woman explained that it had been
visiting hours in the ward and they hadn't been able to take her around from
the labour ward.

The time elapsing between initial contact and the next time they saw the
baby varied between half an hour and twenty-four hours. The average
reported times was 11.45 hours. None of the women talked of examining or
physically exploring their infants with pleasure at the first contact. Joan's
description was most typical of their experience:

"They cut the cord and they helped the doctor put her on my
belly and I gave her a cuddle and they took her away and
wrapped her up and gave her back."

Deborah talked about the nurse wanting to take the child from her.

"She thought he would be getting cold. She thought it was
best to wrap him up. She left him for a little while but she
said it was a good idea to take him."

And Marilyn was one of those who described a lengthy separation from the
baby.

"They took her away .... (I saw her again) the day after. A
full day. The one after, Friday. I wasn't allowed out of bed.
But they brought her in on Thursday night all covered up."
As a group then these women were basically middle class and married. They delivered normal healthy full term babies. They came from intact families and have supportive husbands. Many took advantage of childbirth preparation classes. It would seem that their birth experience should be close to ideal. However, they were aware of the imposed separation of father and child and discussed the desire of the father to be closer to his child. They, too, experienced some degree of separation from the child. On the average they held it for a few minutes after birth and then waited nearly twelve hours to see it once more.

6.2 THE AFFECTIVE EXPERIENCE AFTER BIRTH

6.2.1 Negative Emotions After Birth – Comparison Between Groups of Women

Klaus and Kennell (1976) drew attention to the difference in ward atmosphere in different countries. They compared Russian hospitals where one observes "sad expressions on the faces of the women, their spiritless motions and conversation" and the maternity clinic in Horsholm, Denmark, where "you find a quiet, happy, pleasant atmosphere and mutual support as a group of mothers care for their babies and get to know them" (p.94). The differences between those hospitals were that in one the husbands were not allowed to visit and the mothers saw their babies every four hours for feeding and did not participate in other infant care, and in the other the babies were with the mothers for the whole day and the mothers provided all care with fathers and siblings visiting freely. Klaus and Kennell speculated that separation from the infant and 'experts' doing most of the caretaking tasks are factors in the aetology of post-partum 'blues'.
Kitzinger (1978(a)) believed that the disparity between the real infant and the cultural or media representations of babies may distress the mother. She believed that women need reassurance that more developed feelings of affection will quickly grow as they get to know their babies better. Of course, they cannot get to know them if they are separated.

Brazelton (Klaus and Kennell, 1976) speculated that the 'blues' may be a cry of helplessness in so far as becoming the 'ideal' mother that women in the United States may have in their fantasies. Breen (1975) also mentioned the discrepancy between what the woman experienced and felt, and what she believed she should be experiencing, as a contributing factor in the 'blues'. She argued that the removal of the infant into a nursery by efficient nurses may be interpreted by the woman as a reflection on her ability as a mother. Breen pointed out that the mother is frequently not allowed to express her true feeling and may be left wondering why she has such strange thoughts when all she has been told about is the smiling mother and baby of the magazines. She postulated that the proposal of a hormonal explanation for postpartum depression may serve to promote an avoidance of the social/cultural issues involved in some of our birth rituals.

The contribution of biological factors to the development of postpartum affective disorders has been researched often but the nature of such disorders appears to be complex and the causes far from clear (Kane, 1980). Even if physiological changes are precipitators it is obvious that the psychological burden of separation, adaptation to motherhood, and guilt or feelings of inadequacy will exacerbate the woman's condition.
Mothers with routine separations from their babies expressed significantly less anxiety, were worried less about death and had fewer vague worries than the mothers of premature babies (Appendix 10.1.1). This is indicative of the extreme stresses related to the birth of a premature child rather than a measure of low anxiety in these mothers.

The young working class mothers were the only groups that did not have a high level of uncertainty (Appendix 10.1.1). It is not surprising that the mothers of premature babies had high scores. Their labour was often unexpected and few had much knowledge of premature infants. The interesting comparison is between the two groups who experienced normal labours. Here it can be seen that the separated mothers had significantly more puzzlement and uncertainty (Appendix 10.1.1). Examination of the transcripts provides clues to the reasons for their anxiety. While both separated and premature mothers expressed puzzlement in relation to the infant, the labour and the various aspects of the medical care they received, there seems to be a different flavour to their anxiety. For the separated mothers the anxiety about the child was more frequently a non-integration of the fact of the birth, or an inability to recall the early impact of the child's birth. The mothers often seemed to be trying to recall an experience veiled by the impact of drugs. Unfortunately, no record of administration of medication to the women was obtained so that this cannot be checked. The flavour of the experience can be seen from the following statements:

"I didn't really take any notice when I first saw her because I was too out of it. I'd had a lot of injections and so forth, so I really didn't take much notice of her." (Beth)

"I can't remember. I can't remember (when I first saw him). It must have been late Thursday night. Thursday? I had him
on Thursday. It must have been late Friday. I didn't see him for a while because I wasn't really well. I suppose they don't let them come. If you're not real well or anything, well they just keep them away for just a little while, till you feel up to it I think." (Sandra)

"Oh I don't know (what she looked like when first born). I wasn't really conscious of her when she was first born." (Wendy)

"I don't remember seeing her that night at all. I remember them bringing her around the next morning just showing me. I didn't see her at all the first day because I had an I.V. in and everything." (Sue)

Three women mentioned the difference between the child they had fantasised and the real child. These differences necessitated readjustments.

"(I was impressed by) her dark hair, and the fact that she looked very much like my husband. It was quite surprising because you know, when you're pregnant, you sort of have illusions of what your baby is going to look like and things." (Narelle)

"I was so surprised. I was expecting him to have black hair, cause to take after me. But he's got really fair hair like my husband." (Noeline)

"I was anticipating that she was going to be crying and she's not." (Caroline)

Barbara had a series of readjustments to make, beginning with her labour and going through to her early reaction to the baby and her husband's expectations. Her emotions appear confused and mixed about all of these events.

"I felt it was a very good birth. Better than what I expected really. Because, you know, you hear different things from other people - their experiences. And you sort of try and put them out of your mind but they're always there. And you sort of worry a bit, and a bit scared. I tried to recall the day, you know. I try to go through each event and I'm finding it hard. It's sort of a daze because I was very tired that day too."
She had mixed reactions to the infant:

"I thought she was very red, red all over. And I thought she had blue feet and when they, and when they said, 'Oh, it's a little girl' I thought, 'Oh, it's beautiful'. I was very pleased. (Now) she's lovely. It's my little girl. I've noticed she's changed from the actual birth to now. She was very, um, her skin was peeling and that's going now. That sort of turned me off. I was sort of worried about her hands. But she is really looking lovely.

Her husband had desperately wanted a son.

"Well, actually he wanted a boy for a start. And he was, he had his heart set on it I think, deep down. He wanted a boy and he'd carry on about a name and doing things with him. But when he saw her he really melted. I think it's mellowed him a lot and, you know, he said to me, 'I'll have to look after both my girls now'. You know, so he's changed. He's softened from that, you know, wanting a boy so much to a girl."

Her last comment during that interview was about her own emotions.

"I don't know. I feel sad. I feel happy inside really. Oh, it's silly."

With the mothers of premature infants there was a sense of urgency and distress in their discussion about the speed of the labour, whereas for the mothers experiencing routine separations there was a surprise and a reassessment of their beliefs about labour, but it was not totally unpleasant.

"(The second stage) that was the quick part because it was all over within a matter of minutes. Even the doctor was surprised how quickly. When he arrived he said, 'Oh, it will probably be another hour or so, even more'. Well I think within half an hour the whole business was all over." (Fiona)

"It was, you know, a very fast birth. I didn't expect it to be as fast. I thought it was going to be a lot more painful and that, and I was shocked, you know, because it was so fast." (Elaine)
There was also a lack of awareness of the meaning of the procedures or an inability to recall the events of the labour.

"When I was in the room by myself I was frightened. I was, er I just didn't know what to expect and just wished I had somebody there." (Diana)

"I'm sort of a bit hazy about this. Like I did have the gas and I'd had two injections earlier, sort of to ease it. And in a little while it seemed to be, it was over you know ..... You know I'm very hazy about it all. I try to get everything into perspective but you can't." (Pam)

For Pam the haziness of the experienced also included difficulty in realising her child had been born. She described her reaction to her child's birth.

"It was eerie. He just lay there on my chest, sort of breathing, you know. And I just couldn't get the thing over me. And the doctor said I was frightened of him, but I wasn't. It just was that I didn't believe that it was all over and he'd arrived."

The most interesting finding in the separated mothers' results came from their scores relating to feelings about the hospital, staff and procedures. They expressed significantly more anxiety about separation in relation to medical routines (Appendix 10.1.4) than did the premature mothers, while the working class mothers expressed none at all. They also expressed significantly more anger about the hospital and talked of anger directed towards them by the hospital staff more than the mothers of premature babies. There was no significant difference on hostility scores when they were compared with working class mothers (Appendix 10.2.4).

The separation referred to by these women was usually from their infants but it was spoken of in terms of hospital routines enforcing such separations. Because of this it was decided to classify such statements under 'Separation Anxiety (Medical)'.

"Yes, it was real strange. It was just like as if I was some little kiddy. Well, I presume its the way a small child feels when it's got a toy and it's suddenly taken off them, right out of their reach. That's what I felt, real empty. And as if she was, you know, just gone." (Carol)

"I want her to stay here longer. I think that if they could at least leave them with us for an hour or so after a feeding, after each feed it would be marvellous. But I suppose they've got things in the labour ward and they can't do it that way." (Monica)

"(When she goes back to the nursery) I feel disappointed because in a way I know I should be sort of, you know, with her more so I won't feel as nervous when I get her home. I should be handling her more. It's something I'm a bit scared of." (Fiona)

"I don't want him to go. I just want him to come home and I don't have to hand him over." (Pam)

Because of the criticism often expressed in these separation statements they tended to score on anger as well. This would have contributed to the significantly higher expressed anger about the hospital and its staff.

Some women expressed very direct criticisms of the hospital, or feelings they had that the staff did not approve of their behaviour. Examples of disappointment at the separation of father and child have been given earlier so the following relate solely to the mothers' own experiences.

"They didn't even say I could touch them in there you know. I didn't realise that you could put your hand in. I just thought, oh well, it's better for them, you know, if I don't touch them. They don't really tell you anything around there in that section." (Dierdre - mother of twins)

"I went down to the labour ward and I was really terrified because I was being induced. That morning, about half past six in the morning it was, I went to the toilets and I cried. I was so terrified, you know, cause there was no nurse, cause no nurse had really come up to me and told me what was going to happen or anything. You know, and I felt really sort of scared, terrified. And when I went down to the labour ward I was really shaking. I don't know what, it was cold, but I wasn't shaking from the cold. I was shaking cause I was so scared." (Lee - telling of her induction)
"I tried to breastfeed him but, like, there was just a sister here. I shouldn't say, but she had long nails and she'd grab the baby's head and she'd force it onto my breast. Well, I wanted to breastfeed but it looked like she was hurting him with her nails. Because the baby would scream. I mean screaming. He wouldn't whinge, he'd scream. That was tensing me up and upsetting me and my milk just wouldn't come properly." (Kelly)

"I think it's pretty important the attitudes of the sisters about breastfeeding. If you want to go off there's a mixed reaction. But they can be nasty. I don't like them at all and I feel that's very (1 word missed). But what can you do?" (Thelma)

6.2.2 Negative Emotions After Birth - Comparison With the Wollongong Sample

The women with routine separations expressed significantly more anxiety, worries about mutilation, separation and puzzlement than found in the Wollongong sample (Appendix 10.1.1). A pattern of raised anxiety is part of the birth experience and was also found in Wesbrook's sample (Appendix 14.2). This suggests that the birth of a first child involved a reappraisal and coming to terms with threatening and rapid changes in a novel situation.

These mothers did not, however, have the same high score on the Shame Scale as she found. A partial explanation for this may be that Westbrook did not interview her mothers in the immediate postpartum period and Appendix 11.1.1 shows that by three months the feelings of shame had risen to a mean of .88 (standard deviation .65). While this was still not as high as the Westbrook value of 1.08, it had increased. It is also true that Shame anxiety was one of the scales with lower inter-rater reliability.

At the time of the first interview with these women, they could only express shame about their coping with the birth or the child they
produced. They would not have had an opportunity to take responsibility for the care of the child and, therefore, could not be really expected to express shame or inadequacy in relation to the mother role.

The striking difference with this group was that they were the only group of mothers who expressed a significantly higher concern about separation and loneliness. The reasons for this are apparent. As discussed earlier, their transcripts provided evidence of their reaction to their own separation from the infant and the isolation of their husbands. Because the other two groups of mothers did not show this pattern of raised Separation Anxiety it is clear that this need not be a feature of the anxiety surrounding childbirth and it was related to their hospital experiences.

Although it may be easy to eliminate the anxiety created by the separation of the woman from her infant and husband it would be impossible to significantly reduce the other fears. Childbirth is, realistically, a time when women have fears for themselves in terms of surviving the labour, of pain, and of procedures leading to bleeding and cutting. The discomfort of labour was often mentioned by the women.

"I had dreadful backaches. And plus I was throwing up a lot and they had to put drips in me." (Wendy)

"I was in labour for about twenty hours and I had very bad backaches with it. At times if I could have I would have changed my mind if I was able to." (Grete)

"(The labour) was very trying, even though I think that they classed it as a short labour. It was very painful. For a couple of days I was feeling sick and sorry, but I'm pushing it out of my mind as the days pass." (Fiona)

"I've got four stitches in the skin. I don't know about my muscle. Usually a couple, so probably about half a dozen stitches I think .... I got the impression that the doctor held off a bit to see if I could stretch it myself and sort of only at
the last minute, then he cut it and the head was coming out. I got another injection in the leg afterwards but I don't know what that was for. (Joan)

All mothers-to-be hope for a healthy child, but at some stage wonder if the child will be healthy and normal. This was usually expressed in a simple statement, such as, "I don't care whether it's a boy or a girl, so long as it is alright". The infant being 'alright' as opposed to being damaged was often the only clue to the existence of these fears.

Because the child's survival was not so tenuous as the infants born prematurely the mutilations the mothers spoke of were not so severe. They discussed more the minor damage inflicted by the birth or medical procedures.

"And she still had a funny shaped head and she had a little mark on her forehead." (Marie)

"The doctor gave me the impression that they took every precaution they could simply because, you know, of the fit, and the blood pressure and the toxaemia. So he got a bit bruised and so on from the forceps." (Felicia)

"He wasn't feeding well. He's gone off the breast. He wouldn't take the breast at all ..... He's got a little bit of jaundice but that's taken a while to clear up, but I think it's going." (Thelma)

Their raised Cognitive Anxiety may be partly due to these being primiparous women. They were entering into a new role in life and they could pass this stage only through the initiation rite which was labour. No matter how many films are seen, or how intently one listens to others who have produced children it is never possible to fully anticipate the sensations, stresses and joys which are part of giving birth. Women will continue to fear the unknown. Additionally, for a primiparous woman there is the knowledge that she has never raised a baby before. She has to learn
to listen to the child, understand its needs and attempt to supply them if she is to be a 'good mother'.

The routine separation mothers, like the working class mothers were significantly higher on pawn-like feelings. They expressed a greater lack of ability and influence and were able to expend less effort than the Wollongong sample (Appendix 10.3). Only the mothers of premature infants who had regular meetings with the hospital staff and who were involved with caring for their infant in the intensive care nursery did not have this higher score.

Osherson and AmaraSingham (1981) discuss the mechanisation of childbirth. In that model women in labour are very much at the mercy of the institution, its rules, the work of delivery, the reactions of and health of the infant. It was no wonder that their transcripts were high on Pawn statements. The procedures were often spoken of as though the women had no control over them. Carol provides an excellent example of this. About the birth she seemed to feel she had been unable to go into labour, and her contractions appeared to be something that happened to her and over which she had no control.

"My water broke on the Sunday at three o'clock in the morning and I had a blood show at five o'clock, but I didn't go into labour at all. I just kept losing water. They induced me at four thirty on the Tuesday morning ..... I suppose it was like I had a bad pain in the stomach and couldn't get rid of it. And then it got stronger. And then the next thing I knew they told me to push. And in no time she was around and it was all over."
Elizabeth had much the same sort of experience.

"Well I was brought in the day before because I'd gone into labour a few times and when it got to about the fifteen minutes intervals it would stop. And the night before I came in I had the show and everything, and I was overdue. So when I rang the doctor he just said, 'Come in and we'll induce you'."

Kelly's efforts were painful and she became exhausted.

"And I couldn't breathe properly because I didn't have any antenatal stuff. But the sister told me how to ...... but I did push when the pain was gone, but it hurt me more than anything. So I tried to relax and just couldn't relax myself. I was too tired. Then they calmed me down and put the mask on and just started to knock me out a bit. All I wanted to do was sleep." (Kelly)

A number of statements also related to early difficulties in establishing breastfeeding.

"I think I'll demand feed at home because quite often when they bring her up now she's asleep and I have to sort of struggle with her to wake her up for a feed." (Shirley)

"I've tried twice to feed her but she won't take it. She just takes straight to the bottle. They said that it's easier for her to suck on." (Debbie)

6.2.3 Positive Emotions After Birth – Comparison Between Groups of Women

This sample of mothers had significantly more warm and positive feelings than the mothers of premature babies (Appendix 10.5). They expressed more warmth about the baby and the medical staff. The greatest amount was expressed towards the baby.

"He's a very quiet, calm baby. Very alert, quite happy and a real cuddler. He looked very pretty." (Elizabeth)

"He was a beaut little thing." (Meg)
"She's pretty placid most of the time. She's, I think she's beautiful to look at. When I first saw her she looked pretty messy but I still thought she was beautiful then. Oh gee, it's hard to describe really. She's just like she is. I just, I just love her. I just think she's lovely." (Shirley)

In spite of the hostility and criticisms this group of women expressed in relation to the hospital, staff and procedures, there were a number of women who were full of praise for their doctors and nurses. Diana was one who was most appreciative. She felt quite special.

"The attitude of the nursing staff is fantastic. They were tremendous. The two midwives that were there with me they couldn't have been more helpful. Although when I was in labour I kept saying is there something I can take to relieve it and they couldn't give me anything, but they rubbed my back for me. And then when the doctor got there he was tremendous too. He gave me his back to push on and that was when I was bearing down. I was pushing into the face instead of into my bottom and when he did that it helped tremendously. And I told one of the ladies here and she said, 'Wow, I wish we had something like that because you had nowhere to put your feet'. He was terrific." (Diana)

Stella also spoke most approvingly.

"And the sister was actually really lovely and the girl that was by me. She did exceptionally well. She stayed right beside me and she was panting with me. She helped a great deal - same as the sister. The doctor didn't say what (eight words missed). But gee the staff in here is tremendous. I like every one of them you know." (Stella)

There was a trend (p.02) for mothers with routine separations to have significantly more warm and appreciative feelings in relation to their husbands than did the mothers of premature babies. This was probably more a reflection of the circumstances, increased demands and stresses of a premature birth than an indication that the women felt more positive about their husbands. However, as discussed later, it can be seen from the premature mothers' transcripts they needed support from husband and family at this time of stress, and unfortunately they did not always receive it.
The mothers of this chapter often expressed positive affect in terms of gratitude or happiness at having the husband with them during the labour and this was not possible for more than half the fathers of premature babies. Examples of these husband-related statements have been given earlier.

The Emotional Cost (Appendix 10.6) was significantly less than for the mothers of premature babies. This reflected the high emotional cost of producing a premature child.

6.2.4 Positive Emotions After Birth - Comparison With the Wollongong Sample

The childbirth experience led to a decrease in feelings of ability, effort and competency. These women were significantly lower on this scale than the Wollongong Sample (Appendix 10.3). The same pattern of lower Origin scores occurred in the mothers of premature babies' transcripts. For many women the medical procedures remained a mystery. Kitzinger (1978(b)) discussed the modern hospital's rites of separation and humiliation for women in labour. She concluded "It is all part of the making of a compliant patient" (p.147). Compliant patients do as they are told, do not argue and initiate very little. After the birth the mothers could make few decisions. The medical profession and hospital played an important role in deciding how a newborn infant was to be parented. Mothers may have wished for rooming in, three hourly feeds, breastfeeding, etc., but while they were in hospital the doctors and nurses had the power to override most decisions they made.
Although these mothers were low on Origin, the decisions they made usually concerned coping with the labour or plans for rearing the child.

"I was still having pains down one side but I managed to push her out without forceps being used and I was glad of that." (Shirley)

"The labour was hard but probably no harder than anyone else's labour. But the end, the end was really exciting, when I could actually do pushing it was good." (Deborah)

"I'll try if I can to keep her on the schedule she's on now." (Helen)

"There was one day they left me alone and he went perfect (feeding). I was pleased. And then I told them to leave me alone but they said no, they've got to keep an eye on him feeding. So I said, 'Well I'm bottle-feeding'. Now he's on three hour meals and 60 mls every feed." (Kelly)

Interpersonal relationships (Helping, Intimacy, Influencing) were significantly higher than the Wollongong sample (Appendix 10.4). Not surprisingly, all groups of mothers scored significantly higher on Intimacy than the comparison sample. The separated mothers expressed greater warmth in relation to their husbands (Appendix 10.5) and they were appreciative of the support they received from their husbands and the hospital staff. They also expressed warm feelings towards the infant and shared pride in the birth. Expressions of pleasure, pride and shared family joy have been given earlier.

In summary, this sample of mothers' experience of childbirth and the early postpartum days showed a pattern of increased anxiety (including Separation Anxiety) and some Hostility directed towards the hospital, the staff or procedures. This was, however, balanced by high scores on Positive Affect and Sociality.
6.3 THE AFFECTIVE EXPERIENCE WHEN THE CHILDREN WERE THREE MONTHS OLD

Thirty mothers were seen at this time. Five had declined further contact, twelve moved, one did not answer letters and phone calls, three gave incorrect addresses, one was unavailable at the key developmental time, and with eight the investigator was too late to observe the child at around three months of age.

Because of the high subject mortality rate it is possible that the sample was no longer representative of the mothers who gave birth at the hospital with routine separations. Of the sixteen women who did not initially react with some positive emotions to the child, only four were available at the eighteen month visit. It seems that those whose reaction to, and relationship with the child, was not ideal, were those who were most likely to discontinue. The affect and behaviour scores for these mothers would have been enhanced by the loss of the less well adapted mothers.

6.3.1 Negative Emotions When the Children Were Three Months Old - Comparison Between Groups of Women

There were no significant differences between the three groups of women at this time. The high amount of loneliness and loss of love related to the hospital's routines remained about the same (birth mean .45, three months mean .47), (Appendices 9 and 10). However, the women with premature infants increased their scores on these feelings so that by three months
there was no significant difference. Working class mothers expressed none of this type of anxiety at either birth or three months.

The anger about the hospital, medical staff and procedures remained much the same, and again it was an increase in the premature mothers' scores which accounted for the fact that there was no significant difference between the groups. Young working class mothers from having levels which were similar to those in the first sample were three months later expressing neither of these emotions. However, there were only scores available for three working class women at three months.

Their angry and lonely feelings were still about the same experiences as earlier. This was partly a function of the technique of the interview at this time which used projective material reminding them of the birth.

"I waited a lot on visiting hours. I used to wait for my husband to come up and then it was really good." (Rae)

"I probably wouldn't have liked her with me all the time cause, um, you do need the rest. But I would have liked to have had her for longer. You only had them, they only brought them in and fed them and whisked them straight off." (Monica)

"I didn't feel all those mushy emotional things that you are supposed to feel. I felt as though she was a stranger, I looked at her lying in the crib and thought she was a little stranger. She didn't have anything really to do with me and it was a queer feeling really." (Shirley)

"I didn't get to see her all day. Nearly two days. I had to ask to see her. And they had her in that crib thing after she was born because she was very cold. Because it was cold that night. And I didn't get to see her for two days. I had to ask to see her. They sent for me to go and see her in the nursery, and then I had to feed her then. .... I was saying, 'Oh, I wonder what she looks like'. I want to see her and all that, you know, and so I kept asking the nurses if I could go and see her, and are they going to bring her." (Zoe)
6.3.2 Negative Emotions When the Children Were Three Months Old - Comparison With the Wollongong Sample

The mothers experiencing routine separations were significantly higher on anxiety. They were worried about mutilation and damage. They also felt puzzlement and vague worries much more than the Wollongong sample (Appendix 11.1.1). Although the stimulus pictures used at this interview contained pictures relating to pregnancy, the birth and the hospital there were others depicting mother and child in the home. The anxieties expressed by the mothers were based on some recollections of the labour and the birth, but they also spoke freely of current concerns. Establishing feeding and caring routines had been difficult for many, and adapting to breastfeeding was rewarding for some but quite impossible for others.

"In the first two weeks I really, I thought I'd give up very shortly cause it was hurting so much. But then it seemed to improve. I quite like it. Though sometimes it sort of irritates. He munches because he's a bit of a tough biter." (Jenny)

"I was having so much trouble with it I had to go down and feed in the nursery so someone could watch me feeding, and I used to get milk everywhere. I used to get sodden. It used to go all over, but in this picture she looks really happy about it. That is what I think about it now, and I really enjoy it now. I think it is good. She has been putting weight on and I feel good about it now and I want to carry on as long as I can." (Shirley)

"Well, I didn't feed for that long. I think because John was so difficult feeding. It became routine rather than, you know. I think we've been like a lot closer with bottle feeding. Because he enjoyed it you know ..... Before, it was just a panic all the time and him trying to, you know, get away from me." (Felicia)

"At first I was really tired when I used to get up in the night for feeds and everything. And that's where I found bottle feeding was a nuisance because you'd have to get up and heat the bottle up. But now I'm used to it and that, and getting up. But at first I was sort of surprised. I'd sort of hear a baby waking up and I'd forget that I, that it was my baby."
And I'd sort of think, 'Oh, God, that's the baby crying'. You know, I'd think I was dreaming or something." (Rosalie)

Some women expressed anxiety about their ability to cope as mothers without directly specifying where they felt inadequate. The questions they seem to have asked themselves were "How can I cope in this new role? Can I take care of the baby properly and will I love it enough?"

"I was a bit worried that I was odd, that I didn't have that maternal instinct that you're supposed to have. But it came." (Molly)

"I often think how I'm going to cope when I have my second one. Oh, at first anyway. Because everyone says, 'Oh, it's going to be hard' and I think 'Oh, gee'." (Barbara)

"Well I was very nervous, like specially when I was first home. But we got through it alright. I'm used to it now." (Dana)

"And when I used to bath him I was terrified you know. And the first time I had sweat pouring off me face. Oh, it was terrible." (Rosalie)

Marie summed up the nightmare like experience a number of mothers had.

She described her first night home with her baby:

"All I wanted was just to have the baby and to take it home. You know I was really anxious to be home. And we went. When I got her home I remember the first night was absolutely terrible because she just started crying about 11 o'clock at night. And my husband had to go to work the next day and he, he went into the back room to sleep and he was asleep. And I fed her and she just wouldn't go to sleep and she was crying and crying. And I then rang my mother up. And I said, 'What will I do?' And she said, 'What have you done? Have you fed her? Have you done this? Have you done that?'. And I said, 'Yes, but she's still crying, she's just crying'. And so Mum said, 'Oh, you'll just have to let her cry a little bit'. And the next thing, in the drive, a car pulled up in the driveway and it was my mother. My husband woke up in the morning – at 6 o'clock in the morning and I said 'Oh, I'm glad you've woken up, you'd better take Mum home.' He said, 'What?' And I said, 'Oh, Mum's been here all night'."

She felt responsible for her child and spoke of how this affected her.
"To my husband) I would say 'You go to work and forget about her but I'm here and I, I have to think of her every minute'. And I didn't really have to think of her every minute. Now I realise that and relax and I don't have to. But at that stage I thought if this goes on much longer (3 words). I really thought I was going around the bend. But now I realise that and I'm much more relaxed with her. .... I don't know what it was. It was, I think it was that I thought that it was something wrong with me if she cried. I felt that everything that she did was, you know, I was making her do it. Or, if I was a better mother, she wouldn't cry. Or if she got a rash I'd feel that I'd given her a rash because, you know, I'd done something to her. And I felt that I, I, it was me that was a failure if she was crying sort of thing."

6.3.3 Negative Emotions - Changes Between Birth and Three Months

Fears of damage caused by medical interventions decreased but other anxieties strengthened. Puzzlement and uncertainty increased significantly (Appendix 13.1.1). The women expressed more anxiety and shame about themselves, and there was a tendency ($p$.02) for vague worries and anger in relation to themselves to also increase (Appendix 13.1.1). There was a trend ($p$.02) towards decreased worry about the baby. The excerpts from the transcripts given previously illustrate these emotions.

The pattern of anxiety they showed was consistent with a woman who lost some of her anxieties about her hospital experiences over time and felt less anxiety in relation to her infant. She was still having difficulty in making sense of her new role and felt increased concerns in relation to herself - i.e. anxiety, shame, vague worries and hostility.

Figure 1 shows affect decreasing between birth and three months for mothers with routine separations. Figure 2 shows affect increasing between birth and three months for these mothers.
Figure 1: Affect decreasing between birth and when the children were three months old for mothers with routine separations.
Figure 2: Affect increasing between birth and when the children were three months old for mothers with routine separations.
6.3.4 Positive Emotions When the Children Were Three Months Old – Comparison Between Groups of Women

There were no significant differences between sources on the positive emotions (Appendices 11.3; 11.4; 11.5 and 11.6).

6.3.5 Positive Emotions When the Children Were Three Months Old – Comparison With the Wollongong Sample

Their feelings about their ability, efforts and seeing themselves as powerful or as causal agents were significantly lower than the Wollongong Sample (Appendix 11.3) but this was common to all three groups of mothers. These women were also significantly lower than Westbrook's sample ($t = 3.42, p < .001$). It is difficult to see a reason for this. Westbrook and Viney (1980) found that high socio-economic status, attending prenatal classes and those mothers who reported reading or seeking professional advice to aid in learning about how to care for infants correlated with high Origin scores. These mothers were medium socio-economic status and few reported reading or seeking professional advice as methods for learning about child care (Appendix 7.2). However, 63.3 per cent (Appendix 7.1) of the mothers had attended childbirth education classes. Perhaps the middle-class status and the enforced separation (leading to discharge from hospital when mother and infant were almost strangers) combined to produce the lower Origin scores.

Mothers with routine separations were expressing significantly more warm feelings and feelings of intimacy than the Wollongong Sample (Appendices 11.4 and 11.5). Their relationships with husbands and infants were sources
of satisfaction. Often the husband was spoken of as a support and an aid in the new parenting role, and every transcript produced some example of warmth and pleasure in relation to the child. The three month period was almost like a 'honeymoon' where the early difficulties had been overcome, anxieties about the child were reduced and the child was rewarding them with an extending repertoire of responses. Blake, Stewart and Turcan (1975) noted that when the infant began to smile and become responsive, mothers of preterm infants looked better and handled the baby with pleasure and confidence. At three months of age full term infants would be rewarding their mothers with many social responses. Thus the routine separation mothers were showing the affective differences one would expect from new mothers at this stage. They had an increase in intimacy and a high regard for the infant. They were able to maintain the high levels of warm feelings experienced at the time of the birth. These warm feelings related to both husband and baby.

**Husband Related Statements**

"It was beaut to have him home. Well the first week wasn't so good. Doug was up at 2.30 the second morning washing nappies because he thought we were going to run out. And we had him in our bedroom for a couple of nights. We moved him out of there very quickly because we just couldn't sleep. We'd hear all his goos and gaas and carrying on." (Shirley)

"If it's tea time and I've got to feed the baby, then we've got this, sort of, baby comes first. And he'll go and finish the tea off, and he'll finish setting the tablecloth and that." (Diana)

**Baby Related Statements**

"Around about now when they're really becoming little people you can enjoy them a lot more and, you know, play with them." (Julie)

"When I am sitting holding him everything is really perfect. And that's all I wanted - just a happy little baby." (Elizabeth)
"I think that's a wonderful experience too to feed your own baby. You know specially after a night like when he first slept through. You're thinking, 'Oh, God'. You're getting up in the morning and your breasts are like I don't know what - great big rocks. And then, you know, it's a great feeling when they sort of take it away and relieve you. I don't find it, you know often they say it's a sensual almost sexual exciting experience. I don't feel it like that at all. It's just a very pleasant soothing relaxing time when I'm feeding him. Specially when he enjoys it so much. Now he, now in the middle of a feed, he sort of breaks off and gives you a bit of a smile and wiggles his toes and comes back again. Lovely! And you know his whole little body goes and, then all of a sudden he breaks off and smiles and then comes back again." (Shirley)

"I always enjoy playing with David and nursing him. Every night before I go to bed I take him upstairs and roll around on the double bed and play. He gets great enjoyment out of it. And one night I was in such a rush. We had some visitors. I didn't have time to play with him and I kept him down here longer than usual. And then took him upstairs and fed him and put him down. He didn't like it. Screamed the place down and wanted his play, so I took him out and played with him. I thought 'To Hell with the visitors'." (Judy)

6.3.6 Positive Emotions - Changes Between Birth and Three Months

There were no significant differences in positive emotions between these times. There was a trend (p.02) towards a significant difference in expressions of helping (Appendix 13.1.1). They expressed less of this at three months. This difference reflected the high regard the women had for the help they received at the time of the birth. There was less need for help three months later. Husbands were still spoken of as helping but the discussions of the help and support they received from the hospital and their extended family had practically disappeared.

6.4 THE AFFECTIVE EXPERIENCE WHEN THE CHILDREN WERE EIGHTEEN MONTHS OLD

By this time one infant had died, four families had moved and could not be located, and one mother declined to be interviewed further. Two women
had already produced a second child and eight others were again pregnant or hoping to be. This meant that nearly half of those remaining in the study would probably soon have two pre-school children to care for.

At this visit they were asked about changes in their life since having the child. Their responses were a mixture of positive and negative changes. Usually the first response was a description of the extra demands and personal restrictions. The answers have been classified and are in Table 3.

<table>
<thead>
<tr>
<th>Statement</th>
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<tr>
<td>Restrictions in personal freedom</td>
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<tr>
<td>&quot;Someone else there all the time&quot;</td>
<td>6</td>
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<tr>
<td>Loss of personal identity</td>
<td>3</td>
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<tr>
<td>Increased financial worries</td>
<td>3</td>
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<td>More work</td>
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Table 3: Separated mothers responses describing changes in lifestyle by the time the children were eighteen months old.

The statements about restrictions and irritations varied very much in the degree of emotional cost. Five mothers also mentioned impatience with the growing child.

"We didn't have to cut back on our social life but it's changed in that I think that you're totally thinking of another person all the time (3 words) and have to consider her every hour of every day. She's always around, which takes up quite a lot of time. I like to get her into bed at night. It's beautiful (4 words). You can put up with most things during the day but you just like sort of to have time." (Marie)

"She's made a difference in every way, I think. All ways. You can't do what you want to do. All the time you're with
Barbara also expressed a loss of personal identity. She was one of the mothers with a second child.

The most common statements were a recognition of the restrictions imposed by the child and the routines needed to care for it, but this was tempered by an acceptance of the situation.

"Oh, life's changed quite a lot. That sharing everything with one more person. I think I've forgotten - you tend to forget what it was like without them very quickly .... You try and go out to people's places and take him with us mostly if we can. We don't go out to dinner much any more, do we? How else has it changed Peter? What other things have you done to us? Eh? Oh, we love having him. He's great." (Jenny)

"We can't go for holidays much any more because he doesn't like travelling. So we restrict it to the short one or two hour trips here and there. We obviously haven't got the freedom we used to, which we used to have. But we don't particularly, we don't want to go out all the time anyway. So that doesn't really - it's a change but it doesn't worry us." (Shirley)

There were some beautiful expressions of intimacy and enriched lives as a result of the relationship with the child and four women specially mentioned that the child had strengthened the bond with their husband.

Some expressions of warmth relative to the child were:

"Having children is sort of, I think, brings out a lot of hidden, oh, you can call them qualities. But there's a lot of hidden little feelings, etc. You sort of realise you didn't have them before about the child. And just the love of the child is certainly a lot different to the love you feel for your husband or somebody else. It's a, it's a sort of different kind of feeling altogether. It's, er, just warmth you feel. It brings out a lot." (Fiona)
"There are positive differences too. Like I really enjoy having her with me all day. It sort of makes the housework more fun to have her mucking around. Oh, it's a different sort of happiness that comes out of having her than comes out of going out every night." (Shirley)

"I was offered a part-time job for six weeks last Christmas, but I refused because we didn't really need the money and I didn't want to leave him. I enjoy being with him and would rather stay at home ..... We've been happy with him and way he's growing up. I believe you can't spoil children - only teach them bad habits." (Pam)

Expressions of improved relationship with the husbands were:

"In this past while, I think that she has brought us closer together and I think there's a change especially in this past year. It's just that we're a family." (Sally)

"I think we're a lot closer since being with her. And I, I don't know, I think we're closer since having to look to our future and that, and sort of counting the pay." (Joan)

"Although there was always a bond between my husband and myself I think it's closer than it ever has been before. Because we've, we have something that we've made. And you can say that's the main thing. The family bond we really have." (Diana)

Summarising the statements about their leisure time and time with their husbands, in addition to the four who said the family bond was improved, there were nine who felt their life was the same as before, and twelve who said that they had less time with their husbands. Those who had less time with their husbands often qualified the statements by explaining how hard the husband was working (extra job or study), the time he spent playing with the child, or saying that their own needs were simple.

"It's just that he is doing a milk run as well as teaching so he works. Of an afternoon he only comes home at four o'clock and then he's gone at ten past four, and then he's not home
till half past seven. But Peter doesn't like to sleep till eight o'clock. He won't go to sleep till then. I think he likes to see his Dad for a while." (Jenny)

"Well he's starting up his own business now and he's working a lot late every night. The couple of hours that he does have, like, he spends with David more than he spends with me now. But I don't really mind that because that's the time that I usually get the ironing done and the little trivial things like that, which I can't do during the day because he gets at it." (Judy)

"No, we don't have any hassles going out. When we decide to go, we go, you know. Being here all day (3 words) and at night we're together. You know I'm not the sort of person who needs to go out a lot. I think it's because I've got the children." (Barbara)

When they did go out and leave the child they most often left it with their own family. Three women used neighbours or friends as well. The maternal grandmother was the most frequent baby-sitter. She was occasionally an angel of salvation as well. Rae, who lived in a second storey home unit and had a new baby as well as an active, inquisitive toddler describes her mothers' help and her lifestyle with the children:

"(My husband) works long hours now because the house is being built and whatever else. Because he's a brick carter and he's gone before daylight and it's dark before he comes home. And often, you know, I think that we'll just sit down and watch TV. The boys are asleep and then one of them will wake with toothache, earache, or something. It restricts us. Alan, he gets annoyed sometimes because, like, when we go up the Coast. You know, there's things to do around the new house and he says, you know, it'd be good if we could get in and do it together. But we can't you know. I've got to sort of look after them ..... I don't get out very much at all. I had my mother down for a week last week, which was good. She sort of helped me with things and that. I was behind in sort of washing and everything else, you know. And so, she come down and I was able to go and get my hair done. Because it was all straggly. And she looked after the boys for a couple of hours, and I went and got my hair done. But, as for going out and that, it's been ages since I've gone out."
Slightly less than half the women had decided that their main role was as mother and housekeeper and did not wish to return to work. Figures for return to the workforce are in Table 4.

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<tr>
<td>In part time employment</td>
<td>7</td>
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<tr>
<td>Would like to work at some time in the future</td>
<td>6</td>
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<tr>
<td>Would prefer not to work</td>
<td>11</td>
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Table 4: Return to the workforce among mothers who experienced routine separations

For those who had already resumed work or who wished to, the reasons were not so much financial as their own needs for identity, self expression and meeting others. Only one mother said she returned to work because of the income. Shirley and Sally expressed their needs most clearly.

"I started work in March this year and I think the main reason why I did start back was because I'd, I wasn't thinking very clearly. I don't know. I never quite got over the post-natal business. You know, your brain's not functioning nice and clearly. Which it quite didn't. And I think it was because the girls just talk about babies and nothing very much. So I went back and in about a month I was feeling a lot sharper. I was quite glad of it. There is a lot to be said for women working. Also, it was nice to be out the odd day a week. It gave me a break." (Shirley)

"It was a difficult decision (to go back). I wanted someone I was sure would look after Amanda properly. I was becoming a bored housewife and such, tied to the domestic scene. It's just not me. I don't work full-time. I only work three days a week. Which gives me the best of both worlds I think. I find I
enjoy Amanda much more, I think now than if I was with her all the time. I'm much more patient. Because you, you do have to have a lot of patience with her." (Sally)

At this third interview the mothers were also asked if there was anything they would do differently with another child. Their answers were interesting. By far the most common response was that they would be more relaxed and that they would not fuss as much about little things. Apparently the mothers had learned how tough their infants really were. Feeding, crying and dressing were the three main areas where they would specially feel more relaxed. The categories of answers about changes they would make are in Table 5.

<table>
<thead>
<tr>
<th>N</th>
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<tbody>
<tr>
<td>Relax and not fuss</td>
<td>14</td>
</tr>
<tr>
<td>Do the same things</td>
<td>5</td>
</tr>
<tr>
<td>Breastfeed or feed longer</td>
<td>2</td>
</tr>
<tr>
<td>Introduce bottle earlier</td>
<td>2</td>
</tr>
<tr>
<td>Train the child to sleep</td>
<td>1</td>
</tr>
<tr>
<td>Train the child to be sociable</td>
<td>1</td>
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</table>

Table 5: Planned changes in behaviour with a second child by mothers experiencing routine separations

In addition, one mother also said that she would take childbirth education classes to prepare herself for a second birth and was contemplating acupuncture. The two mothers who wanted to introduce a bottle earlier were breastfeeders who felt the ties of feeding and wanted to be able to
supplement the breast with bottles on occasions. Both mothers who wished to train their child (to sleep and to be sociable) were at a loss as to the way they could achieve this.

Examples of not worrying so much were:

"There's one thing that used to annoy me a lot. And, and when she first started to crawl - about six months. When she crawled I (5 words) from one end of the house to the other and she'd still get into mischief of course. Because she'd reach out. And then I went around the house tearing my hair out and thinking that, you know, it was four o'clock in the afternoon and the house looks like a wreck. So, yeah, we just don't worry about those sort of things any more." (Fiona)

"When she was born my mother came over and, being the first grandchild, if she cried everyone picked her up. When it was time to go to bed we'd nurse her to bed. You know, make sure she went off to sleep and tip-toe in. And in the end, after about I suppose 12 months, it got to the stage she'd wake up at twelve o'clock and she was awake all night and not hungry or anything, and she'd scream, so we'd bring her into bed with us and she'd sleep for the rest of the night. This went on for months and months. So I said to my husband in the end, 'She'll just have to go to bed awake, otherwise it's going to be utter hell later in life'. Anyway, we got her alright. But the next one goes straight to the basinette or cot awake. And if it cries it can cry for a little while. I learned that the hard way. But still with your first I suppose it's sort of like training ground. But I'll only have two I think." (Marilyn)

"I had a lot of trouble breastfeeding the first so I got straight onto the bottle for this one. And now when he cries I just put the bottle in his mouth and I go about cleaning, you know, while he's drinking. Rashes and stuff like that I don't get so worried about them, you know. I'm sort of more relaxed with them and that. Although the other, oh three or four weeks ago, they both came down with German Measles." (Rae)

6.4.1 Negative Emotions When the Children Were Eighteen Months Old – Comparison Between Groups of Women

There were no significant differences between the first two samples of mothers. The working class sample had only one mother left in it at this time so she was not included in comparisons.
6.4.2  **Negative Emotions When the Children Were Eighteen Months Old—**

*Comparison With the Wollongong Sample*

It was only worries about loneliness that gave a trend towards a significant
difference between mothers with routine separations and the Wollongong
Sample (Appendix 12.1.1). The mothers had a higher mean value of .66
compared to the Wollongong mean of .50 (Appendix 14.1). Some of this
anxiety was expressed in relation to the infant but it also related to their
feelings of isolation generally.

"Not full-time work, no. I'd never even consider it really. I
just couldn't bear the thought of giving her to somebody
else. It's like having a baby and giving it away. That's the
way I feel. But sometimes now I wonder whether I'd like to
get something that I could do maybe one day a week, or a few
hours, or something like that. Because you get a bit lonely
you know. I get lonely anyway. And I'd like to get out and
meet some people sometimes. But that's all up in the air."
(Shirley)

"I always said that I'd, you know, I'd stay home with her but I
must say at nine months I was ready. You know on that day
they'd ring me up and I'd be so happy. Not that, you know, I
didn't enjoy her. But, you know it put just that distance
between us and that was good. You know I think we're - I
really enjoy her. When I first went to work I hated it. I used
to think about her. But now I'm so busy at work that I don't
think about her and she's happy. She's with Mum. It's ideal.
She doesn't care about me going at all." (Marie)

As this was the group of women with the significantly higher feelings of
loneliness and loss after birth (Appendices 10.1.1 and 10.1.4) one can
speculate about their earlier experiences of separation from their infant
and its relationship to their current high scores. The mothers of premature
babies also have a relatively high score on loneliness at the eighteen
months visit, but there was no significant difference when they are compared to the Wollongong Sample.

6.4.3 Negative Emotions When the Children Were Eighteen Months Old - Changes Over Time

Uncertainty had significantly decreased between three months and eighteen months after increasing between birth and three months (Appendices 13.1.2 and 13.1.1). These results show their fluctuating uncertainty and their reactions to new situations.

At three months the women also showed other increases - anxiety and shame about themselves as mothers (Appendix 13.1.1). At that time there was also a trend (p.02) towards increases in Diffuse Anxiety (Mother) and Hostility Out (Mother) (Appendix 13.1.1). With their increased experience in the mother role some of their anxieties diminished. They no longer feared physical injury or damage to the child but other anxieties increased. The 'honeymoon' was over. Between birth and eighteen months there were significant increases in shame and hostility relating to themselves, and a trend (p.02) towards increases in shame about many things and anxiety in relation to themselves. Alongside these increases in negative affect the results showed a significant decrease in warm feelings. Much of this came from a decline in positive feelings about the child. There was a trend towards a significance in this difference (p.03). Excerpts showing the demands of the child, the needs they felt about returning to work and the difficulties they had being a housewife and mother have been given already and serve to illustrate the increase in their worries and the decrease in their diffuse positive feelings.
Figure 3: Negative affect decreasing between birth and when the children were eighteen months old for mothers with routine separations.
Figure 4: Negative affect increasing between birth and when the children were eighteen months old for mothers with routine separations.
6.4.4 Positive Emotions When the Children Were Eighteen Months Old -
Comparison Between Groups of Women

There were no significant differences between samples of mothers on
positive emotions at this time.

