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A Good Start: Supporting Families With A First Baby

A thesis presented in partial fulfilment of the requirements for the degree of

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Abstract

The study explored first time parents' experiences during transition to parenthood, focussing on types and aspects of support found helpful or unhelpful. In New Zealand the state has a role in supporting new parents; yet high rates of child maltreatment indicates room for improvement in support provided. In recognising that infants have a basic right to optimal care, and in exploring how families can be better supported to provide such care, the study is aligned with a human rights approach to social work research.

Twenty five women in diverse circumstances were interviewed before and after the birth of a first baby. Twelve 'significant others' were also interviewed, each once, after the baby's birth. In order to build enough knowledge of participants' experience to make pertinent recommendations for beneficial change in the system of support for families in transition to parenthood, attention was paid to gathering detail about practical realities of participants' everyday experience. A narrative approach and a resilience perspective were used in analysing results.

It was found that while keen to parent well, participants were unprepared for the realities of life with a baby. Issues they had not expected included: uncertainty associated with learning to parent; isolation; financial strain; problems linked to returning to paid employment; role and relationship change; and concern about being a 'good' parent. An overarching theme was 'the constantness of it', a phrase denoting absorption in an unremitting new routine marked by chronic tiredness and '24/7' responsibility. The study indicates that first-time parents go through a process of developing competence while coping with new challenges. While financial strain was a pressing issue for participants in diverse circumstances, many wanted to 'be a mum' and were reluctant to use childcare and return to jobs. The data indicate that current policy and service provision does not always meet first time parents' actual needs, including opportunities to learn infant care skills and relevant information for new fathers. A more flexible, responsive set of services might be created by customising standard services to more closely match needs and preferences of specific groups of new parents.

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TABLE OF CONTENTS

CHAPTER 1 Introduction	1
Research questions	2
Resilience	3
Scope of the study	4
A good start: a basic human right	6
Structure of the thesis	7
 CHAPTER 2 The policy context	 9
Local landscape of formal and semi-formal support	9
Demography of childbirth	11
Meaning of family	14
 CHAPTER 3 Documenting resilience: From steel dolls to pathways to resilience	 19
Protective factors	23
<i>Individual attributes</i>	23
<i>Family qualities</i>	24
<i>Supportive systems outside the family</i>	24
The devil in the detail	24
Family resilience	26
<i>Therapeutic perspective</i>	27
<i>Structural perspective</i>	32
<i>Situation focus</i>	34
Terminology: adversity; risk, ‘steeling effects’	37
<i>Adversity</i>	38
<i>Risk</i>	38
<i>Risk chains and cascades</i>	42
<i>Protective chains, steeling effects, inoculation, turning points</i>	44
Competence and good outcomes	46
Context	49
Self-efficacy	49
The big picture	50

CHAPTER 4 Support	55
Support: ‘Complex to assess, to get right and to deliver’	57
Engagement	60
Effectiveness	62
Managing support	66
Support for transition to parenthood	68
Towards fieldwork	71
Connecting resilience to support	72
 CHAPTER 5 Methodology and methods	 75
Methodology	75
<i>Narrative inquiry</i>	81
Methods	83
Recruitment	87
Ethical issues	89
Reflexivity	91
Analysis	94
<i>Process of analysis</i>	102
 CHAPTER 6 ‘Ready or not’: preparing for parenthood	 107
Emotional support and learning	109
<i>‘Hearing stories’</i>	110
<i>‘My own midwife’</i>	110
<i>‘Nothing you couldn’t get out of a book’</i>	114
<i>‘Not too sure’</i>	117
Nesting	121
‘A pressure cooker situation’	122
‘Watching the money’	124
<i>‘Working harder’; ‘saving up’</i>	125
<i>Paid Parental Leave</i>	127
<i>Income Support and tax credit</i>	128
Ready or not?	129
 CHAPTER 7 ‘Meeting the baby’: childbirth and the first few days	 131
Novice parents	131

The birth	133
<i>Childbirth and self-efficacy</i>	135
The 'invisible man'	135
'Consumed by breastfeeding'	136
<i>Support for breastfeeding</i>	139
Being 'looked after'	139
A 'steep learning curve'	145
'In the deep end'	146
<i>'Where's the manual?'</i>	151
First steps on a pathway to family resilience	152
CHAPTER 8 'The constantness of it': the first three months	153
'The constantness of it'	157
'You just don't know'	164
'Nobody cares what I do with my day'	171
'Reining in spending'	175
<i>Financial support</i>	175
'Out of the haze'	178
<i>Back to the workforce</i>	179
'A life-changing experience'	180
'Doing it right'	181
CHAPTER 9 The work/life balancing act: the first year	183
'Asking questions'	185
<i>Plunket</i>	192
'Still the division of labour'	192
<i>'Becoming a father'</i>	194
'Feeling connected'	194
<i>Belonging</i>	201
'I've just got to think what I actually want to do'	201
<i>'Not a dollar spare'</i>	210
'The next level'	210
<i>Avoiding the 'tipping point'</i>	214
'Pressures'	215
'Someone to talk to'	218