6.4.5 Positive Emotions When the Children Were Eighteen Months Old -
Comparison With the Wollongong Sample

The routine separation mothers were significantly higher on all the
Sociality Scales (Total, Helping, Intimacy, Influencing and Sharing) and on
Positive Affect (Appendices 12.4 and 12.5). Similar high scores on these
scales were found by Westbrook (Appendix 14.2) for her women during a
childbearing year. Thus, in spite of their increases in shame and worries
related to themselves (anxiety, anger and shame) and a decrease in warm
feelings between birth and three months, these women were by this time
experiencing a period of their life when relationships with others were
important and these relationships were seen to be rewarding.

6.4.6 Positive Emotions When the Children Were Eighteen Months Old -
Changes Over Time

Between three months and eighteen months appreciation of shared
experiences significantly increased (Appendix 13.1.2). These feelings also
increased significantly between birth and the eighteen month visit
(Appendix 13.1.3). It is clear then that expressions about doing things
together increased by three months and remained significantly higher than
at the time of the birth.
Between three months and eighteen months loving and warm feelings significantly decreased (Appendix 13.1.2). This reinforces the view expressed earlier that the three month interview came during the 'honeymoon' period with the infant. At three months of age infants are smiling and can be most rewarding to the parents. Three months was the time when the women experienced less anxiety in relation to hospital experiences and the baby (Appendix 13.1.1). Although some other anxieties increased there was a maintenance of the high positive affect and intimacy when compared with a 'normal' population (Appendices 11.4 and 11.5).

6.5 SUMMARY

The experience of giving birth in a hospital where routines led to separation of mother and baby was related to different patterns of internal personal responses when compared with other groups of women. There was a trend for women experiencing this type of birth to be still affected eighteen months later.

6.6 CASE STUDY: "SALLY"

Sally was aged 23 years and 3 months when her daughter Amanda was born. She was married and lived with her husband in a rented home unit in the same suburb as the hospital where she was confined. They were saving to build their own home, having already purchased a block of land in a new suburb of a nearby country town. This country town has become a dormitory suburb for the City of Sydney. High housing costs in those areas closer to the heart of the city have driven young couples to what were formerly country and farming areas.
Sally had completed twelve years schooling at a State girls high school and had further nurse training after her schooling was finished. She worked until twelve months before her baby was born.

Both her parents were living and she had not experienced any early separations or traumas in relation to her family. She described her parents as 'beautiful people'. Her sisters had already become mothers and she had gained some experience in infant care from these babies. She also felt it was natural for a woman to be motherly.

She described her own marriage as being 'happy most of the time'.

At the time of the first interview in hospital she had a low score of 1 on the Malaise Inventory. She answered that she did suffer from indigestion.

Her first reaction to her child had been most positive. She described the baby:

"It's beautiful - really chubby cheeks. That's about it. I just thought she was beautiful. She looked lovely. Lots of hair and pink."

Her delivery had been a little uncomfortable and she commented about the forceps, the mask and having a full injection. In spite of that she was philosophical and said:

"But all in all it was very good."

Her husband had been with her during the labour and delivery and she was grateful to him. She felt he had been a great help. After the delivery the baby 'was plonked' on her tummy and then taken away and wrapped up. She
had a short cuddle after that. At the time of the hospital interview she had
not yet seen her child for the second time. She thought she may be seeing
her "for the two o'clock feed, or tea time. ..... She'll be twelve hours old,
if I get her at two o'clock". She planned to breastfeed her baby and would
feed on demand. She regretted not being able to have her baby with her all
the time. She said:

"I just want to have her here with me all the time, and it will
probably be an even stronger urge after I've had her."

By the time her daughter was three months old she still scored 1 on the
Malaise Inventory. However, this time she was answering yes to the
question "Are you scared to be alone when there are no friends near you?"
She was still living in the rented home unit but the new house was
completed and she was to move the next day. In spite of the obvious
difficulties associated with packing she was warm and welcoming. Her
daughter was beautifully dressed and although sleepy, cooed and smiled.
When Sally held her child she was loving and slowly and persistently
sensuous in the way she caressed her daughter. Both of them obviously
enjoyed it.

During the observation she was highly infant involved. She spent a great
deal of time touching and looking at her daughter. She spoke to the baby a
few times, but only spoke to the researcher once. This was not because she
was a 'silent' woman. She talked most freely later while her daughter
slept. She recalled feeling 'tremendous' on the morning she was to leave
hospital with her daughter. However, this changed as her strong feelings of
responsibility and the new demands made upon her left her feeling tearful
and tired. During that difficult time she received help from her husband
and was most appreciate of this. She said:
"The first few weeks when you come home everything's in a mess and you're trying to get yourself organised. It was good because my husband, he was on holidays for a week, so that after I came home, it was terrific because he was able to help me. He got me over the first hurdles of, um, utter chaotic house."

She talked about her first attempt at breastfeeding in hospital - of waiting in vain for a nurse to come and show her how. She described herself as being very sensitive during those first few days after the birth. She had been hurt by a remark from one of the nurses which she interpreted as 'catty'. She had felt naive and clumsy in her early feeding and caring attempts. She also recalled how desperately she wanted her baby with her in the hospital. She believed that her baby could sense her own feelings and reacted to them. She said:

"It's very important for me, breastfeeding, to have a very peaceful mind and nice surroundings. She can tell if you're uptight, the baby - automatically. I don't know. I found that anyway. If I was upset or, you know, the baby just wouldn't behave herself. You know, she would be upset as well."

When she was asked "When the baby cries and has been fed, and the nappies are dry, what do you do?" She replied that her baby didn't cry. Then she qualified it, saying that if she did she was tired or hungry. She explained that once Amanda had a virus and she had carried her around to soothe her. When she was asked about going out and leaving the baby she said that she had not wanted to leave her. She had felt bad and had wondered about her all the time.

She weaned her baby at six weeks because she was not gaining weight. By three months the baby was taking both a bottle and solids.
When Amanda was six months old Sally filled in the Carey Infant Temperament Scale (Carey, 1970 and 1973). I added an extra column to that scale to be scored for the 'Average Baby'. This was done to get an idea of the mother's satisfaction with her own child. Sally described her child as generally being more placid, flexible and tolerant than the average child. The only area of difficulty she reported had been in her early reaction to the bath. At the time of the questionnaire she was reported to smile or laugh in the bath, but her mother said that she had objected to bathing for more than two weeks.

By the third interview they had settled into their new home. They had made friends with the neighbours and had begun establishing a garden. The home was well furnished and Sally remained smiling and warm. She was slightly plump but was well dressed and groomed.

Amanda had an old basket full of her favourite toys in the corner of the family room. During the visit she played with these freely - taking them out and leaving them lying around as her interest turned to something new. Her vocabulary was limited to six words, but her mother explained that she understood a lot more. The accuracy of this assessment was observed during the interactions. She liked playing Peek-a-Boo, dancing and music. She was happy to play independently and both parents said that she always amused herself in the early morning when she first woke. She now loved her bath. Her mother described her behaviour with strangers:

"She stares at them for ages, but once she is around them for a while she comes around."

Her health was described as good except for a number of throat infections which seemed to coincide with teething.
Both her mother and father believed she had a quick temper. They said that "she flies off the handle very easily. She seems to get angry quickly, but forgets easily and the anger goes away easily".

At this visit Sally did not answer 'yes' to any of the items on the Malaise Inventory. The anxieties in her transcript show her concerns for herself. She talked about her own needs to return to work and the stimulus she felt she needed.

Sally expressed regret at weaning so quickly and her husband was anxious to question me about other cultures where holding the child a lot was more common. He said:

"There seems to be a train of thought that the parents should carry their children around a lot more, especially when they are babies. I read an article in the Daily Mirror and they, this lady went around some place - I think it was Africa or somewhere in America - and the babies were always in the arms of their elder brother or sister, or mother or father, or aunts and uncles. I think this is something to do with security as well. The child obviously feels more secure."

They hoped to have another child in about a year and he thought he would like to carry it around a bit more than he had Amanda. At this point his wife interrupted and said:

"I'd hate to ruin my back. They are deceiving little things. I'd quite often just be nipping up to the shops or something and I'd just carry her. And, oh, arms would be falling out."

Both parents bragged about her achievements and her happiness but they also recognised other aspects of her behaviour. Conversation went as follows:
Husband: There are times when she's exasperating.
Sally: She's just mischievous. She really is. That's just it. She's mischievous. She is inquisitive.
Husband: No. She'll go on and on and do something, until, oh well, somehow one of us has to break. And then she usually ends up with a smack on the bum. I don't know. Because there are times when she's done something like, and you chastise her for it. And you can see her looking around and she'll run away and do the same thing again. And then she'll come back. ..... 
Sally: Quite often when she does something wrong I'll say, 'Oh naughty girl', and she'll laugh and run the other way. Thinks it's a great joke. It's very hard to take sometimes. It's, oh, it's not as easy a job as I thought bringing up children.

They were warm and reacting parents who had grown closer together since having their daughter and who now had a much clearer idea of what being parent really involved.
CHAPTER SEVEN

PREMATURE BIRTH - THE BIRTH ENVIRONMENT AND
BACKGROUND INFORMATION ABOUT THE MOTHERS

The Premature Infant: "All movements are minimal and sluggish. The skin is red and wrinkled and soft downy hair (lanugo) is often abundant, especially over the back. The nails and cartilaginous structures such as the pinna of the ear are soft. The head is relatively larger than in the heavier full-time infant. Subcutaneous fat is minimal in amount and this, along with the immaturity of the heat-regulating medulla, makes the temperature unstable. The cry is feeble and respiration but poorly established, so that cyanotic attacks and apnoeic periods are of frequent occurrence, especially during the first few days." Baird (1950), p. 807.

7.1. THE HOSPITAL AND NURSERY

7.1.1 The Hospital

This group of women was selected on the basis of having a premature infant in the neonatal intensive care unit of a large Sydney Hospital. An additional requirement was that they have no other surviving children, so that this was, in effect, a first infant. The hospital was a large teaching hospital having liaisons with Sydney University Medical School. The Neonatal Intensive Care Unit serviced not only the hospital in which it was located, but was also a referral unit for other hospitals within the same Health Commission region. Some of the women were in single rooms, but others were in the same wards as mothers of healthy infants. This was often spoken of as creating difficulty as it accentuated the comparisons between the fragility of the premature baby and the normal fullterm infant.
The residential area covered by the hospital was of a slightly higher status than that covered by the hospital providing routine care with separations and considerably higher than the working class area. Status rankings of suburbs in this region which are based on judgements made two decades ago (Congalton, 1969) do not accurately reflect the present socio-economic ranking of its residents. Included in this region are many older suburbs which, partly because of their proximity to the city and partly because of the age of the houses and the size of the building blocks, are being redeveloped into high-rise dwellings. For example, one of the women included in this study was the wife of an army sergeant. She was living in an above average status suburb, but their home was a second floor flat rented from the army. This flat was far from luxurious and would compare poorly with some of the homes of the first sample.

7.1.2 The Neonatal Intensive Care Unit

This unit had a staff who were committed to helping prepare mothers psychologically for the birth and care of a premature infant. Those women who were hospitalised because of the likelihood of an early labour were visited by the paediatricians. They were, where practicable, shown the nursery and given explanations of the equipment and the infants' physical condition and problems. In cases where the labour was unexpected or had a sudden onset this preparation was not possible. Nor was it practicable where the infant had been brought to this hospital from another referring hospital. In such cases a photo was taken of the infant and this was left with the mother. If the mother was in a different hospital she was moved as soon as possible in order to maintain close contact with her baby. This usually happened within one or two days.
Once the infant was established in the nursery frequent visits from parents were encouraged. Both parents were instructed in many of the normal caretaking routines. For example, it was not uncommon to see mothers tube feeding their baby, nor to see a father bathing his child. Within the limits imposed by the technology required to help keep these infants alive there was an attempt to maintain a relaxed, comfortable and loving relationship between parents and child.

Naturally some women were hesitant about physically and emotionally caring for an infant whose survival was far from certain (Klaus and Kennell, 1976). This was often shown by a reluctance to handle and to name the child. In talking of this problem one woman said:

"I think if I hadn't done it then maybe I would have been a bit nervous of it. But the sisters down there said, 'Oh, come on, pick her up'." (Beth)

Another whose infant later died, said:

"I'm glad that Peter insisted that I touch her at that stage because she looked so tiny I was scared of her. I was just so scared of touching her and having her fall to pieces. It was such a tiny little thing and I really felt if I breathed on her she'd just crumble and turn into dust." (Brenda)

A third woman was appreciative of the thoughtfulness of the nursing staff in carefully wrapping her children (twins) before she held them. She expressed anxiety about the monitors.

"Yes, quite nice (to nurse a tiny baby). Actually, they always wrap them up well each time so the wires and things are covered up." (Vivienne)

A fourth was quite aware of her rejection.

"Oh, well Dr B. ended up having to yank him out and put him in my lap, but I wouldn't have anything to do with him." (Liza)
A group meeting was regularly held between parents of infants in the nursery and hospital staff. At this meeting concerns were discussed and information about infant development was given. At the time of this research mothers were reassured about contacting the staff if they were concerned about the infant - even after it had been discharged from hospital. Since that time, the hospital has employed a community nurse whose role is to make follow-up visits and help and support those parents who need it. It can readily be seen that many attempts have been made to overcome the anxieties and separations which have, in the past, been so much a part of giving birth to a premature infant.

7.2. THE MOTHERS OF PREMATURE INFANTS

Fifteen women were interviewed from this hospital. All had recently given birth to premature infants who were currently in the neonatal intensive care nursery. All the infants were premature rather than small for gestational age. The women were referred by the paediatricians and were interviewed by the author while in the hospital.

7.2.1 Country of Origin

These women differed slightly from the other two groups interviewed in that only 53.3 per cent were born in Australia. This was different from the married Australian female population. Figures show that 72.92 per cent of married Australian women aged between 15 and 44 are Australian born (Australian Bureau of Statistics, 1979). There were three (20 per cent) who came from Northern European countries (Appendix 2.1). From discussions with the women it seems unlikely that the country of origin would make
much difference to childrearing practices. The only one who was unusual in her plans for her infant was the one Asian woman. She had hoped that her mother-in-law would be allowed to migrate and take care of the child while she returned to work. Most of the rest of the women when interviewed after the birth did not mention returning to work, although in fact three of them did by the time the child was eighteen months old. For those who did it was usual for them to leave the infant with relatives. The reasons for wanting an early return to work were partly economic, and partly personal satisfaction. The one woman who was divorced by the time her daughter was eighteen months old returned to part-time employment to satisfy her own needs for adult company outside the home.

7.2.2 Relationships with Parents

Only two (13.3 per cent) of the women had lost their fathers (Appendix 2.2). For the rest both parents were still living. Two of them had lost their fathers at an early age, and one had separated at age 16 when migrating (Appendix 2.4). Thus 80 per cent of the women in this group had never been separated from either parent. Only one woman reported trauma within the family during her early life. Therefore, in spite of having a higher proportion of subjects coming from other countries the families were reported as remaining intact and secure during the women's formative years.

Although they came from stable backgrounds the crisis created by the pregnancy and the premature birth did not always find them with their families ready to support them. Of this set of women only seven (46.67 per cent) did not report some difficulty with their parents at this time. The
comments ranged from simple statements about 'teary sessions' through to feelings of having failed them. One woman had greatest difficulty with her father and his reaction. She said:

"... of course my father can't say terribly much because, Oh, a lot of men and my father in particular is, you know, finds it hard to talk about the situation. He's not a terribly open man." (Wendy)

For two women their in-laws provided quite severe emotional strains at this time. For one woman it revived the earlier rejection by them – she had been told she was not good enough for her husband. For another, the mother-in-law caring for the infant and her visits to the hospital triggered a strong jealousy and excessive possessiveness.

"But all the in-laws keep telling me that it's not a normal baby and that isn't it a shame you're not breastfeeding. And that's all they every say to me. But I feel I've let them down and I suppose I wonder whether I'd ever be a child to them. I've always felt I had to, you know, because when we got married she was quite open about it that I wasn't good enough for John. And I still feel I'm trying to be good enough for them. And this way I've failed them in having a premature baby." (Eve)

"I started to hate my husband's mother since Andy was born ... I have enough trouble feeling that he is mine as it is and especially that I have him, and then when she sort of asks all these medical people about him I sort of feel she is trying to take over the role of the mother." (Maria)

This last woman felt alone and powerless against her in-laws. She had married an Australian and migrated with him from Europe. For her, the birth and her aloneness promoted a longing for her own family.

"I sort of feel they are all gathering up against me, trying to take him away from me. Probably madness, but that's how I feel. I feel I want my family here to put up against them." (Maria)
Two women had problems with their own parents, and in both cases it related to non-acceptance of the husband or the relationship.

"My parents are very upset. You know, cause I was pregnant. We went up to see them when I was pregnant and we weren't married and they did mind." (Patricia)

"Well at the time we had a lot of worry with my mother. We still have. She didn't like my husband and she wanted to have me home with the baby and my husband would not be welcome as far as she was concerned." (Beth)

Only one woman discussed friends and relatives in general. Her own parents were temporarily overseas and she had hoped for support from an extended family. She criticised them for their limitations.

"And we realised that not one of our friends or relatives had been able to bring themselves around to saying congratulatons on your baby girl, or sent any card or any message that would acknowledge the fact of her birth." (Brenda)

This woman went on to emphasise to me that she had given birth to a 'real daughter' and to beg me to go and look at her.

7.2.3 Educational and Occupational History

The majority of the women were educated in State schools (73.3 per cent). The proportion of women educated in State schools was similar to the other two samples (Appendix 3.1). It was in the amount of schooling that the greatest differences were found between these women and those in the other groups. Only four (26.7 per cent) had as little education as the School Certificate. This was the highest level of education received by the young working class women (Appendix 3.2). One third of this group were still completing or had already completed tertiary education. Because of this, it is not surprising to note that the occupational status was also significantly higher (Appendix 3.3).
It is probable that a combination of the early onset of labour and the higher status occupations (frequently at a professional level such as nurse, teacher, physiotherapist) would lead to the differences found in the recent work history when compared to the other groups of women. Four (26.7 per cent) of this group were still working at the time of their confinement. The average time since they last worked was only 3.33 months. It is not known when, or if, these women planned to discontinue working before the birth had the pregnancy gone to term. One woman, a nurse, felt that her working may have exacerbated her other physical problems and led to the onset of labour.

"It was that I had an incompetent cervix. And also I'd had a hard night the night before. I worked on night duty and I had to lift a patient so that might have done it." (Patricia)

Keller (1981) reviewed the epidemiological characteristics of preterm births and concluded that 'both income and education are inversely related to prematurity.' (p. 10). However, he pointed out that income and education are correlated and that the two factors may not be independent in relation to premature births. The sample interviewed here was, therefore, unusual. One would expect a higher proportion of women with poor education and lower socio-economic status. There are two possible explanations. The first is that the suburbs that feed into this hospital are of higher status than those of the other two hospitals. Therefore, the lower status, less educated women would be living in outer suburbs which would be in other hospitals' catchment areas. No mothers of preterm infants were interviewed at the hospital in the working class area, but the figures of educational status of the women from this source confirm the disparity existing between different suburban areas around Sydney. An alternative explanation could be that Australia does not have the same relationship
between income/education and premature births discussed by Keller. Figures are not available on this. But, there is a lot of government funding to public hospitals, and this support for medical services probably leads to more women in Australia having adequate antenatal care than in many other countries. This means that even the poorest women are able to have appropriate professional care, and high risk pregnancies can be detected early.

7.2.4 Marriage Related Factors

All subjects reported that they were married or in stable long-term relationships (Appendix 4.1). This was confirmed during follow-up visits. The two women who were single after the birth were seen when the child was eighteen months old. By that time one had married her de facto husband, and the other was still living in the same relationship and referred to her man as 'my mate'. The decision to remain single was based on philosophical grounds rather than indicating an instability in the union.

All of the women judged their marriage to be happy all or most of the time when questioned after the birth. However, one of the married women had separated from and divorced her husband by the third interview. Although it is hard to place much weight on one case it does indicate a similarity with other studies which have also shown a higher incidence of marriage breakdown in families with a preterm infant (Leifer, Leiderman, Barrett and Williams, 1972; Kempe and Kempe, 1978).

Only one woman in this sample had stepchildren. She declined further contact at the eighteen months interview. Her contribution to the research
would change figures for the group marginally, if at all. Because of the small number of women in this category figures on them were not compared with the rest of the sample.

Having stepchildren may also have influenced their answers to the question on how many children they would like to have. For this group the figure was 2.79 (Appendix 4.4). This was slightly higher than the women with routine separations and lower than the working class women. The difference between the groups was significant (Appendix 4.4).

7.2.5 Husband Related Factors

Most of the husbands of the women in this group were Australian born (80 per cent), with only two coming from Great Britain (13.3 per cent) and one coming from an Asian country (6.7 per cent) (Appendix 5.1).

It could be expected that as 14 of the 15 husbands came from Australian/British stock that their attitudes to child raising and marriage would be representative of those within our culture.

As for the women, the occupation status of the husbands was slightly higher than that for the other two groups. The average was 4.6, compared to 4.96 for those with separations and 6.11 for the working class sample (Appendix 5.2). These husbands were more likely than husbands from the other two groups to wish to attend prenatal classes (Appendix 5.3). This may reflect the higher socio-economic status and better level of education leading to a greater appreciation of childbirth education. However, none of this made it more likely that they would be present at the birth.
The fact that many of the births were medical emergencies would have contributed to the fact that, although 10 (66.66 per cent) wished to be present, only 7 (46.7 per cent) were able to be there (Appendix 5.4). In spite of this, most women were appreciative of the support they received from their husbands. These statements usually referred to the times of greatest anxiety — that is the labour, delivery and when the infant was most vulnerable. The statements they made about their husband's presence during the labour reflected their need for reassurance, information about the progress of the labour and the condition of the child. They also expressed feelings of strangeness and isolation.

"He was just there. He was just there talking to me and I knew he was there and that helped me a lot." (Maria)

"..... because I went into pretty deep shock and I got awful shakes all over. And if John hadn't been there I don't know how I'd have ended up, but he calmed me down completely." (Eve)

"Just having him there you know was the comforting thing." (Susan)

"Well I held onto his arms and he gave me a bit of security to know that he was there to comfort me in the intense pain. I was very happy that he came." (Janice)

"He was the only familiar thing I had. All of sudden I was in a completely strange place surrounded by a lot of different people, with a very urgent situation. I didn't understand the ramifications of what was going on at all, because everything was happening so quickly. And he was the only familiar thing I had and he was very supportive." (Brenda)

"He was pacifying me the whole time about the baby. Because I kept asking questions. What was happening. He was just pacifying me and he was very good. He is a lot stronger character than what I am." (Liza)

Continuing support and encouragement about the child's health and survival was appreciated by the women. The advantages of fathers visiting the intensive care nursery are twofold. They have a messenger role (Klaus and
Kennell, 1976) and also it seems in some cases to be advantageous in the formation of good paternal relationships (Blake et al, 1975; Klaus and Kennell, 1976).

"He sort of says, 'Oh, it's all right, everything is going to be all right'." (Maria)

"He's keeping himself O.K. for me so my mind doesn't go. He just keeps telling me everything is going to be all right." (Emma)

"It helped also that Garry came around when she was taken around to the premature nursery. And they brought back photos of her and he had his hand through the little door and he was stroking her and holding her little hands. And I think that probably helped to give me confidence." (Joanna)

Although the majority of statements about the husband were positive some women also mentioned taking the brunt of the day to day worries and keeping changes in the infant's condition to themselves.

"Well sometimes I don't tell him the little things that go wrong. Because he's got enough on his mind anyway, and he just goes and sees them and they lie there and they look all right." (Vivienne)

7.2.6 Childbirth Related Factors

These women were older than the other groups of women. The average age was 27 years compared with 23 years for mothers who had routine separations and 20 years for working class mothers. This age difference can be explained in part by the difficulty some of the women had in becoming pregnant and carrying a child to term. Sixty per cent (Appendix 6.2) had been pregnant before. One woman had six prior pregnancies - five of which had resulted in early spontaneous abortion, one infant survived for a brief time. Four women had been pregnant twice before. When the child was eighteen months, one of the women who had only had the one pregnancy discussed her fears about being unable to conceive and carry a child.
One third of this group reported having had abortions prior to this pregnancy (Appendix 6.3). Both other groups of women reported no earlier abortions. It is likely that abortions increase the childbearing risks. Only one woman in this sample recognised this when discussing the premature birth and mentioned the possibility of it being caused by her earlier abortions.

Ortof (1980) discussed the ambivalent feelings women expressed following abortion. Combined with overall relief at their decision were feelings of guilt or depression. Mosely, Follingstad, Harley and Heckel (1981) while reporting high pre-abortion anxiety and depression found a reduction in the post abortion period. They believed the social context and social support networks available to women were important in providing a positive reaction to the experience, and all the mothers of premature babies had reported stable relationships and intact families.

The gestation periods were significantly shorter than for the other two groups. They ranged from 25 to 34 weeks. The mean was 29.4 weeks (Appendix 6.4).

Apart from the emotional problems created by the early onset of labour there were many practical problems experienced by the women. These increased the stress of the labour and birth. Family problems and lack of preparation were common concerns.

Family Problems

Changes necessary to allow nursery visits

"I'm going to try and find accommodation close to the hospital if I can. He's made arrangements for our animals to be fed at home. He's been back up twice to check and make sure everything's alright. He's closed up the house." (Brenda)
Stepmother worrying about the rest of the family

"I think the hardest thing is for everybody to keep the family together at the time because you're sort of in the hospital and the baby's upstairs and the other kids are at home. Everybody seems to go in different directions." (Ann)

Husband not feeling like a parent

"I was working on night duty and I was staying at the hospital a lot and I only saw him (husband) every weekend and then for a few days and not very often you know. There wasn't much contact so I'd come over on the weekend and I'd be bigger." (Patricia)

Lack of Preparation

Not prepared for hospital stay

"I had a couple of borrowed nighties because I didn't own any nighties, and although I was going to get myself set up for April I wasn't set up for February." (Joanna)

Missed Childbirth Education Classes

"I thought at these classes I'd find out all I'd need to know. So I really went in there not knowing a thing." (Liza)

Cognitive change to accept birth was imminent

"I knew I had several weeks to go and I had all this bed rest put onto me, which meant I had to think no more of that, and think well I'd better just get on with it." (Vivienne)

When questioned at three months some of the women reported experiencing the 'blues' in the period after the birth (Appendix 6.5). Although the incidence was higher than for those with routine separations it was less than reported by the working class women. This is surprising considering the higher levels of anxiety (Appendix 10.1.1) and frustration (Appendix 10.2.1) expressed by the mothers of premature babies after the birth.
7.2.7 Childbirth Education

There was a significant difference between the groups in their use of childbirth education. The women in this group were more likely to plan to take advantage of classes (73.3 per cent). However, because of the early onset of labour only 2 (13.3 per cent) had completed classes. Sixty per cent had either planned to attend or had begun classes but not completed them (Appendix 6.1). It is obvious that women should be informed of the advantages of attending childbirth education classes earlier in their pregnancy. Premature births make up only a small proportion of all births in Australia. However, it would help those women who do experience such labours if they were given information early in their pregnancy about preterm infants, their appearance, problems and strengths. The aversive properties of a premature infant's cry and the autonomic arousal such cries produce in adults has been well documented (Frodi, Lamb, Leavitt, Donovan, Neff and Sherry, 1978). In addition Frodi, Lamb, Leavitt and Donovan (1978) found that simply labelling a normal infant as premature increased the extent to which physiological arousal in the parents was elicited by its cry and reduced the amount of sympathy it received.

The women in this group had to cope with the less than attractive appearance and cry of their infant as well as the rather elaborate and frightening equipment needed to support the baby. Introduction to the equipment used in intensive care nurseries during prenatal classes would increase women's understanding of the life support systems that are available and probably give them greater confidence in the ultimate survival of the child. Two of the women had already had premature infants and were aware of their appearance. A number of others had been
hospitalised before the birth, had been visited by the paediatricians, or had been shown the intensive care nursery. These were better prepared for the initial appearance of their child. Four were not.

"I was thinking what he would look like - if he's got complete parts. I mean if all the parts of his body are there." (Janice)

"She didn't look like a baby. She wasn't fat and sort of babyish features, but sort of like a doll-like person." (Brenda)

"She looked older than what she looks now. She looked like a little old lady when she was first born." (Jane)

"I worried whether she'd have all her parts there." (Emma)

Even those mothers who accepted the equipment spoke of it in a fair amount of detail. There was obviously a visual and emotional impact in seeing their infant hooked up to a variety of monitors.

"Every arm and leg was hooked up with a drip or a tube and things and he couldn't move. He had no clothes on, just monitors and drips and tubes stuck in him. He had a tube stuck down his throat to help him breathe. And just everything like that. Just a mess of wires and tubes and that and everything." (Ann)

"Tubes everywhere, and drips into her and oxygen probably. And they were giving her needles and trying to keep her alive." (Beth)

"I didn't like him, seeing him with the wires attached to him. I don't mind them just lying there but the wires I found quite upsetting." (Vivienne)

Whilst the monitors had a negative effect on most mothers, there was one woman who worried about her own inadequacy in caring for her child. She felt the machines could do it better.

"They test the heart and breathing and I know everything is O.K. And I think that it's very reassuring knowing that there are machines up there all the time to watch him. He's been on that monitor ever since he's been born and suddenly you take him home and there is no beep, beep to say or to tell you if there is anything wrong. It's just got to be your instinct, hasn't it." (Liza)
She continued to rely on machines. During the home visit at three months this woman showed me the intercom system that had been installed in the house so that she could hear her baby while he was asleep in the nursery.

These women seemed to be more aware than the other groups of their lack of experience and possible inadequacy in caring for their infant. One third of the mothers responded that they did not yet know how to care for their infants when asked about sources of child care information (Appendix 7.2). Only 18.3 per cent of the mothers with routine separations and no working class mothers responded in this way. Experience with other infants (siblings or friends and relatives children) was mentioned as a major source of information.

7.2.8 Childrearing Factors

There were differences in the plans to breastfeed the infant. All of the mothers of premature babies hoped to breastfeed (Appendix 7.4) and were expressing milk in an attempt to establish and maintain lactation. This is a high figure. There was a general recognition that this form of feeding was better for the infant. One woman said:

"I didn't have any desire to breastfeed. But they do say you change once you see the baby and I thought because she is premature it would be better for her." (Susan)

However, the task of establishing lactation was onerous and perceived as being quite different to the normal mother-child feeding pattern. About expressing it was said:

"I'd feel better if the baby is there doing it. The emotional thing is not there. It's too mechanical doing it like that every
now and then, whereas with the baby you'd feel happier." (Janice)

"I'll breastfeed if my milk holds out. It's starting to go off a bit. I'll hold out. I'll just have to keep at it." (Patricia)

In spite of these plans to breastfeed only two actually managed to (Appendix 7.5). The mean duration of breastfeeding was eight months. One woman fed twins for seven months and another was just commencing weaning at seventeen months.

During the home visits notes were taken about the environment created for the child (Appendix 7.6). This group of women overall provided a better environment for the children than did the young working class women, but not as good as those from the first sample - half had poor to very poor environments. They rated better than the mothers studied by Brown and Bakeman (1980) who found that mothers of year old preterm infants, although emotionally and verbally responsive, provided a relatively impoverished environment for the child. They concluded that:

"A majority of infants in our sample were reared in an environment that was not free of hazards, had no toys that would permit hand-eye co-ordination (e.g. blocks), were without access to books or music, and had no special place where their possessions were kept. The mothers typically did not teach their infants names of things, play or look at picture books with them, and, at the same time, they restricted their infants' physical movements and used physical punishment to control their behaviour." (p. 367)

It must be noted that those mothers were from a disadvantaged population. Klaus, et al (1972) found relationships between early and extended contact with the infant and responses to questions about the mothers' reactions to the infant crying, and to leaving the infant while they were out. The same questions were asked of the women at three months. Their answers
indicated that the first two samples were roughly comparable, but that young working class mothers were less likely to pick up the infant when it cried (Appendix 7.7). However, as only three working class women were located at three months comparisons are based on few responses. Those women who agreed to be interviewed at that time were unlike the rest of the working class mothers in that they had relatively stable homes.

Advice to mothers about coping with preterm infants has changed over the years. In 1960, Kaplan and Mason regarded the development of an understanding of the temporary differences between full term and premature babies to be an important task for mothers of preterm infants. They felt this preparation should take place before the infant left the nursery.

"In order to provide the extra amount of care and protection, the mother must see the baby as a premature with special needs and characteristics. But it is equally important for her to see that these needs are temporary and will yield in time to more normal patterns." (p. 544)

This emphasis on the temporary nature of the infants' problems is not supported by the more recent research of Field, Dempsey and Shuman (1981) who found differences at two years of age. Nor do parents react as though the difficulties experienced are short term. Blake, et al (1975) found that parents of low birth weight children tended to be overprotective and over anxious and needed continuing reassurance as the children grew up. They reported on a longitudinal study up to ages 7 and 8 years. Thus, the effect on the parents is far from temporary on the parents.

Brown and Bakeman (1980) observed that preterm infants were less active, exhibited weaker motor movements, had poorer head control, poorer hand-
to-mouth control and less well developed rooting and sucking responses while in hospital. One month after discharge they were significantly less alert and less responsive to auditory and visual stimuli than full term infants. Furthermore, while in hospital the mothers expended more effort in interactions with their infants. They issued more commands and thumped, poked, pinched and rocked their infants more. Brown and Bakeman believed their findings indicated "that the mothers of preterms bore an unequal share of responsibility for the flow of the interaction" (p. 364). The Springfield Study observed infants who had had a clear episode of respiratory distress syndrome and it was found that "mothers of the preterm infants were much more active in their interactions with the children, and may have been more overprotective as the infants grew older". (Sameroff, 1981, p. 390).

To see if there was any observable effect in this group, the mothers' behaviours observed at three and eighteen months which could be classed as 'stimulating' were abstracted from the behaviour observation schedules. Appendix 7.9 shows the comparison between the groups at the three months visit. It can be seen that mothers of premature children spent much more time talking to the infant and less time talking to others. The touching and fondling behaviours were not very different but the 'talking to' and 'smiling at the infant' behaviours were. The factor scales at three months (Appendix 15.2) showed that the mothers of preterms were more infant involved than the other two groups of women. Factor 1 at three months ('Mother Socialising') which includes behaviours such as not smiling at the infant, looking away from the infant, and talking to others, provides evidence of the greater comparative engrossment by mothers of premature babies.
It could be that their higher level of infant oriented behaviour at three months was produced by cultural/socio-economic status values or personal idiosyncrasies within the mothers. But if this were so, one would expect that at eighteen months there would be a similar variation in behaviour. This was not the case as it was only the 'smiling at the infant' which remained higher at eighteen months than for separated mothers (Appendix 7.10). Figure 6 shows comparative mean frequencies for talking to infant or talking to others for the first two samples of mothers at the third interview. Chapter Eleven discusses behavioural differences fully. Briefly, factor 4 "Mother Carrying Child" showed a significant difference between the first two samples of mothers when the children were eighteen months old. This factor had mother carrying child and leaving the room. This sample had a negative mean on factor 4.

7.3. THE CHILDREN WHO WERE PREMATURE

7.3.1 Sex of the Children

There were more female infants than males in this group (Appendix 8.1). This differed from the Australian pattern of births (Australian Bureau of Statistics, 1981). However, it is not essential for this sample to be accurately representative of the birth population.

7.3.2 Age Crawling, Standing and Walking

The developmental milestones are important in giving a mother continuing proof that her child is 'normal', and earlier investigations of preterm infants produced conflicting results. Hunt and Rhodes (1977) found that developmental rates could be largely predicted by a biological model that assumes equality of development for infants of the same conceptual age.
Figure 5: Mean frequency of mothers talking to their children and talking to others at three months.
Figure 6: Mean frequency of mothers talking to their children and talking to others at eighteen months.
Brown and Bakeman (1980) in comparing preterm and full term infants twelve months after discharge from hospital used the Bayley Scales of Infant Development. They found that the preterms still functioned at a maturity level that was approximately one month below that of full term. They lagged in gross and fine motor development and in language related social skills. When the preterm infants' scores were corrected for prematurity they were within normal limits and the two groups did not differ from each other. In contrast, Field, et al (1981) reported that a group of preterm infants who had respiratory distress syndrome showed developmental delays throughout the first 2 years of life and that corrections for gestational age did not compensate for differences they found between the preterm and healthy full term infants.

In this study the premature infants on corrected age levels were about one month later than the full term infants in standing and walking (Appendices 8.3 and 8.4). There was a minimal difference in the age they began crawling (Appendix 8.2). But both groups of infants were ahead developmentally (Bayley, 1935; Bee, 1975). These results were based on mothers' estimates and it may be that the mothers of the infants in this study were 'generous' in their estimates of their own child's skills.

The mothers were ego involved in their own child's achievements and it was noted that, at the home visits, the women fell into two clear groups when asked about the present age of the child. One set of women would reply with the age from birth and then remind the investigator that the child was really developmentally younger. These women were allowing for the prematurity of the child when comparing with other children and were less concerned at the apparent, rather than real, developmental lag. The rest
of the women judged age from date of birth. Two of these expressed strong concern about the child's development and pressed me for judgements on when the infant should crawl and stand, and whether he appeared to be developing favourably in comparison to other infants.

7.3.3 Vocabulary at Eighteen Months of Age

It was interesting to note that the mothers' estimates of the child's vocabulary produced evidence of widely different verbal skills. Some were speaking as few as six words - these were usually limited to the usual 'mamma', 'dadda', 'drink', sets of words, with minor variations coming from family pet names or baby talk. Some children were, by contrast, judged to be extremely fluent. In spite of the wide range of estimates of vocabulary, the average number of words spoken by infants from the first two samples were not very different (Appendix 8.5). The mean vocabulary of 29.22 words compares favourably with the Field, et al (1981) findings of a mean working vocabulary of 30 words in slightly older children (2 year olds) who had been preterm.

It must be remembered that the mothers of the premature infants were talking much more to them at three months than were the other mothers. They also provided much longer transcripts after the birth than the other women. However, this was more probably an indication of their distress and need to talk about their fears and experiences at that time rather than an indication of greater verbal fluency. Considering the lag in language related social skills twelve months after discharge from hospital found by Brown and Bakeman (1980), and the fact that these infants were slightly slower to stand and walk than the full term, it was surprising to find that
their mothers reported that they were saying, on the average, 6.39 more words than the full term infants. Perhaps the mothers' extra verbal stimulation observed at three months (Appendix 7.9) represented an ongoing behaviour pattern and this extra verbal stimulation led to an enhancement of the infants' vocabulary.

Although, as with Field et al (1981) an audio recording of mother-infant interactions was made and transcribed, it was not possible to compare results for infant verbosity (total number of words the infant uttered during the observation) because at this younger age much of the infants' verbalisations were 'babble' sounds rather than distinct words. Tables of the amount of vocalising produced by the infants during the observations when the child was eighteen months old were collated (Appendix 8.6) but no clear evidence can be seen of increased vocal behaviour. The preterm infants vocalised more to themselves and to others than did the infants from the first sample. They also had less vocal interactions with the mother. This did not appear to be related to shyness or temperamental factors as judged by the mother.

7.3.4 Temperament Ratings

The temperament ratings were obtained when the child was eighteen months old. Appendix 8.8 shows that the mothers of both groups of children gave them roughly comparable ratings. Most children were judged to be initially shy but 'warm up' with strangers. When rating temperament (Appendix 8.10) both groups had half the children being rated as 'easy-going and friendly'. No mother classified her child as 'difficult' as did the parents in the Field et al study (1981). Five were positive and described the child as friendly and outgoing. Four mentioned an initial shyness (Appendix 8.8).
7.4. SUMMARY

The women in this sample were unlike mothers in most other studies of preterm birth. They belonged to higher socio-economic groups, were interested in childbirth education and had the support of their husbands. They gave birth in a hospital than encouraged contact between parent and child. There were, therefore, many positive environmental influences at work which may have mitigated the trauma of giving birth to a premature child.
8.1 INITIAL REACTION TO THE CHILD

Unlike both other samples of women these mothers were unable to give unqualified positive reactions to the child. When asked to describe the infant's appearance they often described initial negative reactions but elaborated to give a mixed statement. These descriptions recognised the prematurity, but also showed a positive reaction to the child. Ten of the mothers had initial negative reactions but gave clear 'then and now' statements. Examples are:

When I first saw her she was very bruised and sort of looked like a little prize fighter I thought. But now she's filled out you know, and looks a lot better." (Susan)

"She looked very small and I felt a bit strange I think because I was pretty tired after that. But now I've become accustomed to it. She doesn't look so small and frail anymore. And she's become a little person now." (Joanna)

None expressed unqualified negative initial reactions. They showed evidence of the fluctuations in affect that one would expect considering their fears about the child's survival.

8.2 THE AFFECTIVE EXPERIENCE AFTER BIRTH

The poor physical condition and appearance of the child contributed to the emotional impact of the birth. However, the birth itself was frequently a medical emergency and this affected many women.
8.2.1 Negative Emotions After Birth - Comparison Between Groups of Women

The content analysis scores from the transcripts taken in the period shortly after birth showed the emotional impact of giving birth to a premature infant. Anxiety and vague worries were significantly higher for mothers of premature babies than for the other two groups (Appendix 10.1.1). This shows that the birth of a premature infant produced far more anxiety in the mother than does a normal birth.

They experienced significantly less guilt than the women who had routine separations. This was a rather surprising result as it could be expected that some of the women may have experienced guilt feelings about their contribution to the premature birth. This was particularly likely as this group included those who had earlier undergone abortions. However, as shown below, these women had already been given opportunities to ventilate their concerns about the birth. Cramer (1976) stated that "almost all of the mothers of the premature infants expressed guilt feelings. They accused themselves of being bad mothers, of having exposed their child to great stress by forcing him out of the protective womb". (pp.160-161) Cramer felt that the mothers' guilt feelings interfered in several ways. Firstly, the mother may be prevented from establishing a relationship with the child if she believed that she was dangerous or incapable of protecting the child; secondly, her guilt may prevent her asking hospital and medical staff questions about her baby. With a dearth of information she would be likely to fill the gap with her own guilt ridden explanations of the premature birth and condition of the child. He believed that his research interview was therapeutic for some mothers. The researchers provided the
mother with a straight forward medical explanation of the premature birth and by relocating the sense of guilt, they "were able to neutralize her guilt feelings". (p.162)

At the time I recorded the first transcript the mothers of premature babies had already participated in interviews with hospital staff. Most had already had multiple contact with the paediatricians and nursing staff. They were familiar with the child's condition and aware of the prognosis and reasons for medical interventions occurring.

As one woman described it, the contact with the medical staff fits Cramer's criteria:

"Well actually the paediatricians came down, and they like to be interested in the ladies down there because there is every chance that they're going to have premature births. And, you know, they just sort of discuss your history and everything. The medical history, the reasons for being in hospital for that time, and sort of discuss that. And they say, 'Well we'd like to see you up there and just have a look around'. They're very helpful." (Wendy)

Therefore, their lower guilt confirmed Cramer's findings that interviews providing medical explanations helped to neutralise such feelings.

Cognitive Anxiety, which is a measure of the difficulty found in comprehending situations and making sense of what is happening to one, could have been expected to be higher in these women at this time. For many the birth was sudden and involved a re-examination of their plans and preparations. But there was no significant difference between the first two groups, only a significant difference in comparison with the working class mothers. Thus the birth of a first child, whether full term or premature,
involved a reappraisal and a coming to terms with rapid changes in a novel situation. However, the mothers of premature babies experienced uncertainty in relation to different aspects of the birth experience when compared to mothers suffering routine separations.

Uncertainty and puzzlement were expressed about the infant itself, about the labour and birth, about the doctors and nurses and about the mother's family. The most common expressions related to the baby. They ranged from problems with the prematurity through to acceptance of the sex of the child.

"I really knew nothing about premature babies at all. I went there not knowing a thing." (Liza)

"I never imagined a baby so tiny. As soon as she was born she was breathing almost immediately and everything. I never really believed a baby that small was supposed to." (Brenda)

"I was terribly upset but I didn't know how I would cope. I was just getting upset because I didn't know if he was going to live or die." (Maria)

"I couldn't quite believe I'd had a baby." (Joanna)

"..... and for about 20 minutes I didn't even know what sex he was." (Ann)

"I was expecting to have a boy for a start and I thought he was joking." (Brenda)

"I couldn't believe it was mine." (Patricia)

The speed of the labour and women's lack of knowledge of what was happening to them also created problems.

"The labour was something that happened very quickly." (Janice)

"I kept asking questions and wanting to know all these different questions. What was happening. Everything happened too quickly for me to comprehend what actually
was happening. Even afterward I couldn't believe that it had happened because it was all so quick." (Liza)

"Someone yelled out that the head was showing and that's the first time I knew I was in labour. I didn't know what to do and they said to get down in a bearing down position, and I couldn't think what that was." (Eve)

The hospital atmosphere, the medical and nursing staff, and procedures surrounding the birth led to the mothers having difficulty in understanding and accepting what was happening to them.

"And the doctor's kept saying that there was nothing wrong with him, and I didn't believe them." (Maria)

"And the nurse came and examined me and timed the contractions, and before I knew it they had the head nurse there examining me internally." (Susan)

"It was like a comic bit really - him sitting down the other end stitching you up. I couldn't believe it. You could actually see him stitching away and I'm sitting there with my legs open." (Liza)

Breen (1975) found that postpartum the most important factor cluster in the questionnaire she used referred to confidence. The specific question loading on her factor was "Do you have confidence in yourself?" A lack of confidence implies a feeling of inadequacy and an inability to cope with the new situation. This would be reflected in scores on the Shame Anxiety scale and the Cognitive Anxiety Scale. Although Cognitive Anxiety was higher there were no significant differences between the groups in Shame Anxiety (Appendix 10.1.1).

Breen also concluded that those women who were able to express their fears during pregnancy were better adjusted to motherhood. She wrote: "I interpret this finding as lending support to the notion that the awareness and expression of conflict and 'anticipatory anxiety' (that is, the expression
of anxiety before a difficult event) enable a person to work through
difficulties and are a sign of psychological health." (p.186) This sample of
women had ample opportunity and were encouraged to openly express their
anxieties and uncertainties with the hospital staff during the baby's
hospitalisation. The expression of their difficulties in the early stages of
the mothering experiences could be partly responsible for the decrease in
their anxieties and the increase in the warm feelings about the birth by the
time the child was three months old.

There were no differences between the mothers on anger. But when the
areas giving rise to the hostility were examined in detail (Appendices
10.2.2; 10.2.3 and 10.2.4) it can be seen that the mothers of premature
infants had significantly less ambivalent hostility about the child than the
working class mothers; and they had significantly less anger and ambivalent
hostility about the hospital, its staff and medical procedures than both
other sources. In spite of this lower hostility towards things medical there
was not an increase in warm feelings in that area (Appendix 9.5).

Only a few complained about medical related incidents. One spoke about
the anaesthetic for a caesarian not working fully, resulting in her feeling
the surgeon's knife.

"Nobody ever told me it might not work until him going in and
I could feel it cut." (Emma)

Another felt the doctors had taken too long to decide what was to be done.

"They argued over the caesarian section for nearly a whole
day. Left me in labour with it until it was a quarter past
twelve." (Beth)
However, most of the hostility they did express came in criticisms of their infant's physical appearance.

"When I first saw him I was a bit disgusted because he was so small." (Janice)

"Paul was like a, well all red, red flesh. He looked horrible." (Patricia)

"When she was first born she was very scrawny and she had no fat on her at all. You could see her ribs sticking through. Pretty ugly when she was born." (Eve)

Expressions of disappointment or inadequacy in relation to themselves also occurred.

"I was discouraged enough to ask if I could have an epidural block and fortunately it was too late to have one. (Joanna)

"I'm more disappointed in the way I reacted. It was a disappointment in me that I felt I would be able to cope so well." (Eve)

"I felt real jealous. And I couldn't express the milk or anything. I was just so depressed." (Maria)

"When I first saw him and his face was wrinkled and all that, I was a bit depressed." (Janice)

Pawn scores were significantly lower than for working class women (Appendix 10.3). But as the mothers with routine separations were also significantly lower this difference reflected the coping style of the working class mothers rather than a decrease in pawn like feelings for the other two groups.

When mothers of premature babies expressed these feelings they related to being powerless in hospital routines and also to physical exhaustion. These experiences would have been common to all women in this group.
"I didn't feel I had control of the whole situation. I felt as though I was going to explode. So I felt terrific relief when she came out and I guess I just lay back in relief." (Joanna)

"They kept me up in the labour ward for 2 or 3 days - upstairs. And they brought me down then and I was feeling great, and then the next morning there I was really sick, and they said they'd have to give me a Caesar and take the baby." (Ann)

"And I sort of heard him crying. Then they took him away, and then they took me away and I sort of, when I woke up, I suppose a couple of hours later, they showed me a picture of him." (Ann)

"I was very exhausted because of going through all the labour." (Janice)

"He told me that probably it had to be a Caesarian because of the baby being with its feet down. The only thing I could think of was, as long as the baby lives I don't care what they do. They could have told me anything and I would have said yes. As long as the baby was O.K." (Maria)

"I shook for several hours apparently, a violent shaking that I couldn't control." (Eve)

8.2.2 Negative Emotions After Birth - Comparison With the Wollongong Sample

The mothers of premature infants were significantly higher on anxiety, vague worries and concern about damage and mutilation (Appendix 10.1.1). Items showing concern about damage and disfigurement were present in mothers transcripts from all three sources. Giving birth is a time when women talk of such things as tearing, cutting and blood, in relation to both themselves and their infants. However, mothers of premature babies were particularly high on this affect.

Puzzlement and confusion was also significantly high. It was high for the first two samples of women (Appendix 10.1.1). This increase in confusion was also found by Westbrook (Appendix 14.2).
There were no significant differences in comparison with the Wollongong Sample on any of the Hostility scores.

8.2.3  Positive Emotions After Birth - Comparison Between Groups of Women

These mothers were significantly lower on origin (Appendix 10.3) than working class mothers. There was no significant difference in comparison with routine separation mothers. It is likely that the lack of opportunity to make decisions about the care of the premature infant is partly reflected in this score. It may also be that to some women it would appear like 'tempting fate' to make long term decisions about an infant whose life is at risk.

There were no differences in their interpersonal relationships but it was in the expression of warm feelings that the real differences between the groups of women were found. There was a significant difference between the first two groups in this area. The premature mothers experienced less of the warm emotions (Appendix 10.5).

When the warm feelings expressed in relation to their husbands, the infant, and the medical profession were separated out it could be seen that there was a significant difference between the first two groups on all aspects, with premature mothers scoring less. The greatest difference between the two groups was in the expression of good feelings about the baby (Appendix 10.5). Unlike the other two samples, no mother from this group was able to give an unqualified positive reaction to her child. However, when these women were able to speak warmly of their child they sounded like both
other groups of women. In spite of them having concerns about the child's poor physical conditions and even survival, some were still able to select some attractive and warming things to describe:

"I was thrilled with the way she looked." (Eve)

"She is beautiful naturally." (Sophie)

"She's nice and round and formed and perfect." (Eve)

"When I first saw him I though he looked really beautiful because he was so big." (Maria)

"I've grown to love him very much." (Wendy)

"I sit up in a chair and you can nurse him .... It's a nice feeling." (Ann)

The emotional cost was significantly higher (Appendix 10.6) in the period immediately after the birth for this group of women when compared with the first sample. That is, they had higher anxiety and fewer warm feelings after the birth.

8.2.4 Positive Emotions After the Birth - Comparison With the Wollongong Sample

Like the first group of mothers, these women had significantly lower origin scores (Appendix 10.3). The decisions they could make about the care of the premature child were few, and any long term decisions made about its future may appear to be tempting fate. Viney (1980) found relatives of people presented at Casualty Departments with a life threatening condition were low on Origin. The premature infants were also in a life threatening condition.
Mothers of premature babies were, however, similar to the previous sample of mothers in the areas which did score on decision making.

The sorts of decisions the women discussed usually related to the birth or childrearing.

"I chose to be awake when there was no chance that I could have her through the normal way. I asked if I could have an epidural so that I could be awake and I also asked if my husband could be there." (Brenda)

"I want to breastfeed when she's at that stage." (Joanna)

"Most people that have come to visit we've encouraged to have a cuddle with her. I feel very strongly about holding and I feel very strongly about contact with a baby so I really wanted to stroke her and touch her." (Joanna)

"I actually asked to see my doctor to see if I was dilating." (Eve)

These mothers had a significantly higher score on intimacy than the Wollongong Sample (Appendix 10.4). The infant related expressions scoring on this scale showed a great deal of warmth and appreciation of the developing intimacy between mother and child.

"She looks, and she fixes her eyes on people. When she's awake I sort of talk to her and smile at her and she'll do a funny little sort of smile thing like that." (Joanna)

"They brought her over and I was able to give her a kiss." (Brenda)

"You know every day I just feel more and more for him. I mean he's a part of both of us." (Wendy)

Although there was no significant differences between this group and the Wollongong Sample on Helping this was the scale most husband related statements scored on.

"He was there to support me." (Emma)
"He was great. He held my hand and soothed me and that." (Sophie)

"My husband was there the whole time. Just from the time I came here to the hospital through all the tests and everything I never lost that, that physical contact with him. It was incredible. He was just physically there." (Brenda)

The rest of the family also provided rewards.

"She was tickled pink. Specially when we told her she was a grandmother. And she thought it was really good. My father will be down on the weekend too." (Sophie)

"She wanted me home with the baby." (Beth)

"They seem much kinder and they like seeing their grandson. They think he's great." (Patricia)

The doctors, nurses and the hospital were appreciated.

"And he sat and explained things to me which was really good." (Wendy)

"I was very relieved when Peter gave me some photographs of Paul to keep before he took him from Mona Vale." (Patricia)

"And his voice sort of transferred a lot to me that it was all right because I trust him." (Liza)

"The sisters were good. They kept on listening to her and the heartbeat and they let me know that everything was all right." (Beth)

"You never feel pushed away. The nurses are really wonderful. Everybody is. The doctors are." (Maria)

"There was one sister who was there all the time. I wanted her there all the time. She just didn't go. She was there to talk to and she just seemed to be watching everything going on. Seemed to be in control. I was very happy she was there." (Vivienne)

There was no significant difference between this sample of mothers in warm feelings and the Wollongong Sample (Appendix 10.5). As both other groups of mothers had significantly higher scores this showed that normal childbirth was a time of high positive affect but that the birth of a premature infant was not.
8.3 THE AFFECTIVE EXPERIENCE WHEN THE CHILDREN WERE THREE MONTHS OLD

Twelve mothers were seen at this time. Three mother-infant dyads had been lost from this sample. The reasons were that two infants died, and the third family moved interstate. Therefore, no self-selection was occurring in the continued follow-up. In this aspect the mothers of premature infants were quite unlike the other mothers. As a group they remained much more co-operative and were more willing to discuss their experiences and to show off their children.

8.3.1 Negative Emotions When the Children Were Three Months Old - Comparison Between Groups of Women

This group experienced more negative emotions at the time of the birth than did the other two groups, and it is possible that their scores may have been artificially elevated on the negative emotions because of the method of interview used when the children were three months old. However, the content analysis scales are very sensitive to fluctuations in emotions (Gottschalk and Gleser, 1969; Gottschalk, Winget and Gleser, 1969; Ivey and Bardwick, 1968) and the scores obtained would reflect the women's emotions at the time of the interviews. In addition, the stimulus pictures allowed for scenes to be interpreted in relation to the mothers being at home with their infant and, examination of the transcripts showed that only one of the twelve women confined her discussion to the situations represented in the pictures. The rest mentioned such things as current difficulties and joys as well as recollections of the pregnancy and birth.
The anxiety scores (Appendices 11.1.1; 11.1.2; 11.1.3 and 11.1.4) and hostility scores (Appendices 11.2.1; 11.2.2; 11.2.3 and 11.2.4) showed that there were no significant differences between the three groups of women at this time. The lack of significant differences is surprising on two counts. Firstly, Blake, et al (1975) found that parents of very low birth weight children continued to need a lot of reassurance while their children were growing up and that such normal things as variations in appetite and fighting with siblings became cause for concern. Secondly, the mothers of premature babies I interviewed were more likely to press me for an opinion about the development of the infant than were the other mothers.

8.3.2 Negative Emotions When the Children Were Three Months Old – Comparison With the Wollongong Sample

In comparison with the Wollongong Sample these women had significantly more anxiety, and felt more vague worries, concern about tissue damage and mutilation, and more uncertainty (Appendix 11.1.1). Nearly half the worries about physical damage to the baby related to current concerns about the child. This contrasted with the concerns about themselves which were mainly recollections of past fears of damage during their pregnancy and the birth. Thus, while the women freely expressed old fears they also talked of more current concerns about the infant. The raised anxiety was reflected in their descriptions of their mothering behaviours. Maria had recognised and identified her feelings about the birth and the child. She described her feelings of loss and her need to be protective.

"I used to feel after he was born that he virtually had been stolen from me in some way. That he'd just been taken out when he shouldn't have been. It used to be a terrible feeling. I think I'm more protective than had he been just born under normal circumstances. I didn't think I would have been so protective."
The need to protect and care for her child seemed to lead to a desire to be a perfect mother and, of course, she found that impossible.

"I can't really look after him the way I ought to and I can't organise things and do what I'd like to do. The days just go. I get up in the morning and a few minutes later it's night. I never get the things done that I'd like to have done. And I don't spend as much time with him as I'd like to."

Joanna had decided to devote nearly all her time to her child. The baby slept with the parents and was with one of them for most of her waking hours. She too, felt that she couldn't do all the things she should.

"You feel all the time that you never get anything done and that you wake up each morning ..... (and) ..... I just rush around in the few moments that she is either asleep or quietly playing with this or quietly playing in there. I try to get things done but I feel exhausted by the end of the day. There is always that feeling, but I'm sure that everybody feels the same way. I keep reminding myself not to take it all too seriously."

Discovery of personal limitations and the reality of childrearing is common in new mothers. Oakley (1979) found that 84 per cent of the primiparous women she interviewed felt that media representation of contented babies and happy parents bore little resemblance to the chaos, disruption and confusion of first time motherhood.

The uncertainty expressed at three months by the women was nearly always a reiteration of the concerns they had around the birth period. They again discussed the unexpected onset of labour, the speed of the delivery and the unreality of the birth.

Once more it was Maria who clearly talked about the unpleasantness and dreamlike quality of her experience.
"It was a nightmare to be in hospital with all the other mothers .... I was sure he wasn't going to make it. And his (her husband's) family was annoying me and making me feel that he was theirs and not mine."

Liza said: "After I'd had him it was a very big upheaval for me to find that he was early and in a humidicrib. Really I had everything on my mind constantly."

In summary, at this time there were current anxieties about the infant and their own coping ability as mothers, together with memories of the trauma they experienced at the time of the birth.

8.3.3 Negative Emotions – Changes Between Birth and Three Months

Although there were no differences between the three samples of mothers at this time, it is interesting to look at the development and changes in the emotions of mothers of premature babies over time. By the time the child was developmentally three months old their ambivalent hostility had increased significantly (Figure 7). So too had their expression of anger directed towards them by the medical/hospital sources (Appendix 13.2.1). There was a trend towards a significant increase in expressions of rejection by the baby.

The ambivalent hostility scale scores verbal statements expressing themes about destructive, injurious, critical thoughts and actions of others, or situations directed towards the self.

"They made it pretty nerve-wracking because I couldn't get to see him." (Re hospital situation keeping mother and child apart.) (Patricia)

"I was pretty frustrated because the first two months they just kept me there." (Re hospital.) (Ann)

"I rang him up but he didn't want anything to do with us."
(Re separation from husband.) (Beth)

"His family was annoying me." (Re in-laws.) (Maria)
Perhaps it was only when survival of the infant seemed assured that they dared to feel hostility. Shortly after the birth they had no knowledge of the child's developing personality, little responsibility for the arduous caretaking routines associated with babies, and were dependent on the medical staff and the hospital for the continuing well being of their child.

Ambivalence, hostility and denial of anxiety were clearly expressed in three mothers' transcripts.

"It seems that he's whinging for no reason at all. But it's only because he's sore and because he wants someone to care for him and to cuddle him. And then he gets angry at me because I get angry at him." (Patricia)

"I didn't have any problem with her. But now she's got a hernia and she's got to have an operation. But I've got no trouble at all with her. She's been no worry other than that." (Jane)

"I was frightened there would be a lot of trouble having a baby. But it didn't take long. And she was in a hurry to get out. But she hasn't been any problem besides that, so I've not a lot to worry about. She hasn't been sick. She has never had the terrible colic problems some babies have. I don't think I've really had to worry about too much, And that's the first real cold that she's had. She's eating well and she's sleeping well. I think I was very lucky." (Susan)

8.3.4 Positive Emotions When the Children Were Three months Old - Comparison Between Groups of Women

There were no significant differences between the groups in any of the scales measuring positive emotions at this time (Appendices 11.3; 11.4; 11.5 and 11.6).
8.3.5 Positive Emotions When the Children Were Three Months Old -
Comparison With the Wollongong Sample

This sample of mothers were significantly lower on origin (Appendix 11.3), significantly higher on intimacy (Appendix 11.4) and significantly higher on warm feelings (Appendix 11.5). Viney's findings (1980) relating to the low origin scores in relatives of a patient with a life threatening condition are relevant here. It was apparent from both the scores and the transcripts that the life threatening period for the infant was still influencing responses.

Giving birth and the early child raising period was a time when warm and caring feelings and appreciation of intimacy was high as the first two samples experienced this.

8.3.6 Positive Emotions - Changes Between Birth and Three Months

Warm feelings increased significantly but scores on helping significantly diminished (Appendix 13.2.1). 'Helping' describes a relationship wherein people are construed as resources and is scored when the transcripts describe a person in a supportive or nurturant relationship with another. As these mothers were often talking of the kindnesses and support they received from their husbands and the staff at the hospital at birth it was not really surprising that the scores on this scale decreased. However, the decline in perceived support did not interfere with an increase in contentment.

Figure 7 shows the increase in warm feelings and the increase in ambivalent hostility.
Figure 7: Changes in affect between birth and when the children were three months old for mothers of premature babies.
8.4 THE AFFECTIVE EXPERIENCE WHEN THE CHILDREN WERE EIGHTEEN MONTHS OLD

By the time of this visit there were only eight women left in this group. By three months, two infants had died and one family left for another State. Now three more mothers had moved and left no forwarding address, and one mother declined to be interviewed. All of those who moved had been living in high rise flats and two were married to servicemen. The mother who declined further interviews had allowed her child to play with an electrical cord when three months old. Her own illness had led to the early birth and the emotional and physical cost to her had been high. She showed the same less positive initial reactions as some of the separated mothers (Table 2).

The transcripts obtained from the women at this time were shorter. They were more related to current concerns and had very little recall of the birth, the prematurity or the mothers' earlier anxieties.

During this interview they were asked about major changes in their lives since the birth of the child. Five of the eight women mentioned restrictions on freedom, leisure and general activities. Maria explained herself like this:

"It's very different because I can hardly get out on my own any more. Hardly ever really. Because I don't like to leave him with anyone. So I don't get out much and I don't drive. It's terrible. I should get a licence. I just don't get around to doing it. I'm too scared ..... We are more or less stuck in the house all the time."
Jane had already had another daughter and she felt very much trapped.

"I can't do anything. I can't get out because I don't drive. So I'll have to wait until I can get a double stroller to put the two of them in to go out."

Joanna, Liza and Vivienne complained of limitations but also expressed some of their own needs.

"It made financial changes - very greatly. It's brought me to the ground. I can't dash off overseas and sort of flit about and do things like that. And it just makes me far less independent because I can't just do things when I feel like doing them. I mostly put her first - I guess I don't always, and she has to fit in with me too..... I organise myself a lot around her needs." (Joanna)

"You're not free to do everything you want to do. You've got somebody else to consider. You don't get a good night's sleep. Virtually that's all that's really changed in our lives. You've just got somebody else to consider and you just can't do everything that you want to do. You've got to limit yourself. I still go to tennis and we go to Playgroup twice a week. I've got a car and I just go out. We go around to parks and that when he gets a bit crotchety or fed up." (Liza)

"It's entirely different. I'm staying at home and not working now and I think that's the major change ..... I think you realise you need friends more when you're at home. That's a big thing. I'd never been a person for having many girl friends - I still don't have many - but I appreciate having a talk now with someone like me." (Vivienne)

They were also questioned about their experiences in childrearing and asked if there was anything they would do differently if they were raising another child. Maria felt her isolation. She had decided that she would not have another child until she could drive and she would plan for more outings with her children. Two mothers talked about children being different individuals and felt that they would like to be able to respond to that individuality. Joanna said that she didn't have all the answers to childrearing problems
but that she would probably behave in much the same way with another child. However, four of the eight mothers insisted that they would not worry as much with future children. Jane said:

"I hope to leave this one and not pamper her as much as I did Kate. With Kate I was fanatical about germs. I think it was only because of being in the premature ward. They made you fanatical. But I was over so."

Liza, who had earlier talked of loss of sleep and whose husband had half jokingly complained about a lack of privacy in the bedroom and a decrease in their sexual relationships, said:

"I'd make them stay in their cot. That's about all. I'd let them scream a lot more. He's too old to do it now. We made a mistake in the beginning. Both of us can't stand him crying so naturally we'd just go and pick him up out of the cot. But if I had another one - no."

Vivienne, who had twins, had more complex emotions. She denied anxiety, discussed their illnesses and recalled her concerns:

"I haven't worried much with these two, but I'd worry even less than I have done. I've got to toilet train them yet. But I'm not worried about it. But I have worried about food a little bit. If they weren't getting enough sort of thing. But I'm realising more and more that they don't seem to suffer if they don't get food. What's made me realise that is they both had very bad bouts of diarrhoea. At which time they hadn't been eating at all and you realise that they just seem to keep on, even if they don't eat. So I'm not so worried about them eating all their fruits and their vegetables and things now."

Perhaps Susan sums it up best:

"I wouldn't worry as much about little things. I'd be more confident I suppose about lots of little things."

They were questioned about the amount of time they had free to spend with their husbands and most replied that they had less time together than
before the baby was born. However, this did not seem to be an area of concern. There was a tendency to elaborate on the answers with descriptions of time spent mutually with the child, or the father's time playing with the child.

8.4.1 Negative Emotions When the Children Were Eighteen Months Old – Comparison Between Groups of Women

There were no significant differences between the first two samples at this time.

8.4.2 Negative Emotions When the Children Were Eighteen Months Old – Comparison With the Wollongong Sample

There were no significant differences between mothers of premature babies and the Wollongong Sample.

8.4.3 Negative Emotions When the Children Were Eighteen Months Old – Changes Over Time

Anxiety showed a significant decrease between the three month and eighteen month visits (Appendix 13.2.2). They had continued to be anxious when the children were three months old. The significant difference shown between birth and eighteen months (Appendix 13.2.2) was based on the decline in worries between the second and third interview. Fears about damage showed the same pattern of slow decline (Figure 8).
Figure 8: Decrease in total anxiety and mutilation anxiety for mothers of premature children between birth and three months, and three months and eighteen months.
It is interesting to compare the means for both Total Anxiety and Mutilation Anxiety for the first two samples of mothers at eighteen months. Both had a Total Anxiety mean of 1.47. Mutilation Anxiety mean for mothers with routine separations was .59 and the mean for mothers of premature children was .54 (Appendix 12.1.1). Thus both groups of mothers at that time were very similar in these emotions.

It seems that the hospital and birth experiences faded as the mother got on with the task of raising an active child. The women's concerns in relation to themselves which increased between birth and eighteen months were loneliness and depression (Appendix 13.2.3). They were also more guilty and expressed more ambivalent hostility when talking of the child.

In spite of these increases in negative affect there was a trend (p.02) towards a reduction in the emotional cost of this psychosocial event as the child grew up. Maria's description of her life style as her child grew up showed these feelings. She emphasised the restrictions on her freedom and then went on to say:

"I don't know how I would cope if he was a demanding child. I probably wouldn't cope. He's very easy - entertains himself a lot. I mean, I play with him a lot and he's never cranky and whinging unless he's tired or hungry or something. So he's a very easy child. It's just me because I think I feel so isolated."

8.4.4 Positive Emotions When the Children Were Eighteen Months Old - Comparison Between Groups of Women

There were no significant differences between the first two samples.
8.4.5 Positive Emotions When the Children Were Eighteen Months Old –
Comparison With the Wollongong Sample

There were no significant differences between these mothers and the
Wollongong sample on expressions of warm feelings. However, it cannot be
argued that the mothers of premature infants have 'normalised' their affect
by referring only to this comparison. It should be noted that those women
who experienced routine separations expressed significantly more positive
emotions than the Wollongong Sample (Appendix 14.1). The first sample
was higher on sociality, intimacy, influencing and sharing as well as talking
more about warm feelings. The mothers of premature children did not
show these same differences.

8.4.6 Positive Emotions When the Children Were Eighteen Months Old –
Changes Over Time

It was only on measures of emotional cost of the childbirth and child raising
experience that there was a trend towards a significant change. The cost
decreased between birth and eighteen months (Appendix 13.2.3). The other
positive emotions which changed significantly after the birth were the
more diffuse warm feelings and helping. However, these changed
significantly only between birth and three months (Appendix 13.2.1).

In summary, it seemed that the increases in warm feelings and anger
occurred more quickly than did the changes in anxiety (Figure 7). It took
up to eighteen months for anxiety and worries about physical injury to
decrease. Also, it was pleasing to see that by the time of the visit when
the children were eighteen months that fears about dying had almost
completely disappeared from their affective repertoire.
8.5 SUMMARY

Giving birth to a premature baby has been shown to lead to an increase in anxiety and a lowering of warm feelings around the time of the birth. Hospital practices designed to help the mother adjust to the trauma were able to ease the family disturbances created by this crisis. The survival of the child changed the internal personal feelings of the mothers, and by the time the baby was three months old different reaction patterns were found. Both warm and angry feelings changed more rapidly than did the anxieties and worries.

8.6 CASE STUDY - "MARIA"

Maria was not typical of mothers of premature babies in that her degree of anxiety at all times was higher than most. However, her case is interesting and she had insight into her own reactions to the birth and a willingness to talk about these which provided a wealth of information.

She was aged 28 years, at the time of her son Andy's birth. She had been pregnant twice before. One she carried for twenty-two weeks and the other for twenty-three weeks. Andy was born at twenty-eight weeks. Only one of the two earlier pregnancies produced a living child and that child she described as only surviving for a few minutes.

She was married and living with her husband in a northern suburb of Sydney. She had finished high school at a co-educational State school in Europe. After schooling she had trained as a Secretary. She had done childminding and secretarial jobs during her time in the work force. She
stopped working two and a half years before Andy's birth. She was married to a tradesman who ran his own business. Her marriage was described as "happy most of the time".

Both of her parents were living and she had not been separated from them until she migrated following her marriage to an Australian. This separation she felt most keenly when her anxieties were highest immediately after the birth of her child.

At the time of the hospital interview her score on the Malaise Inventory was eight.

She described an early labour which led to a Caesarian. She had planned to be delivered at a nearby District Hospital. She was admitted there when labour began. She was then transferred to the Teaching Hospital so she could have ready access to specialist neonatologists. She was hospitalised for two days before the delivery. She said:

"I had labour pains and I had had them for about two days and they just couldn't stop - they tried to stop them with a drip and everything but it just couldn't. They sort of held it back for a while, but then it just came on and they couldn't stop it. The baby was just on its way out. And they decided on a Caesarian because it was with the feet down and such a small baby it wouldn't have made it."

Like the other mothers she appreciated the help she had from the hospital and her husband but she had great difficulty coping with her feelings of jealousy and her continuing fear that the child would die. About her feelings of alienation from the child she said:

"I sort of feel that he is more theirs than mine. He is more part of the hospital. He's not really a part of me. I sort of
have to force myself to realise that he is mine. I sort of start to think that he is mine now, but during the first days I was in hospital I felt all the time that I didn't really know why I went up there. Because he was the nurses' baby, not mine. But now I sort of start to feel more that he is mine. I was sort of jealous of the nurses. Sometimes I sort of didn't want them to even touch him. I felt really jealous."

She watched her baby closely for signs of survival, but noted only those signs that she felt indicated he was dying.

"A couple of days after he was born when I sort of could see that he was going, getting - he was going down. He lost all that weight and he looked, he looked lifeless and thin. And the doctors kept saying to me that there was nothing wrong with him and I didn't believe them. Because I thought I can see that, I thought that he was dying in front of my eyes and no-one wanted to tell me about it."

She compared herself with the mothers of healthy infants and again became jealous.

"And then I was downstairs where all the women have their full term babies. And it just made me so I was terribly jealous. That made me so I was terribly depressed then. And I thought there was only me in the whole world. That was the problem."

She felt alone except for her husband and longed for her own family to be with her.

When Andy was three months I visited her home. She was still anxious and scored ten on the Malaise Inventory.

Andy was bottle fed. He seemed well and happy. She said that she had been depressed but that as he got better and stronger her depression had gradually lifted. However, she remained concerned for the child. She worried about his health even though she realised that this was a remnant
of the past. She had maintained contact with another mother in the study and talked of meeting her socially. At these times she compared her child's development with the other baby. Although friendly and pleased to have me visit her, she was tense and there was some tremor in her facial muscles. Her home was imaginatively decorated, neat and well furnished. There were small Swedish dolls and hand-painted pieces of art work in the house. There was a painted sign 'Welcommen' on the front door.

In the sitting room she had combined a luxurious soft lounge with scrubbed wooden furniture and a rocking chair. Andy's bedroom was bright green with a giant colourful hippopotamus mural. There were many toys in his room and mobiles dangled over the cot.

During the observed interaction she spent most of her time talking to or smiling at Andy. She changed his nappy and at that time took the opportunity to show his room and she talked of her husband's work in painting and making it ready for Andy.

She recalled her early conviction that Andy was going to die and her feelings about the nurses and her in-laws. She said that she now got on really well with her husband's family and that those earlier feelings had "completely gone".

Her reaction to her short pregnancy now surfaced as something that puzzled her.

"You see sometimes I feel I wasn't pregnant and Andy wasn't born under normal circumstances. He is mine and I've got him, but I didn't bear him through pregnancy. I know I did, but it doesn't feel like I went through that sort of thing. I
sometimes feel I just got him. I was never pregnant. I never
gave birth to him really. I don't know why. I mean I know it -
I know he's mine and he grew inside me. But I don't feel he
ever did. That he was more or less given to me. They gave
him to me from the hospital. I don't think I'd like him any -
love him any less or more because of it. Not at all."

She also recognised she was over-protective and that this was due to her
earlier worries. She could not yet go out and leave him.

"And I just can't leave him with anyone else. Just the thought
of it makes me sick. It's all right with my husband. I went
out once. And I could do that again, but no-one else. I just
can't face up to that yet. Even when I sometimes think it
would be lovely just to stay out on my own. But I just can't
face it."

This need to be with her son led to her decision that she could never have
another child. She knew that her pregnancies had been difficult and if that
happened again she would be hospitalised and would have to leave Andy at
home. She said:

"They said if I wanted another child I'd have to go into
hospital for about 3 or 4 months, and I could never ever leave
him with anyone else for that length of time. I'd go mad. I'm
sort of convinced I'm not having any more."

Her last complaint at that visit was about the hospital and the way she had
been in the same ward as mothers of healthy infants. The pain of her
earlier comparisons between infants was obviously still with her.

"I felt much happier when I was home and my husband was
there. It was much better to come home. It's just the way
that they put the mothers of premature babies - that much
premature - I don't think should be in the same ward as
mothers of healthy babies. I guess they can't do anything else
but it would be good if they had another, just another room
somewhere, where they put mothers who don't have their
babies with them. I think it would be better. I thought that
was the hardest bit."

By the time Andy was eighteen months old her Malaise Inventory score had dropped to six. This is still high. Once again she spent a great deal of her time talking to her infant, smiling at him and playing with him. He was not held and she seemed intent on demonstrating his skills. She found a cart full of blocks and asked him to push it around. She interrupted this play to talk to him about neighbours' activities in the street. Both were looking out the window and she asked questions and provided the answers in a teaching way. For example, "That's a funny noise. That's someone cutting their lawn", and "Yes that's Linda going out isn't it? What can you see? Linda. It's a nice day isn't it? There's a dog outside".

Andy had an estimated vocabulary of ten words. She said he was healthy and was never sick. She described him as determined and quick tempered – saying that he got upset if things were taken from him.

Her life by now revolved around Andy and her home. She still couldn't bear to leave him with anyone. She was trapped in the house and felt that caring for him, in spite of him being an 'easy' child, was demanding.

She was angry with herself for not being able to drive.

Because I don't like to leave him with anyone. So I don't get out much and I don't drive. It's terrible - I should take a licence. I just don't get around to doing it. I'm too scared. I mean I've got the car and all."

She sounded as though she was depressed and not coping with her life very well.

"It's not hard, it's sort of just mentally demanding. Maybe it's because I don't get out much I find it terribly mentally demanding. And that's what gets to me sometimes and I get
terribly depressed. And I feel I don't want to do anything - just sit around. Sort of more or less just coping with what I have to do. But I think that's because I'm stuck around the house so much. I think it's because I don't see many people."

Obviously being isolated worried her and she now gave not being able to drive as a reason for not having another baby. She recognised that it may be better for her to separate a little from her son but indulged in a sort of 'magical' thinking about the consequences of such actions.

"I think that it would also help me to feel better if I left him with someone and went out on my own. But I just don't seem to be able to do that yet. I get the sort of feeling that he'll fall down steps, or that sort of thing. But I guess it would be good for both him and me to get away from each other for a bit."

Her difficulties and anxieties were obvious. She was a woman who still had lots of dilemmas about the mother role. Her insights and openness was disarming and she produced a protective or 'therapist' response in the writer. She was one mother for whom I would have liked to step outside the research role and be of help in other ways.
CHAPTER NINE

YOUNG WORKING CLASS BIRTH – THE BIRTH ENVIRONMENT

AND BACKGROUND INFORMATION ABOUT THE MOTHERS

"One way to fill time and to increase one's sense of contribution is to go to work; another is to have a baby." Hoffman and Wyatt, 1960, p.238.

The data included in this sample came from a group of young women who had been initially interviewed in the antenatal clinic of a large Sydney hospital. The original intention had been to gather information during the third trimester of pregnancy and follow these women through their adaptation to the birth and early development of the child. This proved impracticable because of the amount of time involved collecting antenatal data relative to the number of women who made themselves available for interview following the birth of the child. Approximately forty-five cases were interviewed to produce only fourteen at birth. This was in spite of multiple contacts with the staff in the antenatal clinic and the maternity ward. The hospital records of women interviewed were codemarked and my telephone number was left with the ward clerk and was prominently displayed. As the hospital staff were most co-operative one can only assume that, either pressure of work prevented notification of the birth, or that the women declined further contact. This high drop-out rate remained a feature of the research with these young women.

9.1 THE HOSPITAL AND ENVIRONMENT

The hospital in this investigation served an outer suburb of Sydney. It fed mainly from working class areas – some of which are new and still
developing. It was an area where many of the residents were protected by government support in some way - either living in government housing or receiving pensions.

The hospital itself was fairly new. Its maternity ward was built only in 1977. It was large, light and airy with many windows and was planned on modern open lines. Most wards contained 6 beds. Care was taken to ensure that public (non-paying) patients were not readily identifiable. The files of such patients were allocated to one of the hospital's visiting specialists. Rooming in was readily available to all women. In fact, it seemed to be the norm rather than the exception. Babies were left with their mothers unless the mother specifically asked for it to remain in the nursery.

On entering the unit one was impressed by the size and openness of the layout and by the relative informality and friendliness. Babies were beside most women (except for visiting hours) and it was usual to see women wandering from one ward to another with a cup of tea - to drop in for a chat with someone down the corridor. An easy camaraderie seemed to exist between the women and they obviously talked easily to one another. The easy and informal conversations were surprising when contrasted with the emotionally impoverished transcripts these women provided when I interviewed them.

Most patients in the maternity ward were young and came from the immediately surrounding district.
9.2 YOUNG WORKING CLASS MOTHERS

Fourteen mothers were seen shortly after the birth of their first child. All infants were healthy and were full term. Data were also collected in the third trimester of pregnancy for this group and this provided some extra background material on these women.

9.2.1 Working Class Women During the Third Trimester of Pregnancy

These women were the only group to have a significantly high score on the Malaise Inventory. The mean for the group when interviewed during pregnancy was 8.57 with a range of from 3 to 16. Rutter, Tizard, Yule, Graham and Whitmore (1976) found that the Malaise Inventory was a satisfactory screening instrument for emotional disturbance in adults. They also found that, of mothers with a psychiatric disorder, three-fifths had a score on the Inventory of 7 or more whereas only one in twenty without such a disorder scored so high. By this yardstick then, the young working class mothers were 'disturbed'. There is, however, one other factor that should be taken into consideration. Rutter et al (1970) discussed the 'grumble' factor in relation to scores on the Inventory. They concluded that although many people suffer occasionally "unless there is preoccupation with sickness they are unlikely to place sufficient weight on the bodily sensations for them to regard "yes" as an appropriate answer to the questions", (p.161). Pregnancy may change this as women at this time do become preoccupied with the developing child and with the changes in their own bodies. This increased interest in bodily changes could lead to an increase in the scores on the Malaise Inventory. For example, such questions as "Do you often have backache?" and "Do you usually have great
difficulty in falling asleep or staying or asleep?" would be answered "yes" by women who were uncomfortably aware of the increasing size of the uterus and the postural changes that occur, and by those who were troubled by increased frequency in urination.

An additional factor likely to increase the young working class women's scores came from their coping style. They appeared to have a 'passive' way of coping and this has been related to somatisation of distress (Lerner and Shannon, 1972).

By the time of the birth the mean for the Malaise Inventory had dropped to 5.50 (Table 9.7). This is still relatively high.

Several researchers (Mechanic, 1974; Bart, 1968) have commented on the tendency for lower socioeconomic patients to express their psychological distress in physiological symptoms.

"Patients who express psychologic distress through a physical language tend to be uneducated or to come from cultural groups where the expression of emotional distress is inhibited. Such patients frequently face serious life difficulties and social stress, but the subculture within which they function does not allow legitimate expression of their suffering nor are others attentive to their pleas for support when they are made." (Mechanic, 1974, p.36)

Minuchin (1967) noted the complication of therapy with the presentation of physical symptoms. He believed that low income patients expect and seek suggestion, direct advice, attention to physical problems with medicine and physical treatment, as well as warmth, support and understanding when they are seeking help for personal problems.
Whatever the cause of this expression of psychological distress in physical symptoms it was obvious that this sample of women came from a similar sub-culture to that described by Mechanic and Minuchin. Thus, in addition to the 'grumble' factor, and the real discomforts of late pregnancy, was added the probability that the questions on the Malaise Inventory may be allowing what is for this group of women the only legitimate expression of their psychological distress.

In a somewhat similar vein Wise and Grossman (1980) in an attempt to measure feminine identification in low socioeconomic adolescent mothers used the Thematic Apperception Test. They found the adolescents to be "selfconscious about and resistant to the verbal and imaginative task presented to them" (p.465). Speaking about feelings may, therefore, be extremely difficult for this group.

Inability to identify and describe affect, emphasis on bodily symptoms and an absence of fantasies referable to drives and feelings are features of alexithymia (Nemiah, Freyberger and Sifneos, 1976). The young working class mothers were unable to describe emotions, and their fantasies and planning were minimal.

While pregnant these young women were asked "What do you think life will be like after the baby is born?" The answers fell into five categories. These are shown in Table 6.

None mentioned the extra work and emotional demands one could expect when coping with a new baby. Few planned to attend childbirth education
classes and none felt any need for training in child care. Their response to pregnancy and labour seemed fatalistic and without curiosity about the future. Perhaps this is related to an inability to fantasise and plan.

<table>
<thead>
<tr>
<th>Response</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life will be the same</td>
<td>4</td>
</tr>
<tr>
<td>I haven't thought about it</td>
<td>2</td>
</tr>
<tr>
<td>I don't know</td>
<td>4</td>
</tr>
<tr>
<td>Life will be better</td>
<td>2</td>
</tr>
<tr>
<td>Happy, I hope</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 6: Expectations of working class women about life with a baby

Their failure to seek information about childbirth was similar to Scott, Illsley and Biles' (1965) research findings with lower class women. They concluded that such women "would rather not know".

As most of these young women were not living with the child's father (Appendix 4.1) family relationships could have provided alternative support networks for them. However, their relationships with parents while they were pregnant tended to be strained. Few had good relationships with both mother and father at this time. Parental descriptions are in Table 7. They described their mothers more positively than their fathers. Few fathers were seen as being available or being affectionate.
Table 7: Working class women's descriptions of their parents

The young woman whose parents were deaf went on to say that she had not learned to speak until the age of four. Their handicap had obviously made life more difficult for their daughter.

The boyfriend of one of these young women also described his parents and provided a vivid picture of his homelife and the cultural values there:

"My old man had a bad temper and belted Christ out of me most of the time. And now I'm a good boy. My mom is beautiful, trustful, loyal, friendly, sisterly, cheerful, brave, useful, tidy, respectful."
9.2.2 Country of Origin

Most of the women were Australian born (71 per cent). Three came from Great Britain and only one came from a non-English speaking background - she was Italian (Appendix 2.1). The group was subjectively homogenous, and the migrant women saw themselves as 'Australian'.

9.2.3 Relationships With Parents

The parental descriptions obtained during pregnancy provided a better insight into the quality of family than did the statistics on the parents. Only two (Appendix 2.5) reported trauma in their early lives yet the descriptions given of their parents indicated difficulties within many of the families. Twelve of the women had both parents still living (Appendix 2.2), and thirteen reported that they had not been separated from parents before the age of thirteen (Appendix 2.3). In addition, one of the women who reported early family trauma said that her parents had separated when she was seven years old but that she had remained on good terms with both mother and father. The other woman reporting trauma was the daughter of a woman with a recurring mental illness. Her father was a heavy drinker.

Early good relationships within the family did not predict parental acceptance of the pregnancy. The Italian woman had the highest score on the Malaise Inventory (Score 16) during pregnancy. She said her earlier relationships with her parents had been good, but once she became pregnant her mother forced her to leave home and both refused to speak to her. Their rejection persisted after the birth of her baby. They did not visit her in hospital and she did not expect them to come.
9.2.4 Educational and Occupational History

More than two thirds of these women attended State Co-educational high schools (Appendix 3.1). Their education was limited (Appendix 3.2). As a group they had no special skills training and none of them completed the Higher School Certificate.

The poor quality of education was reflected in their occupation status. The mean for this group was 6.07 (Appendix 3.3) and this was significantly higher (that is, lower status) than for the other groups. The majority of them had worked in status rank 6 employment. Typically, they had worked as machinists or shop assistants. The status of the suburbs in which they lived were significantly different also (Appendix 3.4).

Within the Sydney teenage culture the youth from these suburbs have been nick-named 'Westies', i.e. coming from the Western Suburbs. They are regarded as disadvantaged and as being members of a subculture which is different from that of other Sydney teenagers. The recognition of the subculture has helped to build a 'mateship' among the youth from the far Western Suburbs, but it has also led to prejudice and division. Some employers frown on them as potential workers.

The young women's work history was poor. One of them had never worked, one was receiving unemployment benefits, and several reported regularly changing jobs. The mode period between last time they worked and the confinement was 12-24 months (Appendix 3.5). The mean number of months since their last employment and the confinement was 16.92 months.
9.2.5  **Marriage Related Factors**

Although nine women said that they were married or had a stable relationship with the child's father this was not borne out by the follow-up investigations. Only six of those who felt they had a stable relationship were living with the child's father. The rest of the women were living with friends or with parents. Even for those who were living with a male, life would have been far from ideal. Three husbands were employed in low status jobs, and three of them were out of work. Accommodation in Sydney is relatively expensive and one young woman whose husband was threatened with job loss said that they would have to move if this happened. Those who were located when the child was three months old were all living in sub-standard housing.

Two of the three women who said their marriage was happy all the time (Appendix 4.2) were married. The third was a pregnant schoolgirl who was describing her 'stable, long-term relationship' with her child's father - she was still living with her parents.

In spite of the poor economic conditions in which they lived and the apparent lack of permanent liaisons these young women reported that they wanted to have more children than the other groups of women (Appendix 4.4). Nearly 43 per cent wanted to have four children.

9.2.6  **Husband Related Factors**

The working class 'husbands' were all English speaking and most (77.8 per cent) were born in Australia (Appendix 5.1). Their occupational status was
low. Two were on unemployment benefits and the mean occupation ranking was 6.11 (Appendix 5.2). Occupations ranking 6 are spray painters, storemen and machinists.

Only two of the husbands attended prenatal classes. These were two men who were legally married and whose wives said that the child was planned. Both families had a background of emotional deprivation, as described below. Four men were present at the birth of the child and two more had planned to be present but missed (Appendix 5.4).

9.2.7 Childbirth Related Factors

At the time of the birth the working class mothers were significantly younger than the other groups of mothers (Appendix 6.1). The mean age was 20 years. None of them reported previous pregnancies (Appendix 6.2) nor previous elective abortions (Appendix 6.3). It may be that the women sampled from the antenatal clinic of this hospital came from a group who do not accept abortion as a solution to the problems created by an unplanned pregnancy. During the pre-term interview they were asked whether the pregnancy was planned, and twelve answered that it was "unplanned". Scott et al (1956) found more lower class women had a limited knowledge of reproduction and were less likely to use contraception. For the two who had planned pregnancies it was evident that there had been a background of emotional deprivation and one could hypothesise that their needs for affection led to the pregnancy. One who had a planned pregnancy was the young woman whose mother was schizophrenic and whose father was a heavy drinker. The other girl was Anne (her case study is in the next chapter). Her mother had been ill
during her own pregnancies and had complained of high blood pressure. She and her husband feared the same problems for Anne as her own blood pressure was reported to be high. She had a retarded sister and blamed her mother's health problems for the retardation. Her husband was an orphan and was still aged under 21 when his son was three months old. When the child was three months old both husband and wife seemed sad, lonely and struggling to cope with poverty and the world's demands. These two families were the only ones from which the husband attended prenatal classes.

Like the first sample, these babies were approximately 40 weeks gestation (Appendix 6.4). All infants were regarded as healthy even though some were kept under observation for a few hours and one child needed physiotherapy for her feet.

At the home visit when the child was three months old the mothers were asked about experiencing postnatal 'blues'. Only three women were able to be located at that time, but all three reported some degree of depression (Appendix 6.5).

9.2.8 Childbirth Education

Twelve women did not attend childbirth education classes (Appendix 7.1). This was in spite of being constantly reminded of them in the antenatal clinics. Notices about classes and dates for film screenings were displayed prominently at the clinics. The medical staff also suggested to the women that they should attend classes. Not many of the women were still working during late pregnancy (Appendix 3.5) and their attendances at the antenatal
clinic were relaxed, social and unhurried. Therefore, it was not pressure on their time that prevented attendance at classes. They frequently used taxis or were driven by friends to the clinics so it would seem that lack of transport was not the reason for non-attendance. Scott et al (1956) reported that a common coping mechanism of working class women was that they would rather not know about childbirth and they believed that they would "do better" if they didn't know too many details. The sources of information on child care most frequently given were experience with other infants, or information from friends (Appendix 7.2).

9.2.9 Childrearing Factors

Newson and Newson (1963) and Richards and Bernal (1972) found social class was related to plans to breastfeed. Lower socioeconomic groups were more likely to plan to bottle feed their babies. The same relationship was found in this study. The working class mothers were, as a group, much less interested in breastfeeding the infant (Appendix 7.4). Only 64 per cent planned to breastfeed when they were interviewed in the hospital. It is impossible to guess how successful those who wished to breastfeed were. Only one mother was located eighteen months later when duration of breastfeeding was assessed. She had fed for three months, then weaned her child. When weaned this child developed severe infantile eczema.

The environment provided for the children (rated at the home visits) was poor to very poor. However, only three women were visited.

The nature of the mother's lifestyle and accommodation contributed to the lower environment ratings. Cheap over-crowded accommodation does not
lend itself to having a house which is geared towards the child's needs. With too many people in too small a space it is very difficult to adapt and make the home stimulating for the child. One mother from the previous sample managed this but she was intelligent (with tertiary education), and the home, though poor, was not overcrowded. She had been resourceful enough to use a discarded mirror as a play toy, and had banks of cushions around for the child to roll on. The lower class women were not creative in this way. They seemed to believe that plastic manufactured toys were the only ones that could amuse a child.

During the home visit at three months they were asked, "When baby cries, has been fed, nappy is dry, what do you do?". One said that she tended to let it cry and two said that they tended to pick up the child (Appendix 7.7). The numbers are few but there was a trend for them to be less responsive to the crying than both the other samples of mothers.

All of these women had been out and left the child with someone else to mind. None 'felt good' about leaving the child – one thought about the baby, one worried about the baby and the third did not want to leave it (Appendix 7.8).

Appendix 7.9.1 shows that this sample of young mothers were the least stimulating in their behaviour towards the infant during the visit when the child was three months old. They also spent more time 'talking to others' (Appendix 7.9.2). From this it can be seen that they were less infant-involved than the other groups of women.
9.2.10  Reasons for Discontinuing

This group had the highest subject mortality rate. They were a group of young women whose lifestyles were in transition. Not only were they entering into motherhood, but they were also attempting to establish adult relationships (marriage for some) and to find satisfactory accommodation for themselves and the child. Five had moved from the address given and there were no answers to the letters sent to another eight. It is probable that a number of the latter had moved, but some may have decided not to participate further in the research.