CHAPTER 10 From shore to shore	221
Looking back	222
An overview of year of parenthood	224
An application of the concept of resilience	233
<i>Developing competence</i>	233
<i>In danger of sliding towards a cascade of problems</i>	233
<i>Turning points</i>	234
<i>Drawing on resources at all ecological levels</i>	234
<i>Self-efficacy</i>	238
<i>Recognising context</i>	239
A blurred and incomplete big picture	239
A view of support	241
CHAPTER 11 Conclusion	249
Implications for policy and service provision	249
<i>Further research</i>	251
Who benefits? Who misses out?	252
Bibliography	256
Appendices	276
Appendix 1 <i>Table 2: Participant list</i>	276
Appendix 2 <i>Table 3: Helpful and potentially helpful types of support</i>	277
Appendix 3 <i>Ethical approval</i>	286
Appendix 4 <i>Recruitment flyer</i>	289
Appendix 5 <i>Information sheets</i>	290
Appendix 6 <i>Consent forms</i>	292
Appendix 7 <i>Interview guides</i>	296
Appendix 8 <i>List of support providers</i>	300
Appendix 9 <i>Midwife shortage cartoon</i>	301
List of tables	
Table 1 <i>Number of births to women having a first baby in year to June 2004</i>	11
Table 2 <i>Participant list</i>	276
Table 3 <i>Helpful and potentially helpful types of support</i>	277

CHAPTER 1 INTRODUCTION

The excitement with which the birth of a first child is normally anticipated may be followed by exhaustion and bewilderment when the realities of life with a baby become apparent to new parents (Figs, 2000). Adaptation to parenthood is recognised as a challenging life transition (Pancer et al., 2000; Wilkins, 2006) bringing profound change in roles, relationships, established routines and material circumstances. Postnatal depression causes difficulties for a significant proportion of new mothers (Matthey et al., 2004).

While it is regrettable that delight in a new baby should be clouded by any such issues, worse consequences may follow if new parents struggle with change inherent in their new situation and become stressed to the point where ability to overcome difficulties is undermined. Ultimately the baby may suffer. Parental stress is associated with child maltreatment (Burrell et al., 1994; Russell et al., 2007). A child's development is shaped by early experiences, including secure care on the positive side and, on the negative side, erratic care and exposure to violence. Infants under one year are particularly vulnerable (Perry et al., 1995; Connolly et al., 2005; Perry, 2009).

New Zealand is a signatory to the United Nations Convention on the Rights of the Child (UNCROC), which states that the family, as 'the environment for the growth and well-being of all its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community'. Article 27 advocates for a standard of living adequate for the child's physical, mental, spiritual, moral and social development. Yet, New Zealand has a comparatively high rate of child death by maltreatment (UNICEF, 2003; Child, Youth and Family, 2006; Duncanson et al., 2009). This rate has been found to be on average three times higher for children under the age of 12 months than it is for children aged between one and four years (Connolly & Doolan, 2007). These grim statistics highlight the importance of ensuring that families adapting to life with a first baby are in a position to access what is required to enable them to get off to a good start in the parenting role.

In New Zealand the state has significant involvement in supporting families around the time of the birth of a child. The 2005 Ministry of Social Development¹ Statement of Intent affirms that the state has a role in supporting families to develop resilience:

Our work for families is about enabling families to be strong and resilient and supporting them to function well. Resilient families have good parenting and communication skills, and cope well with pressure and change...The resilience of some families is put under strain by factors such as low income, debt and unemployment, family change and separation, and work and family demands. While most families cope well with these issues, others can find coping more difficult. Strong connected support that is easy to access and provides the right help at the right time is essential to helping these families cope (MSD, 2005: 75)

This quotation highlights the value of 'strong connected support' in addressing a broad range of issues that compromise family resilience. My purpose in studying first time parents' experiences of transition to parenthood is not the classic aim of qualitative researchers seeking to understand the 'other', but rather a means to another end: contributing to knowledge about what types of support might be 'the right help at the right time' for families in transition to parenthood so that they may be provided with the 'protection and assistance' for which UNCROC advocates.