9.3  THE CHILDREN OF THE WORKING CLASS MOTHERS

9.3.1  Sex of the Children

Like the other two groups there were more female infants than male (Appendix 8.1). A reason for this is difficult to find.

9.3.2  Child Development

Only one mother (Sandra) provided information when her child was eighteen months. This child was achieving the milestones at about the same time as both other groups of infants. He did, however, have a limited vocabulary of only three words. Messer and Lewis (1972) found lower class infants vocalised significantly less than middle class infants in play.

Tulkin and Kagan (1972) also found that, though working class mothers were affectively similar to middle class mothers in their interactions with
infants (kissing, holding) they vocalised less to the infant. Sandra's child
developed eczema and his mother remained protective. She stated that she
would have difficulty letting him leave her and go to school. Her own
needs for affection from the child became apparent when she said that she
planned to have another child by the time he started school. Sandra and
her child are fully described in a case study in the following chapter.

9.4 SUMMARY

Young working class mothers were limited in many ways. They came from
poor backgrounds and did not have good relationships with their families of
origin. Many were producing a child without the support of a loving
husband. They lacked curiosity about the future and they were fatalistic
when pressed about childbirth and childrearing. Their environment prior to
the birth produced expectations and reactions that would be likely to
interfere with the development of loving relationships with their babies.
CHAPTER TEN

INTERNAL PERSONAL EXPERIENCES FOLLOWING WORKING CLASS BIRTH

10.1 THE LACK OF AFFECT

For this group of young women the most noticeable feature was the lack of expression of emotions. Appendix 13.4.3 shows lists of affect not scoring for them at each of the three times. Of course the small number of subjects at the second and third interviews contributes to some of the restriction in the range, but even soon after birth, the difference is noticeable.

The lower affect and the non-expression of emotion found here is quite different to that which Westbrook found (Westbrook, 1975). She found that working class women during a childbearing year suffered significantly more anxiety, which was largely composed of guilt and fears of damage, than did upper and middle class women. However, Westbrook also concluded that "working class women are less likely to select active strategies. They use cognitive manipulations, or defences, such as fatalism or optimism rather than attempt to change the situation", (Westbrook, 1975, p.324). The transcripts of the women in this sample support this conclusion. They reacted with a fatalism about the changes during pregnancy, the experience of labour and the birth process. There was no seeking after knowledge, there was an unquestioning acceptance of the hospital procedures and routines. Gina described her labour in this way:
"They put me on the drip first and then they, they gave me the mask and they put me in stirrups and tied my leg up and gave me anaesthetic, cause I had everything strong."

Lerner and Shanan (1972) found that passive coping styles are characterised by somatisation and an emphasis on pain and physical symptoms. Bart (1968) and Mechanic (1974) have also noted the relationship between low socio-economic status and the presentation of physical symptoms when under psychological stress. This appears to have been the coping strategy adopted by these women. They continued to have a relatively high score on the Malaise Inventory (Appendices 10.7; 11.7 and 12.7). Those scores indicated a continuing distress in the women which was not being clearly expressed in the transcripts.

Many early researchers have commented on inadequate expression of emotion and underlying tension. This was frequently linked with physiological symptoms (Cramond, 1954; Maclean, 1954 and Scott and Thomson, 1956). Nemiah and Sifneos (1970) noted and then developed (Nemiah, et al, 1976) the description of a syndrome which they named alexithymia. This syndrome they say is characterised by an inability of the patient to describe and identify feelings. The patients also have a peculiar absence of fantasies. The main features are as follows:

(1) Although the individuals may speak of being, for example, nervous or sad they are totally unable to describe their feelings further when pressed.

(2) Patients are often unable to localise affects in their bodies and appear unaware of any of the common automatic somatic reactions that accompany the
experience of a variety of feelings. What somatic components are recognised are identical with the symptoms of their bodily illnesses.

(3) Patients have difficulties in distinguishing among the common affects. Nemiah, et al, (1976) cite the example of a patient who appeared to be unable to distinguish between frightened and 'mad'.

(4) Although the patients are inarticulate about their affects and give little external evidence of experiencing them they may, on occasion, manifest brief but violent outbursts of affective behaviour. For example a patient may be unaware of feeling sad but will start crying when questioned and be at a loss to give a reason.

(5) The patients have an absence of fantasies referable to drives and feelings and their thought content is characterised by a preoccupation with external events. These may include their somatic dysfunctions and the reactions of others to their illness. When asked to describe how they feel they respond with a description of external events.

(6) Individuals with alexithymic characteristics are often stiff and wooden in their manner. They have a restricted behaviour and this, combined with the lack of emotional colour in their speech and preoccupation with mundane external details often makes them appear dull and boring to others.

Two explanations of the aetiology of this syndrome have been provided. The first originates from a French research group and is related to early
mother-child relationships, while the second is physiologically oriented.

The first explanation has been put in this way:

"Because of disturbances in the earliest mother-child relationship, the individual destined to exhibit the features of the 'psychosomatic character' fails to develop the ability to experience feelings or to achieve the capacity for fantasy as a means of (temporarily, at least) gratifying instinctual drives. As a result his attention is preoccupied with his environment, he makes a 'super-adaptation to external reality' and grows into an adult manifesting those disturbances in his affective and fantasy life we have termed alexithymic." (Nemiah, et al, 1976, pp.435-436)

Many of the young working class women described difficulties in their early home life. Although it is true that nine described their mother positively the descriptions tended to be in non-emotional words, such as "good", "kind". The only emotion used in parental descriptions was in relation to the father and that was "angry". The young mothers may also have been limited in their fantasy life. They were unable to foresee the period after the child was born and they remained relatively concrete in their descriptions of the labour and birth. The three who were interviewed three months after the birth when the prompt picture was used gave short and limited statements. In many ways they exhibited the first three indicators of alexithymia, and to some extent they also showed the fifth feature - absence of fantasies and preoccupation with external events.

A modelling/learning explanation is hinted at in results of research by Tulkin and Kagan (1972). They found working class mothers communicated verbally less often with their ten month old child. Many mothers believed that their infants did not possess the ability to express 'adult-like' emotions or to communicate with other people.
Excerpts from Kylie’s transcript illustrate the impoverished descriptions of the experience which was common to these women, and the rather painful extraction of information which was so often necessary when interviewing them.

Int.: Can you tell me what your baby is like now and what he was like when you first saw him?
Kylie: What he was like when I first saw him? Um, oh well, what do you mean? In what way?
Int.: What did he look like to you?
Kylie: I don't know. It's hard to say.
Int.: What does he look like now?
Kylie: Oh. He looks all right to me.
Int.: Can you describe him?
Kylie: Nope.
Int.: Can you tell me about the labour and the birth and how you knew when to come into hospital?
Kylie: I was put in four days before I had him.
Int.: Why was that?
Kylie: Oh, my feet were all swollen and I probably had blood pressure.
Int.: And then did you go into labour naturally?
Kylie: No. They induced.
Int.: How long was your labour?
Kylie: Oh, four and a half hours.
Int.: Pretty quick?
Kylie: Yes, it wasn't that bad.
Int.: How long was the first stage?
Kylie: You mean until I got me bad pains?
Int.: Yes.
Kylie: About two, two and half hours.
Int.: And then, when you felt like pushing - how long did it take?
Kylie: Three pushes.
Int.: That wasn't very long.
Kylie: No.

Int.: Do you have him with you all the time?
Kylie: Mmm.
Int.: How do you feel about that?
Kylie: Um, it's better.
Int.: How do you feel when he has to go back to the nursery at visiting hours?
Kylie: Um, it doesn't worry me.

Kalucy (1979) was hypothesised that it is precisely the paucity of fantasy life that prevents the translation of dysphoric feelings into a
defence response, i.e. a neurosis. If this is true, the lack of fantasy life may be seen as a defence against reactions to life's stresses. Kalucey states that:

"The alexithymic style is a ubiquitous character style, and that it can be a normal and healthy variant of personality. Conceivably it may be the end of a spectrum of coping styles, where the dependent variable is the use which is made of fantasy life as a means of problem-solving and coping." (p.91)

The working class mothers, therefore, can be construed to be coping in a relatively 'normal' way.

In another study, using Gottschalk-Gleser content analysis scales, von Rad, Drucke, Knauss and Lolas (1979) found significant differences between psychoneurotic and psychosomatic (alexithymic) patients on Total Anxiety, Separation, Guilt, Shame, Ambivalent Hostility, Hostility Inwards and Total Hostility. In that sample they found increased scores in the denial category of the subscales for the psychosomatic patients and a high correlation between Guilt and Hostility In. This did not happen in this sample of mothers. There were only two instances of denial of affect in their transcripts obtained after the birth. These instances were for women who denied Separation and Diffuse Anxiety. Nor did the working class women show a high correlation between Guilt and Hostility In.

The von Rad, et al, (1979) study examined transcripts from an initial psychoanalytic interview and the sample included subjects from a higher socio-economic group than the working class mothers. It would appear that it is easy to identify and measure clients showing features of alexithymia but the precise nature of the presentation may vary across cultures and subgroups.
10.2 INITIAL REACTION TO THE CHILD

When asked to describe their infant after the birth the statements were brief. Four had unqualified positive reactions to the child, four gave 'then and now' statements like the other two groups of mothers, two were unable to remember first seeing the child, one initially rejected (she had wanted a girl but delivered a boy) and two said their infants were "alright".

None elaborated on their descriptions or showed evidence of the same excitement or euphoria seen in some of the other mothers.

10.3 THE AFFECTIVE EXPERIENCE AFTER BIRTH

Even though these women provided impoverished descriptions of their experiences it was possible to obtain some measurement of affect.

10.3.1 Negative Emotions After the Birth – Comparison Between Groups of Women

As could be expected they showed significantly less anxiety, fears for the baby, vague worries and puzzlement than did the mothers of premature babies (Appendices 10.1.1 and 10.3.1). This was a function of the trauma of the birth of a premature infant rather than necessarily being an indication of less stress in the working class women in relation to the birth. They also expressed more anger and pawn-like feelings than the premature mothers. The lower anger in mothers of premature babies is discussed elsewhere.
The most interesting comparisons were between the first and third samples of mothers. There was a significant difference in uncertainty and puzzlement between these two groups of women, with the younger working class group experiencing less (Appendix 10.1.1). They had less concern about making sense of new or sudden changes in life, and this supports the points made earlier about the use of passivity or fatalism as a coping mechanism.

This sample of mothers were significantly higher on pawn-like feelings than either of the other two groups of women (Appendix 10.3). Pawn statements occurred in every transcript. Excerpts show their passive acceptance of the labour and delivery. They also show the emphasis on physical problems.

"They took me down and induced it at twenty to twelve, and the pains started about two, I think, and finished at a quarter to ten, so it was fairly good .... (I did have stitches but) I don't know how many. I asked him but he was an Indian doctor and I couldn't understand him." (Mary)

"He tried to talk to me but I couldn't answer him I was too tired. I wouldn't, like they were all talking to me, all the nurses and that but I couldn't answer them, I was too tired." (Vicki)

"They filled me up with needles. I couldn't remember nothing that much after I started to push .... (my husband) he held me down. If it wasn't for him I think I'd have been all over the place. .... They just kept on giving me needles. I was really giddy. I remember one doctor coming in and going out. That's about all." (Helen)

"Well I was in a lot of pain because it was a hard labour and they had to give me a lot of pain killers. The next time it will be a Caesarian because it was so bad. That's about all. It was very hard." (Sandra)

"The pains in the back were sort of severe pains and pressure pains in the front. Apart from that it was alright. Cause they give me an epidural block and that stopped all the pain. It was better. It was long, er 12, 13, or 15 hours. They put me in for my blood pressure and they induced me." (Robin)

Young working class mothers were significantly higher than mothers with routine separations on the Malaise Inventory (Appendix 10.7).
10.3.2 Negative Emotions After Birth - Comparison With the Wollongong Sample

Working class mothers had significantly more anxiety, worries about damage and pawn-like feelings than did the Wollongong Sample (Appendices 10.1.1 and 10.3). Increased worries about physical damage are natural when describing childbirth. The birth process is a new experience for primigravidae and it involves threats of mutilation to themselves and the child. Like the other groups of mothers they talked of pains, surgical interventions, jaundice and crying infants.

"They had her in the crib for all the marks and they wanted to look after her." (Gina)

"She was really yellow see, and they said that she didn't have jaundice but she still looked a bit funny, but she's getting better now." (Shirley)

"My feet were all swollen and I probably had blood pressure." (Kylie)

"Oh, she's a lot different to what she was. She was wrinkled up and a little bit fatty. She's lost a bit of weight they told me this morning. She's lost weight ..... She was terrible. She looked real ugly. And she's real cute now." (Vicki)

"I had labour pains for a few hours and then when I came in it was sort of like decided on a Caesarian because of the breech, and sort of like I didn't feel nothing after that. But afterwards, I've still got pains you know. And the hospital they look after you now and show you about the baby. I'm a bit upset. I've lost my bag in the labour ward and it's got my birth certificate and everything in it." (Carleen)

They felt less powerful and expressed more statements showing they felt at the mercy of external events than did the Wollongong Sample (Appendix 10.3). The high pawn scores reflected the passivity they used as a coping mechanism at this time.
10.3.3 Positive Emotions After Birth - Comparison Between Groups of Women

Working class women were significantly higher on statements showing decisions and intentions than the mothers of premature babies (Appendix 10.3). They also expressed more warm feelings about the baby than the premature mothers (Appendix 10.5). This was due to the second sample of mothers expressing less of these emotions as a result of the effects of giving birth to a premature child.

10.3.4 Positive Emotions After the Birth - Comparison With the Wollongong Sample

There was only one significant difference. The working class women were significantly higher on intimacy than the Wollongong sample. High intimacy scores were a feature of all groups of mothers.

The problems created by the non-expression or non-recognition of emotion show up markedly here. By contrast the first sample of mothers who also had a relatively normal birth, expressed significantly greater scores on four of the Sociality scales (Total, Helping, Intimacy and Influencing) when compared to the Wollongong Sample (Appendix 10.4). They also had significantly more loving and warm feelings (Appendix 10.5).

It was apparent that this group of women had difficulties in recognising and verbalising positive emotions as well as negative emotions.
10.4 THE AFFECTIVE EXPERIENCE WHEN THE CHILDREN WERE THREE MONTHS OLD

Only three women were available at this time. Letters were sent to all women interviewed earlier. None had been able to give phone numbers at that time. A few letters were returned marked 'address unknown' but most went unacknowledged. However, it was not uncommon for the writer to drive to the home on the day suggested in the letter, knock on the door, hear a radio playing inside and still find that no one would answer the door.

10.4.1 Negative Emotions When the Children Were Three Months Old - Comparison Between Groups of Women

The mean Malaise Inventory Score had increased and was now 8.00 (Appendix 11.7). Although this was high there were no significant differences between the groups.

There were no significant differences between groups in the expression of negative feelings at this time. Appendix 13.4.3 lists fifteen negative emotions which were not scoring for this group when the children were three months old. It was also noticeable that feelings about the hospital and the medical staff were nearly all gone. The hospital experience seemed to have faded more than for the other samples of mothers.

10.4.2 Negative Emotions When the Children Were Three Months Old - Comparison With the Wollongong Sample

The mothers in this sample had more vague worries and fears about physical damage than the Wollongong sample at this time (Appendix
11.1.1). Differences like this were found in all groups of mothers. Working class women were the only group of mothers to have significantly more pawn feelings (Appendix 11.3). This is in line with their passive style of coping with stress.

The transcripts showed their concrete approach to the task of talking about their recent experiences using a prompt stimulus picture. They were again low in affect. Anne's transcript particularly shows this limitation and leads one to wonder whether she can differentiate between 'thinking' and 'worrying' or 'being uncertain'.

"I can't think of anything really. I'm just thinking or, er. Oh, I don't know, can't think of anything she could be thinking of. .... Um, the only thing that I remember thinking about was the baby being small, because they were always reckoning he was going to be real tiny. I wasn't that big. And he wasn't really that small. That's the only thing I really thought of and, and, um, thinking if he was going to be alright and things like that. And then with the blood pressure, because Mum had a kidney fit with my sister. She was born retarded, like I thought of that. But not that often you know, just every now and then."

Carleen had the same limited ability to work with fantasy and projections.

"What's she thinking, um, about? Oh, the last months. She's getting on her nerves. Um, I wouldn't know about that one cause, um, I had a Caesarian. Visiting the clinic. This one, um, the first time feeding the baby - oh, a good feeling. Er, I wouldn't know about the labour and I wouldn't know about that either. Is that feeding at home? Um, I don't know. That's in the hospital actually that picture. It's just talking about the baby. But I wouldn't know what that one was. Just the overall, the last couple of, the operation, having the baby and just before the baby, and just after the baby sort of - like, say, two months before having it, in hospital, and then just after the baby."

10.4.3 Negative Emotions - Changes Between Birth and Three Months

The only significant change was an increase in anxiety about themselves between the birth and the next interview. Anne and Sandra were the two
mothers with highest anxiety. Anne's 'thinking' about her blood pressure, her retarded sister and wondering if things would be 'alright' were interpreted as concerns for her own welfare during the labour and whether she would cope. Sandra spoke of her need to stop breastfeeding and how she was sorry and upset. She also went on to briefly recall the labour and concluded:

"Um when I was in labour, it hurt. They say you forget, but I don't. I couldn't forget."

Sandra expressed more affect that the other mothers and she was the only one who remained in the study until her child was eighteen months old.

10.4.4 Positive Emotions When the Children Were Three Months Old - Comparison Between Groups of Women

There were no significant differences between the three samples of mothers at this time.

10.4.5 Positive Emotions When the Children Were Three Months Old - Comparison With the Wollongong Sample

There was a trend (p<.02) for working class women to be significantly lower on origin than the Wollongong Sample (Appendix 11.3). Few expressions of ability or effort were found in any of the groups of mothers.

The more interesting finding was the lack of significance on the scales measuring interpersonal relationships - particularly intimacy. Both other groups of mothers were significantly higher on this affect when compared
to the Wollongong Sample (Appendix 11.4). The young working class mothers were also the only group not showing a significantly higher score on warm feelings at this time (Appendix 11.5).

10.4.6 Positive Emotions - Changes Between Birth and Three Months

There were no significant changes in emotion between the time just after birth and when the children were three months old. However, these mothers were now expressing emotion on fewer scales than at the earlier interview. They did not express any warm feelings about their husbands nor any positive regard for the hospital (Appendix 13.4.3). As the birth was three months prior to the interview it was perhaps not surprising, given their limited verbalisation, that the medical related feelings had been dropped, even though this did not happen with the other groups of women. It was surprising that they did not express good feelings about their husbands. Two of the women interviewed at this time were married. The lack of feeling about the husbands may indicate that this was an area of minimal emotional importance to them, or it may be that they were again demonstrating their inability to speak of their feelings.

10.5 SUMMARY

The working class mothers were unusual because of the emotional impoverishment of their responses. Few internal personal reactions were given. They were a sample of mothers who somatised their distress. The Malaise Inventory allowed them to express their worries in a way that was appropriate and acceptable to them. High scores on that scale were common.
10.6 CASE STUDIES AND AFFECT WHEN THE CHILDREN WERE EIGHTEEN MONTHS OLD

Two case studies follow. The first is of Anne who did not answer letters after the visit when her son was three months old. She lived near and knew Sandra (the other case study) who promised to remind her to reply to the letters - but to no avail. Both women were married and, in that sense, do not truly represent the other women in this sample. However, Anne shows some of the features discussed by Kempe and Kempe (1978) and Sandra is the one woman from this sample who was interviewed when her son was eighteen months old.

10.6.1 Case Study - "Anne"

At the time of the interview during pregnancy Anne was aged 19 years. She was born in Australia. She attended school until the age of 15 and then worked in a factory for a while. She stopped working two years prior to her pregnancy. She was married to a young man of about the same age as she was. He was born in England and came to Australia as a child.

Both her parents were alive and she described her mother and father as kind, gentle and helpful.

She said that her pregnancy was planned and that she had learned how to look after children from her sister-in-law and her friends. She thought her husband had been helpful during her pregnancy and when asked "In what ways?" she replied that he "worried about me a lot and looks after me. He is a born worrier". She said that her marriage was happy most of the time.
and she believed life would be good after the birth of the baby. Her Malaise Inventory score at that time was 14.

Her baby was induced because she developed high blood pressure. At the time of the hospital interview her Malaise Inventory score had dropped to 7.

She had an initial mixed reaction to her infant but basically gave a 'then and now' description.

"Beautiful. He had a little mark on his face because they had to use instruments but I seen him for a short while and then they took him away and I seen him the next morning .... He had a bit of trouble breathing but after that he went real well. And they brought him out and he's going real well on his feeds now."

Her description of the labour reflected her passive and pawn like acceptance of procedures happening to her.

"They put a drip up and they put something in it to bring the labour on. That's how they did it. They had to break the waters."

Her husband waited outside during the labour but she appreciated even the distant contact she felt in knowing he was nearby.

"My husband waited outside. He was out in the next room, but it was still good knowing he was there all the time. He didn't want to be there because he, you know, he was a bit worried about me. So they let him stay outside seeing it was being induced but he was in the next room all the time. It was just knowing he was there it made it easier."

She had not been able to have the baby rooming in for the first few days because of his breathing troubles and he also developed jaundice. She had difficulty putting words to her feelings about this.
"Oh, I get upset sometimes, not having him here because it's not the same, you know. ... At one stage I worried because he wasn't feeding, you know. I didn't think he was getting anything. But after that he's picked up and I've sort of stopped worrying about him and whether he is getting anything. And they explained to me everything about him because he had a touch of jaundice, and they said that's starting to go away."

At the home visit when the baby was three months old things were not going well for this family. Both parents were still under twenty-one.

The family lived in a three room flat at the rear of an old house. The landlord and his family lived in the front. His children were noisy, inquisitive and intrusive. The house itself was an old weatherboard home painted bright blue. The furniture in the flat looked very second hand and the chairs were covered with crochet rugs to hide the holes in the upholstery. This visit was made early in November, but already there was a small Christmas tree set up in one corner with a large number of parcels underneath. There was a chihuahua running around the flat, jumping on the furniture, smelling and licking the baby's things. There were flies in the room and the baby was asleep on the settee while the television was on. One of the few possessions the family had was their car and Anne's husband was very proud of the stereo equipment it contained. That had been stolen during the preceding week.

Anne now had a Malaise Inventory score of 10. She said she had been depressed for about four days of the third week after the birth of the child, but her mood had improved since then. She had also been what she described as "hospitalised" for migraine in the past week for about two hours. She had been referred to a specialist during the last three months because her blood pressure continued to be high.
The baby's arm was in plaster and she explained that he had broken it "falling off a lounge" two weeks before the visit.

The visit had been pre-arranged but Anne's hair was not combed and her clothes were either very old and a little stained, or were dirty. She gave the impression of being shy, depressed, inadequate and in need of support to be able to cope.

She said that the baby on occasions cried all day. He cried so much one day when he was a couple of weeks old that they took him to the hospital Casualty Department but they were too busy to see him. She had also taken the child to a doctor because "he could not make tears yet when he cried".

When the baby woke he smiled quite a lot and his mother kissed him and talked to him but she occasionally played rather rough games with him - throwing him up in the air and catching him.

Anne was asked what she did when the baby cried after it had been fed and his nappy was dry. She replied that she tended to let him cry it out. When asked about going out since the birth she said that she had been out and had thought about the infant while she was out.

The visit was interrupted and had to be resumed two days later. Anne was slow to open the door of the flat. The baby had just had a bath and had his arm out of plaster and in a sling. She apologised for being slow to open the door and added:
"I've just given him a bath. He didn't want it. He screamed. Anyone would think I was doing something to him."

Her husband was home and his recollections of the last few months are below:

"The thing which I really remember was Anne going in hospital about six or seven times. .... I was in the waiting room for about two hours. And then the last couple of minutes I walked out and came back in. And I just went up the pub and had a few drinks. And Anne was sad that she wasn't breastfeeding. And just waiting outside the ward for a couple of hours - that's the longest bit. I'm real glad to see him when he was born. That's all I can really say."

By the time her son was eighteen months old they had moved to another very old timber home in an outlying suburb. The house was slightly bigger than the flat but was far from luxurious. Anne avoided all further contact after the visit when her child was three months old.

10.6.2 Case Study - "Sandra"

Sandra was aged 20 years and five months when interviewed in the antenatal clinic. She was married to a labourer and had an unplanned pregnancy. She went only to year eight at school (i.e. she was two years below sitting for the minimal school examination - the School Certificate). She had no special training in any skills after schooling and she worked as a machinist until six months before the interview. She said that she was looking forward to the birth of the baby and that she hoped her life would be happy after the baby was born.

She wanted to have two children - a boy and a girl. She had done some babysitting in the past and had also learned about child care from her mother.
She said her husband was helpful while she was pregnant. He helped her clean the home and would not allow her to do any lifting. She also said that he "liked kids".

She described her mother as being always helpful and very kind. Her father was sometimes "cranky" but most of the time "he is good to us". She was the eldest in her family and had a sister 18 and brothers aged 13 and 10. Her husband described his parents - "Father good and helpful, mother thoughtful".

At the time of the antenatal interview she had a Malaise Inventory score of 12. At the hospital interview after the birth her Malaise Inventory score had dropped to 7.

She said she had been drowsy when she first saw her infant and that she thought he was beautiful. She thought that he had a "slight twitch". She said that he was very healthy and that she was pleased with him. She described the labour as painful and "hard". She would have a Caesarian in any future delivery because the experience had been so bad.

By the three months home visit she had moved twice and had twice written to tell me of her new address. This co-operation and willingness to be interviewed made her most unusual. Her husband at this time was unemployed.

The home in which she now lived was very old, small and built of fibrous cement. The furniture was second hand and the sitting room was decorated with photos of Sandra's husband in competition cycling races. He was at
home and he looked a shadow of his former athletic self – he was very thin with lank dark hair and a pale skin.

Sandra herself was overweight – she looked to be about 15 stone. She had a couple of teeth missing behind the canines, and the gap showed when she smiled. She was unhurried and finished her work in the kitchen in a leisurely way at the beginning of the visit.

The house, the baby and Sandra were all clean. She was talkative and so was her husband. They were pleased to co-operate and when thanked for notifying their change of address their reply showed a sense of responsibility and obligation, but also finished with "there isn't anything else to do".

Although Sandra smiled readily and often, it seemed unhappiness was not far away. Her lower lip trembled and there appeared to be some tension in her face at times. Her Malaise Inventory score was now 10.

Both parents were anxious to show off the child and they pushed him to sit up, but he kept wobbling sideways. They were not always accurate in picking up the baby's cues.

He had caused concern to them recently as he had been suffering from eczema and was now allergic to cow's milk. He was currently being fed on a soya bean mixture. For several days at the height of his allergy he had to lie wrapped in sheets and Condy's crystals. His mother described him as looking "like a little mummy". She said he had had scales all over his head and a lot of his hair fell out. This had begun to regrow.
She still remembered the pain of the labour, saying how hard it had been and that it hurt. She regretted having to stop breastfeeding, but felt that "it was best for him now that he's on the bottle".

When she was asked about what she would do when he cried, had been fed and had dry nappies, she said that she tended to pick him up. She let him cry for about 10 minutes and then picked him up.

She had only been out once for an hour or two since he had been born. This was a trip to the bank and shops. She had worried about him while out and wondered what he was doing.

During the observed interaction she spent a lot of time smiling at and talking to the infant. The times when she wasn't interacting in this way she was changing his nappy.

Sandra's husband was able to describe his emotions about the birth of his son. His continuing pride shows in his transcript:

"Well, when I first found out Sandra was pregnant I was happy and very proud about it. Well I was there at the birth and it was a very exciting sort of moment you know, and, um, it's hard to express. It felt like seeing a miracle happen. You know it doesn't happen every day. Well, it happens every day but you don't see it every day. ... I sort of told everyone. I was very proud about it. I let everyone know about it."

His pride at the birth grew to become a pride in his son.

"I felt very proud about it all. I still am actually. Actually I can't wait until he starts crawling around and I'm wondering what his first words will be. It's a little hard to say very much about it, except that it's, um, I'm very proud about it all, very happy and excited. It's not every day a person becomes a father."
Sandra was still living in the same house when her child was eighteen months old. She was still overweight. The day was exceptionally hot and she had a towel under her dress tucked beneath her breasts to absorb perspiration. At this time her Malaise Inventory score was 9.

Her son was walking and helped his mother open the front door. He smiled immediately and did not seem shy. His vocabulary was small but he used his voice a lot in infant's babble. His exzema had gone but he had recently had some ear infections and was allergic to penicillin. Sandra described him as easygoing, friendly, but with an occasional temper outburst.

Sandra again spent a lot of the observed interaction time playing with and talking to her child. Perhaps it was because of his poor language skills but it appeared that he was vocalising to himself a great deal and Sandra took most of the initiative in the verbal interchanges.

Her husband was away. He had recently got a job and was currently doing a course of training to become a pest exterminator. She said that she was glad to have her son now that her husband was working, "It stops boredom..... he's the only thing around here to keep me company".

She felt that her life was restricted and talked about "worries" when she went out.

"You can't go out on your own and that. And sometimes it's a bit hard to get on the bus and that. But I don't usually worry about going out sometimes. If I go out I might take him down the park or take him into town on the train. The only time to worry is when you've got to go somewhere and you can't take him, and you have to leave him outside a door or something. Then that worries me. Like, the ladies toilets. You can't take him inside the ladies toilets with you. Well, it's a bit hard for you to go in and have him and you've got to leave him outside the door. That's the only thing that worries me."
She appeared to need her son very much. She explained that although he played with his father he would only let her feed him. She also said that if she went out and left him with someone, even his grandmother, he would cry. She said that she would miss him when he went to school and hoped to have another child before that happened.

She had a lot of contact with her mother and sister and, though she appeared to need a great deal of affection and support from others, she had her life well organised to provide this. Her son needed her exclusively to satisfy his needs, her husband was a proud father and her extended family lived fairly close by and shared shopping and craft interests with her.
CHAPTER ELEVEN

MOTHERING BEHAVIOUR

It was not possible to obtain permission to observe mother-infant interactions after the birth at all three hospitals, so behavioural observations were only made at three and eighteen months.

11.1 BEHAVIOUR WHEN THE CHILDREN WERE THREE MONTHS OLD

The literature on mother-infant interactive behaviours is vast. There are many researchers who find significant differences between groups based on their birth experience (Brown and Bakeman, 1980; de Chateau and Wiberg, 1977; de Chateau, 1980; Kennell, Jerauld, Wolfe, Chesler, Kreger, McAlpine, Steffa and Klaus, 1974; Klaus, et al, 1972; Leiderman and Seashore, 1975; Whiten, 1977). In some research the effects of neonatal events appear to be short-lived, while in others the effects are still evident years later.

In this study, in spite of dramatic differences in their birth experiences and significantly different affective expressions, there was little difference between groups in their interactive behaviour with their infants when they were three and eighteen months old. A full description of the behaviour categories observed at the three months visit is given in Appendix 15.1. Although twenty categories were recorded, there was only one which showed a significant difference between samples of mothers. This was the behaviour 'looks away'. This was scored for those times when the mother
looked at anyone or anything other than the infant. The mothers of premature babies looked away from their infant significantly less than did the mothers with routine separations (Appendix 15.2).

Mothers of premature babies were more infant involved during the observation than the separated mothers. Confirmation of this was in the amount of time spent talking to and smiling at the infant. Although the differences were not statistically significant, Appendix 7.9 shows that they spoke to and smiled at the infant more frequently than both other groups of mothers.

Field (1977) observed feeding behaviours of mothers with their month old infants and showed that mothers of preterm infants stimulated them significantly more than did mothers of normal or postmature infants. Brown and Bakeman (1980) found that mothers of preterm infants were more likely to initiate behavioural interchanges than were mothers of full term infants; and mothers of preterms were more likely than the infant, at three months, to initiate interactions; whereas with the full term infants both partners bore almost equal responsibility for initiating interactions.

In this study mothers of premature babies were behaving in much the same way as was found by Field (1977) and Brown and Bakeman (1980). They were looking away from significantly less, and were talking to and smiling more at their infant.

11.2 BEHAVIOUR FACTORS WHEN THE CHILDREN WERE THREE MONTHS OLD

Because of the overall similarity in behaviour between all three groups of mothers it was decided to combine all data for a factor analysis. A
principal components factor analysis was carried out and seven factors were extracted. Appendix 15.3.1 shows the factor correlation matrix and Appendix 15.3.2 gives the variance explained by each factor. The factors were rotated using the varimax routine and factor score coefficients (based on standard scores) were obtained. These factor loadings are given in Appendix 15.4.

The seven factors were readily identifiable. Factor loadings, suggested names, descriptions and pictorial representations are in Appendix 15.4. It was in fact most exciting to observe the internally consistent and meaningful factor patterns which emerged.

11.2.1 Factor 1 "Mother Socialising"

The first factor covered behaviour that was basically not involved with the three month old infant because the mother socialised with another adult. In almost all cases this was myself. This first factor 'Mother Socialising' was the only one which showed a significant difference between groups (Appendix 15.5). Mothers of preterm infants were more involved with their children than both other groups. They were looking away from the infant significantly less, and were talking to and smiling at their infants more frequently than the other mothers and these are the behaviours which loaded on this factor.

Dahlstrom and Liljestrom (1967) quote from the then current debate in Sweden about working mothers and point out the weaknesses of the traditional housewife and child caretaking role:
"The most serious weakness of the tradition is, however, that when it places almost exclusively upon the woman the responsibility for the care and supervision of the child, it creates an alienation, a gap between the husband and wife in marriage. For the woman is then forced to live in a special world: she has sole rights to intimate contact with the children, she becomes financially supported by the man, she becomes generally isolated from vocational and social life." (p.39)

This traditional role was exactly the one filled by the mothers of the three month old infants who were observed. All those seen at this time were dependent financially on their husbands and took most of the responsibility for the care of the child.

Being a mother involves doing things that may not be intrinsically rewarding. For example, in Oakley's study (1980) 43 per cent of the women interviewed at five weeks postpartum said they found baby care monotonous. Kitzinger (1978(b)) and Richards (1978) have also written of the drudgery that is often involved in child care. They felt that many aspects of caring for a dependent infant were both repetitive and exhausting. When this lack of reward for many tasks is combined with the isolation of living in the suburbs and limited social activities it was not surprising that these mothers of very young children seized upon the opportunity when another adult female came into their home. Those women who were available for interviews in the follow-up period were obliging, generous hostesses, and eager to display their child's skills.

By the time the child was eighteen months old and was more mobile, home routines had been better established and a similar 'Mother Socialising' factor only emerged as Factor 7 (Appendix 16.4). At the three months visit 'Mother Socialising' accounted for 16.5 per cent of the behaviour variance
(Appendix 15.3.2), whereas the later time 'Mother Socialising' accounted for only 5.4 per cent of the variance (Appendix 16.3.2). Many women adapted their life styles to include more frequent outings and some had returned to the work force as their children grew older. Thus their isolation and concern with the drudgery of motherhood had decreased.

The emergence of this factor and the relative importance of socialising at each time points out the importance of naturalistic assessments of mother-infant interactions. For a variety of reasons, it is not likely that this factor would emerge in a laboratory situation. Women who are available to take their infants to university laboratories are already moving outside the home environment. They would also spend some time talking to the researcher before the laboratory observation began. They would, therefore, have their socialising and chatting done before the observation began. It is also likely that the situation would be explained in such a way that the mother would perceive that she was to interact with her child - i.e. the demand characteristics would preclude adult to adult socialising. In many instances it would be physically impossible to relate to anyone other than the child as the mother would be isolated with the child and observed through a one-way screen or videotaped.

It is also unfortunately true that neither traditional laboratory observations of mothers, nor this research, have sought information on the proportion of baby oriented duties performed by a mother which are not directly interactive. A large proportion of a new mother's time is taken up with tasks directly related to the infant but which are not interactions - e.g. food preparation, washing and cleaning. It is most likely that the mother's attitude to childbirth and the infant would colour the way she perceived
and performed these routine tasks. Also, the more obsessional housekeepers and mothers may devote a greater proportion of their energy to these tasks, leaving them tired and drained when with their infant.

11.2.2 **Factor 2 "Mother Stimulating and Caring" and Factor 3 "En Face"**

Factors 2 and 3 were both of mother and infant inter-relationships. Factor two has been named "Mother Stimulating and Caring". The behaviours loading on this factor were changing the infant's position, holding the infant at the shoulder, talking to, rocking and caressing the baby. The movement in the behaviours (changes position and rocks) implied stimulation, and this stimulation also covered touch and talking. This was a loving stimulation as it involved caresses. Factor 3 had a much more quiescent set of behaviours. The mother was infant involved, was not talking to others and was in the en face position. It has been named "En Face". These two factors together account for twenty-five per cent of the variance (Appendix 15.3.2). At age six months a factor analysis of observed interactions in the laboratory produced a first factor relating to affectionate contact (Bates, Olson, Pettit and Bayles, 1982). This factor was similar to Factors 2 and 3 in this research. Klaus et al (1972) found that extended contact mothers at a filmed feeding when the infant was one month old spent 6.1 per cent of their time fondling the baby and 11.6 per cent of the time in the en face position. Very few of the mothers interviewed for the current research were feeding at the time of the visit and were free to stimulate and caress their infants without the interruptions that often go with checking the bottle and winding the baby. It was, therefore, not surprising that these affectionate behaviours emerged as important factors.
By three months infants are responding more to social interchanges. Whiten (1977) noted the increased length of social interchanges between mother and infant by the third month of life. Smiling begins in infants between one and two months. Three months is in the stage Piaget named the stage of "primary circular reactions" within the Sensorimotor Period (Sherrod, Vietze and Friedman, 1978). This is a stage when the infant varies responses and greatly elaborates on them as a result of a growing awareness of the world. The occurrence of smiles and early interactive responses are rewarding for the parents. Bell (1974) hypothesised that, in addition to other factors enhancing the parent-child relationship, the emergence of novel behaviours may contribute to attachment. These early months are a time of particularly rapid development of social responses.

11.2.3 Factor 4 "Infant Lying"

Factor 4 "Infant Lying" was simply a positional factor. It accounted for 8.7 per cent of the variance. It's emergence was partly a function of the age of the child - being non-mobile - and partly a result of the common Australian practice of leaving the infant in a 'bouncinette'. A bouncinette has a steel frame and is covered with a mesh hammock-style cover. Gross motor movements by the infant will produce a rocking effect in the bouncinette. The mesh cover allows free circulation of air around the infant and this has some practical value in the heat of Australian summers.

11.2.4 Factor 5 "Fussing and Nappy Change", Factor 6 "Mothering Loving" and Factor 7 "Baby Burped"

Factors 5 and 7 were caretaking factors, and Factor 6 described another pattern of maternal affectionate behaviour.
Factor 5 described an infant fussing and mother changing the nappy. The behaviour 'mother leaves room' loaded on this factor but it was not a description of the mother neglecting the child, it more often described the mother leaving to get a clean nappy then returning.

Factor 6 has been named "Mother Loving". The behaviour loading highest on this factor was 'mother kisses infant'. It could be grouped with factors two and three as they all demonstrate maternal affection - between them they accounted for 32.6 per cent of the variance.

Factor 7 was the mother attempting to bring up baby's wind. It has been named "Baby Burped".

11.2.5 Summary of Behaviours When the Children Were Three Months Old

The first factor reflected the isolated mother's need for other adult company. There were three factors based on affectionate behaviours (Factors 2, 3 and 6). Two factors were caretaking and related to changing the nappy and winding the baby. There was one factor which described the child's position.

11.3 Behaviour When the Children Were Eighteen Months Old

As discussed earlier the observation schedules were changed between the three and eighteen months visits to allow accurate recording of the changes in the childrens' behaviours as they grew older.
Twenty behaviours were observed at this time. A full description is given in Appendix 16.1. There were no significant differences between samples of women on observed behaviour items at this time, but there was a significant difference between samples on one of the factors. This lack of difference between the three groups of women even though they have had different birth experiences is similar to some other research findings. Although de Chateau (1980) and Klaus and Kennell (1976) reported long term effects following early and extended contact, other studies on specific populations (such as preterm infants) tend to find consistency in maternal style during early interactions (Minde et al., 1978) but do not find behavioural differences continuing as the child grows up (Brown and Bakeman, 1980), or find only small differences (Leiderman and Seashore, 1975).

Other studies have found significant relationships between early life experience and mothering behaviours (Minde, Marton, Manning and Hines, 1980; Wolkind, Hall and Pawlby, 1977). The women in my three different groups had varying early histories even though the birth experience was relatively similar within each group. Marton et al., (1981) concluded: "It appears that a mother enters the nursery with a predetermined set that influences her interactional style. The nature of her background and personal history influences the intensity with which a mother will interact with her infant and the degree to which she will be responsive. The specific events surrounding the birth seem to play a less direct role", (p.202). It would be naive to assume that the birth experience itself was so important it would outweigh developmental experiences.
One of the problems in comparing studies of behaviour is the wide variety of observations made. Another is the complexity of the interactions. Whiten (1977) points out "that mothers are likely to respond to such a wide variety of behaviour that it is virtually impossible to define a category of 'eliciting behaviour'" (p.412). Therefore, although there were few differences between sources in this study it is possible that an analysis of different behaviours, or an analysis done at a micro-level of observation may have found significant differences between the groups of women.

11.4 BEHAVIOUR FACTORS WHEN THE CHILDREN WERE EIGHTEEN MONTHS OLD

Data from all groups were combined for the factor analysis. A principal components factor analysis was carried out and seven factors were extracted. Appendix 16.3.2 gives the variance explained by each factor. The factors were rotated using the varimax routine and factor score coefficients (based on standard scores) were obtained. Factor loadings, descriptions, suggested names and pictorial representations are in Appendix 16.4.

Because of the increased maturity of the child and the sophistication of behaviour at this time three of the factors were related to the children and their activities. They were Factor 1 ("Active Child"), Factor 3 ("Socialising Child") and Factor 6 ("Chatty Child"). The remaining four factors related to the mothers' behaviour.

There was a significant difference between the two samples of mothers in Factor 4 "Mother Carrying Child". Mothers of premature babies showed less of this pattern of behaviours than did the separated mothers (Appendix 16.5).
11.4.1 Factor 1 "Active Child"

Factor 1 involved the child walking, standing and moving away from the mother at a distance of more than one metre. The child was not held and was not crawling (Appendix 16.4). This factor accounts for 21.3 per cent of the variance (Appendix 16.3).

One of the decisions made early in this research was to interview in the follow-up times when infant behaviour was likely to be fairly consistent across all cases. Therefore, I decided not to follow-up at about twelve months of age because some infants would be walking while others would still be crawling. Such differences in infant behaviour would naturally affect the behaviours appropriate to mothering.

In spite of this decision, in early attempts to develop scales of behaviour based on 'clinical acumen' and not factor analysis I was seduced into concentrating on mother behaviour and thus ignored the activity level of the child - having taken it for granted. The value of the factor analysis showed up 'clinical acumen' for prejudice and reinstated the activity of the child as an important variable at this time.

Once again, the value of observing in the home was obvious. The child was not so likely to be shy or awkward on home ground, although the presence of a stranger may have interfered a little. Familiarity with the surroundings and toys may prevent exploration but will produce behaviour which is most typical of that child in everyday life.
11.4.2 Factor 2 "Mother Plays With Child"

Factor 2 has been named "Mother Plays With Child" (Appendix 16.4). It involved stimulation of the infant as did the second factor when the children were three months old ("Mother Stimulating and Caring"). This factor accounted for 12.5 per cent of the variance (Appendix 16.3). The mother displayed a pattern of talking to and playing with the child and the child responded verbally. Many of the mothers at this visit spent a large part of the observation period playing with the child, talking to and encouraging them to demonstrate their skills. Excerpts of vocalisation during these visits clearly showed this. The children's part of the following conversations are approximations of the sounds they made.

1. Fiona and Daughter

Fiona: Come on, come on and build a house. Build a house with all the blocks. Come on. You like this game. There you are. Build a house.
Child: Gooa era.
Fiona: No don't (4 words) still yours.
Child: Squeal (child scatters blocks).
Fiona: Yes, (laughs). Look at this big house. Oh. Look. Oh, let me finish. Please. Oh. (Scattering blocks.) Now what are you going to do? Um?
Child: Mer (sound of blocks clapping together).
Fiona: Yes, yes. Try this one too. No you play with those ones and I'll build you another house.
Child: EEEEEEEE ....
Fiona: Oh, I'm trying to build a house again. Are you finished?
Child: Errrr.
Fiona: Yes. Aren't you clever. Look, here's your drum. Play your drum (3 words). Oh, that's very nice. Are you going to sing too? Sing a song. La, La.
Child: Ya, Ya.
Fiona: La, La.
Fiona and Child: La la la la la (mother).
Child: Ya la ya la (child).
Together: Come on. Play your drum and sing a song. La, La, La.
Child: La, La, La, La. .....
Child: Ya.
Shirley: Eh. Are we going to put the little man on top? Eh? Ha, ha. You dropped it. Come over here. It will be a bit easier. Put it on there.
Child: Ya.
Shirley: The little man goes on top. Mummy will help him. There he is. Good boy. Now you know that doesn't go that way.. It doesn't go that way. Put it on top. Does it go like that?
Child: Ya.
Shirley: Good boy. Put it together again. The other way. Around the other way. Mm.
Child: Eh, Eh.
Shirley: What else do you want to do. Good boy. Do you want your Leggo. Want to play with your Leggo, eh? Look here. Are you going to put that on top too? That goes on top? Try putting the little man on top. Mm. That's the boy. Turn it around a little bit more. Whoops. Good boy. You're a smart boy. No that one doesn't go on top does it? Why don't you put that on top of that one? That's the way. That's getting a bit tough. ....

Both the above excerpts demonstrate the teaching component which is so often a part of mother-child play at this stage. Clarke-Stewart (1978) observing fifteen month old infants in the home noted different interactive styles between parents. Mothers chose activities that were non-social and intellectual (usually involving materials), while fathers selected those that were social and physical. At about the same age as the Clarke-Stewart infants the children in this research were being played with in the same way.

11.4.3 Factor 3 "Socialising Child"

Factor 3 has been named "Socialising Child". In this set of behaviours the child vocalised to others, was not close to the mother but was hovering
around more than a metre away from her. This factor accounted for 10.8 per cent of the variance (Appendix 16.3). In practice, the child was usually talking to me during the observation. This talk was most often infant babble rather than words. Appendix 8.5 has details of estimated vocabulary of the children at this time - the mean was less than thirty words. There often seemed to be some curiosity in this approach to the investigator and occasionally the child offered a toy or attempted some other play interaction.

11.4.4 Factor 4 "Mother Carrying Child"

Factor 4 is not as clearly an interactive behaviour as the other mother-infant factors. It involved mother leaving the room and the child not talking or fussing, but being held. In this instance, because of the mobility of the child and mother during the interaction 'mother leaves room' was scored when she moved out of the room where the observation began. This was scored whether she took the child with her or not, unlike the earlier observation, when it was scored only when she left the room the child was in. Factor 4 accounted for 9.2 per cent of the variance (Appendix 16.3) and like Factor 1 could be interpreted as a measure of mobility at this time. As mentioned above mothers of premature babies did this less often.

11.4.5 Factor 5 "Warm Mother"

Factor 5 has been named "Warm Mother" (Appendix 16.4). It could be a description of a slightly more regressive set of infant behaviours while the mother smiled and touched the child. As most infants could walk well by the age of eighteen months, crawling and being quiet (or non fussing) would
be performed either as part of play or would be regressive. As play usually involved verbalisations to mother, self or others it is most likely that this represented regressive behaviour. Whatever the explanation of the child’s behaviour it is obvious that the mother responded warmly to it as she smiled and touched. It accounts for 7.3 per cent of the variance.

11.4.6 **Factor 6 “Chatty Child”**

Factor 6 was another child factor. It has been named "Chatty Child" (Appendix 16.4). This was not the same as "Socialising Child". It involved talking to the mother (both initiating and responding) and some fussing. It loaded negatively on crawling. The child was not relating to others as in Factor 3 and because it had 'fussing' loading on it, the child was not completely happy. During the observations it was clear that the infants could, and did, make their wishes felt. Protests sometimes occurred if the play did not progress as they wished and fussing complaints were made if toys, objects, or adults could not be manipulated as desired. This factor accounted for 6.9 per cent of the variance.

11.4.7 **Factor 7 "Socialising Mother"**

Factor 7 was similar to a factor found at the earlier observation. It has been named "Socialising Mother". It involved mother talking to others (usually me), touching the proximal child but basically not responding to him or her (Appendix 16.4). The variance explained by this was only 5.4 per cent (Appendix 16.3). The socialising which had been so important to the new and relatively isolated mother earlier declined in importance as discussed previously.
11.4.8 **Summary of Behaviours When the Children Were Eighteen Months Old**

At this time, one of the features of the factor pattern was the increased mobility of both mother and child (Factors 1 and 4) and the importance of infant behaviours and initiatives (Factors 1, 3 and 6). Maternal affection was still evident and warm interactive behaviours still occurred (Factors 2 and 5). Because of changes in lifestyle and greater freedom (including for some a return to work) socialising with me did not assume the same importance as at the first visit. Of course, it could be argued that the increased activity of the child would make greater demands of the mother and prevent her having the time to talk to the writer, but this was not the case as, at this young age, the children were easily controlled and, if necessary, disciplined by the mothers. The transcripts discussed earlier also produced evidence of the reduced isolation in the discussion of return to work and plans to satisfy their own needs.

11.5 **INTERCORRELATIONS OF BEHAVIOUR FACTORS AT THREE MONTHS AND EIGHTEEN MONTHS**

Consistency in mothering styles has been reported in the past (Minde et al., 1978) and it was expected that some continuity might occur in the behaviour factor scales between the two observations. Correlation coefficients were computed (using only those who were interviewed at both times) and the results are in Appendix 18.4. Only two significant relationships were found. These were:
1. Three months Factor 1 "Mother Socialising" correlated significantly \((r.55, p.001)\) with the eighteen months Factor 7 "Mother Socialising".

2. Three months Factor 5 "Fussing and Nappy Change" correlated negatively \((r-.39, p.01)\) with the eighteen months Factor 2 "Mother Plays With Child".

### 11.5.1 Correlation of "Mother Socialising" Factor

When the children were three months old the behaviours included in this factor were indicative of a low involvement with the infant (the mother was not smiling at the child, was not talking to it, and was not holding it at her shoulder). She was looking away from the child, rocking it and talking to others (Appendix 15.4). When I called at that time the mother knew the research involved an interest in the child. If the child was awake it was most often in the same room as the mother and was either held or in a 'bouncinette'. It is probable that the behaviour 'rocks infant' was part of a soothing pattern of behaviour which was performed to ensure that the child interfered minimally in the conversation. Thus, although the child was held and rocked, the mother was basically non-responsive while she talked to others.

At the later visit the behaviours were somewhat similar (Appendix 16.4). The child was more mobile at that time so that 'rocks infant' would no longer be appropriate as soothing behaviour. However, one of the item's loading on this factor at this time was 'mother touches child'. This would have the same effect at this age as rocking would have at three months. The other behaviours were 'mother talks to others' and 'mother does not
respond to the child'. The child was close to the mother. Given what is appropriate behaviour to the age of the child there was the same limited involvement combined with non-response and a talking to others as displayed earlier.

11.5.2 Correlation of "Fussing and Nappy Change" With "Mother Plays With Child"

This was a negative correlation. The behaviours in "Fussing and Nappy Change" (Appendix 15.4) involved both mother and infant. The infant was fussing and the mother left the room, walked, and changed the child's nappy. Many of the infants fussed during the nappy change rather than before it and factor analysis provides clusters of behaviours (not cause-effect relationships), so one cannot interpret this factor as the child being upset leading to the mother responding with a change of nappy.

The factor "Mother Plays With Child" described a pattern of behaviours with the mother interacting vocally and in play with the child close to her (Appendix 16.4). The behaviour loading most highly on this was 'mother talks to child - she initiates', the second was 'mother plays with child'. The other two variables' loading on this were child variables - the child vocalised in response to the mother and was close to her.

It is difficult to see why there should be a relationship between these two factors. Perhaps those mothers who were intent on caretaking activities found less time to play with the child as it grew older. It is possible that concern with cleanliness and nappy changing may be found more in women who spend much of their time tidying the house and have little time left to
play with the child, or have difficulty tolerating the litter of toys and objects that are part of a toddler's play pattern. It could also be that this significant result is spurious and is a chance result.

11.6 SUMMARY

The different birth environments only minimally influenced mothers' behaviours when their children were growing up. The mothers of premature babies showed some signs of greater attachment, when their babies were three months old, than women who experienced a birth followed by hospital routines which enforced separation of mother and baby. When the children were eighteen months old there was only one behaviour factor showing a difference between the two samples of women.

The developing skills of the child produced changes in factor patterns of observed interactions between the three and eighteen months visit. By the time of the second home observation the children were mobile, showed greater independence and were developing social skills. These changes in the children demanded different responses from the mother. Mothers of toddlers had greater freedom and were less hungry for 'socialising' with me. Their home environments changed as the child grew up.

Therefore, behaviour was influenced by changing environmental factors. Internal personal reactions can also influence, or be influenced by, behaviour and this is discussed in the following chapter.
CHAPTER TWELVE

RELATIONSHIPS BETWEEN BEHAVIOUR AND INTERNAL PERSONAL FACTORS

Earlier chapters have shown the affective reactions of the three groups of women to their different birth environments, and the changes in their personal reactions as their children began to grow up. The previous chapter showed that there were few behavioural differences between the samples of women in spite of each group having had to adjust to giving birth under markedly different conditions. This chapter will examine the relationship between their behaviour and their internal personal reactions.

The reciprocal determinism model points to the bidirectional influence pattern between E, B and P factors. These interactions are associated with change. It follows then that, over time, changes occur. The most clearcut associations between factors will, therefore, be obtained between those E, B and P elements which are measured at one point in time. For example, a depressed mother may have little energy and be emotionally unavailable to her child for a period of time. If seen at that time her depressed affect would be related to restricted interactive behaviours with the child. When the depression lifted, her behaviours would change and there would be little relation between her former depressed mood and behaviours displayed when she was no longer depressed. Changes in environment, behaviour and personal factors over time will make longitudinal relationships more
difficult to interpret. This is especially true as it is impossible to ensure measurement of all the relevant objective and subjective factors for each woman.

12.1 SENSITIVITY OF MEASUREMENTS AND FLUCTUATIONS IN AFFECT AND BEHAVIOUR

The sensitivity of the content analysis scales to fluctuations in affect has been well documented. One of the most telling results was reported by Ivey and Bardwick (1968). They found consistent and significant differences in anxiety levels when they compared verbal samples from women who were in ovulation and premenstrual. Viney and Westbrook (1981) found different patterns of affect in the same patients when hospitalised with a chronic illness and when at home six months later. Because of this sensitivity the content analysis scales are extremely valuable as indices of internal personal reactions to a particular situation. This means that they are most useful when relating emotion at one time to behaviour at that same time.

Measuring fluctuations in mothering behaviour is a much more complex research problem than measuring changes in internal reactions. Mothers' emotional repertoires change very little. But with behaviour there are the obvious problems created by the differing demands of mothering children of different ages. For example, feeding and nappy changing and such caretaking routines are more common with children in the early months than they are at, say, two years of age. Attempts to look for consistency must be tempered by the child's input into the interaction. That input is at least twofold. One type of input is the growing maturity and competency
of the child, and the other is the child's personality and 'attractiveness'.

This simple analysis based on the mother-infant dyad ignores the part played by the father in family interactions. The importance of the father in the family triad has been examined by others (Clarke-Stewart, 1978; Parke, 1979; Parke, Power and Gottman, 1978; Parke and Sawin, 1977). My research concentrated on changes in mothering over time following different birth experiences.

Thompson, Lamb and Estes (1982) have examined the stability of infant-mother attachment and changes in life circumstances. They examined infants and mothers in the Strange Situation procedure when the infants were 12.5 and 19.5 months old. They found that changes in family circumstances which seemed likely to influence the quality of infant-mother interaction (such as the mother returning to work) were associated with changes in attachment status. Their conclusions were as follows:

"Clearly, temporal changes in attachment classifications are more typical of normal populations than we had earlier thought. In light of this, we suggest that attachment classifications be viewed as an index of the current status of the infant-mother relationship, the quality of which is likely to change in response to changing family and caregiving circumstances." (p.148)

Although my research did not look at behaviour and attachment status in the same terms as Thompson et al, it did examine mother-infant interactive behaviours. Attachment is one part of interaction. Therefore, one would expect changes in behaviour over time.

Because psychosocial events are complex there are many E, B and P factors which can interact to produce changes. It is harder to be sure that all important variables have been considered when measurements are taken at
different times. It is difficult to assess all important factors occurring in the period intervening between research visits. Conditional probabilities relating to interactions of factors can be stated much more confidently when measurements are taken at the one point in time.

12.2 PROBLEMS IN CORRELATING BEHAVIOUR FACTORS FROM ONE OCCASION WITH MOTHERS' PERSONAL EXPERIENCES FROM ANOTHER TIME

Because of the sensitivity of the content analysis scores to emotional fluctuation it is likely that only the strongest emotions would be linked to behaviours on other occasions. In addition, behaviours have been found to change as a result of changes within the family (Thompson et al, 1982). Because both affect and behaviour were changing in response to ongoing environmental and internal changes it is probable that intercorrelations over time were clouded by such changes.

Full lists of significant intercorrelations are given in Appendices 17 and 18. I feel that setting the level of significance at $p \leq .005$ for correlations between behaviour and affect at different times may eliminate some of the 'noise' in these data. Summary tables of these results are given in Tables 8 and 9. These tables confirm the notion of change over time because behaviour factors obtained when the children were eighteen months old showed no correlations with emotions at birth, whereas three factors at three months showed correlations with feelings at the time of birth.
Factors | Birth | Eighteen Months |
--- | --- | --- |
1. Mother Socialising | Nil | Mutilation (Mother) (.46) |
| | | Sharing (.46) |
2. Mother Stimulating and Caring | Nil | Helping (-.52) |
3. En Face | Nil | Nil |
4. Infant Lying | Mutilation (Infant) (.45) | Nil |
5. Fussing and Nappy Change | Shame (Mother) (.38) | Nil |
6. Mother Loving | Nil | Nil |
7. Baby Burped | Hostility In (.50) | Hostility In (Infant) (.47) |
| | | Separation (.40) |

Table 8: Behaviour factors when the children were three months old correlating (p<.005) with internal personal reactions following the birth and when the children were eighteen months old.
<table>
<thead>
<tr>
<th>Factors</th>
<th>Birth</th>
<th>Three Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Active Child</td>
<td>Nil</td>
<td>Positive Affect</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Infant) (-.52)</td>
</tr>
<tr>
<td>2. Mother Plays</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td>With Child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Socialising Child</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Mother Carrying</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td>Child</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Warm Mother</td>
<td>Nil</td>
<td>Positive Affect</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(.50)</td>
</tr>
<tr>
<td>6. Chatty Child</td>
<td>Nil</td>
<td>Cognitive Anxiety</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(-.55)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total Anxiety</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(-.46)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shame</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(-.45)</td>
</tr>
<tr>
<td>7. Mother Socialising</td>
<td>Nil</td>
<td>Positive Affect</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Medical) (.46)</td>
</tr>
</tbody>
</table>

Table 9: Behaviour factors when the children were eighteen months old correlating (p .005) with internal personal reactions following the birth and when the children were three months old.
12.3 RELATIONSHIPS BETWEEN BEHAVIOUR AND MOTHERS' PERSONAL EXPERIENCES WHEN THE CHILDREN WERE THREE MONTHS OLD

There were significant relationships between the mothers socialising and feelings about the hospital and medical staff. Socialising mothers expressed warm feelings, worries about mutilation, and depression in relation to their hospital experience (Appendix 17.2). The behaviour 'talking to others' loaded on this factor, and when they were doing this they were usually talking to me. As I had been given their names by hospital staff and was frequently taken to them and introduced to them by a nurse or a doctor, it is probable that I had become identified with the hospital. Because of this identification it was natural that feelings related to the hospital and the medical profession should be produced as part of their socialising. It is of interest to note that when the children were eighteen months old socialising behaviour correlated significantly with depression about their hospital experiences (Appendix 18.3). Monica, who gave birth at the hospital practicing routine separations spoke to me a lot during the home observation when her baby was three months old. At that time she expressed some of the feelings related to this behaviour.

"There was nothing wrong with myself or the baby. I enjoyed feeding her. ..... Labour Ward, that was the worst part. I was in labour for a fair while - getting severe backaches every couple of minutes. I didn't enjoy that part very much. I love cuddling her. She's a real little cuddle-pot and she loves being cuddled and snuggles into you all the time. Um, I thought we didn't have the babies often enough in the hospital. I probably wouldn't have liked them with me all the time, cause, um, you do need the rest. But I would have liked to have had her for longer. You only had, er, they only brought them in and fed them and whisked them straight off."
Beryl gave birth at the same hospital as Monica and she too spent a lot of her time chatting to me during the observation when her baby was three months old:

"It was lovely the first time I did get to nurse him because it wasn't for a long time after. I forget when it was now. It was a couple of days. And the sister was really lovely - who was in there that day and she took him out to give him a bath - out of the crib, and, um, because I used to have to feed him through the holes, um, and she sort of looked around and gave me a little nurse which I don't think she was supposed to. And that was, you know, really lovely just to nurse him for the first time. .... The time seemed to fly by. Oh, except, I mean the pain, you know you still remember pain I think but, um, the time just seemed to really go. .... I used to like people visiting me in hospital. But I wasn't, if nobody came, you know, like some afternoons nobody could make it, it didn't worry me at all."

The mothers who were stimulating and caring for the baby make an interesting comparison with those mothers who left the baby lying. Caring behaviours were negatively related, and leaving the child lying down was positively related, to the women remembering how they felt lonely and separated in hospital. That is, the less lonely they remembered being the more the mother was likely to be stimulating and caring. The behaviours being performed were changing the infants' position, holding the baby at her shoulder, talking to, rocking and caressing the baby. The greater the anxiety expressed about separation as a result of the hospital procedures when I visited at three months the more likely it was that the child was lying down.

Liza's son was in a bouncinette during the observation when he was three months old. She began feeding him towards the end of the interaction, but left him lying in the bouncinette to do so. Although she smiled at him she did not touch or caress him.
"And that's really all that sticks out in my mind through the whole thing is him being in the intensive care. Awful. Awful. Cause you had all the motherly instincts and yet there was nothing there for you. You know, you can go up and see him but he's stuck in this humidicrib. You can't give him all the cuddles and the kisses and really out of the whole thing that's what sticks out in my mind. I wouldn't touch him - I wouldn't. I couldn't. The crib and the cords - well. Dr B. ended up having to yank him out and put him in my lap but I wouldn't have anything to do with him. It wasn't him, it was all the equipment. I used to come home here and cry and cry and cry. Every night. When I got home and I was going back (to visit) and going to the hospital that just wrecked me. You know, having to go down there and then leave him and then come home and then go back down and leave him and come back home. That to me is the thing that sticks out in my mind, above everything else."

By comparison Helen was much more positive. She did not remember her hospital experience as being a lonely time at all. She cuddled and caressed her daughter throughout the observation and talked to her almost continuously. When responding to the stimulus picture she spoke in the third person:

"Oh, I suppose if she was happy about it she felt terrific. The third picture she'd be thinking about when she went back for her check up to the doctors. And the next one she'd be thinking about how good it was to breastfeed and have the baby close to her. In this one she'd be thinking about what it was like in labour - terrible. In the next one she'd be thinking about how close she was with the baby too.

This pattern of relationships confirms de Chateau's (1980) findings. He compared routine care and early extra contact. He observed two samples of mothers. One group received routine care and the other group had early and extended contact with their infants. He used an interview and observed free play at three months and found that "Mothers in the 'extra contact' group spent more time kissing and looking face-to-face at their infants ....", (p.142). At one month post-partum Klaus et al (1972) reported more fondling and en face periods among extended contact mothers.
The correlations found here help to explain those findings. The content analysis scores were indicators of current internal personal experiences. Therefore, feelings of loneliness and separation anxiety about hospital experiences remained with the mother for some time and continued to influence behaviour. It could be argued that I reminded the mother of the hospital experience, but the argument still holds that low Separation Anxiety (Medical) was related to holding and caressing behaviour and high Separation Anxiety (Medical) was found to be related to having the infant lying.

Being en face with the baby was significantly correlated with discussions of influencing types of relationships (Appendix 17.2). Statements scoring on this describe people influencing one another - sometimes as status differences, or as acts of control. For example, "I asked my husband to do the washing"; "We decided that she should get into a routine" would score on this. Shirley spent a lot of time en face with her baby and provided some evidence of being aware of influence in relationships.

"Around twelve I told my husband he could go for lunch because I wouldn't have the baby for a while. But when he went I was alone and um, it was the first time I'd been alone. ..... When she was born they said you can touch her and I could feed her, and I tried to feed her but she wasn't really interested."

The reason for influence statements relating to behaviour indicative of bonding is hard to understand. One could hypothesise that those mothers who were comfortable in their relationships with others were those who could make demands and accept instructions and were happier about displaying intimacy while under observation. However, such hypotheses need further testing and no clear answer came from my research.
Changing the child's nappy was correlated with many anxiety scales as well as depression (Appendix 17.2). Uncertainty, guilt, feelings of loneliness, anxiety, worries about damage, and feelings of depression were all related to this factor. Women who spent time changing nappies during the observation were anxious, uncertain and depressed.

Judy spent just over half the time of the observation changing David's nappy. She chose to respond to the stimulus pictures mainly in the third person.

"It looks like she might have bathed the baby. I don't think much of that. If I do then I'll start worrying you see. I'd rather not worry. That one there, I was a bit upset after three weeks I couldn't breastfeed him any more because my milk went bad. And I got quite upset about that. ... That one there, I suppose that's her visit after having the baby. Oh, I just went along. I didn't think anything. It might be that she's hoping that the doctor was going to say she was pleased with the way I was handling him. She stripped him down until he had nothing on. Checked him all over. Made sure he didn't have nappy rash. I must admit I did feel a bit sick in the stomach then. Because she would be the type of doctor that would come down on me like a ton of bricks if you weren't taking proper care. But, oh, she commended me actually. She thought I was doing a fine job. I didn't feel so bad."

There are three possible explanations for these correlations. The first is that when anxious, depressed and uncertain the mothers returned to routine caretaking activities that required little thought and initiative. Society demands that a mother take good care of her infant, and routine caretaking would give the mother one way of proving to others and to herself that she was a 'good mother'.

A second explanation relates to the woman's beliefs about housekeeping and the mother role. It could be that those mothers who set extremely high -
even 'obsessional' - standards for house and child care would find themselves not coping successfully and end up depressed and anxious. This position was supported a little by the negative correlation between this factor and 'Mother Plays With Child' obtained at the visit when the child was eighteen months. It could be argued that those mothers who need to be obsessively tidy would be least able to tolerate breaks in house-cleaning routines and the clutter of toys left by a toddler.

The third possibility is that having a soiled infant when I was present would increase the mother's anxieties, depression and uncertainty, particularly as most mothers wished to display their child at his or her best and to demonstrate their mothering capabilities. This last explanation is not really adequate, as about half the mothers provided their transcript while the baby was asleep and before the observed interaction. Therefore, it would be unlikely that they would know that the nappy would be soiled. In addition, rapport was usually good and the women seemed to react normally and to be behaving as they would if I had not been there. I believe, therefore, that uncertainty, anxiety and depression are related to increases in routine caretaking - such as nappy changing.

When the mother was kissing, caressing and cradling the infant she was less likely to be worried about the child (Appendix 17.2). That is, the less anxiety expressed in relation to the infant the more likely the mother was to be kissing, caressing and cradling the infant. Shereshefsky, Liebenberg and Lockman (1973) noted the withdrawal of emotional investment on the part of a mother of an ill child and believed this was due to the mother's need to defend herself against the possible loss of the infant. Cramer (1976) also mentioned the withdrawal of emotional investment in the child
when at risk following a premature birth. The last two cases referred to very ill infants, but this research indicated that, to a lesser degree, there was the same linkage between anxiety and lower emotional investment in healthy three months old infants.

Burping the baby was significantly related to expressions of anger about the baby and the mother herself. Remembering the vigour that I saw sometimes used to perform this act I was not surprised that it correlated with hostility. This factor described another caretaking behaviour and it is interesting that, like changing the child's nappy, it correlated with raised negative affect. In contrast, all three factors showing positive mother-infant interactions were related to positive feelings (influencing), or to an absence of negative emotions (separation in relation to the hospital's routines and worry about the baby).

In summary, the behaviour factors when the child was three months old showed the reciprocal interaction of internal personal experiences and behaviour and continuing damage to the mother-child relationship associated with separation and worry. The results also showed that routine caretaking activities were associated with negative emotions.

12.4 RELATIONSHIPS BETWEEN BEHAVIOUR AND MOTHERS' PERSONAL EXPERIENCES WHEN THE CHILDREN WERE EIGHTEEN MONTHS OLD

There were fewer significant correlations between affect and behaviour at this time (Appendix 18.3). The increasing behavioural repertoire of the child and thus the increased complexity of the observed interactions made
it more difficult to interpret those correlations which were significant. There were more factors relating to the infant than earlier. At three months "Infant Lying" was the only factor to solely describe infant behaviour, whereas when the children were toddlers there were three child factors - "Active Child", "Socialising Child" and "Chatty Child". It was not considered possible to assess infant emotion. There were observable differences between the children which, even allowing for mood changes, would indicate personality differences. Beryl's son was very active. He tore around the house, racing from kitchen to sitting room, carrying an old newspaper. He left sheets of it around the room and happily shredded bits when he felt like it. Joanna's daughter laughed, danced in front of a mirror and rolled on a soft cushion. She frequently sought body contact with her mother. Fiona's daughter was still not walking well. Fiona sat with her playing musical games and encouraging her daughter to sing. She seemed to be a more placid child than most.

The children being active and socialising was not related to any emotions. It is not surprising that the factors describing these child behaviours were not related to mothers' feelings as the activities were frequently directed towards me. Observations of the mother playing with the child were not associated with any feelings and it may have been that the women behaved in this way, not because of how they were feeling, but rather in response to their beliefs about my expectations of the interaction. It would, in that case, reflect cultural value systems and perceived demand characteristics of the observation.

When the mother spent time carrying the child she was likely to express anger about herself and feel depressed about the child (Appendix 18.3). The
behaviours loading on this factor were the mother leaving the room, the mother holding the child and the child not vocalising to him or herself, and not fussing. Although the mothers' feelings were angry and depressed the behaviours did not make a clear enough pattern to allow for a meaningful interpretation of the relationship obtained.

There was no significant correlation between emotion and the mother being warm, smiling and touching her child at this time.

"Chatty Child" (which loaded on child vocalises to mother - initiates; child vocalises to mother - responds; child not crawling and child fusses) was negatively related to the women feeling depressed about themselves, and positively related to expressions of hostility being received from others (Appendix 18.3). Considering that the child was fussing as well as interacting vocally with the mother their statements about receiving anger from others (including the child) were understandable. The negative relationship with depression probably reflects an activity level and the availability of a non-depressed mother. That is, it described a mother who was emotionally available and interacted with her child, even though the child was not behaving like an angel.

The women who were socialising with me were talking of interpersonal experiences and sharing. They were also depressed about their medical related experiences (Appendix 18.3). The correlation with this form of depression has been argued earlier to be indicative of them identifying me with the hospital and medical profession. As discussed earlier, significant correlations occurred between socialising at the three months visit and feelings about the hospital and medical profession (Appendix 17.2). The
correlation between this set of behaviours and the Sociality Scale, which is based on scoring for positive interpersonal relationships, confirmed the validity of the naming of this factor and indicated the strong relationship between internal personal experience and observed behaviour.

In summary, when the children were eighteen months old, the behaviour factors showed few correlations with emotions. I believe this may have been due to the increasing complexity of mother-infant interactions at that age, including relationships with significant others. Hostility emerged as one of the feelings most commonly correlating with behaviours. Sociality and sharing correlated with mothers socialising.

12.5 CORRELATIONS OF BEHAVIOUR FACTORS WHEN THE CHILDREN WERE THREE MONTHS OLD WITH MOTHERS' PERSONAL EXPERIENCES AT BIRTH

Three factors showed significant correlations. These were "Infant Lying", "Fussing and Nappy Change" and "Baby Burped" (Table 9). All were related to negative emotions. Leaving the infant lying was related to early worries about damage to the baby. Excerpts from Liza's transcript at three months have been given earlier in the discussion about this factor. She had been worried about damage to her son when he was newborn.

"At the actual time when I first came in I was worried about the baby being premature. Once the contractions started I just became completely hopeless. It started to really upset me, you know. ..... He was screaming his lungs out when he was born. Because they had told me that if they whizzed him into the other room without me seeing or hearing him it didn't
mean there was anything wrong, they just had to get some oxygen into him. And that was worrying."

Having the child fussing and the mother changing the nappy was related to the mother experiencing feelings of shame at the time of the birth. Judy, who has been discussed earlier, at the interview in the hospital talked about her own and her family's shame:

"Yesterday I fed him on demand and I told fibs to the nurses and he fed a lot better yesterday. He's not feeding too good now because I had to wake him up .... (My mother) never says much, but then she never does. But she's been in every time she comes in here. She doesn't have to say much. See, she had four girls and she's tickled pink about a grandson. Her first grandchild was a little girl and she's got cerebral palsy and she's a spastic child, and that was my twin sister's child. So the second grandchild, my other sister, she had a little boy. But it was illegitimate, and so she was, you know, a bit so-so about it. They are very strict religious-wise, my parents."

Performing the action of burping the baby at three months was related to depression, sadness about the baby, and feelings of loneliness shortly after the birth. Janice spent half the observation time at three months burping her son. At the interview after the birth she had said:

"Oh, he was very tiny and small when I first saw him and his face is wrinkled and all that. So I was a bit depressed when I saw him. But then now he's gaining weight, and I think that he's a bit different than what he used to be. ..... I'm expressing my milk which is being given to him. I'd feel better if the baby is there doing it. The emotional thing is not there. It's too mechanical doing it like that every now and then, whereas with the baby you feel happier. So I wish I could do it soon. But he couldn't suck yet. He's too small for that. ..... My parents are in the Philippines. It's only the three of us here, and some friends. It's a bit harder because had I been at home, well, my parents are there to help me take care of the baby."
12.6 CORRELATIONS OF BEHAVIOUR FACTORS WHEN THE CHILDREN WERE THREE MONTHS OLD WITH MOTHERS' PERSONAL EXPERIENCES AT EIGHTEEN MONTHS

"Mother Socialising" and "Mother Stimulating and Caring" showed significant correlations (Table 8). Socialising behaviour has already been extensively discussed. Stimulating and caring for the baby at three months was negatively related to expressions of helping relationships at birth. This relationship is difficult to understand.

12.7 CORRELATIONS OF BEHAVIOUR FACTORS WHEN THE CHILDREN WERE EIGHTEEN MONTHS OLD WITH MOTHERS' PERSONAL EXPERIENCES AT BIRTH AND THREE MONTHS

There were no significant correlations between these behaviours and mothers' personal experiences shortly after the birth (Table 9). "Active Child", "Warm Mother", "Chatty Child", and "Mother Socialising" showed correlations with emotions obtained from the transcripts when the children were three months old.

Mothers whose children were active at eighteen months had fewer warm feelings about the infant at three months (Table 9). No cause-effect conclusions can be drawn, but one wonders whether the lack of warm feelings in the mother may lead to greater infant activity and less proximal attachment behaviours. Activity levels and using the mother as a secure base from which to explore strange situations have been discussed by Ainsworth, Bell and Stayton (1971). It would be most interesting to assess mothers' internal personal experiences and at a later time to test their
children in the Strange Situation procedure in order to examine the relationship between maternal emotion and infants' behaviours.

Being a warm mother at eighteen months was related to expressions of warm feelings when the child was three months old (Table 9). Expression of loving and positive feelings being followed by a display of loving behaviours is not surprising. However, positive feelings expressed at eighteen months did not show a significant correlation with this factor. Elizabeth talked to and touched her child during the eighteen months visit. She had expressed loving and positive feelings during the visit at three months, as follows:

"The thing that really sticks in my mind is all the excitement of it. I thought I was the only one to have a baby. When I am sitting holding him everything is really perfect, and that's all I wanted - just a happy little baby. ..... I had him so easy. All I can remember is just looking down and seeing him there and feeling so happy."

"Chatty Child" was negatively related to puzzlement, anxiety and shame at three months (Table 9). This factor had been related to a lack of depression, and to expressions of hostility being received from others in transcripts obtained at the eighteen months visit. The correlations with internal personal experiences when the child was three months old are difficult to interpret. The mothers socialising has been discussed earlier. It again showed the linkage between me and the medical profession as it was related to good feelings about things medical.

12.8 **SUMMARY**

Relationships were found between behaviour factors and internal personal experiences. These relationships were clearest and most meaningful when the measurements were obtained during only one visit - that is, at one point in time.
Mothers socialised with the interviewer during both home visits, indicating the extent to which the women had identified me with the hospital and the medical staff. This behaviour was related to recall and expression of feelings about their hospital experiences.

At the three months visit recalling experiences of loneliness while in hospital was related to leaving the infant lying, and to being less stimulating and caring. Changing the child's nappy was related to feelings of uncertainty, guilt, loneliness, anxiety, worries about damage, and feelings of depression. Burping the baby was related to expressions of anger about the baby and about the mother herself. By contrast, the loving factors were related to more positive feelings. Loving mothers were not feeling worried about their children, and being en face with the baby was correlated with discussions of influencing types of interpersonal relationships.

At the eighteen months visit there were behaviour factors describing the child's behaviour. Having a talkative, chatty child was negatively related to the mothers feeling depressed about themselves, and positively related to expressions of hostility being received from others. The mother carrying the child was related to the women being angry with themselves and depressed about the child.

Some correlations between behaviour factors and personal experiences which were measured at different points in time were also significant. Negative emotions expressed during the interview while the women were still in hospital were related to behaviours when the children were three months old. These behaviours were leaving the infant lying, changing the
child's nappy and burping the baby. There were no significant relationships between behaviour factors at the eighteen months visit and mothers' emotions expressed in the interview shortly after birth. There were relationships with the women's personal experiences when the children were three months old and behaviours at eighteen months. Being a warm, touching mother at that time was related to positive and happy feelings when the child was three months old. Having an active eighteen months old toddler was negatively related to warm feelings about the infant at three months, and having a talkative, chatty child was negatively related to puzzlement, anxiety and shame at three months.

Although patterns of interactions did emerge from the combined data, it was clear that each individual interaction between mother and child was complex. Each woman interpreted her own experience and then integrated it into her ongoing developing family pattern. Much of an individual mother's behaviour depended on her own personal constructs, her support system and the stresses she experienced.
CHAPTER THIRTEEN

CONCLUSIONS

This research was based on the assumption that the birth of a first child and early childrearing are important psychosocial events, and that the reciprocal determinism model provides a useful frame of reference from which to view them. This period in a woman's life is accompanied by many changes and adaptations. Each woman comes to this experience with expectations, hopes and fears. She will have observed and learned from her own mother and from acquaintances. But, in spite of a life time of preparation for her initiation into motherhood, she must inevitably pass through great physical changes and intensely emotional experiences that are new to her. No film, lecture or discussion can fully describe the experience of giving birth. Even after a woman has satisfied the rites of passage into motherhood there still remains the task of adjusting to the child and getting on with the job of childrearing. Each mother is confronted with a unique human being and must adapt to the child's developing personality as well as learn to cope with motherhood in the light of her perceptions of her own needs and society's demands. The reciprocal determinism model has the value of pointing to the importance of examining the interactive effects of the different elements of a psychosocial event such as this one - behaviour, environment and personal experiences.

In this final chapter I will evaluate this research, discuss the hypotheses proposed and examine the effectiveness of the reciprocal determinism model.
13.1 THE RESEARCH

Although I found the different experiences of the three samples of mothers fascinating there were some difficulties experienced in relation to securing viable samples and in the measurement of the E, B, and P factors.

13.1.1 Sample Size and Composition

One of the biggest problems I encountered in doing this research was the loss of contact with the mothers over time. The young working class women were the most difficult to locate as the children grew older. Lack of stable relationships and inadequate accommodation were difficulties that probably led this group of women to change address frequently. I also believe that they were less motivated to be part of the study. They tolerated the intrusion into their lives but were not as anxious to help, or as curious about the results as the higher socio-economic status women. Better education and higher status seemed to be linked to a greater appreciation of learning and a higher and better informed motivation to be part of the research programme.

Another factor influencing motivation to stay with the research would have been the attitudes of the mothers to the baby, the hospital and medical profession. Many of the mothers of premature babies and the women who experienced routines leading to separation were loud in the praise of the doctors and nurses. The working class women had few feelings about the doctors or the hospital staff. As discussed earlier, the women clearly identified me with the hospital and it is likely that the more grateful they were, the more they would be pleased to help an associate of the hospital.
It is unfortunate that this may have led to a bias in the results as those with the less positive experiences would be more likely to drop out. There appeared to be a linkage between a negative or mixed initial reaction to the baby and being unavailable for follow-up visits (Table 2). Anne was a good example of this. Her son had broken his arm by the time he was three months old and she avoided all future contact in spite of letters from me and requests passed through a friend of hers.

The loss of the working class women from the research over time is particularly regrettable because of their impoverished capacity to express emotions. The alexithymic response style evident in their transcripts was very interesting and clearly differentiated them from the two other samples of mothers. I regret not having data on the development of the mother–child relationship for this group of women. I would have dearly loved to continue to study them and their children, to observe their interactions, and listen to the mothers describe their growing children and their lifestyle. With this group it would have been interesting to maintain observations until the children started school in order to assess the development (or blunting) of emotional expression in the children.

13.1.2 Environmental Factors

There may have been some inaccuracies in the E data as past environmental factors were measured by taking a case history from each woman. Unfortunately memory is fallible. Direct observation of past events was impossible and each woman's recollection of her own past environment was a description of the environment that was 'real' to her. Therefore, this method gave a clear picture of how she interpreted the
past. The value of a subjective approach to the assessment of E factors became obvious from the information supplied by the mothers of premature babies. They came from intact families and appeared to be close to their relatives and to the child's father yet they felt they lacked the support they needed.

My decision to observe in the home led to the emergence of special behaviours not likely to arise in the laboratory setting and also to insights into the lifestyles of mothers and children. Without home visits I would never have become aware of the differences in imagination and creativity between the women. There were mothers who used mass produced plastic toys and others who allowed the child to experiment and learn. Fiona taught her daughter to sing and used musical games; Joanna had a broken mirror and banks of soft cushions as toys; Liza played rough and tumble ball games; and Helen said her child loved to play in the mud. The experienced environment of each child was, therefore, unique.

A key factor in a mother's environment is the attractiveness and temperament of her child. Although I asked the mothers for their impressions of the children's temperament at eighteen months I regret not measuring this at the other interviews. It would have added to the research data to have an assessment of temperament at each time. That measurement could then be compared with the mother's responses and her perception of the child.

13.1.3 Internal Personal Factors

The content analysis scales proved valuable in providing valid measurements of a wide variety of emotions. The data obtained clearly
described the complex internal personal reactions occurring at each stage. These scales also made it easy to compare the women's experiences with those of a 'normal' population.

The transcripts which were content analysed provided a wealth of information concerning the beliefs, attitudes and emotions of the mothers. However, the working class women left me with many unanswered questions about the nature of their internal experiences. Were they constitutionally unable to produce or use fantasy? Was this inability to fantasise related to their passive coping styles and lack of planning for the future? Does the need for an outlet for tensions through fantasy lead to a greater emphasis on physical illness? Did this group suffer more physical problems or did they simply report them more? Did they represent a group of women who develop bodily illnesses rather than neurotic illnesses when under stress? Is there a physical substrate or neurophysiological explanation for this condition? If so, is it inherited by their children?

13.1.4 Behaviour Factors

Finding that the mothers needed to socialise with another adult vindicated the decision to observe within the home. Women who travel to a laboratory, chat to the researcher before an observation begins, and who are issued with instructions on what sequences of observations (presence/absence of mother and stranger) will occur have probably fulfilled their socialising needs before the observation begins. They will also have clear cut expectations about relating to the child rather than the observer during the experimental period. Allowing free roaming behaviour
in the home was particularly valuable when the children were eighteen months old. The increased mobility and independance of the child was demonstrated by the factor behaviour patterns obtained then. Past research has frequently looked solely at mother behaviours or child development. Neither set of behaviours occurs in a vacuum. As the child grows and becomes more active and competent, an important task for the mother is to adapt to this, to accept the changes in the child, and in some ways to come to terms with her own increasing redundancy. Women can be inadequate mothers not only through neglect of the child, but also by being overprotective and smothering.

The transcripts from the interviews with the mothers gave me some information on changes in lifestyle following the birth of the baby, but I believe there were other differences between the women that I did not tap. Not all mothering behaviours are interactive and the recorded observation was brief. It became clear, specially when the children were eighteen months old, that there were considerable differences in the amount of time and energy the women put into mothering and keeping house. For example, Joanna could not sleep without her child in the same room, Maria remained tied to the house and the child because of her fears and her inability to drive, Sally had accepted her own needs for personal fulfilment outside the home and returned to work. Sandra's personal fulfilment lay in the mother role and she planned another baby before her son went to school. Some homes were spotless with nothing out of place; in some, special areas had been set aside for the child and for toys; and in others, there was a jumble of toys, washing, child and pets. If I were repeating the research I would ask each mother to keep a diary for several days around the time of each visit. I would like to have a record of her
feelings of fatigue, attitude to household routines, time spent on child-care related duties (washing, cleaning, preparing meals), time available for play with the child, time free to follow her own interests, and activities shared with her husband. These records would help in obtaining some measure of the time spent in, and the physical cost of, behaviours related to raising a child.

In spite of the foregoing limitations it was possible to draw conclusions about many of the hypotheses I proposed. These are discussed in detail in the next section.

13.2 HYPOTHESES GENERATED FROM THE MODEL

13.2.1 Hypothesis 1

Hypothesis 1: "Different birth environmental conditions (E) will produce differences in maternal internal personal experiences (P) and behaviours (B)". [E changes P and B]

The different environmental conditions experienced by the women were related to differences in personal experiences. The difference was greatest at the time of the birth. Each sample showed different worries.

1. Women experiencing routine separations had significantly higher feelings of loneliness or separation in relation to hospital procedures.
2. Mothers of premature babies had significantly higher anxiety, less anger about the hospital and fewer warm feelings.
3. Young working class mothers felt more like pawns than did the other mothers.

By the time the children were three months old these differences had disappeared. However, the affective pattern of responses created by the childbearing experience had a continuing effect which was demonstrated by the significant differences found between groups of mothers and the 'normal' comparison population. There were more worries, more pawn-like feelings and a tendency for more intimacy and warm feelings.

When the children were eighteen months old there was again no difference between the samples of mothers. Mothers of premature babies showed no differences when compared with the 'normal' population, but mothers who had experienced separations from their infants at birth, were at that time significantly higher on feelings of loneliness than the comparison population.

It can be seen therefore, that the birth environment was associated with differences in responses. Although these differences seemed to disappear they probably had a long term effect. The need for longitudinal studies is emphasised by this finding.

In examining behaviours it was found that mothers of premature babies were behaving slightly differently at both visits. They tended to be more infant involved than did the separated mothers. The behaviours observed were macroscopic and a more detailed study of interactions may have revealed further differences. Because of the high dropout rate of mothers, and bearing in mind that those who had an initial negative reaction to the
infant were those least likely to stay with the research, it is possible that different results would have been found if all women had been observed at all times.

Longitudinal studies comparing mothers' involvement with their child are indicated.

13.2.2 Hypothesis 2

Hypothesis 2: Objectively similar birth environments (E) may be interpreted (P) and reacted to (B) differently according to the individual's personal needs and past experience or learning. [P changes E and B]

Within any group there were great differences in women's reactions. A good example of this was the different initial response to the child and their descriptions of the labour. Sally, Anne and Shirley gave birth to full term infants yet their subjective experiences were very different. Sally was happy even though she had felt some discomfort, whereas Anne remembered her pain and the flaws in her child.

"It's beautiful - really chubby cheeks. That's about it. I just thought she was beautiful. She looked lovely. Lots of hair and pink ..... A very good labour, a short labour for a first pregnancy I thought - for it's size. And the birth - a forceps lift out which was a bit uncomfortable, but all in all it was very good." (Sally)

"Beautiful. He had a little mark on his face because they had to use instruments but I seen him for a short while and then they took him away and I seen him the next morning ..... He had a bit of trouble breathing but after that he went real well. ..... Well I can't remember all of it (the labour) but I can remember some of it. It wasn't real bad but I had a fair amount of pain in it, and I got some sharp cramps as the head
was coming through. But other than that it went O.K. I was so tired. I did have to have some needles in the second stage of labour because the blood pressure went quite high and they had to give me three to bring it down." (Anne)

Shirley gave birth in the same hospital as Sally and her reaction was different again. She was not feeling very motherly but she had an excellent recall of her labour.

"Well I must admit I'm not terribly maternal at the moment. ..... But when I first saw him he looked lovely. Because the doctor was really wonderful. He brought him up and showed me and I was watching him sort of come out and feeling him come out, and he was all blue and terrible. I went into labour and I'd been dribbling from about 5 o'clock Friday and I thought, er. On Sunday night I rang, and I thought, oh, you know, it's probably nothing. But they said come in and we'll examine you. And they decided to keep me here the night and I went into labour at four o'clock in the morning. So I was around in Labour Ward at 6.30 and the doctor was called. I was having five minute contractions and the doctor was called. And he came about 7.30 and ruptured the membranes and there was muconium, a lot of muconium in the water so they put me on a foetal heart monitor and they started to speed up, speed up the birth. So then I was going fairly easy actually, and I had a pethidine injection about 11 o'clock and another one about three and the baby was born at five. I was in second stage for an hour. But that was quite, that was really very satisfying and enjoyable. And I don't remember feeling any pain at all in the second stage. It was beautiful." (Shirley)

The women's past experience and internalised values about childrearing also led to vast differences in plans to breastfeed, and in the quality of environments they created for the child.

Sally and Clare had both moved to a new suburb on the outskirts of Sydney. They lived in new homes in the same suburb. As mentioned earlier, Sally and her husband were aware of societies where parents carry children a lot. They had also read LeBoyer and were looking for alternative birth experiences for their second child. They were both warm and friendly.
They agreed with each other, corroborated and added to each other's anecdotes about their daughter. They talked about how she loved to play in the garden, her love of dogs and the neighbour's chickens. They said she was easygoing and placid yet also told how she could behave like a 'terror'.

"She's just mischievous. She really is. That's just it. She's mischievous. She is inquisitive."

She had an old washing basket full of toys in the corner of the living room. She took out toys, played with them and then dropped them as her interests changed. There was no coercion for her to perform in any special way. It seemed that both parents loved and accepted their daughter for the person she was.

Clare had finished high school before beginning work in a bank. She had a sister who had completed a university degree. She spoke about her and mentioned her training each time I visited her. When her son was eighteen months old she explained how much he loved books. She encouraged him to 'read' pages to me. At that visit she said:

"He's so enquiring. He loves other children. He always goes up and hugs them when he meets them. I think he'd be pretty good (at school). He's always looking and learning which is always a good quality. He doesn't dream as much as Mummy."

At the visit when the child was eighteen months old she and her husband spoke assertively, even aggressively, to each other at times. They corrected inaccuracies in each other's account of events. They both complained that the child 'whinged' a lot. He did in fact do this a couple of times during the observation. Each time he did they responded - sometimes with rewards ('kiss it better') or sometimes with verbal punishments, such
as "stop that now". When they offered me a cup of tea the child had just drained a drink of his own. He climbed onto his father's knee and tried to drink the hot tea from the cup. Both parents allowed him to keep on trying to do this. He burned his hands on the outside of the mug and his mouth on the rim. He cried with frustration, yet it took his mother about five minutes to decide to get him a drink of his own, and in the meantime, she continued to offer him the hot tea and laughed at his discomfort. She described his temperament as:

"When happy he is very happy. Very impatient. Not very docile at all. He will sit while you cuddle him but jumps up again."

13.2.3 Hypothesis 3

**Hypothesis 3:** A birth experience (E) which has high emotional cost (P) will produce differences in mothering behaviour (B). [E changes P and B]

The birth experience with the highest emotional cost was that of giving birth to a premature infant. The cost of giving birth prematurely was significantly greater than suffering routine separations. As discussed above, this experience led to a difference in behaviour when the children were three months old. The mothers of premature babies looked at their children more than did other mothers. Therefore, this hypothesis was only tentatively supported - one would have expected to find wider differences between groups and these differences indicating more mothering difficulties for parents of premature babies. This did not occur as the mothers of premature babies were more infant involved. However, as discussed earlier, the contact between hospital staff and the mothers from this group fitted the criteria established by Cramer (1976). The lack of
differences was specially surprising as these mothers at birth expressed some negative reactions to the infant. They talked about the visual impact of the monitors and their attempts to breastfeed were usually unsuccessful. The positive outcome may have been produced by the care and follow-up provided by the hospital. If so, then this vindicates the extra work involved in this sort of caring and reinforces the notion that mothering behaviours may be changed as a result of experiences. The difference found between samples of mothers in the amount of time they spent carrying the child is hard to understand.