Research questions

The research questions are:

What was the experience of first time parents in a range of circumstances in New Zealand today as they adapted to life with a baby?

What factors did a diverse set of first time parents experience as helpful or unhelpful as they dealt with challenges encountered during transition to parenthood?

What are the implications for policy and service delivery?

¹ Hereafter referred to as MSD.

Resilience

As noted above, the 2005 MSD Statement of Intent affirms that the state has a role in supporting families to develop resilience. Resilience has been described as ‘manifested competence in the context of significant life challenges’ (Masten & Coatsworth, 1998: 206). The literature on family resilience is less developed than that on individual resilience. By capturing the experience of a group of first time parents in New Zealand, this thesis aims to extend understanding of family resilience and produce information that may inform policy and service delivery for people in transition to parenthood in New Zealand. The construct of resilience, which centres on how people cope with challenges, draw on resources available to them and develop competence (Masten & Coatsworth, 1998; Fraser et al., 1999; Lietz & Strength, 2011), provides a way of linking social experience to social policy by furnishing a conceptual framework for exploring and critiquing the whole system of support for transition to parenthood.

In the literature the term ‘resilience’ has been applied to people in a wide range of difficult situations.² Transition to parenthood is challenging (Figes, 2000, Pancer et al., 2000; Wilkins, 2006) and the term ‘resilience’ has been applied to successful adaptation to life with a baby (e.g. Walsh, 2003). Originally envisaged as a characteristic or trait, resilience is now seen as a process (e.g. Cicchetti, 2003) that may be fostered by drawing on available resources to get through a hard time and even, perhaps, emerge stronger. This resonates with the strengths perspective’s focus on identifying and mobilising assets, capabilities and resources (Saleebey, 2002b; Fergus & Zimmerman, 2005) including the supportive community resources referred to below by Patterson (2002a: 244) in explaining the importance of strengthening the support system available to families facing challenges:

A family’s ability to be resilient in the face of normative or significant risk is related not only to their internal processes but also to the risks or opportunities in the social systems in their ecological context. Living in poverty and in crime-ridden violent neighborhoods places families at high risk and undermines their ability to satisfactorily accomplish their core functions...The absence of needed community resources to support families in fulfilling their core functions further undermines family resilience. Public

² See Chapter 3.

programs and policies, societal norms and values, and other community institutions all shape the style and degree to which families are able to fulfill their functions as well as their ability to acquire and develop new capabilities when challenged...The cumulative costs of a family's inability to fulfill their core functions are significant.

Resilience is now understood to be the product of complex interaction between personal qualities and supportive resources available in the environment (e.g. Walsh, 1998; Luthar & Cicchetti, 2000; Waller, 2001; Prillettensky et al., 2001; Connolly, 2001; Waller, 2001; Duncan et al., 2005). My study focusses on the environmental side of this equation in the form of the availability and suitability of resources and assistance required by first time parents adapting to life with a baby in New Zealand. From a practical point of view, the state can do far more to influence external resources available to new parents than it can to influence their personal functioning. However helpful the latter might be, it is the system of support provided under the auspices of the state that could potentially be adjusted or augmented to more successfully meet needs and enhance families' ability to 'fulfill their core functions' (Patterson, 2002a: 244).

Scope of the study

By exploring how new parents experience adaptation to parenthood in New Zealand and by finding out what types of support that appear to be helpful, or otherwise, as they carry out family functions inherent in their new roles, I hoped to produce research that would be useful in a practical sense, a resource for informing action and intervention, enhancing decision making and perhaps solving problems (Patton, 1990). The scope of the study extends to strategies that participants used to help themselves and to the provision of informal support³ by family and friends; it is possible that knowledge of these helpful strategies and types of support could be used to inform guidance or information provided to new parents or their family members; or that aspects of helpful informal support could be incorporated into the delivery of formal support available through the state system.

Acknowledging that people currently experiencing transition to parenthood are well placed to reflect on what 'the right help at the right time' might mean to them and to consider the kinds of policy and services required to meet their needs and the needs of others in similar

³ Chapter 4 discusses formal, semi-formal and informal support.

circumstances, this thesis explores the detail of how first time parents in diverse circumstances in New Zealand today experience and cope with transition to parenthood and collects their views and ideas about the current support system and how it might be improved. Family resilience has been described as 'the trajectory a family follows as it positively adapts to or bounces back from stressful circumstances' (Hawley & DeHaan, 1996: 293). Resilience conceptualised as a trajectory in this way is a process that takes time. For my study of the experiences of families with a first baby, recognising that resilience develops over time required that I follow each participant's 'trajectory', inquiring into their experiences over a period of time. It was also important to explore their situation in enough detail to be able to discern what helped them adapt to life with a baby. This meant taking a close interest in what happened to them, what they found difficult and what helped them cope.