It would have been interesting to compare mothering behaviours in the neonatal period. It may then have been possible to observe any early differences between the samples of mothers and note changes over time. Such observations would be complicated by the physical condition of the premature babies. Any study of such a group may have had to be deferred until the baby's health permits interactions.

13.2.4 Hypothesis 4

Hypothesis 4: Personal constructs (P) of the experience of childbirth and childrearing will change over time as a result of events (E) and responses (B and P). [P is changed by E, B, and P]

This hypothesis was supported. The changes in the content analysis scores over time indicated how the women's responses altered. Their personal constructs changed as the environment and they, themselves, adapted to their new role. As the child grew and they developed mothering skills they were better able to cope with the lifestyle change involved in becoming a
mother. They were able to reassess mothering behaviours and plan
different ways of behaving with a second infant.

Reactions to the hospital routines also varied a great deal. As discussed
earlier there were some women who accepted separation from their baby,
deciding that they 'needed the rest', while others resented it but said
nothing, and some complained angrily.

Further research in this area should be directed towards isolating specific
conditions within the mother which relate to differences in reactions.

13.2.5 Hypothesis 5

Hypothesis 5: Although some mothering behaviours (B) will change as the
mother adapts to her new role there will be other behaviours (B) which will
show consistencies over time. \([B = B]\)

This hypothesis was supported but only for a few behaviours. There were
two sets of factors which showed correlations. The first intercorrelation
was between the socialising behaviours observed on each occasion. The
second was a negative relationship between the mother playing with the
child at eighteen months and the mother changing a fussing child's nappy at
three months. This has been discussed earlier. I had expected that there
would be greater consistency in behaviours indicating engrossment, and
that behaviours such as looking en face at the child and the mother being
warm and loving might have been correlated. But this did not occur.
13.2.6 Hypothesis 6

Hypothesis 6: Particular patterns of behavioural interactions (B) and affect (P) will change as a response to the input of the child changing the environmental (E) conditions. [E changes B and P]

This hypothesis was supported. There was no doubt that the role of the child in the interactions was important as the infant matured and became less dependent upon the mother. The emergence of the child behaviour factors when the children were eighteen months old showed the growing independence of the child and that much of the dyadic interaction then depended upon input from him/her.

Changes in mothers' personal constructs relating to change in the child were not so clear cut. The affects correlating with child behaviour factors have been discussed earlier. It was only when the child was talking to the mother that there was a significant correlation with emotion at the time of the observation. That relationship was between (1) a child who initiated verbal interactions, responded verbally, was fussing and (2) feelings of depression in the mother and discussion of hostility received from others.

Also of relevance to this hypothesis were the changes in the internal personal experience of mothers of premature babies. It appeared that once the infant was perceived as likely to survive and apparently healthy there were changes in affect - for example, increases in both anger and warm feelings.
13.2.7 Hypothesis 7

Hypothesis 7: Separation of mother and infant during the lying in period will influence both mothering behaviours and maternal affect. [E changes P and B]

Only working class mothers did not experience early separations. Greatest differences should have been found in comparison with them. Unfortunately, there were only three of these women interviewed at three months and one at eighteen months. Therefore, no conclusions can be drawn. In addition, the working class mothers had few affective responses making them an unusual sample and limiting comparisons.

13.2.8 Hypothesis 8

Hypothesis 8: Over time, with increasing experience, women's behavioural responses to their infants will change. [B is changed by E and P]

This hypothesis related not to the environmental changes produced by the changes in the child as it grew, but rather to the learning effect and the internal changes within each mother which would lead to change in behaviour. Research shows that experienced mothers tend to have more confidence and to be more sensitive to the needs of the child than inexperienced mothers.

Evidence to support this hypothesis was contained in the statements made by the women interviewed when their children were eighteen months old. They said that they would behave differently with another child. They
discussed things they would like to do differently. Changes they would make included simple things like not worrying as much, learning to drive, and reacting to the individuality of the child.

13.2.9 Hypothesis 9

Hypothesis 9: Mothers of premature babies will have greater difficulty in developing an emotional attachment to their infants initially and will continue to be slower to do so. [E changes P]

Mothers of premature babies showed differences in internal personal responses at the time of the birth when compared with other mothers. However these differences disappeared rapidly. By the time the children were three months old their warm feelings had increased. Joanna had the typical fears that other mothers of premature babies had after the birth.

"I think it must be very hard for people who suddenly find their babies are in a premature nursery and they have never seen them. The equipment would be a bit scary at first. Even when I first saw her wired up with this here, and a drip in her arm I found, I just - I didn't know that I could take her out and hold her."

When her daughter was three months old she finished the visit by saying:

"(In hospital) I had lots of nice attention and visits. And Garry was really terrific and really good with her all the time. He spent a lot of time with her. He's still good with her. He believes in lots of cuddles and contact, and things like that. He plays with her and takes her for a walk and changes nappies without being asked now, even dirty ones. So he's sort of come a long way. He insists that I, that she sleep in bed with us, but he moves out if it gets too hectic and sleeps in the other room so he can get a full night's sleep. But he won't hear of her sleeping in the other room. And I, by now I wouldn't be able to go to sleep if she wasn't there anyway. I'm too used to it. So she's part of me now, and part of both of us. She's had a lot of good effects on us."
Hypothesis 10: Mothers of premature infants will not demonstrate bonding behaviours until after the trauma of the birth, whereas other mothers will show bonding soon after the birth. [E changes B]

This hypothesis was not supported. The behavioural differences between separated mothers and mothers of premature babies were small. It is a shame that it was not possible to observe behavioural interactions for all samples while the babies were still in the hospital nurseries. Greater differences may have been found at that time. Many of the mothers of premature babies talked of the impact of seeing their child hooked up to monitors. Several mentioned reluctance to hold the baby and others were like Maria, and talked of their own relative incompetence in caring for the baby.

Joanna provided an excellent example of a mother who overcame the early trauma quickly. At birth she said:

"I wanted to (touch her). I wasn't sure how they would be. I feel very strongly about holding, and I feel very strongly about contact with a baby so I really wanted to stroke her and touch her. It helped also that Garry came around when she was taken around to the premature nursery. And they brought back photos of her, and he had his hand through the little door and he was stroking her and holding her little hands. And I think that probably helped to give me confidence."

By the three months visit she had furnished her home to provide stimulation for her daughter. The decorations were simple and imaginative. There were old family photos ('Grandma as a baby') around the room. The bookshelf held some academic books but also contained books on
alternative lifestyles. There was a beautiful fern in a black bucket standing on an old water heater in the sitting room. It was not immediately obvious that the fern on the pedestal in the room had such pedestrian underpinnings. The overall affect as the sun shone on it through the window was lovely, and it disguised the shabbiness of parts of the rest of the room. There were mobiles around for the baby and there was a rocking cradle in the room. Joanna responded well to her baby and was aware of communications from the child. When playing with the mobile she encouraged her child to reach and gave minimal help to her in grasping the bright toys. They interacted well together. She spent almost the entire time looking at her daughter. By the time the child was eighteen months old there was a mirror on the floor near a door, and large soft cushions were heaped together at one end of the room. Joanna's daughter played and danced in front of the mirror and bounced on the cushions. At this time Joanna smiled at her daughter throughout the observed interaction. She played with her and there was much touching during that play.

13.2.11 Hypothesis 11

Hypothesis 11: Young women from disadvantaged backgrounds will have less positive reactions to childbirth and will exhibit deprived interactional relationships with their infants. [E changes P and B]

The working class mothers had emotional reactions that were impoverished. They tended to somatise their stress. Comparison of their internal personal reactions and their Malaise Inventory scores provided an indication of stress and lack of expressed affect. It was not possible to reach any conclusions about behavioural patterns as these were not
observed at the time of birth and only three women were seen when the babies were three months old. Further research needs to be done with this kind of population to discover their long term adjustment and the adjustments of their children.

13.2.12 Hypothesis 12

Hypothesis 12: Women isolated from social support networks will have less positive relationships with their infants. [E changes P]

The transcripts provided by the mothers of premature babies showed how difficult it was to measure isolation from social support networks. They came from intact families and retained contact with their own families of origin. Yet their needs for support at the time of the birth were so great that they frequently interpreted the reactions of family and friends as indicating only limited or conditional support.

Working class women had limited social support networks, but little can be argued from their transcripts because of the general lack of affect they showed.

Therefore, the results neither confirm nor refute this hypothesis. Further research needs to be carried out assessing the individual's perception of, and need for, support networks. Only when this is done can an answer to the question about social support networks and the development of mother-infant relationships be answered.
13.3 EVALUATION OF THE RECIPROCAL DETERMINISM MODEL

The reciprocal determinism model has pointed to the importance of examining the interaction of different aspects of the event of childbirth and child raising. It proved most valuable in identifying key factors of this psychosocial experience and the many patterns of interaction between them. This model answers some of the criticisms about the current philosophy of science in psychology raised by Manicas and Secord (1983). They argued that the behaviour of people in their life settings are open events that involve a vast range of codetermining structures and systems. They contrast the complex reality of psychosocial events with a closed system. The latter is the ideal if one wishes to develop scientific laws. They say:

"But it is important to recognise that social variables enormously complicate experimentation, making closure extraordinarily difficult to achieve, and further, that even when their experiments are technically successful, in the realist view of science social psychologists have no more warrant than general experiments for believing that their experiments explain everyday behaviour. The fruits of such experimentation provide only partial knowledge and understanding of social behaviour in life situations. Phenomena in open systems require knowledge of additional conditions and contexts and frequently biographical/historical knowledge as well." (p.409)

The main weakness within the reciprocal determinism model is that, while extending the search for 'codetermining structures and systems', it does not provide a guarantee that for each person all the important 'additional conditions and contexts' and key 'biographical/historical knowledge' will be either sought by, or available to, the researcher. I was keenly aware of the wide variety of modifying experiences the mothers must have had between my visits. These modifying experiences were unavailable for inclusion in
my account because they were not observed or recorded. For any individual mother the model made it easy to explain the behaviour and personal experiences recorded, but it did not facilitate prediction of future reactions. For example, if one of the mothers who experienced routine separations had a second child one would need to know her current environment, perceived stresses and supports as well as her phenomenological interpretation of the first birth experience in order to predict her experiences of that.

Although there were similarities within samples of women it became obvious that, for each woman, giving birth and raising a child was an individual experience in which she responded to her own configuration of E, B, and P factors. The model also had the advantage of pointing out the ongoing nature of human experience. The interlocking effects were not confined to one moment in time. It did allow for the bidirectional consequences of specific events.

At birth only environmental (E) and internal personal (P) factors were studied. There were interesting relationships between hospital practices and women's experience of birth. Maria's case study (Chapter 8.5) showed her personal reactions to giving birth to a premature baby. She described the fears she had for the child and the feelings she had that her baby had been stolen from her. These thoughts were associated with strong feelings of jealousy. She was envious of mothers of healthy full term infants, she resented her mother-in-law's enquiries about the baby, and believed she was much less competent than the hospital staff in taking care of her baby. In contrast, Sally's reaction (Chapter 6.6) was one of joy. She thought her daughter was 'beautiful'. But in spite of having the support of her husband
and feeling very positively about her baby her experience was clouded by the separations she experienced. She said, "I just want to have her here with me all the time ....."

Bandura (1977(b) ) postulated that: "..... people activate and create environments as well as rebut them." (p.205)

It was, therefore, interesting to note how these women incorporated their experiences and developed their coping strategies. In planning for the future both Maria and Sally demonstrated evidence of wishing to increase personal control, institute changes, or to make plans to prevent distressing childbirth environments. Sally and her husband reacted to the early separation from their daughter. They were intent on creating a different environment for their next child. They read about, and were intrigued by, societies where children had more body contact with their parents. Sally's husband had been the one most separated from the baby and he was very keen to hold and carry their second child more than the first. Maria's difficulties with her premature son led to her withdrawing (or rebutting) thoughts of future similar experiences. When she thought about future pregnancies she was worried about her difficulties in carrying to term. She believed she would have to be hospitalised for months before any future birth. This would lead to her being separated from Andy. There were remnants of her early jealousy of others caring for Andy in her statements even when he was eighteen months old. She could not leave him with anyone other than her husband, even though she recognised that it may be good for both of them 'to get away from each other for a bit'. Her method of coping with her unpleasant birth experiences and threat of future separations from her son (which she believed would be very distressing - "I'd go mad") was to decide not to have any more children.
The working class women proved different from the other two groups of mothers. They were more passive and there was little evidence of creating or rebutting environments (Chapter 10.6) as Bandura has suggested. Anne continued to be concerned about physical ills. She was barely coping and I wondered about child abuse. Sandra was also stuck in the physical illness model with her child developing eczema and allergies. She was coping better than Anne and had made some plans to take control of her environment. She decided that she would like another child before her son went to school (because she would miss him), and that future births would be Caesarian because her experience had been so 'bad'.

When behaviours were directly observed at the time the children were three months old it was found that there were few differences between mothers who had premature babies and those who had suffered routines leading to separation of mother and baby. Those behaviours that were different indicated greater 'infant involvement' in the mothers of premature babies. The hospital where their infants had been cared for had a staff dedicated to increasing contact between parents and children whenever possible. It seems likely that the care and concern taken to develop parental bonding was rewarded by increased loving behaviours between mother and child. This occurred in spite of the trauma associated with premature birth. These mothers’ transcripts provided vivid evidence of their personal experiences of that crisis. Their fears diminished slowly. They had a significant change in their warm feelings by the time their babies were three months old, when the child's survival seemed assured, but their fears persisted and were slow to disappear.

The different birth environment conditions (E) were associated with some differences in internal personal (P) experiences. Hospital procedures
modified the women's reaction to giving birth. Mothers who attended the hospital where the staff were involved in promoting good relationships had a different pattern of interacting E, B and P factors than mothers who experienced routine separations.

By the time the children were toddlers it was evident that the women had adapted to the demands of their everyday lives and that the birth experiences had faded somewhat from their minds. They were able to speak of their own personal needs. If there were long term **behavioural** effects of giving birth prematurely or attending a hospital that practised routines that separated mother and child, I found little evidence of it.

Reactions were interlocking. The different environmental conditions led to some small differences in behaviour and to changes in personal reactions:

```
Different Birth
Environments (E)  Behaviours with Child (B)  Personal Reactions (P)
```

For some women personal reactions led to decisions about changes for the future - preventing similar environmental conditions recurring:

```
Personal Reactions (P)  Behaviours with Child
Decisions to Change Future
Birth Environments (E)
```
It was also true that experience gained in childrearing led some women to decide to make changes before they had any other children:

There were also some suggestions that when experiences are similar to earlier experiences they may revive emotions experienced earlier. It seems that a sensitisation process occurred. The two women who were pregnant again when I visited them eighteen months after the first birth were the only women to express anxieties about birth (Appendix 12.1.4). There was also a trend towards greater feelings of loneliness than found in a normal population among women who had experienced routine separations when they were interviewed at the time the children were toddlers (Appendix 12.1.11). This was a time when they would again be anticipating separation as many young children go to play group or attend kindergarten. Although, as Bandura points out, human beings play a part in creating their own environments, this evidence for sensitisation shows the need for psychologists to obtain biographical/historical information if they wish to predict or explain individuals' behaviour.

13.4 SUMMARY

The reciprocal determinism model when applied to this psychosocial event enabled conclusions to be drawn about the nature of the childbirth
experience and early childrearing. However, the model could not provide a guarantee that for each person all important E, B, and P factors had been assessed. Each woman had her own pattern of interacting environmental, behavioural and personal factors. This means that for every individual their subjective interpretation of life's experiences will always be unique. I would have needed to be a wise experimenter indeed to be able to treat psychosocial events as closed systems and to measure all the key environmental, behavioural and personal factors involved in childbirth and child raising experiences.
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APPENDIX 1.

Interview schedule after the birth and Malaise Inventory

1.1 Interview schedule after the birth

1.2 Malaise Inventory
Appendix 1.1 : Interview schedule after the birth

1. Date of the interview was recorded.
2. "What is your name?"
3. "When was your baby born? What was the gestation period? Was it full term?" (Scored in weeks.)
4. "How many pregnancies have you had?" (Number recorded. If more than 1, they were asked whether they had had any elective abortions.)
5. "Was this pregnancy planned?"
6. "What is your address?" (The suburb was rated for socio-economic status on a scale of 1 to 7 according to Congalton's (1969) rating of Sydney suburbs. If available a phone number was also obtained for ease of future contact.)
7. "Are you married?" (Women were classed as 'married' if they reported a long term relationship with the infant's father.)
8. "What is your husband's occupation?" (Occupations were classified according to Congalton's (1969) rating of occupations on a scale of 1 to 7. However, this rating scale does not include those on a social service pension - 'the dole' - and an additional ranking of 8 was added to classify those in this category. Pineo and Porter (1967) found that those living on relief had no prestige at all and received the lowest ranking on ratings of occupational prestige.
9. "How far did you go at school? Did you have any further training after you left school? What was it?" (This was classified in terms of years of schooling. Less than the School Certificate - less than 10 years; the School Certificate - 10 years; Higher School Certificate - 12 years; other training after school - usually this was the School Certificate plus skills training such as secretarial training; still completing tertiary studies; and completed tertiary education.)
10. "What high school did you go to?" (This was categorised as Private, Roman Catholic, State, and whether it was unisex or co-educational.)
11. "What occupation did you have after you left school?" (Occupations were classified according to the Congalton (1969) survey of occupational status on a 1 to 7 scale, with the additional ranking of 8 being allotted to those who were unemployed and seeking work.)
12. "When did you stop work?" (This was scored according to months since last worked.)

13. "How many children would you like to have?" (Numbers were recorded on a scale of 1 to 4 plus.)

14. "Where were you born?" (This was categorised into six different groupings — Australia; New Zealand; Great Britain; Northern Europe; Latin countries; Other.)

15. "Where was your husband born?" (This was coded in the same way as above.)

16. "Did you attend prenatal classes?" (Answers were classed according to Yes; No; Planned to attend but didn't; Did not complete attendance at classes.)

17. "Did your husband attend prenatal classes?" (Answers were scored as for 16 above.)

18. "Was your husband present at the birth?" (This was classed according to whether present; absent; or planned to attend but didn't.)

19. "How did you find out how to look after babies?" (Answers were grouped into 7 different categories — Don't know yet; Maternal instinct; Experience with other infants; Information from the woman's own mother; Information from friends; Reading; or Professional sources such as doctors and nurses.)

20. "What were any other sources of information?" (These were scored according to the number of sources mentioned.)

21. "How are you feeding the baby? How do you plan to feed after leaving hospital?" (This was scored according to whether they had chosen breast or bottle feeding; whether they had the infant on demand feeding or scheduled feeds. If they were presently breast feeding they were asked how long they planned to breast feed.)

22. "Thinking of your marriage (or relationship with the baby's father) would you say that it is happy all the time; happy most of the time; happy some of the time; or happy occasionally or never?" (Answers were coded according to which was selected.)

23. "Do you have any step children?" (Scored for number.)
24. "Are both your parents alive?" (Scored for Yes or No, and if 'No' which parent had died.)

25. "Were you separated from either or both of your parents before you were 13 years old?" (Scored for Yes or No, and if 'Yes' from which parent.)

26. "What age were you separated from your parents?" (Scored for age, but those women who had only separated when married and lived in the same city maintaining close contact with parents were not scored as 'separated'.)

27. "Would you say that there was much trauma or trouble in the family when you were growing up?" (Scored for Yes or No.)

28. "Can you briefly describe your parents?" (Notes were taken as completely as possible.)
Appendix 1.2. : The Malaise Inventory

1. Do you often have backache?  Yes  No
2. Do you feel tired most of the time?  Yes  No
3. Do you often feel miserable or depressed?  Yes  No
4. Do you often have bad headaches?  Yes  No
5. Do you often get worried about things?  Yes  No
6. Do you usually have great difficulty in falling asleep or staying asleep?  Yes  No
7. Do you usually wake unnecessarily early in the morning?  Yes  No
8. Do you wear yourself out worrying about your health?  Yes  No
9. Do you often get into a violent rage?  Yes  No
10. Do people often annoy and irritate you?  Yes  No
11. Have you at times had a twitching of the face, head or shoulders?  Yes  No
12. Do you often suddenly become scared for no good reason?  Yes  No
13. Are you scared to be alone when there are no friends near you?  Yes  No
14. Are you easily upset or irritated?  Yes  No
15. Are you frightened of going out alone or of meeting people?  Yes  No
16. Are you constantly keyed up and jittery?  Yes  No
17. Do you suffer from indigestion?  Yes  No
18. Do you often suffer from an upset stomach?  Yes  No
19. Is your appetite poor?  Yes  No
20. Does every little thing get on your nerves and wear you out?  Yes  No
21. Does your heart often race like mad?  Yes  No
22. Do you often have bad pains in your eyes?  Yes  No
23. Are you troubled with rheumatism or fibrositis?  Yes  No
24. Have you ever had a nervous breakdown?  Yes  No

To score the scale each question is checked 'Yes' or 'No' and the score is the total number of 'Yes' answers.
APPENDIX 2.

Early family history of the women

2.1 Place of birth

2.2 Parents still living

2.3 Separation from parents before age 13

2.4 Age at which separated from parents

2.5 Reported family trauma in early life
### Appendix 2.1: Place of birth of the women

<table>
<thead>
<tr>
<th>Country</th>
<th>Separated Frequency (%)</th>
<th>Premature Frequency (%)</th>
<th>Working Class Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>48 (80.0)</td>
<td>8 (53.3)</td>
<td>10 (71.4)</td>
</tr>
<tr>
<td>New Zealand</td>
<td>1 (1.7)</td>
<td>1 (6.7)</td>
<td></td>
</tr>
<tr>
<td>Great Britain</td>
<td>8 (13.3)</td>
<td>2 (13.3)</td>
<td>3 (21.4)</td>
</tr>
<tr>
<td>Northern Europe</td>
<td></td>
<td></td>
<td>3 (20.0)</td>
</tr>
<tr>
<td>Latin</td>
<td>3 (5.0)</td>
<td></td>
<td>1 (7.1)</td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>1 (6.7)</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>60</td>
<td>15</td>
<td>14</td>
</tr>
</tbody>
</table>
Appendix 2.2 : Parents Living

<table>
<thead>
<tr>
<th></th>
<th>Separated Frequency (%)</th>
<th>Premature Frequency (%)</th>
<th>Working Class Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both living</td>
<td>50 (83.3)</td>
<td>13 (86.7)</td>
<td>12 (85.7)</td>
</tr>
<tr>
<td>Mother only</td>
<td>6 (10.0)</td>
<td>2 (13.3)</td>
<td>1 (7.1)</td>
</tr>
<tr>
<td>Father only</td>
<td>3 (5.0)</td>
<td></td>
<td>1 (7.1)</td>
</tr>
<tr>
<td>Don't know</td>
<td>1 (1.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>60</td>
<td>15</td>
<td>14</td>
</tr>
</tbody>
</table>

A between sources Chi square was computed comparing those having both parents still alive with all other categories combined (i.e. those who had lost one parent or who had lost contact with both). There was no significant difference between groups.
Appendix 2.3: Separation from parents before age 13

<table>
<thead>
<tr>
<th>Country</th>
<th>Separated Frequency (%)</th>
<th>Premature Frequency (%)</th>
<th>Working Class Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not separated</td>
<td>47 (78.3)</td>
<td>13 (86.7)</td>
<td>13 (92.9)</td>
</tr>
<tr>
<td>Separated from mother</td>
<td>1 (1.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Separated from father</td>
<td>9 (15.0)</td>
<td>2 (13.3)</td>
<td>1 (7.1)</td>
</tr>
<tr>
<td>Separated from both</td>
<td>3 (5.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>60</td>
<td>15</td>
<td>14</td>
</tr>
</tbody>
</table>

A between groups comparison using Chi square was carried out, comparing "not separated" with the other three categories combined. There was no significant difference.
### Appendix 2.4: Age separated from parents

<table>
<thead>
<tr>
<th>Age</th>
<th>Separated Frequency (%)</th>
<th>Premature Frequency (%)</th>
<th>Working Class Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-5</td>
<td>8 (13.3)</td>
<td>1 (6.7)</td>
<td></td>
</tr>
<tr>
<td>6-10</td>
<td>3 (5.0)</td>
<td>1 (6.7)</td>
<td>1 (7.1)</td>
</tr>
<tr>
<td>11-15</td>
<td>3 (5.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16-20</td>
<td>5 (8.3)</td>
<td>1 (6.7)</td>
<td>2 (14.2)</td>
</tr>
<tr>
<td>20+</td>
<td>1 (1.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never Separated</td>
<td>40 (66.7)</td>
<td>12 (80.0)</td>
<td>11 (78.6)</td>
</tr>
</tbody>
</table>

**N**

60 15 14

One Way Analysis of Variance showed there was no significant difference between groups.
Appendix 2.5 : Reported trauma in early life

<table>
<thead>
<tr>
<th></th>
<th>Separated Frequency (%)</th>
<th>Premature Frequency (%)</th>
<th>Working Class Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>8 (13.3)</td>
<td>1 (6.7)</td>
<td>2 (14.3)</td>
</tr>
<tr>
<td>No</td>
<td>52 (86.7)</td>
<td>14 (93.3)</td>
<td>12 (85.7)</td>
</tr>
<tr>
<td>N</td>
<td>60</td>
<td>15</td>
<td>14</td>
</tr>
</tbody>
</table>

A Chi square between groups comparison was calculated. There were no significant differences.
APPENDIX 3

Educational and occupational history of the women

3.1 Type of high school attended

3.2 Amount of schooling

3.3 Occupational status

3.4 Suburb status

3.5 Months since women last worked (at time of confinement)
Appendix 3.1: Type of high school attended

<table>
<thead>
<tr>
<th>School</th>
<th>Separated Frequency (%)</th>
<th>Premature Frequency (%)</th>
<th>Working Class Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roman Catholic</td>
<td>14 (23.3)</td>
<td>4 (26.7)</td>
<td>2 (14.3)</td>
</tr>
<tr>
<td>State Unisex</td>
<td>13 (21.7)</td>
<td>5 (33.3)</td>
<td>1 (7.1)</td>
</tr>
<tr>
<td>State Co-educational</td>
<td>33 (55.0)</td>
<td>6 (40.0)</td>
<td>11 (78.6)</td>
</tr>
<tr>
<td>N</td>
<td>60</td>
<td>15</td>
<td>14</td>
</tr>
</tbody>
</table>
### Appendix 3.2: Amount of schooling

<table>
<thead>
<tr>
<th>Education Level</th>
<th>Separated Frequency (%)</th>
<th>Premature Frequency (%)</th>
<th>Working Class Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than School Certificate (less than 10 years)</td>
<td>10 (16.7)</td>
<td>7 (50.0)</td>
<td></td>
</tr>
<tr>
<td>School Certificate (10 years)</td>
<td>22 (36.7)</td>
<td>4 (26.7)</td>
<td>7 (50.0)</td>
</tr>
<tr>
<td>Higher School Certificate (12 years)</td>
<td>2 (3.3)</td>
<td>1 (6.7)</td>
<td></td>
</tr>
<tr>
<td>Other training after school (usually School Certificate plus skills training such as secretarial)</td>
<td>13 (21.7)</td>
<td>5 (33.3)</td>
<td></td>
</tr>
<tr>
<td>Still completing tertiary education</td>
<td>6 (10.0)</td>
<td>2 (13.3)</td>
<td></td>
</tr>
<tr>
<td>Completed tertiary education</td>
<td>7 (11.7)</td>
<td>3 (20.0)</td>
<td></td>
</tr>
</tbody>
</table>

**N**

60 15 14
Appendix 3.3 : Women's occupational status

These figures were based on the most recent occupation. A lowest ranking (8) was added to the scale to allow for those receiving an unemployment pension (the "dole").

<table>
<thead>
<tr>
<th>Occupation Status</th>
<th>Separated Frequency (%)</th>
<th>Premature Frequency (%)</th>
<th>Working Class Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>1 (1.7)</td>
<td>1 (6.7)</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>3 (20.0)</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>14 (23.3)</td>
<td>3 (20.0)</td>
<td>1 (7.1)</td>
</tr>
<tr>
<td>5</td>
<td>28 (46.7)</td>
<td>7 (46.7)</td>
<td>12 (85.7)</td>
</tr>
<tr>
<td>6</td>
<td>15 (25.0)</td>
<td>1 (6.7)</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>1 (1.7)</td>
<td></td>
<td>1 (7.1)</td>
</tr>
<tr>
<td>8</td>
<td>1 (1.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>N</strong></td>
<td>60</td>
<td>15</td>
<td>14</td>
</tr>
<tr>
<td><strong>Mean</strong></td>
<td>5.05</td>
<td>4.27</td>
<td>6.07</td>
</tr>
<tr>
<td><strong>S.D.</strong></td>
<td>.93</td>
<td>1.10</td>
<td>.62</td>
</tr>
</tbody>
</table>

One Way Analysis of Variance between samples was calculated.

\[
F = 14.04 \\
\text{df} = 88 \\
P = .001
\]
Appendix 3.4: Suburb status

<table>
<thead>
<tr>
<th>Suburb Status</th>
<th>Separated Frequency (%)</th>
<th>Separated Mean</th>
<th>Separated S.D.</th>
<th>Premature Frequency (%)</th>
<th>Premature Mean</th>
<th>Premature S.D.</th>
<th>Working Class Frequency (%)</th>
<th>Working Class Mean</th>
<th>Working Class S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>(6.7)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>(6.7)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>2 (3.3)</td>
<td>(31.7)</td>
<td>8 (53.3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>34 (56.7)</td>
<td></td>
<td>3 (20.0)</td>
<td>1 (7.1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>5 (8.3)</td>
<td>(6.7)</td>
<td>2 (13.3)</td>
<td>9 (64.3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>60</td>
<td>15</td>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>4.70</td>
<td>3.27</td>
<td>5.21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S.D.</td>
<td>.67</td>
<td>1.03</td>
<td>.58</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

One Way Analysis of Variance between samples was calculated.

\[
F = 30.192
\]
\[
df = 88
\]
\[
P = <.001
\]
## Appendix 3.5: Months since women last worked
(at time of confinement)

<table>
<thead>
<tr>
<th>Months Separated</th>
<th>Frequency (%)</th>
<th>Months Premature</th>
<th>Frequency (%)</th>
<th>Months Working Class</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Still working</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-3</td>
<td>1 (1.7)</td>
<td>4 (26.7)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4-6</td>
<td>27 (45.0)</td>
<td>9 (60.0)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7-9</td>
<td>11 (18.3)</td>
<td>1 (6.7)</td>
<td>2 (14.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-12</td>
<td>5 (8.3)</td>
<td>3 (21.4)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12-24</td>
<td>5 (8.3)</td>
<td>7 (50.0)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24+</td>
<td>4 (6.7)</td>
<td>1 (6.7)</td>
<td>1 (7.1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never worked</td>
<td>2 (3.3)</td>
<td></td>
<td></td>
<td></td>
<td>1 (7.1)</td>
</tr>
</tbody>
</table>

| N    | 60 | 15 | 14 |
| Mean | 10.72 | 3.33 | 16.92 |
| S.D. | 22.60 | 7.51 | 10.04 |

One Way Analysis of Variance between samples omitting the "never worked" cases was calculated. There were no significant differences.
APPENDIX 4

Factors relevant to marriage

4.1  Marital status

4.2  Reported quality of marriage

4.3  Number of step children

4.4  Number of children women would like to have
Appendix 4.1 : Marital status

For this table "married" includes those who responded that they were living in a stable relationship with the child's father or who claimed the relationship (even if temporarily living apart) was long-term and stable. Figures are based on self-report.

<table>
<thead>
<tr>
<th>Status</th>
<th>Separated Frequency (%)</th>
<th>Premature Frequency (%)</th>
<th>Working Class Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>56 (93.3)</td>
<td>15 (100.0)</td>
<td>9 (64.3)*</td>
</tr>
<tr>
<td>Single</td>
<td>4 (6.7)</td>
<td></td>
<td>5 (35.7)</td>
</tr>
<tr>
<td>N</td>
<td>60</td>
<td>15</td>
<td>14</td>
</tr>
</tbody>
</table>

* Of the Working Class "married" women only six were living with a male. Another said she would be legally marrying and living with the child's father "soon".
Appendix 4.2: Reported quality of marriage

<table>
<thead>
<tr>
<th></th>
<th>Separated Frequency (%)</th>
<th>Premature Frequency (%)</th>
<th>Working Class Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Happy all the time</td>
<td>36 (60.0)</td>
<td>7 (46.7)</td>
<td>3 (21.4)</td>
</tr>
<tr>
<td>Happy most of the time</td>
<td>20 (33.3)</td>
<td>8 (53.3)</td>
<td>4 (28.6)</td>
</tr>
<tr>
<td>Happy some of the time</td>
<td></td>
<td></td>
<td>1 (7.1)</td>
</tr>
<tr>
<td>Happy occasionally or never</td>
<td></td>
<td></td>
<td>1 (7.1)</td>
</tr>
<tr>
<td>Not married</td>
<td>4 (6.7)</td>
<td></td>
<td>5 (35.7)</td>
</tr>
<tr>
<td>N</td>
<td>60</td>
<td>15</td>
<td>14</td>
</tr>
</tbody>
</table>
Appendix 4.3: Number of step-children

<table>
<thead>
<tr>
<th>Step-children</th>
<th>Separated Frequency (%)</th>
<th>Premature Frequency (%)</th>
<th>Working Class Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>58 (96.7)</td>
<td>14 (93.3)</td>
<td>14 (100.0)</td>
</tr>
<tr>
<td>2</td>
<td>1 (1.7)</td>
<td>1 (6.7)</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>1 (1.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>60</td>
<td>15</td>
<td>14</td>
</tr>
<tr>
<td>Mean</td>
<td>.10</td>
<td>.13</td>
<td></td>
</tr>
<tr>
<td>S.D.</td>
<td>.57</td>
<td>.52</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4.4 : Number of children the women would like to have (reported at Birth)

<table>
<thead>
<tr>
<th>Children Wanted</th>
<th>Separated Frequency (%)</th>
<th>Premature Frequency (%)</th>
<th>Working Class Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>3 (5.0)</td>
<td>1 (6.7)</td>
<td>1 (7.1)</td>
</tr>
<tr>
<td>2</td>
<td>34 (56.7)</td>
<td>5 (33.3)</td>
<td>3 (21.4)</td>
</tr>
<tr>
<td>3</td>
<td>9 (15.0)</td>
<td>5 (33.3)</td>
<td>2 (14.3)</td>
</tr>
<tr>
<td>4</td>
<td>8 (13.3)</td>
<td>2 (13.3)</td>
<td>6 (42.9)</td>
</tr>
<tr>
<td>4+</td>
<td>1 (6.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don't know</td>
<td>6 (10.0)</td>
<td>1 (6.7)</td>
<td>2 (14.3)</td>
</tr>
<tr>
<td>N</td>
<td>60</td>
<td>15</td>
<td>14</td>
</tr>
</tbody>
</table>

Mean 2.41 2.79 3.08  
S.D. .81 1.05 1.08

("Don't know" category omitted from calculation of Mean and S.D.)

One Way Analysis of Variance between samples was calculated.

\[
\frac{F}{df} = 3.24 \\
\frac{df}{f} = 79 \\
\frac{p}{.05}
\]
APPENDIX 5

Husband related factors

5.1 Husband's place of birth

5.2 Husband's occupational status

5.3 Husband's attendance at prenatal classes

5.4 Husband's presence at birth
Appendix 5.1 : Husband's place of birth

<table>
<thead>
<tr>
<th>Country</th>
<th>Separated Frequency (%)</th>
<th>Premature Frequency (%)</th>
<th>Working Class Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>44 (78.6)</td>
<td>12 (80.0)</td>
<td>7 (77.8)</td>
</tr>
<tr>
<td>New Zealand</td>
<td>1 (1.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Great Britain</td>
<td>3 (5.4)</td>
<td>2 (13.3)</td>
<td>2 (22.2)</td>
</tr>
<tr>
<td>Latin</td>
<td>5 (8.9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northern Europe</td>
<td>1 (1.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>2 (3.6)</td>
<td>1 (6.7)</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>56</td>
<td>15</td>
<td>9</td>
</tr>
</tbody>
</table>
### Appendix 5.2: Husband's occupational status

<table>
<thead>
<tr>
<th>Occupation Status</th>
<th>Separated Frequency (%)</th>
<th>Premature Frequency (%)</th>
<th>Working Class Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>3 (5.4)</td>
<td>1 (6.7)</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>1 (1.8)</td>
<td>1 (6.7)</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>14 (25.0)</td>
<td>5 (33.3)</td>
<td>1 (11.1)</td>
</tr>
<tr>
<td>5</td>
<td>21 (37.5)</td>
<td>4 (26.7)</td>
<td>1 (11.1)</td>
</tr>
<tr>
<td>6</td>
<td>11 (19.6)</td>
<td>4 (26.7)</td>
<td>5 (55.6)</td>
</tr>
<tr>
<td>7</td>
<td>6 (10.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td>2 (22.2)</td>
</tr>
<tr>
<td>N</td>
<td>56</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td>Mean</td>
<td>4.96</td>
<td>4.60</td>
<td>6.11</td>
</tr>
<tr>
<td>S.D.</td>
<td>1.19</td>
<td>1.18</td>
<td>1.50</td>
</tr>
</tbody>
</table>

One Way Analysis of Variance was carried out. There was no significant difference between samples.
Appendix 5.3: Husband's attendance at prenatal classes

<table>
<thead>
<tr>
<th></th>
<th>Separated Frequency (%)</th>
<th>Premature Frequency (%)</th>
<th>Working Class Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>26 (46.4)</td>
<td>6 (40.0)</td>
<td>7 (77.8)</td>
</tr>
<tr>
<td>Planned to but didn't classes</td>
<td>2 (3.6)</td>
<td>5 (33.3)</td>
<td></td>
</tr>
<tr>
<td>Incomplete classes</td>
<td></td>
<td>2 (13.3)</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>28 (50.0)</td>
<td>2 (13.3)</td>
<td>2 (22.2)</td>
</tr>
<tr>
<td>N</td>
<td>56</td>
<td>15</td>
<td>9</td>
</tr>
</tbody>
</table>

Chi square was computed. There was no significant difference between samples.
### Appendix 5.4: Husband's presence at birth

<table>
<thead>
<tr>
<th></th>
<th>Separated Frequency (%)</th>
<th>Premature Frequency (%)</th>
<th>Working Class Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>10 (17.9)</td>
<td>5 (33.3)</td>
<td>3 (33.3)</td>
</tr>
<tr>
<td>Planned to</td>
<td>8 (14.3)</td>
<td>3 (20.0)</td>
<td>2 (22.2)</td>
</tr>
<tr>
<td>but missed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>38 (67.9)</td>
<td>7 (46.7)</td>
<td>4 (44.4)</td>
</tr>
<tr>
<td>N</td>
<td>56</td>
<td>15</td>
<td>9</td>
</tr>
</tbody>
</table>

Chi square was calculated. There was no significant difference between samples.
APPENDIX 6

Childbirth related factors

6.1 Mothers' age at the time of the birth.

6.2 Number of previous pregnancies.

6.3 Number of reported elective abortions.

6.4 Estimated gestation period in weeks.

6.5 Mothers reporting postnatal blues or depression.
Table 6.1: Mothers' age at the time of the birth

<table>
<thead>
<tr>
<th>Age in Years</th>
<th>Separated Frequency (%)</th>
<th>Premature Frequency (%)</th>
<th>Working Class Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16-18</td>
<td>5 (8.3)</td>
<td></td>
<td>3 (21.4)</td>
</tr>
<tr>
<td>19-21</td>
<td>14 (23.3)</td>
<td></td>
<td>8 (57.1)</td>
</tr>
<tr>
<td>22-24</td>
<td>18 (30.0)</td>
<td>4 (26.7)</td>
<td>2 (14.3)</td>
</tr>
<tr>
<td>25-27</td>
<td>14 (23.3)</td>
<td>6 (40.0)</td>
<td>1 (7.1)</td>
</tr>
<tr>
<td>28-30</td>
<td>8 (13.3)</td>
<td>1 (6.7)</td>
<td></td>
</tr>
<tr>
<td>30+</td>
<td>1 (1.7)</td>
<td>4 (26.7)</td>
<td></td>
</tr>
</tbody>
</table>

N 60 15 14
Mean 23.45 27.00 19.93
S.D. 3.84 3.55 2.34

t-tests*

<table>
<thead>
<tr>
<th>Separated/</th>
<th>Separated/</th>
<th>Premature/</th>
<th>Working Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>t</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>df</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>p</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3.41 4.42 6.38
63 62 27
.01 .001 .001

* t-tests for independent means were calculated
### Appendix 6.2: Number of previous pregnancies

<table>
<thead>
<tr>
<th>Pregnancies</th>
<th>Separated Frequency (%)</th>
<th>Premature Frequency (%)</th>
<th>Working Class Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>55 (91.7)</td>
<td>6 (40.0)</td>
<td>14 (100)</td>
</tr>
<tr>
<td>1</td>
<td>3 (5.0)</td>
<td>3 (20.0)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2 (3.3)</td>
<td>4 (26.7)</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>1 (6.7)</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>1 (6.7)</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>60</td>
<td>15</td>
<td>14</td>
</tr>
<tr>
<td>Mean</td>
<td>.15</td>
<td>1.4</td>
<td></td>
</tr>
<tr>
<td>S.D.</td>
<td>.58</td>
<td>1.7</td>
<td></td>
</tr>
</tbody>
</table>

One Way Analysis of Variance between samples was calculated.

\[
F = 14.49 \\
\text{df} = 88 \\
p = .000
\]
Appendix 6.3: Number of reported elective abortions

<table>
<thead>
<tr>
<th>Abortions</th>
<th>Separated Frequency (%)</th>
<th>Premature Frequency (%)</th>
<th>Working Class Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>60 (100.0)</td>
<td>10 (66.7)</td>
<td>14 (100.0)</td>
</tr>
<tr>
<td>1</td>
<td></td>
<td>2 (13.3)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>3 (20.0)</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>60</td>
<td>15</td>
<td>14</td>
</tr>
</tbody>
</table>

Mean: .53
S.D.: .83

One Way Analysis of Variance between samples was calculated.

\[
\begin{align*}
F &= 15.67 \\
\text{df} &= 88 \\
\text{p} &= <.001
\end{align*}
\]
### Appendix 6.4: Estimated gestation period in weeks

<table>
<thead>
<tr>
<th>Weeks</th>
<th>Separated Frequency (%)</th>
<th>Premature Frequency (%)</th>
<th>Working Class Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-26</td>
<td>3 (20.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27-28</td>
<td>4 (26.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29-30</td>
<td>2 (13.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31-32</td>
<td>3 (20.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33-34</td>
<td>3 (20.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35-36</td>
<td>1 (1.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37-38</td>
<td>3 (5.0)</td>
<td>1 (7.1)</td>
<td></td>
</tr>
<tr>
<td>39-40</td>
<td>56 (93.3)</td>
<td>13 (92.9)</td>
<td></td>
</tr>
</tbody>
</table>

| N     | 60                      | 15                      | 14                          |

| Mean  | 39.78                   | 29.40                   | 39.86                       |
| S.D.  | .86                     | 2.99                    | .53                         |

One Way Analysis of Variance between samples was calculated.

\[ F = 334.17 \]
\[ df = 88 \]
\[ p < .000 \]
Appendix 6.5: Mothers reporting postnatal "Blues" or Depression
(Reported when the children were three months old)

<table>
<thead>
<tr>
<th>School</th>
<th>Separated Frequency (%)</th>
<th>Premature Frequency (%)</th>
<th>Working Class Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>14 (46.7)</td>
<td>3 (25.0)</td>
<td></td>
</tr>
<tr>
<td>Brief (not severe)</td>
<td>11 (36.7)</td>
<td>6 (50.0)</td>
<td>2 (66.7)</td>
</tr>
<tr>
<td>Some &quot;blues&quot; (no medication)</td>
<td>4 (13.3)</td>
<td>3 (25.0)</td>
<td></td>
</tr>
<tr>
<td>Nervous and Upset (medication or professional help)</td>
<td>1 (3.3)</td>
<td></td>
<td>1 (3.3)</td>
</tr>
</tbody>
</table>

N 30 12 3
APPENDIX 7

Childbirth education and childrearing variables

A. Education

7.1 Attendance at prenatal classes.

7.2 Sources of information on child care.

7.3 Number of sources of information mentioned.

B. Behaviour and beliefs

7.4 Plans to breast feed at birth.

7.5 Reported duration of breast feeding.

7.6 Environment provided for child.

7.7 Attention to crying infant.

7.8 Attitude to leaving infant.

7.9 Mothers stimulating behaviours with children at 3 months.

7.10 Mothers stimulating behaviours with children at eighteen months.
Appendix 7.1 : Attendance at prenatal classes

<table>
<thead>
<tr>
<th>7.1(a)</th>
<th>Separated Frequency (%)</th>
<th>Premature Frequency (%)</th>
<th>Working Class Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>21 (35.0)</td>
<td>4 (26.7)</td>
<td>12 (85.7)</td>
</tr>
<tr>
<td>Planned to but didn't</td>
<td>1 (1.7)</td>
<td>5 (33.3)</td>
<td>4 (26.7)</td>
</tr>
<tr>
<td>Incomplete classes</td>
<td></td>
<td>4 (26.7)</td>
<td>2 (13.3)</td>
</tr>
<tr>
<td>Yes</td>
<td>38 (63.3)</td>
<td>2 (13.3)</td>
<td>2 (14.3)</td>
</tr>
<tr>
<td>N</td>
<td>60</td>
<td>15</td>
<td>14</td>
</tr>
</tbody>
</table>
Appendix 7.1: Attendance at prenatal classes (cont.)

<table>
<thead>
<tr>
<th>7.1(b)</th>
<th>Separated Frequency (%)</th>
<th>Premature Frequency (%)</th>
<th>Working Class Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not attended (No + planned and didn't)</td>
<td>22 (36.7)</td>
<td>9 (60.0)</td>
<td>12 (85.7)</td>
</tr>
<tr>
<td>Attended (Yes + incomplete classes)</td>
<td>38 (63.3)</td>
<td>6 (40.0)</td>
<td>2 (14.3)</td>
</tr>
<tr>
<td>N</td>
<td>60</td>
<td>15</td>
<td>14</td>
</tr>
</tbody>
</table>

Chi square between sources was calculated.

\[
\text{Chi square} = 11.92
\]
\[
\text{df} = 2
\]
\[
\text{P} = .003
\]
Appendix 7.2: Sources of information on child care

The sources listed in this table are those considered to be the most important by the respondents.

<table>
<thead>
<tr>
<th>Source</th>
<th>Separated Frequency (%)</th>
<th>Premature Frequency (%)</th>
<th>Working Class Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Don't know yet</td>
<td>11 (18.3)</td>
<td>5 (33.4)</td>
<td></td>
</tr>
<tr>
<td>Maternal instinct</td>
<td>1 (1.7)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience with other infants</td>
<td>22 (36.7)</td>
<td>7 (46.7)</td>
<td>5 (35.7)</td>
</tr>
<tr>
<td>Woman's own mother</td>
<td>3 (5.0)</td>
<td></td>
<td>3 (21.4)</td>
</tr>
<tr>
<td>Information from friends</td>
<td>6 (10.0)</td>
<td>1 (6.7)</td>
<td>4 (28.6)</td>
</tr>
<tr>
<td>Reading</td>
<td>9 (15.0)</td>
<td>2 (13.3)</td>
<td>1 (7.1)</td>
</tr>
<tr>
<td>Professional sources - e.g.</td>
<td>8 (13.3)</td>
<td></td>
<td>1 (7.1)</td>
</tr>
<tr>
<td>doctors, nurses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>60</td>
<td>15</td>
<td>14</td>
</tr>
</tbody>
</table>
Appendix 7.3 : Number of sources of information mentioned

<table>
<thead>
<tr>
<th>Sources of Information</th>
<th>Separated Frequency (%)</th>
<th>Separated Mean</th>
<th>Separated S.D.</th>
<th>Premature Frequency (%)</th>
<th>Premature Mean</th>
<th>Premature S.D.</th>
<th>Working Class Frequency (%)</th>
<th>Working Class Mean</th>
<th>Working Class S.D.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>8 (13.3)</td>
<td>1.30</td>
<td>.72</td>
<td>3 (20.0)</td>
<td>1.13</td>
<td>.74</td>
<td>8 (57.1)</td>
<td>1.43</td>
<td>.51</td>
</tr>
<tr>
<td>1</td>
<td>27 (45.0)</td>
<td></td>
<td></td>
<td>7 (46.7)</td>
<td></td>
<td></td>
<td>8 (42.9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>24 (40.0)</td>
<td></td>
<td></td>
<td>5 (33.3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>1 (1.7)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>60</td>
<td>15</td>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Analysis of Variance was calculated. There were no significant differences between sources.
## Appendix 7.4: Plans to breast feed at Birth

<table>
<thead>
<tr>
<th></th>
<th>Separated Frequency (%)</th>
<th>Premature Frequency (%)</th>
<th>Working Class Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Yes</strong></td>
<td>49 (81.7)</td>
<td>15 (100.0)</td>
<td>9 (64.3)</td>
</tr>
<tr>
<td><strong>No</strong></td>
<td>10 (81.7)</td>
<td></td>
<td>4 (28.6)</td>
</tr>
<tr>
<td><strong>Don't know</strong></td>
<td>1 (1.7)</td>
<td></td>
<td>1 (7.1)</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td>60</td>
<td>15</td>
<td>14</td>
</tr>
</tbody>
</table>
### Appendix 7.5: Reported duration of breast feeding

<table>
<thead>
<tr>
<th>Months</th>
<th>Separated Frequency (%)</th>
<th>Premature Frequency (%)</th>
<th>Working Class Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>4 (16.0)</td>
<td>6 (75.0)</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>5 (20.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>3 (12.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>2 (8.0)</td>
<td></td>
<td>1 (100.0)</td>
</tr>
<tr>
<td>4</td>
<td>4 (16.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>5 (20.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td>1 (12.5)</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>1 (4.0)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 (ongoing)</td>
<td>1 (4.0)</td>
<td>1 (12.5)</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>25</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Mean</td>
<td>3.64</td>
<td>3.00</td>
<td></td>
</tr>
<tr>
<td>S.D.</td>
<td>3.86</td>
<td>5.47</td>
<td></td>
</tr>
</tbody>
</table>

A t-test for independent means was calculated comparing separated and premature mothers. There was no significant difference.
## Appendix 7.6: Environment provided for child

<table>
<thead>
<tr>
<th>Environment</th>
<th>Separated Frequency (%)</th>
<th>Premature Frequency (%)</th>
<th>Working Class Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>World revolves around child</td>
<td>2 (6.7)</td>
<td>3 (25.0)</td>
<td></td>
</tr>
<tr>
<td>(stimulating toys and house geared to child)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very good (toys and provisions made for child)</td>
<td>7 (23.3)</td>
<td>1 (8.3)</td>
<td></td>
</tr>
<tr>
<td>Good</td>
<td>11 (36.7)</td>
<td>2 (16.7)</td>
<td></td>
</tr>
<tr>
<td>Barely adequate</td>
<td>7 (23.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor (few toys and little provision for child)</td>
<td>3 (10.0)</td>
<td>5 (41.7)</td>
<td>1 (33.3)</td>
</tr>
<tr>
<td>Very Poor (no toys, no adaptation or limited non-stimulating environment)</td>
<td>1 (8.3)</td>
<td>2 (66.6)</td>
<td></td>
</tr>
</tbody>
</table>

N 30 12 3
Appendix 7.7: Attention to crying infant
(Responses to question "When baby cries, has been fed, nappy is dry, what do you do?")

<table>
<thead>
<tr>
<th>Response</th>
<th>Separated Frequency (%)</th>
<th>Premature Frequency (%)</th>
<th>Working Class Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always allows infant to cry</td>
<td>1 (3.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>it out</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tend to let it cry it out</td>
<td>3 (10.0)</td>
<td></td>
<td>1 (33.3)</td>
</tr>
<tr>
<td>Tend to pick up</td>
<td>14 (46.7)</td>
<td>7 (75.0)</td>
<td>2 (66.7)</td>
</tr>
<tr>
<td>Always pick up</td>
<td>12 (40.0)</td>
<td>3 (25.0)</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>30</td>
<td>12</td>
<td>3</td>
</tr>
</tbody>
</table>
Appendix 7.8 : Attitude to leaving infant
(Responses to questions: "Have you gone out since infant was born? How did you feel?"

<table>
<thead>
<tr>
<th></th>
<th>Separated Frequency (%)</th>
<th>Premature Frequency (%)</th>
<th>Working Class Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes and felt good</td>
<td>1 (8.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thought about infant while out</td>
<td>2 (6.7)</td>
<td>2 (16.7)</td>
<td>1 (33.3)</td>
</tr>
<tr>
<td>Worried about infant while out</td>
<td>5 (16.7)</td>
<td></td>
<td>1 (33.3)</td>
</tr>
<tr>
<td>Did not want to leave infant</td>
<td>7 (23.3)</td>
<td>1 (8.3)</td>
<td>1 (33.3)</td>
</tr>
<tr>
<td>Leaves only with mother and doesn't worry</td>
<td>6 (20.0)</td>
<td>3 (25.0)</td>
<td></td>
</tr>
<tr>
<td>Leaves only with mother and worries</td>
<td>5 (16.7)</td>
<td>2 (16.7)</td>
<td></td>
</tr>
<tr>
<td>Would not leave child at all</td>
<td>5 (16.7)</td>
<td>3 (25.0)</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>30</td>
<td>12</td>
<td>3</td>
</tr>
</tbody>
</table>
Appendix 7.9: Mothers' stimulating behaviours with children at three months

Table 7.9.1: Stimulating Child

<table>
<thead>
<tr>
<th></th>
<th>Separated Mean (S.D.)</th>
<th>Premature Mean (S.D.)</th>
<th>Working Class Mean (S.D.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kisses infant</td>
<td>1.50 (3.10)</td>
<td>1.67 (3.75)</td>
<td>1.00 (1.73)</td>
</tr>
<tr>
<td>Touches infant on bare skin (caresses)</td>
<td>4.37 (4.96)</td>
<td>3.50 (3.87)</td>
<td>3.37 (4.73)</td>
</tr>
<tr>
<td>Touches infant on clothes (caresses)</td>
<td>2.33 (2.84)</td>
<td>2.92 (3.70)</td>
<td>1.67 (.58)</td>
</tr>
<tr>
<td>Talks to infant</td>
<td>11.93 (5.61)</td>
<td>15.33 (5.05)</td>
<td>8.67 (1.53)</td>
</tr>
<tr>
<td>Smiles at infant</td>
<td>9.50 (6.08)</td>
<td>12.75 (5.74)</td>
<td>6.67 (3.51)</td>
</tr>
<tr>
<td>N</td>
<td>30</td>
<td>12</td>
<td>3</td>
</tr>
</tbody>
</table>

Appendix 7.9.2: Verbalising to child and others

Mean values for "talks to others" are given below. They provide an interesting comparison with "talks to infant".

<table>
<thead>
<tr>
<th></th>
<th>Separated Mean (S.D.)</th>
<th>Premature Mean (S.D.)</th>
<th>Working Class Mean (S.D.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Talks to others&quot;</td>
<td>5.57 (4.60)</td>
<td>3.83 (3.38)</td>
<td>6.67 (2.52)</td>
</tr>
</tbody>
</table>
Appendix 7.10 : Mothers stimulating behaviours with children at eighteen months

Appendix 7.10.1 : Stimulating Infant

<table>
<thead>
<tr>
<th></th>
<th>Separated Mean (S.D.)</th>
<th>Premature Mean (S.D.)</th>
<th>Working Class Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Touches infant on bare skin</td>
<td>.48 (.92)</td>
<td>1.00 (1.69)</td>
<td></td>
</tr>
<tr>
<td>(caresses)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Touches infant on clothes</td>
<td>.72 (1.27)</td>
<td>.62 (1.06)</td>
<td></td>
</tr>
<tr>
<td>(caresses)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Talks to infant infant - mother initiates</td>
<td>13.96 (5.16)</td>
<td>12.62 (4.4)</td>
<td>14</td>
</tr>
<tr>
<td>Plays with child</td>
<td>9.72 (7.04)</td>
<td>6.62 (4.78)</td>
<td>20</td>
</tr>
<tr>
<td>Smiles at child</td>
<td>8.84 (5.58)</td>
<td>12.62 (5.95)</td>
<td>12</td>
</tr>
<tr>
<td>N</td>
<td>25</td>
<td>8</td>
<td>1</td>
</tr>
</tbody>
</table>

Appendix 7.10.2 : Verbalising to child and others

Mean values for "talks to others" are given below to provide a comparison with "talks to infant".

<table>
<thead>
<tr>
<th></th>
<th>Separated Mean (S.D.)</th>
<th>Premature Mean (S.D.)</th>
<th>Working Class Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talks to others</td>
<td>2.60 (2.33)</td>
<td>1.87 (1.55)</td>
<td>0</td>
</tr>
</tbody>
</table>
APPENDIX 8

Variables relating to the Children

8.1 Sex of children.
8.2 Age crawling.
8.3 Age standing.
8.4 Age walking.
8.5 Children's vocabulary at eighteen months.
8.6 Child's observed verbal behaviour at eighteen months.
8.7 Children's preferred games as reported by mothers.
8.8 Mother's report on child's response to strangers.
8.9 Mother's estimate of adaption to school.
8.10 Mothers impression of child's temperament.

(NOTE: Gestation period is in Table 6.4)
Appendix 8.1: Sex of Children

<table>
<thead>
<tr>
<th></th>
<th>Separated Frequency</th>
<th>Premature Frequency</th>
<th>Working Class Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>27</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Female</td>
<td>31</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>Male twins</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Different sex twins</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Total male infants</td>
<td>30</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Total female infants</td>
<td>32</td>
<td>9</td>
<td>9</td>
</tr>
</tbody>
</table>

| N              | 62                  | 16                  | 14                     |
Appendix 8.2 : Age Crawling (based on Mother's report)

<table>
<thead>
<tr>
<th>Age in Months</th>
<th>Separated Frequency</th>
<th>Premature Frequency</th>
<th>Working Class Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-6</td>
<td>11</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>7-8</td>
<td>9</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>9-10</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>11-12</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>25</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Mean</td>
<td>7.04</td>
<td>7.22</td>
<td></td>
</tr>
<tr>
<td>S.D.</td>
<td>1.88</td>
<td>1.08</td>
<td></td>
</tr>
</tbody>
</table>

A t-test for independent means was calculated comparing those experiencing separations and mothers giving birth prematurely. There was no significant difference.
Appendix 8.3 : Age Standing (based on Mother's report)

<table>
<thead>
<tr>
<th>Age in Months</th>
<th>Separated Frequency</th>
<th>Premature Frequency</th>
<th>Working Class Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>7-8</td>
<td>8</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>9-10</td>
<td>13</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>11-12</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>13-14</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>25</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Mean</td>
<td>9.48</td>
<td>10.33</td>
<td></td>
</tr>
<tr>
<td>S.D.</td>
<td>2.06</td>
<td>1.83</td>
<td></td>
</tr>
</tbody>
</table>

A t-test for independent means was calculated comparing mothers experiencing separations and women giving birth prematurely. There was no significant difference.
Appendix 8.4 : Age walking (based on mother's report)

<table>
<thead>
<tr>
<th>Age in Months</th>
<th>Separated Frequency</th>
<th>Premature Frequency</th>
<th>Working Class Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>8-9</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-11</td>
<td>9</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>12-13</td>
<td>7</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>14-15</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>16-17</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>25</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Mean</td>
<td>11.52</td>
<td>12.78</td>
<td></td>
</tr>
<tr>
<td>S.D.</td>
<td>2.38</td>
<td>1.13</td>
<td></td>
</tr>
</tbody>
</table>

A t-test for independent means was calculated comparing mothers experiencing separations and women giving birth prematurely. There were no significant difference.
## Appendix 8.5: Children's vocabulary at eighteen months

<table>
<thead>
<tr>
<th>Number of Words</th>
<th>Separated Frequency</th>
<th>Premature Frequency</th>
<th>Working Class Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-5</td>
<td>3</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>6-10</td>
<td>6</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>11-15</td>
<td>6</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>16-20</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21-60</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>61+</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

\[ \begin{array}{lcccc}
\text{N} & 25 & 9 & 1 \\
\text{Mean} & 25.32 & 29.22 \\
\text{S.D.} & 26.03 & 37.38 \\
\end{array} \]

A t-test for independent means was calculated comparing women experiencing routine separations and mothers giving birth prematurely. There was no significant difference.

**NOTE:** This table is based on mother's report of words used rather than words recognised.
### Appendix 8.6: Child's observed verbal behaviour at eighteen months

<table>
<thead>
<tr>
<th></th>
<th>Separated Mean</th>
<th>Separated (S.D.)</th>
<th>Premature Mean</th>
<th>Premature (S.D.)</th>
<th>Working Class Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vocalises to self</td>
<td>4.48</td>
<td>(3.78)</td>
<td>7.22</td>
<td>(2.28)</td>
<td>12</td>
</tr>
<tr>
<td>Vocalises to mother - initiates</td>
<td>3.20</td>
<td>(2.71)</td>
<td>3.44</td>
<td>(2.30)</td>
<td>4</td>
</tr>
<tr>
<td>Vocalises to mother - responds</td>
<td>5.96</td>
<td>(3.87)</td>
<td>4.22</td>
<td>(2.59)</td>
<td>4</td>
</tr>
<tr>
<td>Vocalises to others</td>
<td>2.84</td>
<td>(3.13)</td>
<td>3.67</td>
<td>(2.69)</td>
<td>3</td>
</tr>
<tr>
<td>N</td>
<td>25</td>
<td></td>
<td>9</td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

**NOTE:** This table is based on the occurrence and not duration of verbal activities during each of the 30 second observation blocks in the ten minute period sampled.
Appendix 8.7: Children's Preferred Games as reported by mothers

<table>
<thead>
<tr>
<th></th>
<th>Separated Frequency</th>
<th>Premature Frequency</th>
<th>Working Class Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ball</td>
<td>6</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>&quot;Boy&quot; games</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Girl&quot; games</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical -</td>
<td>10</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>e.g. jumping</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musical - singing</td>
<td>4</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Sand games</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blocks</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>25</td>
<td>9</td>
<td>1</td>
</tr>
</tbody>
</table>
### Appendix 8.8: Mother's Report on Child's Response to Strangers

<table>
<thead>
<tr>
<th></th>
<th>Separated Frequency</th>
<th>Premature Frequency</th>
<th>Working Class Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very friendly - will talk to anyone</td>
<td>3</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Friendly with adults</td>
<td>8</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Shy or selectively shy with adults</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initially shy but &quot;warms up&quot;</td>
<td>12</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>N</td>
<td>25</td>
<td>9</td>
<td>1</td>
</tr>
</tbody>
</table>
## Appendix 8.9 : Mother's estimate of adaptation to School

<table>
<thead>
<tr>
<th></th>
<th>Separated</th>
<th></th>
<th>Premature</th>
<th></th>
<th>Working Class</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td></td>
<td>Frequency</td>
<td></td>
<td>Frequency</td>
<td></td>
</tr>
<tr>
<td>Child will like it</td>
<td>21</td>
<td></td>
<td>7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and cope well</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child won't like it</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother will have</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>trouble letting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>child go</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teachers will</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>have trouble</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>with child</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>N</strong></td>
<td><strong>25</strong></td>
<td><strong>9</strong></td>
<td><strong>1</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Appendix 8.10 : Mother's impression of Child's Temperament**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Separated Frequency</th>
<th>Premature Frequency</th>
<th>Working Class Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easygoing, friendly</td>
<td>11</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Talkative, cheeky, &quot;fresh&quot;</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loving, friendly, happy</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Determined, strong-willed</td>
<td>3</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Feminine, &quot;a real little girl&quot;</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quick tempered when frustrated</td>
<td>6</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Quiet and shy</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>N</strong></td>
<td><strong>25</strong></td>
<td><strong>9</strong></td>
<td><strong>1</strong></td>
</tr>
</tbody>
</table>
APPENDIX 9

Numbers of women interviewed on each occasion

9.1 Retention rates at each time.

9.2 Reasons for lack of follow up.
**Appendix 9.1 : Retention Rates at each time**

<table>
<thead>
<tr>
<th>Time</th>
<th>Separated Frequency (%)</th>
<th>Premature Frequency (%)</th>
<th>Working Class Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth</td>
<td>60 (100.0)</td>
<td>15 (100.0)</td>
<td>14 (100.0)</td>
</tr>
<tr>
<td>Three Months</td>
<td>30 (50.0)</td>
<td>12 (80.0)</td>
<td>3 (21.4)</td>
</tr>
<tr>
<td>Eighteen Months</td>
<td>25 (41.7)</td>
<td>8 (53.3)</td>
<td>1 (7.1)</td>
</tr>
</tbody>
</table>
### Appendix 9.2: Reasons for Lack of Follow-up

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Separated Frequency</th>
<th>Premature Frequency</th>
<th>Working Class Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>They declined</td>
<td>6</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Moved away</td>
<td>15</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>No answer to letters</td>
<td>1</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Interviewer late for key times</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family unavailable at key times</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Death of child</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Incorrect address given</td>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX 10

Content Analysis Data and Malaise Inventory Scores
when the children were new born

10.1.1 Anxiety
10.1.2 Anxiety in relation to mothers
10.1.3 Anxiety in relation to the infant
10.1.4 Anxiety in relation to the hospital, medical staff and procedures

10.2.1 Hostility and frustration
10.2.2 Hostility in relation to mothers
10.2.3 Hostility in relation to the infant
10.2.4 Hostility in relation to the hospital, medical staff and procedures

10.3 Pawn and Origin

10.4 Sociality

10.5 Positive Affect

10.6 Emotional Cost

10.7 Malaise Inventory

NOTE 1: t-tests for independent means were calculated. Tables of Bonferroni $t$ values were used to obtain levels of significance.

NOTE 2: t-tests comparing these results with the Wollongong Sample were not computed for those results which were based on affect relating to different causes (that is, for those affect scales that have been partialled out to show emotion in relation to specific areas, such as anxiety in relation to the mother, etc.).
Appendix 10.1.1: Anxiety at birth

1. Means and Standard Deviations

<table>
<thead>
<tr>
<th></th>
<th>Separated Mean (S.D.)</th>
<th>Premature Mean (S.D.)</th>
<th>Working Class Mean (S.D.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Anxiety</td>
<td>1.87 (.35)</td>
<td>2.16 (.39)</td>
<td>1.71 (.44)</td>
</tr>
<tr>
<td>Death</td>
<td>.38 (.14)</td>
<td>.50 (.31)</td>
<td>0</td>
</tr>
<tr>
<td>Mutilation</td>
<td>1.33 (.49)</td>
<td>1.28 (.37)</td>
<td>1.42 (.60)</td>
</tr>
<tr>
<td>Separation</td>
<td>.80 (.40)</td>
<td>.73 (.34)</td>
<td>.62 (.32)</td>
</tr>
<tr>
<td>Guilt</td>
<td>.41 (.18)</td>
<td>.29 (.22)</td>
<td>0</td>
</tr>
<tr>
<td>Shame</td>
<td>.68 (.40)</td>
<td>.85 (.45)</td>
<td>.56 (.26)</td>
</tr>
<tr>
<td>Diffuse</td>
<td>.70 (.38)</td>
<td>1.09 (.28)</td>
<td>.54 (.27)</td>
</tr>
<tr>
<td>Cognitive Anxiety</td>
<td>1.50 (.49)</td>
<td>1.76 (.34)</td>
<td>1.09 (.58)</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td>60</td>
<td>15</td>
<td>14</td>
</tr>
</tbody>
</table>

2. t-tests

Between Sources

<table>
<thead>
<tr>
<th></th>
<th>Separated/ Premature t</th>
<th>Separated/ Working Class t</th>
<th>Premature/ Working Class t</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Anxiety</td>
<td>2.66 (.01)</td>
<td></td>
<td>3.23 (.01)</td>
</tr>
<tr>
<td>Guilt</td>
<td>2.46 (.02)</td>
<td></td>
<td>4.21 (&lt;.01)</td>
</tr>
<tr>
<td>Diffuse</td>
<td>3.85 (&lt;.01)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cognitive Anxiety</td>
<td>2.87 (.01)</td>
<td></td>
<td>3.72 (&lt;.01)</td>
</tr>
<tr>
<td><strong>df</strong></td>
<td>73</td>
<td>72</td>
<td>27</td>
</tr>
</tbody>
</table>

Compared with Wollongong Sample (W'g)

<table>
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<th>Working Class/ W'g t</th>
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<td>6.49 (&lt;.01)</td>
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<td>5.29 (&lt;.01)</td>
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<td>4.00 (&lt;.01)</td>
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<td>112</td>
<td>67</td>
<td>66</td>
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Appendix 10.1.2: Anxiety at birth in relation to mothers

1. Means and Standard Deviations

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<td>.22 (.85)</td>
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<tr>
<td>Mutilation</td>
<td>.50 (.31)</td>
<td>.56 (.52)</td>
<td>.63 (.40)</td>
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<td>.41 (.31)</td>
<td>.50 (.26)</td>
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<tr>
<td>Guilt</td>
<td>.39 (.15)</td>
<td>.27 (.21)</td>
<td>0</td>
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<td>Shame</td>
<td>.52 (.33)</td>
<td>.49 (.33)</td>
<td>.43 (.12)</td>
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<tr>
<td>Diffuse</td>
<td>.51 (.29)</td>
<td>.65 (.27)</td>
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N: 60, 15, 14

2. t-tests

Between Sources

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## Appendix 10.1.3: Anxiety at birth in relation to the infant

### 1. Means and Standard Deviations

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<td>0</td>
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<td>Shame</td>
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<td>(.25)</td>
<td>.58</td>
<td>(.30)</td>
<td>.53</td>
<td>(.27)</td>
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<tr>
<td>Diffuse</td>
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<td>(.22)</td>
<td>.56</td>
<td>(.29)</td>
<td>.47</td>
<td>(.15)</td>
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| N                 | 60   | 15     | 14   |        |      |        |

### 2. t-tests

There were no significant differences between sources.
Appendix 10.1.4 : Anxiety at birth in relation to the hospital, staff and procedures

1. Means and Standard Deviations

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<th>Working Class Mean (S.D.)</th>
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</thead>
<tbody>
<tr>
<td>Total Anxiety</td>
<td>1.08 (.42)</td>
<td>1.00 (.41)</td>
<td>.83 (.60)</td>
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<tr>
<td>Death</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mutilation</td>
<td>.95 (.41)</td>
<td>.75 (.37)</td>
<td>.83 (.60)</td>
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<tr>
<td>Separation</td>
<td>.45 (.21)</td>
<td>.29 (.18)</td>
<td>0</td>
</tr>
<tr>
<td>Guilt</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Shame</td>
<td>.43 (.21)</td>
<td>.35 (.31)</td>
<td>0</td>
</tr>
<tr>
<td>Diffuse</td>
<td>.48 (.26)</td>
<td>.49 (.22)</td>
<td>0</td>
</tr>
<tr>
<td>N</td>
<td>60</td>
<td>15</td>
<td>14</td>
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2. t-tests

Between Sources

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<th>Separated/Premature</th>
<th>t</th>
<th>(p)</th>
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<tr>
<td>Separation</td>
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<td>(.01)</td>
</tr>
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</table>

df 73
Table 10.2.1: Hostility at Birth

1. Means and Standard Deviations

<table>
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<th>Premature Mean (S.D.)</th>
<th>Working Class Mean (S.D.)</th>
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</thead>
<tbody>
<tr>
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<td>.94 (.53)</td>
<td>.98 (.41)</td>
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<td>Hostility In</td>
<td>.63 (.29)</td>
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<td>.53 (.17)</td>
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<td>Ambivalent Hostility</td>
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<td>Frustration</td>
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There were no significant differences between sources or in comparison with the Wollongong Sample.
### Appendix 10.2.2: Hostility at Birth in relation to mothers

1. **Means and Standard Deviations**

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<td>.45 (.20)</td>
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<td>.46 (.18)</td>
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<tr>
<td>Hostility In</td>
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<tr>
<td>Ambivalent Hostility</td>
<td>.42 (.17)</td>
<td>.38 (.21)</td>
<td>.46 (.21)</td>
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| N       | 60  | 15  | 14   |

2. **t-tests**

There were no significant differences between sources.
Appendix 10.2.3 : Hostility at birth in relation to the infant

1. Means and Standard Deviations

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<tbody>
<tr>
<td>Hostility Out</td>
<td>.68 (.39)</td>
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<td>Hostility In</td>
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<td>Ambivalent Hostility</td>
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2. t-tests

Between Sources

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Appendix 10.2.4: Hostility at birth in relation to the hospital, staff and procedures

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2. t-tests

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Appendix 10.3 : Pawn and Origin at Birth

1. Means and Standard Deviations

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2. t-tests

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Compared with Wollongong Sample (W'g)

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<td>67</td>
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Appendix 10.4: Sociality at Birth

1. Means and Standard Deviations

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<th>Premature Mean (S.D.)</th>
<th>Working Class Mean (S.D.)</th>
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</thead>
<tbody>
<tr>
<td>Sociality Total</td>
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<td>.47 (.24)</td>
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<td>Helping</td>
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<td>.23 (.18)</td>
<td>.16 (.11)</td>
</tr>
<tr>
<td>Intimacy</td>
<td>.26 (.11)</td>
<td>.18 (.15)</td>
<td>.28 (.16)</td>
</tr>
<tr>
<td>Influencing</td>
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<td>.15 (.19)</td>
<td>.12 (.09)</td>
</tr>
<tr>
<td>Sharing</td>
<td>.21 (.12)</td>
<td>.20 (.19)</td>
<td>.19 (.11)</td>
</tr>
</tbody>
</table>

| N  | 60 | 15 | 14 |

2. t-tests

Between Sources

There were no significant differences between sources.

Compared with Wollongong Sample (W'g)

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<thead>
<tr>
<th></th>
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<th>Working Class/ W'g</th>
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</thead>
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<td>t (p)</td>
<td>t (p)</td>
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</tr>
<tr>
<td>Helping</td>
<td>5.29 (&lt;.01)</td>
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</tr>
<tr>
<td>Intimacy</td>
<td>8.82 (&lt;.01)</td>
<td>2.73 (.01)</td>
<td>4.13 (&lt;.01)</td>
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<td>Influencing</td>
<td>3.85 (&lt;.01)</td>
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| df | 112 | 67  | 66  |
Appendix 10.5: Positive Affect at birth

1. Means and Standard Deviations

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<th>Separated Mean (S.D.)</th>
<th>Premature Mean (S.D.)</th>
<th>Working Class Mean (S.D.)</th>
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<tbody>
<tr>
<td>Positive Affect</td>
<td>1.07 (.38)</td>
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<tr>
<td>Positive Affect (Infant)</td>
<td>.85 (.32)</td>
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<td>.88 (.40)</td>
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<tr>
<td>Positive Affect (Husband)</td>
<td>.46 (.22)</td>
<td>.32 (.15)</td>
<td>.44 (.13)</td>
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<tr>
<td>Positive Affect (Medical)</td>
<td>.42 (.18)</td>
<td>.29 (.15)</td>
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</table>

| N              | 60                    | 15                     | 14                       |

2. t-tests

Between Sources

<table>
<thead>
<tr>
<th></th>
<th>Separated/Premature t (p)</th>
<th>Premature/Working Class t (p)</th>
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<tbody>
<tr>
<td>Positive Affect</td>
<td>3.23 (.01)</td>
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<tr>
<td>Positive Affect (Infant)</td>
<td>3.90 (&lt;.01)</td>
<td>3.31 (.01)</td>
</tr>
<tr>
<td>Positive Affect (Husband)</td>
<td>2.58 (.02)</td>
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<td>Positive Affect (Medical)</td>
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| df            | 73                      | 27                           |

Compared with Wollongong Sample (W'g)

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<th>Separated/W'g t (p)</th>
<th>Working Class/W'g t (p)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive Affect</td>
<td>7.45 (&lt;.01)</td>
<td>3.22 (.01)</td>
</tr>
</tbody>
</table>

| df            | 112                  | 66                       |
Appendix 10.6: Emotional Cost at Birth

1. Means and Standard Deviations

<table>
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<th></th>
<th>Separated Mean (S.D.)</th>
<th>Premature Mean (S.D.)</th>
<th>Working Class Mean (S.D.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Cost</td>
<td>2.08 (1.40)</td>
<td>3.17 (1.28)</td>
<td>2.10 (1.62)</td>
</tr>
<tr>
<td>N</td>
<td>60</td>
<td>15</td>
<td>14</td>
</tr>
</tbody>
</table>

2. t-tests

Between Sources

<table>
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<th>2.74 (.01)</th>
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<td>df</td>
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<td>73</td>
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</tbody>
</table>

There were no significant differences in comparison with the Wollongong Sample.
Figure 10.7: Malaise Inventory Scores at Birth

<table>
<thead>
<tr>
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<th>Premature</th>
<th>Working Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>3.18</td>
<td>5.00</td>
<td>5.50</td>
</tr>
<tr>
<td>S.D.</td>
<td>2.53</td>
<td>3.50</td>
<td>3.72</td>
</tr>
<tr>
<td>N</td>
<td>60</td>
<td>15</td>
<td>14</td>
</tr>
</tbody>
</table>

\[ t = 2.45 \]
\[ df = 72 \]
\[ p = .02 \]
APPENDIX 11

Content Analysis Data and Malaise Inventory scores when the children were three months old

11.1.1 Anxiety
11.1.2 Anxiety in relation to mothers
11.1.3 Anxiety in relation to the infant
11.1.4 Anxiety in relation to the hospital, medical staff and procedures

11.2.1 Hostility and frustration
11.2.2 Hostility in relation to mothers
11.2.3 Hostility in relation to the infant
11.2.4 Hostility in relation to the hospital, medical staff and procedures

11.3 Pawn and Origin

11.4 Sociality

11.5 Positive Affect

11.6 Emotional Cost

11.7 Malaise Inventory

NOTE 1: t-tests for independent means were calculated. Tables of Bonferroni _t_ values were used to obtain levels of significance.

NOTE 2: t-tests comparing these results with the Wollongong Sample were not computed for those results which are based on affect relating to different causes (that is, for those affect scales that have been partialed out to show emotion in relation to specific areas, such as anxiety in relation to the mother, etc.).

NOTE 3: Tests of significance were not calculated for working class mothers.
Appendix 11.1.1: Anxiety at three months

1. Means and Standard Deviations

<table>
<thead>
<tr>
<th></th>
<th>Separated Mean (S.D.)</th>
<th>Premature Mean (S.D.)</th>
<th>Working Class Mean (S.D.)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Anxiety</strong></td>
<td>1.88 (.127)</td>
<td>2.15 (.46)</td>
<td>2.42 (.60)</td>
</tr>
<tr>
<td><strong>Death</strong></td>
<td>.41 (.13)</td>
<td>.57 (.31)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Mutilation</strong></td>
<td>1.01 (.86)</td>
<td>1.00 (.51)</td>
<td>1.33 (.44)</td>
</tr>
<tr>
<td><strong>Separation</strong></td>
<td>.85 (.66)</td>
<td>.81 (.47)</td>
<td>.83 (.58)</td>
</tr>
<tr>
<td><strong>Guilt</strong></td>
<td>.53 (.51)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Shame</strong></td>
<td>.88 (.65)</td>
<td>.95 (.56)</td>
<td>1.35 (.71)</td>
</tr>
<tr>
<td><strong>Diffuse</strong></td>
<td>.97 (.50)</td>
<td>1.21 (.46)</td>
<td>1.32 (.39)</td>
</tr>
<tr>
<td><strong>Cognitive Anxiety</strong></td>
<td>2.04 (1.05)</td>
<td>1.70 (.70)</td>
<td>2.64 (.98)</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td>30</td>
<td>12</td>
<td>3</td>
</tr>
</tbody>
</table>

2. t-tests

There were no significant differences between sources.

Compared with Wollongong Sample (W'g)

<table>
<thead>
<tr>
<th></th>
<th>Separated/W'g t (p)</th>
<th>Premature/W'g t (p)</th>
<th>Working Class/W'g t (p)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Anxiety</strong></td>
<td>3.16 (.01)</td>
<td>9.66 (&lt;.01)</td>
<td>3.13 (.01)</td>
</tr>
<tr>
<td><strong>Mutilation</strong></td>
<td>3.13 (.01)</td>
<td>3.04 (.01)</td>
<td>3.13 (.01)</td>
</tr>
<tr>
<td><strong>Diffuse</strong></td>
<td>2.66 (.01)</td>
<td>3.42 (.01)</td>
<td>2.66 (.02)</td>
</tr>
<tr>
<td><strong>Cognitive Anxiety</strong></td>
<td>2.97 (.01)</td>
<td>3.44 (.01)</td>
<td></td>
</tr>
</tbody>
</table>

df 82 64 55
Appendix 11.1.2 : Anxiety at three months in relation to mothers

1. Means and Standard Deviations

<table>
<thead>
<tr>
<th></th>
<th>Separated Mean (S.D.)</th>
<th>Premature Mean (S.D.)</th>
<th>Working Class Mean (S.D.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Anxiety</td>
<td>1.19 (.54)</td>
<td>1.47 (.28)</td>
<td>1.64 (.37)</td>
</tr>
<tr>
<td>Death</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mutilation</td>
<td>.58 (.33)</td>
<td>.72 (.47)</td>
<td>.70 (.36)</td>
</tr>
<tr>
<td>Separation</td>
<td>.50 (.24)</td>
<td>.55 (.31)</td>
<td>0</td>
</tr>
<tr>
<td>Guilt</td>
<td>.45 (.20)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Shame</td>
<td>.72 (.39)</td>
<td>.72 (.50)</td>
<td>1.12 (.43)</td>
</tr>
<tr>
<td>Diffuse</td>
<td>.71 (.42)</td>
<td>.79 (.45)</td>
<td>1.00 (.67)</td>
</tr>
<tr>
<td>N</td>
<td>30</td>
<td>12</td>
<td>3</td>
</tr>
</tbody>
</table>

2. t-tests

There were no significant differences between sources.
Appendix 11.1.3: Anxiety at three months in relation to the infant

1. Means and Standard Deviations

<table>
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<tr>
<th></th>
<th>Separated Mean (S.D.)</th>
<th>Premature Mean (S.D.)</th>
<th>Working Class Mean (S.D.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Anxiety</td>
<td>0.85 (.49)</td>
<td>1.02 (.59)</td>
<td>1.33 (.61)</td>
</tr>
<tr>
<td>Death</td>
<td>0.39 (.12)</td>
<td>0.54 (.33)</td>
<td>0</td>
</tr>
<tr>
<td>Mutilation</td>
<td>0.57 (.33)</td>
<td>0.63 (.34)</td>
<td>0.80 (.14)</td>
</tr>
<tr>
<td>Separation</td>
<td>0.50 (.34)</td>
<td>0.67 (.45)</td>
<td>0.70 (.36)</td>
</tr>
<tr>
<td>Guilt</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Shame</td>
<td>0.50 (.28)</td>
<td>0.59 (.41)</td>
<td>0.75 (.44)</td>
</tr>
<tr>
<td>Diffuse</td>
<td>0.49 (.25)</td>
<td>0.45 (.25)</td>
<td>0.80 (.49)</td>
</tr>
</tbody>
</table>

N 30 12 3

2. t-tests

There were no significant differences between sources.
Appendix 11.1.4 : Anxiety at three months in relation to the hospital, staff and procedures

1. Means and Standard Deviations

<table>
<thead>
<tr>
<th></th>
<th>Separated Mean (S.D.)</th>
<th>Premature Mean (S.D.)</th>
<th>Working Class Mean (S.D.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Anxiety</td>
<td>.83 (.39)</td>
<td>.86 (.53)</td>
<td>1.04 (.65)</td>
</tr>
<tr>
<td>Death</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mutilation</td>
<td>.61 (.33)</td>
<td>.46 (.27)</td>
<td>.83 (.76)</td>
</tr>
<tr>
<td>Separation</td>
<td>.47 (.22)</td>
<td>.42 (.17)</td>
<td>0</td>
</tr>
<tr>
<td>Guilt</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Shame</td>
<td>.42 (.18)</td>
<td>.38 (.14)</td>
<td>.68 (.29)</td>
</tr>
<tr>
<td>Diffuse</td>
<td>.53 (.29)</td>
<td>.70 (.56)</td>
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</table>

N  30  12  3

2. t-tests

There were no significant differences between sources.
Table 11.2.1 : Hostility and Frustration at three months

1. Means and Standard Deviations

<table>
<thead>
<tr>
<th></th>
<th>Separated Mean</th>
<th>(S.D.)</th>
<th>Premature Mean</th>
<th>(S.D.)</th>
<th>Working Class Mean</th>
<th>(S.D.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hostility Out</td>
<td>.80</td>
<td>(.35)</td>
<td>.75</td>
<td>(.38)</td>
<td>.96</td>
<td>(.30)</td>
</tr>
<tr>
<td>Hostility In</td>
<td>.79</td>
<td>(.53)</td>
<td>.81</td>
<td>(.35)</td>
<td>1.07</td>
<td>(.33)</td>
</tr>
<tr>
<td>Ambivalent Hostility</td>
<td>.60</td>
<td>(.27)</td>
<td>.66</td>
<td>(.23)</td>
<td>.78</td>
<td>(.18)</td>
</tr>
<tr>
<td>Frustration</td>
<td>1.59</td>
<td>(.67)</td>
<td>1.57</td>
<td>(.53)</td>
<td>2.02</td>
<td>(.17)</td>
</tr>
<tr>
<td>N</td>
<td>30</td>
<td>12</td>
<td>3</td>
<td></td>
<td></td>
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</tbody>
</table>

2. t-tests

There were no significant differences between sources or in comparison with the Wollongong Sample.
Appendix 11.2.2 : Hostility at three months in relation to mothers

1. Means and Standard Deviations

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<tr>
<th></th>
<th>Separated Mean (S.D.)</th>
<th>Premature Mean (S.D.)</th>
<th>Working Class Mean (S.D.)</th>
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<tbody>
<tr>
<td>Hostility Out</td>
<td>.53 (.26)</td>
<td>.44 (.16)</td>
<td>.75 (.44)</td>
</tr>
<tr>
<td>Hostility In</td>
<td>.66 (.45)</td>
<td>.69 (.31)</td>
<td>.90 (.52)</td>
</tr>
<tr>
<td>Ambivalent</td>
<td>.44 (.16)</td>
<td>.50 (.14)</td>
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N 30 12 3

2. t-tests

There were no significant differences between sources.
Appendix 11.2.3: Hostility at three months in relation to the infant

1. Means and Standard Deviations

<table>
<thead>
<tr>
<th></th>
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<th>Working Class</th>
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<tr>
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<td>Mean (S.D.)</td>
<td></td>
<td>Mean (S.D.)</td>
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</tr>
<tr>
<td>Hostility Out</td>
<td>.52 (.25)</td>
<td></td>
<td>.52 (.23)</td>
<td></td>
<td>.68 (.29)</td>
<td></td>
</tr>
<tr>
<td>Hostility In</td>
<td>.46 (.19)</td>
<td></td>
<td>.49 (.25)</td>
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<td>0</td>
<td></td>
</tr>
<tr>
<td>Ambivalent</td>
<td>.49 (.25)</td>
<td></td>
<td>.43 (.17)</td>
<td></td>
<td>.68 (.29)</td>
<td></td>
</tr>
<tr>
<td>Hostility</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>30</td>
<td></td>
<td>12</td>
<td></td>
<td>3</td>
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</tr>
</tbody>
</table>

2. t-tests

There were no significant differences between sources.
Appendix 11.2.4: Hostility at three months in relation to the hospital, staff and procedures

1. Means and Standard Deviations

<table>
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<tr>
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<th>Working Class</th>
<th></th>
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</thead>
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<tr>
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<td>Mean</td>
<td>(S.D.)</td>
<td>Mean</td>
<td>(S.D.)</td>
</tr>
<tr>
<td>Hostility Out</td>
<td>.55 (.29)</td>
<td></td>
<td>.52 (.36)</td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Hostility In</td>
<td>.45 (.21)</td>
<td></td>
<td>.39 (.17)</td>
<td></td>
<td>.75 (.44)</td>
<td></td>
</tr>
<tr>
<td>Ambivalent Hostility</td>
<td>.46 (.15)</td>
<td></td>
<td>.46 (.16)</td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>30</td>
<td></td>
<td>12</td>
<td></td>
<td>3</td>
<td></td>
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</tbody>
</table>

2. t-tests

There were no significant differences between sources.
Appendix 11.3: Pawn and Origin at three months

1. Means and Standard Deviations

<table>
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<tr>
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<th>Working Class</th>
<th></th>
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</thead>
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<tr>
<td></td>
<td>Mean (S.D.)</td>
<td>Mean (S.D.)</td>
<td>Mean (S.D.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pawn</td>
<td>1.22 (.50)</td>
<td>1.16 (.37)</td>
<td>1.68 (.40)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Origin</td>
<td>.70 (.35)</td>
<td>.59 (.18)</td>
<td>.63 (.21)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>30</td>
<td>12</td>
<td>3</td>
<td></td>
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</table>

2. t-tests

Between Sources

There were no significant differences between sources.

Compared with Wollongong Sample (W'g)

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<th>Working Class/W'g</th>
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</thead>
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<td>t  (p)</td>
<td>t  (p)</td>
<td></td>
<td>t  (p)</td>
<td></td>
</tr>
<tr>
<td>Pawn</td>
<td>2.83 (.01)</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Origin</td>
<td>4.31 (&lt;.01)</td>
<td>4.67 (&lt;.01)</td>
<td>2.39 (.02)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>df</td>
<td>82</td>
<td>64</td>
<td>55</td>
<td></td>
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</tbody>
</table>
Appendix 11.4: Sociality at three months

1. Means and Standard Deviations

<table>
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<th>Working Class</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (S.D.)</td>
<td>Mean (S.D.)</td>
<td>Mean (S.D.)</td>
<td></td>
<td>Mean (S.D.)</td>
<td></td>
</tr>
<tr>
<td>Sociality Total</td>
<td>.48 (.13)</td>
<td>.39 (.14)</td>
<td>.35 (.24)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Helping</td>
<td>.16 (.09)</td>
<td>.11 (.07)</td>
<td>.15 (.08)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intimacy</td>
<td>.29 (.15)</td>
<td>.22 (.14)</td>
<td>.24 (.22)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influencing</td>
<td>.10 (.07)</td>
<td>.10 (.06)</td>
<td>.09 (.05)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sharing</td>
<td>.24 (.12)</td>
<td>.20 (.13)</td>
<td>.30 (.21)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>N</td>
<td>30</td>
<td>12</td>
<td>3</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

2. t-tests

Between Sources

There were no significant differences between sources.

Compared with Wollongong Sample (W'g)

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<th>Separated/W'g</th>
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<th>Premature/W'g</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>t (p)</td>
<td></td>
<td>t (p)</td>
<td></td>
</tr>
<tr>
<td>Intimacy</td>
<td>7.14 (&lt;.01)</td>
<td></td>
<td>2.83 (.01)</td>
<td></td>
</tr>
<tr>
<td>df</td>
<td>82</td>
<td></td>
<td>64</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 11.5: Positive Affect at three months

1. Means and Standard Deviations

<table>
<thead>
<tr>
<th></th>
<th>Separated Mean (S.D.)</th>
<th>Premature Mean (S.D.)</th>
<th>Working Class Mean (S.D.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive Affect</td>
<td>1.28 (.58)</td>
<td>1.14 (.39)</td>
<td>.93 (.44)</td>
</tr>
<tr>
<td>Positive Affect (Infant)</td>
<td>.98 (.54)</td>
<td>.75 (.32)</td>
<td>.93 (.44)</td>
</tr>
<tr>
<td>Positive Affect (Husband)</td>
<td>.56 (.47)</td>
<td>.39 (.12)</td>
<td>0</td>
</tr>
<tr>
<td>Positive Affect (Medical)</td>
<td>.43 (.16)</td>
<td>.44 (.23)</td>
<td>0</td>
</tr>
</tbody>
</table>

N 30 12 3

2. t-tests

Between Sources

There were no significant differences between sources.

Compared with Wollongong Sample (W'g)

<table>
<thead>
<tr>
<th></th>
<th>Separated/W'g t (p)</th>
<th>Premature/W'g t (p)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive Affect</td>
<td>5.69 (&lt;.01)</td>
<td>4.07 (&lt;.01)</td>
</tr>
</tbody>
</table>

df 82 64
Appendix 11.6: Emotional Cost at three months

1. Means and Standard Deviations

<table>
<thead>
<tr>
<th></th>
<th>Separated Mean (S.D.)</th>
<th>Premature Mean (S.D.)</th>
<th>Working Class Mean (S.D.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional Cost</td>
<td>1.84 (1.60)</td>
<td>2.27 (1.28)</td>
<td>2.98 (1.44)</td>
</tr>
<tr>
<td>N</td>
<td>30</td>
<td>12</td>
<td>3</td>
</tr>
</tbody>
</table>

2. t-tests

There were no significant differences between sources or in comparison with the Wollongong Sample.
Appendix 11.7: Malaise Inventory Scores at three months

<table>
<thead>
<tr>
<th></th>
<th>Separated</th>
<th>Premature</th>
<th>Working Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>2.57</td>
<td>3.25</td>
<td>8.00</td>
</tr>
<tr>
<td>S.D.</td>
<td>2.27</td>
<td>2.53</td>
<td>3.46</td>
</tr>
<tr>
<td>N</td>
<td>30</td>
<td>12</td>
<td>3</td>
</tr>
</tbody>
</table>

There were no significant differences between sources.
APPENDIX 12

Content Analysis Data and Malaise Inventory scores when the children were eighteen months old

12.1.1 Anxiety
12.1.2 Anxiety in relation to mothers
12.1.3 Anxiety in relation to the infant
12.1.4 Anxiety in relation to the hospital, medical staff and procedures

12.2.1 Hostility and frustration
12.2.2 Hostility in relation to mothers
12.2.3 Hostility in relation to the infant
12.2.4 Hostility in relation to the hospital, medical staff and procedures

12.3 Pawn and Origin

12.4 Sociality

12.5 Positive Affect

12.6 Emotional Cost

12.7 Malaise Inventory

NOTE 1: t-tests for independent means were calculated. Tables of Bonferroni t values were used to obtain levels of significance.

NOTE 2: t-tests comparing these results with the Wollongong Sample were not computed for those results which are based on affect relating to different causes (that is, for those affect scales that have been partialled out to show emotion in relation to specific areas, such as anxiety in relation to the mother, etc.).

NOTE 3: Tests of significance were not calculated for working class mothers.
### Appendix 12.1.1 : Anxiety at eighteen months

#### 1. Means and Standard Deviations

<table>
<thead>
<tr>
<th></th>
<th>Separated</th>
<th></th>
<th>Premature</th>
<th></th>
<th>Working Class</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>(S.D.)</td>
<td>Mean</td>
<td>(S.D.)</td>
<td>Score</td>
</tr>
<tr>
<td>Total Anxiety</td>
<td>1.47</td>
<td>(.67)</td>
<td>1.47</td>
<td>(.66)</td>
<td>2.53</td>
</tr>
<tr>
<td>Death</td>
<td>.39</td>
<td>(.21)</td>
<td>0</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Mutilation</td>
<td>.59</td>
<td>(.40)</td>
<td>.54</td>
<td>(.33)</td>
<td>1.25</td>
</tr>
<tr>
<td>Separation</td>
<td>.66</td>
<td>(.34)</td>
<td>.85</td>
<td>(.61)</td>
<td>2.02</td>
</tr>
<tr>
<td>Guilt</td>
<td>.43</td>
<td>(.21)</td>
<td>.48</td>
<td>(.29)</td>
<td>0</td>
</tr>
<tr>
<td>Shame</td>
<td>.83</td>
<td>(.42)</td>
<td>.73</td>
<td>(.39)</td>
<td>0</td>
</tr>
<tr>
<td>Diffuse</td>
<td>.84</td>
<td>(.57)</td>
<td>.67</td>
<td>(.47)</td>
<td>.97</td>
</tr>
<tr>
<td>Cognitive Anxiety</td>
<td>1.20</td>
<td>(.65)</td>
<td>1.32</td>
<td>(.80)</td>
<td>2.49</td>
</tr>
</tbody>
</table>

**N**

<table>
<thead>
<tr>
<th></th>
<th>Separated/W’g</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>t</td>
<td>(p)</td>
</tr>
<tr>
<td>Separation</td>
<td>2.54</td>
<td>.02</td>
</tr>
<tr>
<td>df</td>
<td>77</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 12.1.2: Anxiety at eighteen months in relation to mothers

1. Means and Standard Deviations

<table>
<thead>
<tr>
<th></th>
<th>Separated Mean (S.D.)</th>
<th>Premature Mean (S.D.)</th>
<th>Working Class Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Anxiety</td>
<td>1.07 (.41)</td>
<td>1.08 (.32)</td>
<td>.56</td>
</tr>
<tr>
<td>Death</td>
<td>.40 (.20)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mutilation</td>
<td>.50 (.30)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Separation</td>
<td>.49 (.26)</td>
<td>.73 (.31)</td>
<td>0</td>
</tr>
<tr>
<td>Guilt</td>
<td>.44 (.20)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Shame</td>
<td>.69 (.31)</td>
<td>.55 (.29)</td>
<td>0</td>
</tr>
<tr>
<td>Diffuse</td>
<td>.57 (.34)</td>
<td>.68 (.37)</td>
<td>.56</td>
</tr>
</tbody>
</table>

N  25  8  1

2. t-tests

There were no significant differences between sources.
Appendix 12.1.3: Anxiety at eighteen months in relation to the infant

1. Means and Standard Deviations

<table>
<thead>
<tr>
<th></th>
<th>Separated Mean</th>
<th>Separated (S.D.)</th>
<th>Premature Mean</th>
<th>Premature (S.D.)</th>
<th>Working Class Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Anxiety</td>
<td>.99</td>
<td>(.51)</td>
<td>1.14</td>
<td>(.46)</td>
<td>2.31</td>
</tr>
<tr>
<td>Death</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Mutilation</td>
<td>.48</td>
<td>(.31)</td>
<td>.62</td>
<td>(.24)</td>
<td>1.25</td>
</tr>
<tr>
<td>Separation</td>
<td>.56</td>
<td>(.27)</td>
<td>.62</td>
<td>(.40)</td>
<td>1.80</td>
</tr>
<tr>
<td>Guilt</td>
<td>.39</td>
<td>(.13)</td>
<td>.52</td>
<td>(.22)</td>
<td>0</td>
</tr>
<tr>
<td>Shame</td>
<td>.55</td>
<td>(.29)</td>
<td>.56</td>
<td>(.30)</td>
<td>0</td>
</tr>
<tr>
<td>Diffuse</td>
<td>.66</td>
<td>(.40)</td>
<td>.61</td>
<td>(.32)</td>
<td>.86</td>
</tr>
</tbody>
</table>

N 25 8 1

2. t-tests

There were no significant differences between sources.
Appendix 12.1.4 : Anxiety at eighteen months in relation to the hospital, staff and procedures

Only two women expressed this type of anxiety at this time. Both were pregnant and discussing the inevitable labour and delivery. Four other women had already given birth to a second child. They did not express anxiety in this area.
Appendix 12.2.1 : Hostility and Frustration at eighteen months

1. Means and Standard Deviations

<table>
<thead>
<tr>
<th></th>
<th>Separated Mean</th>
<th>(S.D.)</th>
<th>Premature Mean</th>
<th>(S.D.)</th>
<th>Working Class Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hostility Out</td>
<td>1.01 (.61)</td>
<td></td>
<td>1.11 (.53)</td>
<td></td>
<td>.97</td>
</tr>
<tr>
<td>Hostility In</td>
<td>.71 (.25)</td>
<td></td>
<td>.83 (.42)</td>
<td></td>
<td>1.25</td>
</tr>
<tr>
<td>Ambivalent Hostility</td>
<td>.67 (.30)</td>
<td></td>
<td>.72 (.39)</td>
<td></td>
<td>.86</td>
</tr>
<tr>
<td>Frustration</td>
<td>1.72 (.63)</td>
<td></td>
<td>1.94 (.50)</td>
<td></td>
<td>2.23</td>
</tr>
</tbody>
</table>

N 25 8 1

2. t-tests

There were no significant differences between sources or in comparison with the Wollongong Sample.
Appendix 12.2.2: Hostility at eighteen months in relation to mothers

1. Means and Standard Deviations

<table>
<thead>
<tr>
<th></th>
<th>Separated Mean (S.D.)</th>
<th>Premature Mean (S.D.)</th>
<th>Working Class Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hostility Out</td>
<td>.57 (.27)</td>
<td>.42 (.08)</td>
<td>0</td>
</tr>
<tr>
<td>Hostility In</td>
<td>.61 (.23)</td>
<td>.70 (.30)</td>
<td>.72</td>
</tr>
<tr>
<td>Ambivalent Hostility</td>
<td>.45 (.17)</td>
<td>.49 (.18)</td>
<td>0</td>
</tr>
<tr>
<td>N</td>
<td>25</td>
<td>8</td>
<td>1</td>
</tr>
</tbody>
</table>

2. t-tests

There were no significant differences between sources.
Appendix 12.2.3: Hostility at eighteen months in relation to the infant

1. Means and Standard Deviations

<table>
<thead>
<tr>
<th></th>
<th>Separated Mean (S.D.)</th>
<th>Premature Mean (S.D.)</th>
<th>Working Class Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hostility Out</td>
<td>.84 (.56)</td>
<td>.95 (.42)</td>
<td>.86</td>
</tr>
<tr>
<td>Hostility In</td>
<td>.42 (.22)</td>
<td>.63 (.28)</td>
<td>.97</td>
</tr>
<tr>
<td>Ambivalent</td>
<td>.57 (.31)</td>
<td>.56 (.27)</td>
<td>.86</td>
</tr>
</tbody>
</table>

N 25 8 1

2. t-tests

There were no significant differences between sources.
Appendix 12.2.4 : Hostility at eighteen months in relation to the hospital, staff and procedures

1. Means and Standard Deviations

<table>
<thead>
<tr>
<th></th>
<th>Separated Mean (S.D.)</th>
<th>Premature Mean (S.D.)</th>
<th>Working Class Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hostility Out</td>
<td>.39 (.13)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Hostility In</td>
<td>.39 (.15)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Ambivalent Hostility</td>
<td>.39 (.12)</td>
<td>.43 (.14)</td>
<td>0</td>
</tr>
<tr>
<td>N</td>
<td>25</td>
<td>8</td>
<td>1</td>
</tr>
</tbody>
</table>

2. t-tests

There were no significant differences between sources.
### Appendix 12.3: Pawn and Origin at eighteen months

1. **Means and Standard Deviations**

<table>
<thead>
<tr>
<th></th>
<th>Separated Mean (S.D.)</th>
<th>Premature Mean (S.D.)</th>
<th>Working Class Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pawn</td>
<td>1.13 (.49)</td>
<td>1.16 (.71)</td>
<td>1.62</td>
</tr>
<tr>
<td>Origin</td>
<td>.91 (.42)</td>
<td>.84 (.48)</td>
<td>1.07</td>
</tr>
<tr>
<td>N</td>
<td>25</td>
<td>8</td>
<td>1</td>
</tr>
</tbody>
</table>

2. *t*-tests

There were no significant differences between sources.
Appendix 12.4 : Sociality at eighteen months

1. Means and Standard Deviations

<table>
<thead>
<tr>
<th></th>
<th>Separated Mean (S.D.)</th>
<th>Premature Mean (S.D.)</th>
<th>Working Class Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sociality Total</td>
<td>.54 (.10)</td>
<td>.49 (.15)</td>
<td>.44</td>
</tr>
<tr>
<td>Helping</td>
<td>.17 (.14)</td>
<td>.23 (.12)</td>
<td>.29</td>
</tr>
<tr>
<td>Intimacy</td>
<td>.21 (.12)</td>
<td>.23 (.15)</td>
<td>.24</td>
</tr>
<tr>
<td>Influencing</td>
<td>.13 (.10)</td>
<td>.12 (.07)</td>
<td>.04</td>
</tr>
<tr>
<td>Sharing</td>
<td>.36 (.12)</td>
<td>.24 (.14)</td>
<td>.12</td>
</tr>
<tr>
<td>N</td>
<td>25</td>
<td>8</td>
<td>1</td>
</tr>
</tbody>
</table>

2. t-tests

Between Sources

There were no significant differences between sources.

Compared with Wollongong Sample (W'g)

<table>
<thead>
<tr>
<th></th>
<th>Separated/W'g</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>t</td>
<td>p</td>
<td></td>
</tr>
<tr>
<td>Sociality</td>
<td>3.71</td>
<td>&lt;.01</td>
<td></td>
</tr>
<tr>
<td>Intimacy</td>
<td>4.61</td>
<td>&lt;.01</td>
<td></td>
</tr>
<tr>
<td>Influencing</td>
<td>2.86</td>
<td>.01</td>
<td></td>
</tr>
<tr>
<td>Sharing</td>
<td>5.38</td>
<td>&lt;.01</td>
<td></td>
</tr>
<tr>
<td>df</td>
<td>77</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 12.5 : Positive Affect at eighteen months

1. Means and Standard Deviations

<table>
<thead>
<tr>
<th></th>
<th>Separated Mean</th>
<th>(S.D.)</th>
<th>Premature Mean</th>
<th>(S.D.)</th>
<th>Working Class Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive Affect</td>
<td>.91 (.41)</td>
<td></td>
<td>.90 (.62)</td>
<td></td>
<td>.72</td>
</tr>
<tr>
<td>Positive Affect (Infant)</td>
<td>.68 (.35)</td>
<td></td>
<td>.78 (.58)</td>
<td></td>
<td>.72</td>
</tr>
<tr>
<td>Positive Affect (Husband)</td>
<td>.43 (.22)</td>
<td></td>
<td>.39 (.18)</td>
<td></td>
<td>.72</td>
</tr>
<tr>
<td>Positive Affect (Medical)</td>
<td>0</td>
<td></td>
<td>.40 (.22)</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>N</td>
<td>25</td>
<td></td>
<td>8</td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

2. t-tests

Between Sources

There were no significant differences between sources.

Compared with Wollongong Sample (W'g)

<table>
<thead>
<tr>
<th>Separated/W'g</th>
<th>t</th>
<th>(p)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive Affect</td>
<td>2.81</td>
<td>(.01)</td>
</tr>
</tbody>
</table>

df 77
Appendix 12.6: Emotional Cost at eighteen months

1. Means and Standard Deviations

<table>
<thead>
<tr>
<th></th>
<th>Separated</th>
<th>Premature</th>
<th>Working Class</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean (S.D.)</td>
<td>Mean (S.D.)</td>
<td>Score</td>
</tr>
<tr>
<td>Emotional Cost</td>
<td>1.81 (1.06)</td>
<td>1.74 (1.08)</td>
<td>3.49</td>
</tr>
<tr>
<td>N</td>
<td>25</td>
<td>8</td>
<td>1</td>
</tr>
</tbody>
</table>

2. t-tests

There were no significant differences between sources or in comparison with the Wollongong Sample.
There were no significant differences between sources.
APPENDIX 13

Significant changes in affect between birth, three months and eighteen months

13.1.1 Significant changes between birth and three months for separated mothers.

13.1.2 Significant changes between three months and eighteen months for separated mothers.

13.1.3 Significant changes between birth and eighteen months for separated mothers.

13.2.1 Significant changes between birth and three months for mothers of premature babies.

13.2.2 Significant changes between three months and eighteen months for mothers of premature babies.

13.2.3 Significant changes between birth and eighteen months for mothers of premature babies.

13.3.1 Changes for working class mothers.

13.4.1 Affect not expressed by separated mothers at each of the three times.

13.4.2 Affect not expressed by mothers of premature babies at each of the three times.

13.4.3 Affect not expressed by working class mothers at each of the three times.

NOTE: Paired t-tests were used to calculate the significances of the differences from one time to a later time. Only those cases remaining in the study at the later stage could be used in each comparison.

Mean differences and their standard deviations are reported in these tables.
Appendix 13.1.1 : Significant changes between birth and three months for separated mothers

<table>
<thead>
<tr>
<th>Variables</th>
<th>Mean Change $^{(1)}$</th>
<th>S.D.</th>
<th>t $^{(2)}$</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shame (Mother)</td>
<td>-.28</td>
<td>.42</td>
<td>3.69</td>
<td>.001</td>
</tr>
<tr>
<td>Total Anxiety (Mother)</td>
<td>-.43</td>
<td>.74</td>
<td>3.20</td>
<td>.003</td>
</tr>
<tr>
<td>Cognitive Anxiety</td>
<td>-.63</td>
<td>1.16</td>
<td>3.01</td>
<td>.005</td>
</tr>
<tr>
<td>Mutilation (Medical)</td>
<td>.28</td>
<td>.53</td>
<td>2.90</td>
<td>.01</td>
</tr>
<tr>
<td>Diffuse (Mother)</td>
<td>-.24</td>
<td>.51</td>
<td>2.55</td>
<td>.02</td>
</tr>
<tr>
<td>Hostility Out (Mother)</td>
<td>-.13</td>
<td>.28</td>
<td>2.46</td>
<td>.02</td>
</tr>
<tr>
<td>Total Anxiety (Infant)</td>
<td>.33</td>
<td>.74</td>
<td>2.45</td>
<td>.02</td>
</tr>
<tr>
<td>Helping</td>
<td>.06</td>
<td>.13</td>
<td>2.40</td>
<td>.02</td>
</tr>
</tbody>
</table>

Note (1) Mean Change = Mean at birth - Mean at three months

Note (2) df = 29
Appendix 13.1.2: Significant Changes between three months and eighteen months for separated mothers

<table>
<thead>
<tr>
<th>Variables</th>
<th>Mean Change (1)</th>
<th>S.D.</th>
<th>t (2)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive Affect</td>
<td>.43</td>
<td>.62</td>
<td>3.35</td>
<td>.003</td>
</tr>
<tr>
<td>Cognitive Anxiety</td>
<td>.81</td>
<td>1.22</td>
<td>3.23</td>
<td>.004</td>
</tr>
<tr>
<td>Sharing</td>
<td>-.11</td>
<td>.18</td>
<td>3.00</td>
<td>.01</td>
</tr>
</tbody>
</table>

Note (1) Mean Change = Mean at three months - Mean at eighteen months

Note (2) df = 23
### Appendix 13.1.3 : Significant Changes between birth and eighteen months for separated mothers

<table>
<thead>
<tr>
<th>Variables</th>
<th>Mean Change $^{(1)}$</th>
<th>S.D.</th>
<th>t $(^2)$</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mutilation</td>
<td>.71</td>
<td>.64</td>
<td>5.46</td>
<td>.0001</td>
</tr>
<tr>
<td>Sharing</td>
<td>-.16</td>
<td>.18</td>
<td>4.39</td>
<td>.0001</td>
</tr>
<tr>
<td>Total Anxiety</td>
<td>.44</td>
<td>.59</td>
<td>3.68</td>
<td>.001</td>
</tr>
<tr>
<td>Shame (Mother)</td>
<td>-.22</td>
<td>.30</td>
<td>3.52</td>
<td>.002</td>
</tr>
<tr>
<td>Hostility Out (Mother)</td>
<td>-.18</td>
<td>.30</td>
<td>2.93</td>
<td>.01</td>
</tr>
<tr>
<td>Multilation (Infant)</td>
<td>.28</td>
<td>.48</td>
<td>2.87</td>
<td>.01</td>
</tr>
<tr>
<td>Total Anxiety (Mother)</td>
<td>-.27</td>
<td>.53</td>
<td>2.50</td>
<td>.02</td>
</tr>
<tr>
<td>Shame</td>
<td>-.18</td>
<td>.37</td>
<td>2.46</td>
<td>.02</td>
</tr>
</tbody>
</table>

**Note (1)**: Mean Change = Mean at birth - Mean at eighteen months

**Note (2)**: df = 23
### Appendix 13.2.1: Significant Changes between birth and three months for mothers of premature babies

<table>
<thead>
<tr>
<th>Variables</th>
<th>Mean Change (1)</th>
<th>S.D.</th>
<th>t (2)</th>
<th>( \text{P} )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambivalent Hostility (Medical)</td>
<td>-.18</td>
<td>.16</td>
<td>3.90</td>
<td>.002</td>
</tr>
<tr>
<td>Positive Affect</td>
<td>-.42</td>
<td>.42</td>
<td>3.50</td>
<td>.005</td>
</tr>
<tr>
<td>Ambivalent Hostility (Infant)</td>
<td>-.24</td>
<td>.27</td>
<td>3.05</td>
<td>.01</td>
</tr>
<tr>
<td>Helping</td>
<td>.08</td>
<td>.10</td>
<td>2.86</td>
<td>.01</td>
</tr>
<tr>
<td>Ambivalent Hostility - (Infant)</td>
<td>-.18</td>
<td>.23</td>
<td>2.72</td>
<td>.02</td>
</tr>
</tbody>
</table>

**Note (1)** Mean Change = Mean at birth - Mean at three months

**Note (2)** df = 11
Appendix 13.2.2 : Significant Changes between three months and eighteen months for mothers of premature babies

<table>
<thead>
<tr>
<th>Variables</th>
<th>Mean Change (1)</th>
<th>S.D.</th>
<th>t (2)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Anxiety</td>
<td>.53</td>
<td>.42</td>
<td>3.60</td>
<td>.01</td>
</tr>
<tr>
<td>Mutilation</td>
<td>.44</td>
<td>.39</td>
<td>3.16</td>
<td>.02</td>
</tr>
</tbody>
</table>

**Note (1)** Mean Change = Mean at three months - Mean at eighteen months

**Note (2)** df = 7
Appendix 13.2.3 : Significant Changes between birth and eighteen months for mothers of premature babies

<table>
<thead>
<tr>
<th>Variables</th>
<th>Mean Change (1)</th>
<th>S.D.</th>
<th>t (2)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mutilation</td>
<td>.78</td>
<td>.31</td>
<td>7.23</td>
<td>.0001</td>
</tr>
<tr>
<td>Guilt (Infant)</td>
<td>-.30</td>
<td>.19</td>
<td>4.42</td>
<td>.003</td>
</tr>
<tr>
<td>Total Anxiety</td>
<td>.69</td>
<td>.57</td>
<td>3.46</td>
<td>.01</td>
</tr>
<tr>
<td>Ambivalent Hostility (Infant)</td>
<td>-.31</td>
<td>.27</td>
<td>3.32</td>
<td>.01</td>
</tr>
<tr>
<td>Hostility In (Mother)</td>
<td>-.22</td>
<td>.19</td>
<td>3.25</td>
<td>.01</td>
</tr>
<tr>
<td>Separation (Mother)</td>
<td>-.36</td>
<td>.33</td>
<td>3.17</td>
<td>.02</td>
</tr>
<tr>
<td>Emotional Cost</td>
<td>1.47</td>
<td>1.41</td>
<td>2.95</td>
<td>.02</td>
</tr>
</tbody>
</table>

Note (1)  Mean Change = Mean at birth - Mean at eighteen months
Note (2)  df = 7
Appendix 13.3: Significant Changes for working class mothers

<table>
<thead>
<tr>
<th>Variables</th>
<th>Mean Change $^{(1)}$</th>
<th>S.D.</th>
<th>$t^{(2)}$</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Anxiety (Mother)</td>
<td>-.68</td>
<td>.06</td>
<td>20.25</td>
<td>.002</td>
</tr>
</tbody>
</table>

Note (1) Mean Change = Mean at birth - Mean at three months

Note (2) df = 2

At eighteen months only 1 working class woman was interviewed. Therefore, no t-tests were calculated using that data.
Table 13.4.1: Affect not expressed by separated mothers at each of the three times

<table>
<thead>
<tr>
<th>Birth</th>
<th>Three Months</th>
<th>Eighteen Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death (Mother)</td>
<td>Death (Mother)</td>
<td>Death (Infant)</td>
</tr>
<tr>
<td>Death (Medical)</td>
<td>Guilt (Infant)</td>
<td>Anxiety (Medical)</td>
</tr>
<tr>
<td>Guilt (Medical)</td>
<td>Death (Medical)</td>
<td>Death (Medical)</td>
</tr>
<tr>
<td></td>
<td>Guilt (Medical)</td>
<td>Multilation (Medical)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Separation (Medical)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Guilt (Medical)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shame (Medical)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diffuse (Medical)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Positive Affect (Medical)</td>
</tr>
</tbody>
</table>
Table 13.4.2: Affect not expressed by mothers of premature babies at each of the three times

<table>
<thead>
<tr>
<th>Birth</th>
<th>Three Months</th>
<th>Eighteen Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guilt (Infant)</td>
<td>Guilt</td>
<td>Death</td>
</tr>
<tr>
<td>Death (Medical)</td>
<td>Death (Mother)</td>
<td>Death (Mother)</td>
</tr>
<tr>
<td>Guilt (Medical)</td>
<td>Guilt (Mother)</td>
<td>Mutilation (Mother)</td>
</tr>
<tr>
<td></td>
<td>Guilt (Infant)</td>
<td>Guilt (Mother)</td>
</tr>
<tr>
<td></td>
<td>Death (Medical)</td>
<td>Death (Infant)</td>
</tr>
<tr>
<td></td>
<td>Guilt (Medical)</td>
<td>Anxiety (Medical)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Death (Medical)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mutilation (Medical)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Separation (Medical)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Guilt (Medical)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shame (Medical)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diffuse (Medical)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hostility Out (Medical)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hostility In (Medical)</td>
</tr>
</tbody>
</table>
### Table 13.4.3: Affect not expressed by working class mothers at each of the three times

<table>
<thead>
<tr>
<th>Birth</th>
<th>Three Months</th>
<th>Eighteen Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death</td>
<td>Death</td>
<td>Death</td>
</tr>
<tr>
<td>Guilt</td>
<td>Guilt</td>
<td>Guilt</td>
</tr>
<tr>
<td>Death (Mother)</td>
<td>Death (Mother)</td>
<td>Shame</td>
</tr>
<tr>
<td>Guilt (Mother)</td>
<td>Separation (Mother)</td>
<td>Death (Mother)</td>
</tr>
<tr>
<td>Diffuse (Mother)</td>
<td>Guilt (Mother)</td>
<td>Mutilation (Mother)</td>
</tr>
<tr>
<td>Death (Infant)</td>
<td>Death (Infant)</td>
<td>Separation (Mother)</td>
</tr>
<tr>
<td>Guilt (Infant)</td>
<td>Guilt (Infant)</td>
<td>Guilt (Infant)</td>
</tr>
<tr>
<td>Death (Medical)</td>
<td>Death (Medical)</td>
<td>Shame (Infant)</td>
</tr>
<tr>
<td>Separation (Medical)</td>
<td>Separation (Medical)</td>
<td>Guilt (Infant)</td>
</tr>
<tr>
<td>Guilt (Medical)</td>
<td>Guilt (Medical)</td>
<td>Shame (Infant)</td>
</tr>
<tr>
<td>Shame (Medical)</td>
<td>Diffuse (Medical)</td>
<td>Anxiety (Medical)</td>
</tr>
<tr>
<td>Diffuse (Medical)</td>
<td>Ambivalent Hostility (Mother)</td>
<td>Deatb (Medical)</td>
</tr>
<tr>
<td>Hostility In (Infant)</td>
<td>Hostility In (Medical)</td>
<td>Mutilation (Medical)</td>
</tr>
<tr>
<td>Positive Affect (Medical)</td>
<td>Ambivalent Hostility (Medical)</td>
<td>Separation (Medical)</td>
</tr>
<tr>
<td>Positive Affect (Husband)</td>
<td>Ambivalent Hostility (Medical)</td>
<td>Guilt (Medical)</td>
</tr>
<tr>
<td>Positive Affect (Medical)</td>
<td>Ambivalent Hostility (Mother)</td>
<td>Shame (Medical)</td>
</tr>
<tr>
<td>Hostility Out (Mother)</td>
<td>Diffuse (Medical)</td>
<td>Hostility Out (Medical)</td>
</tr>
<tr>
<td>Hostility In (Medical)</td>
<td>Hostility In (Medical)</td>
<td>Ambivalent Hostility (Mother)</td>
</tr>
<tr>
<td>Ambivalent Hostility</td>
<td>Hostility In (Medical)</td>
<td>Ambivalent Hostility (Mother)</td>
</tr>
<tr>
<td>(Medical)</td>
<td></td>
<td>Hostility Out (Medical)</td>
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<td></td>
<td>Hostility In (Medical)</td>
</tr>
<tr>
<td>(Medical)</td>
<td></td>
<td>Ambivalent Hostility (Medical)</td>
</tr>
</tbody>
</table>
APPENDIX 14

Affect scores for comparative populations

14.1 Affect scores for the Wollongong Sample

14.2 Affect scores for women in a child-bearing year
Table 14.1 : Affect scores for the Wollongong Sample (N=54)

<table>
<thead>
<tr>
<th>Affect Category</th>
<th>Mean</th>
<th>(S.D.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Anxiety</td>
<td>1.29</td>
<td>(.67)</td>
</tr>
<tr>
<td>Death</td>
<td>.46</td>
<td>(.33)</td>
</tr>
<tr>
<td>Multilation</td>
<td>.52</td>
<td>(.38)</td>
</tr>
<tr>
<td>Separation</td>
<td>.50</td>
<td>(.34)</td>
</tr>
<tr>
<td>Guilt</td>
<td>.43</td>
<td>(.33)</td>
</tr>
<tr>
<td>Shame</td>
<td>.67</td>
<td>(.46)</td>
</tr>
<tr>
<td>Diffuse</td>
<td>.69</td>
<td>(.50)</td>
</tr>
<tr>
<td>Cognitive Anxiety</td>
<td>.94</td>
<td>(.64)</td>
</tr>
<tr>
<td>Hostility Out</td>
<td>.79</td>
<td>(.58)</td>
</tr>
<tr>
<td>Hostility In</td>
<td>.70</td>
<td>(.48)</td>
</tr>
<tr>
<td>Ambivalent Hostility</td>
<td>.60</td>
<td>(.35)</td>
</tr>
<tr>
<td>Pawn</td>
<td>1.01</td>
<td>(.43)</td>
</tr>
<tr>
<td>Origin</td>
<td>.95</td>
<td>(.41)</td>
</tr>
<tr>
<td>Sociality</td>
<td>.41</td>
<td>(.21)</td>
</tr>
<tr>
<td>Helping</td>
<td>.13</td>
<td>(.10)</td>
</tr>
<tr>
<td>Intimacy</td>
<td>.09</td>
<td>(.09)</td>
</tr>
<tr>
<td>Influencing</td>
<td>.07</td>
<td>(.06)</td>
</tr>
<tr>
<td>Sharing</td>
<td>.22</td>
<td>(.09)</td>
</tr>
<tr>
<td>Positive Affect</td>
<td>.66</td>
<td>(.29)</td>
</tr>
<tr>
<td>Emotional Cost</td>
<td>2.65</td>
<td>(2.37)</td>
</tr>
</tbody>
</table>

Source: Viney, L.L. & Westbrook M: Psychosocial reactions to heart disease: An application of Content analysis methodology.

Table 14.2: Affect scores for women in a childbearing year (N=92)

<table>
<thead>
<tr>
<th>Category</th>
<th>Mean</th>
<th>(S.D.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Anxiety</td>
<td>2.26</td>
<td>(.80)</td>
</tr>
<tr>
<td>Death</td>
<td>.52</td>
<td>(.21)</td>
</tr>
<tr>
<td>Multilation</td>
<td>1.07</td>
<td>(.64)</td>
</tr>
<tr>
<td>Separation</td>
<td>.90</td>
<td>(.52)</td>
</tr>
<tr>
<td>Guilt</td>
<td>.49</td>
<td>(.19)</td>
</tr>
<tr>
<td>Shame</td>
<td>1.08</td>
<td>(.70)</td>
</tr>
<tr>
<td>Diffuse</td>
<td>1.27</td>
<td>(.70)</td>
</tr>
<tr>
<td>Cognitive Anxiety</td>
<td>1.62</td>
<td>(.74)</td>
</tr>
<tr>
<td>Hostility Out</td>
<td>1.01</td>
<td>(.53)</td>
</tr>
<tr>
<td>Hostility In</td>
<td>1.03</td>
<td>(.55)</td>
</tr>
<tr>
<td>Frustration</td>
<td>1.41</td>
<td>(.65)</td>
</tr>
<tr>
<td>Pawn</td>
<td>1.02</td>
<td>(.37)</td>
</tr>
<tr>
<td>Origin</td>
<td>.95</td>
<td>(.33)</td>
</tr>
<tr>
<td>Sociality</td>
<td>.55</td>
<td>(.18)</td>
</tr>
<tr>
<td>Helping</td>
<td>.41</td>
<td>(.17)</td>
</tr>
<tr>
<td>Intimacy</td>
<td>.23</td>
<td>(.14)</td>
</tr>
<tr>
<td>Influencing</td>
<td>.12</td>
<td>(.08)</td>
</tr>
<tr>
<td>Sharing</td>
<td>.21</td>
<td>(.12)</td>
</tr>
<tr>
<td>Positive Affect</td>
<td>1.25</td>
<td>(.47)</td>
</tr>
<tr>
<td>Emotional Cost</td>
<td>2.68</td>
<td>(1.49)</td>
</tr>
</tbody>
</table>

APPENDIX 15

Behaviour when the Children were three months old

15.1 Description of behavioural categories used in the observation when the children were three months old

15.2 Differences between samples for behaviour when the children were three months old

15.3.1 Factor analysis at three months – correlation matrix

15.3.2 Factor analysis at three months – Factor variance explained

15.4 Description of behaviour scales at three months

15.5 Differences between samples at three months on behaviour scales
Appendix 15.1: Description of behavioural categories used in the observation when the children were three months old

1. **Mother/infant categories**

   **Behaviour 1**  
   **Rubs or pats infant.** Gross rubbing or patting movements which are usually seen during winding or if the infant chokes.

   **Behaviour 2**  
   **Kisses infant.**

   **Behaviour 3**  
   **Rocks infant.** Repetitive side to side, or backwards and forwards, movements of the infant, or both mother and infant.

   **Behaviour 4**  
   **Changes nappies.**

   **Behaviour 5**  
   **Touch/stroke on bare skin.** Touching infant on bare skin - usually a light stroking of arms, legs or hands. The movements are lighter than rubs and pats.

   **Behaviour 6**  
   **Touch/stroke on clothes.** Touching infant in a caressing manner on a clothed area.

   **Behaviour 7**  
   **Walk.** The mother moving around carrying her infant.

   **Behaviour 8**  
   **Talks to infant.** The content of the speech is used to determine whether or not the speech is directed at the infant.

   **Behaviour 9**  
   **Talks to others.** Talking to anyone other than the infant, including the observer.

   **Behaviour 10**  
   **Looks away.** Looking at anyone or anything other than the infant.

   **Behaviour 11**  
   **Leaves room.** The mother leaves the room containing the infant or is out of that room.

   **Behaviour 12**  
   **Smiles at infant.** The mother smiles at the infant. This is scored whether or not the infant is aware of the smile.
2. **Infant's position, vocalisations, state, etc.**

Behaviour 13  **Cradled.** Held more or less horizontally across the mother's body, supported by her arms.

Behaviour 14  **Shoulder.** Held more or less vertically against the mother's body, supported by her arms.

Behaviour 15  **Sitting.** Supported on the mother's lap or any horizontal surface with the infant's back at about 90° to his legs.

Behaviour 16  **Lying.** More or less horizontal across the mother's lap or any other horizontal surface. This includes infant's in a "bouncinette" which has the infant's body supported at about a 30° angle.

Behaviour 17  **Change.** A change of position.

Behaviour 18  **Cries, fusses.** Crying and the less active and less distressed category of fussing are both scored.

Behaviour 19  **En face.** The mother was in the "en face" position with the child, recorded regardless of whether the child was awake or asleep.

Behaviour 20  **Not held.** This was recorded but omitted from Factor Analysis because of the common practice in Australia of using a "bouncinette". Thus "NOT HELD" was not related in any way to the warmth or style of the mother's interaction with her infant.

3. **Others present**

Those present during the interaction were recorded.

**Note (1)** These categories have been adapted from Richards and Bernal (1972).
Appendix 15.2 : Differences between samples for
behaviour when the children were three months old

$t$ tests were calculated for all behaviour categories to test for differences between samples.

Only "looks away" from infant showed a significant difference. This was between mothers experiencing routine separations and mothers of premature babies

"Looks away"

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>S.D.</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separated</td>
<td>7.87</td>
<td>5.88</td>
<td>30</td>
</tr>
<tr>
<td>Premature</td>
<td>2.00</td>
<td>1.71</td>
<td>12</td>
</tr>
</tbody>
</table>

$t = 4.97$
$df = 40$
$p = .001$
Appendix 15.3.1: Factor analysis at three months

Correlation Matrix

<table>
<thead>
<tr>
<th></th>
<th>Leaves room x (1)</th>
<th>Talks to infant x (8)</th>
<th>Talks to others x (9)</th>
<th>Looks away x (10)</th>
<th>Rubs x (1)</th>
<th>Kisses x (2)</th>
<th>Changes nappy x (4)</th>
<th>Touched bare skin x (5)</th>
<th>Touched clothes x (6)</th>
<th>Cradled shoulder x (13)</th>
<th>Sitting x (15)</th>
<th>Lying x (16)</th>
<th>Crying x (18)</th>
<th>Cries x (19)</th>
<th>Smiles at infant x (12)</th>
<th>Change face x (17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leaves room x (1)</td>
<td>1.00</td>
<td>0.00</td>
<td>-0.01</td>
<td>-0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
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<tr>
<td>Talks to infant x (8)</td>
<td>-0.01</td>
<td>1.00</td>
<td>0.00</td>
<td>0.00</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Talks to others x (9)</td>
<td>0.00</td>
<td>0.00</td>
<td>1.00</td>
<td>0.00</td>
<td>0.00</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Looks away x (10)</td>
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<td>-0.00</td>
<td>0.00</td>
<td>1.00</td>
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<td>0.00</td>
</tr>
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<td>Rubs x (1)</td>
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<td>0.00</td>
<td>0.00</td>
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<td>0.00</td>
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<td>0.00</td>
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<tr>
<td>Kisses x (2)</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Changes nappy x (4)</td>
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<td>0.00</td>
<td>0.00</td>
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<td>0.00</td>
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### Appendix 15.3.2: Factor analysis at three months

**Factor variance explained**

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<th>Cumulative Proportion of Total Variance</th>
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<td>65.5%</td>
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<td>7</td>
<td>1.09</td>
<td>71.2%</td>
</tr>
</tbody>
</table>
Appendix 15.4 : Description of behaviour scales at three months

**Factor 1**

- Mother smiles at infant: -.79
- Mother looks away from infant: .78
- Mother talks to infant: -.58
- Mother rocks infant: .58
- Infant held to shoulder: -.35
- Mother talks to others: .34

(The mother is not involved with the infant. She is looking away and talking to others.)

**Factor Name:** "Mother Socialising"

**Factor 2**

- Mother changes infant's position: .87
- Mother holds infant at shoulder: .74
- Mother talks to infant: .46
- Mother rocks infant: .44
- Mother touches infant on clothes (caresses): .38

(The mother is infant-involved. She is caring and interacting.)

**Factor Name:** "Mother Stimulating and Caring"

**Factor 3**

- En face position: .78
- Mother cradles infant: .74
- Mother talks to others: -.56
- Mother touches infant on bare skin (caresses): .54

(The mother is infant-involved. She is caressing "en face").

**Factor Name:** "En Face"
Factor 4
Infant lying
Infant sitting

(The infant is lying - this is a posture factor.)

Factor Name: "Infant Lying"

Factor 5
Infant fusses
Mother leaves room
Mother walks
Mother changes infant's nappy

(Baby cries before or during nappy change.)

Factor Name: "Fussing and Nappy Change"

Factor 6
Mother kisses infant
Mother touches infant on clothes (caresses)
Mother cradles infant
Mother touches infant on bare skin (caresses)

(The mother is kissing and touching infant.)

Factor Name: "Mother Loving"

Factor 7
Mother rubs/winds infant
Mother changes nappy
Mother touches infant on clothes (caresses)

(The mother is busy trying to make infant bring up wind.)

Factor Name: Baby Burped"
The following sketches are offered as an aid to conceptualising the factors and are the author's personal indulgence. Apologies and gratitude are due to the professional artists from whom the characters were borrowed.
MOTHER SOCIALISING
MOTHER STIMULATING AND CARING
EN FACE
FUSSING AND NAPPY CHANGE
BABY BURPED
Appendix 15.5: Differences between samples at three months on behaviour scales

Analysis of variance was computed for all factors. Factor 1 was the only one showing a significant difference.

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<th>S.D.</th>
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APPENDIX 16

Behaviour when the children were eighteen months old

16.1 Description of the behavioural categories used in the observation when the children were eighteen months old

16.2 Differences between samples for behaviour when the children were eighteen months old

16.3.1 Factor analysis at eighteen months - Correlation matrix

16.3.2 Factor analysis at eighteen months - Factor variance explained

16.4 Description of behaviour scales at eighteen months

16.5 Differences between samples at eighteen months on behaviour scales
Appendix 16.1 : Description of behavioural categories used in the observation when the children were eighteen months old

1. Mother/child categories

   1. **Mother plays with child.** Any mutual activity which was perceived as play by mother and child. Included singing, blocks, peek-a-boo, etc.

   2. **Mother touches child.** Touches on skin or clothes - usually a light rubbing.

   3. **Mother talks to child.** She initiates the verbal interchange.

   4. **Mother talks to child.** She responds to him.

   5. **Mother talks to others.**

   6. **Mother leaves the room.** This was scored whether mother left with or without the child. It is an estimate of her mobility.

   7. **Mother smiles at infant.**

2. Child vocalisations and state

   8. **Child fusses.** Crying and the less distressed category of fussing are both scored.

   9. **Child vocalises to self.** The content of the child's speech, body posture and nature of interactions were used to help determine whether speech was directed to others or to self.

   10. **Child vocalises to mother - initiates.** Vocalisations where the child initiates an interaction with the mother.

   11. **Child vocalises to mother - responds.** Child vocalisations directed to the mother in response to her actions or vocalisations.

   12. **Vocalises to others.** Infant vocalisations directed to other persons than the mother.
3. **Child's position**

Behaviour 13  **Child held.** The child is held by the mother.

Behaviour 14  **Child standing.**

Behaviour 15  **Child walking.**

Behaviour 16  **Child crawling.**

4. **Direction of movement and distance**

Behaviour 17  **Child moving towards the mother between 0 and 1 metre.**

Behaviour 18  **Child moving towards the mother from over 1 metre.**

Behaviour 19  **Child moving away from the mother between 0 and 1 metre.**

Behaviour 20  **Child moving away from the mother from over 1 metre.**
Appendix 16.2 : Differences between samples for behaviour when the children were eighteen months old

There were no significant differences in behaviour between samples.
### Appendix 16.3.1: Factor Analysis at Eighteen Months

#### Correlation Matrix

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<th>Mo. touches child initiates</th>
<th>Mo. talks to child responds</th>
<th>Mo. fusses to self</th>
<th>Child vocalises to mo. - initiates</th>
<th>Child vocalises to others</th>
<th>Child holds</th>
<th>Child standing</th>
<th>Child walking</th>
<th>Child crawls</th>
<th>Towards mo. 0-1 metre</th>
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Appendix 16.3.2: Factor analysis at eighteen months
Factor variance explained

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<th>Cumulative Proportion of Total Variance</th>
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<td>73.4%</td>
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</table>
Appendix 16.4: Description of behaviour scales at eighteen months

**Factor 1**

Child walking \( .84 \)
Child held (cradled, shoulder, sitting or lying) \( -.84 \)
Child standing \( .74 \)
Child moving away from mother 1+ metres \( .47 \)
Child crawling \( -.42 \)

This is an infant only factor and describes movement.

**Factor Name:** "Active Child"

**Factor 2**

Mother talks to child - she initiates \( .91 \)
Mother plays with child \( .74 \)
Child vocalises in response to mother \( .64 \)
Child moving away from mother 1+ metres \( -.49 \)

(This is mother interacting vocally and in play with her child close to her.)

**Factor Name:** "Mother plays with Child"

**Factor 3**

Child vocalises to others \( .85 \)
Child moving towards mother 0-1 metre \( -.71 \)
Child moving towards mother 1+ metres \( .65 \)

(The child is talking to others, usually the researcher, and is hovering about one metre from the mother.)

**Factor Name:** "Socialising Child"

**Factor 4**

Mother leaves room \( .82 \)
Child vocalises to self \( -.75 \)
Child fusses \( -.36 \)
Child held (cradled, shoulder, sitting or lying) \( .30 \)

(Mother leaves room with a quiet infant.)

**Factor Name:** "Mother carrying Child"
Factor 5
Mother smiles at child .68
Child crawls .56
Mother touches child .49
Child fusses -.43

(Mother smiles and touches her child. As the child is crawling it is probably showing regressive behaviour.)

Factor Name: "Warm mother"

Factor 6
Child vocalises to mother - initiates .76
Child vocalises to mother - responds .70
Child crawls -.41
Child fusses .40

(This factor relates to the child's vocalisations - and not all are happy.)

Factor Name: "Chatty Child"

Factor 7
Mother talks to others .83
Child moving away from mother 0-1 metre -.51
Mother touches child .34
Mother responds to child -.32

(This factor describes a mother talking to others while maintaining physical contact with the child.)

Factor Name: "Mother Socialising"
The following sketches are offered as an aid to conceptualising the factors and were the author's personal indulgence. Apologies and gratitude are due to the professional artists from whom the characters were borrowed.
ACTIVE CHILD
MOTHER PLAYS WITH CHILD
SOCIALISING CHILD
MOTHER CARRYING CHILD
WARM MOTHER
CHATTY CHILD
MOTHER SOCIALISING
Appendix 16.5 : Difference between samples at eighteen months on behaviour scales

Only Factor 4 ("Mother carrying Child") showed any significant differences.

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<th>Premature</th>
<th>Mean</th>
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$\frac{t}{df} = 3.03$

$df = 31$

$p = .01$
APPENDIX 17

Behaviour scales obtained when the children were three months old related to affect

17.1 Correlations of behaviour scales at three months with affect at birth

17.2 Correlations of behaviour scales at three months with affect at three months

17.3 Correlations of behaviour scales at three months with affect at eighteen months
Table 17.1: Correlations of behaviour scales at three months with affect at birth

<table>
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## Appendix 17.2: Correlations of behaviour scales at three months with affect at three months

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Appendix 17.3 : Correlations of behaviour scales at three months with affect at eighteen months

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APPENDIX 18

Behaviour scales obtained when the children were eighteen months old related to affect at birth, three and eighteen months, and also to behaviour scales at three months

18.1 Correlations of behaviour scales at eighteen months with affect at birth

18.2 Correlations of behaviour scales at eighteen months with affect at three months

18.3 Correlations of behaviour scales at eighteen months with affect at eighteen months

18.4 Correlations between behaviour scales
Appendix 18.1 : Correlations of behaviour scales at eighteen months with affect at birth

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<td>Factor 7</td>
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Appendix 18.2: Correlations of behaviour scales at eighteen months with affect at three months

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<td>Cognitive Anxiety</td>
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### Factor 6

**"Chatty Child"**

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<tr>
<td>Separation</td>
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<td>.01</td>
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### Factor 7

**"Mother Socialising"**

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Appendix 18.3: Correlations of behaviour scales at eighteen months with affect at eighteen months

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<td>Factor 4</td>
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<td>Hostility In (Child)</td>
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Appendix 18.4 : Correlations between behaviour scales

There were only two significant intercorrelations.

1. Three months $r = .55$ (p.01) Eighteen months
   Factor 1
   "Mother Socialising"

2. Three months $r = -.39$ (p.01) Eighteen months
   Factor 5
   "Fussing and Nappy Change"

   Factor 2
   "Mother Plays with Child"