The study design eventually settled upon was to undertake qualitative interviews with a diverse group of new mothers and encourage them to talk about their experiences from their own point of view and in their own way. To take account of the importance of following them over time, the plan was to interview these women three times, first shortly before the birth of a first baby, then around three months afterwards, and then again around the time of the baby's first birthday. Of the 27 women recruited for the study, 25 were interviewed twice and 23 three times. Interviews took place in their homes or wherever they preferred,⁴ thus inconveniencing them as little as possible at a time when they were likely to be finding life busy, unpredictable and exhausting. While the main reason for this was that many of the women lived in rural areas and it was simply easier for them to be at home at times when they were in the late stages of pregnancy or busy with a new baby or active one-year old, an additional advantage was that they were at ease, quite literally 'at home' with the environment. Some of the partners of the women interviewed were also interviewed after the birth of the baby, in most cases between the second and third interview with the woman. These men were invited to take part in the study by being told about it by the woman, who also passed on the relevant written information. One grandmother was also interviewed as a 'significant other'.

⁴ The only interviews that did not take place in participants' homes were during the first set of interviews, before the birth. At this time one woman preferred to be interviewed in a café, two were interviewed at the homes of their parents, two in the birthing centres where they were attending antenatal appointments and one at a residential facility for teenage mothers.

Narrative inquiry (Sandelowski, 1991; Reissman, 1993; 2008) provided a methodological foundation. By encouraging careful attention to the detail of participants' experience, the notion of 'phronesis',⁵ as adapted by Flyvbjerg (2001), provided a way of thinking about making information collected during the study useful in a practical sense by suggesting where changes could be made to make the system of support available to families in transition to parenthood in New Zealand more relevant to actual needs and preferences. Resilience is used in this thesis as a conceptual framework to help explore and describe how participants coped with transition to parenthood and the supportive resources that helped them cope. As a result of reviewing the general resilience literature, key factors for understanding resilience are identified. In discussing the results of the study I consider the relevance of these factors to participants' experience of transition to parenthood and to how they became competent in dealing with tasks and responsibilities inherent in their new roles.

As the study progressed, understanding of the support system for families in transition to parenthood was enhanced through discussions with a range of people with relevant knowledge, including the director of a residential facility for teenage mothers, the Chief Executive of the New Zealand College of Midwives and a number of midwives currently in practice. Aspects of the study were presented at relevant forums⁶ and feedback sought and received.

A good start: a basic human right

Improving families' abilities to cope with changes associated with transition to parenthood should provide important benefits for the children themselves. A key motivation for my study was the belief that babies have a basic right to the best start possible (MacCormick, 2008). In this respect the study is aligned with a human rights approach to social work research (Ife, 2008). While New Zealand has an avowed commitment to child protection, high rates of child maltreatment (UNICEF, 2003; Child, Youth and Family, 2006; Connolly & Doolan, 2007; Duncanson et al., 2009) indicate that many children do not receive adequate care. Developing competence at an early stage of life with a baby may establish a family on a positive trajectory of benefit to the baby, the family and the community in which they live. Resilience has been described as the 'positive pole' (Rutter, 1987: 316) of a continuum of response to difficulty spanning a positive cycle of achievement

⁵ Discussed in Chapter 5.

⁶ Such as the Plunket Centennial Conference (2007)

characterised by increasing self-efficacy and a negative cycle of risk characterised by increasing disequilibrium and multiplying problems. A family that becomes enmeshed in a 'chain of risk' (Rutter, 1987) is less likely to be able to provide the responsive infant care known to be essential to optimal development during the first year of life (Brainwave, n.d.). Disentangling families thus enmeshed is likely to require tertiary intervention and specialist expertise. Finding straightforward and simple ways to respond to challenges, as experienced by parents themselves, may enhance the potential for developing low cost but effective interventions.

Structure of the thesis

The thesis is presented as eleven chapters. In this introductory chapter I have put forward the view, the keystone for the thesis, that for children, a good start in life is a basic human right which may be compromised if parents or caregivers are not in a position to provide optimal care or do not have the support required to do so. I have listed the research questions, which explore how first time parents experience transition to parenthood, with a particular focus on how they experience support, and inquire into what this might mean for policy and service provision. I have registered my interest in how the system of support for first time parents in New Zealand might be made more effective in assisting them to develop competence and resilience as they adapt to the multiple changes involved in transition to parenthood.

Chapter 2 sets the scene by presenting relevant demographics; describing what the system currently provides for families in transition to parenthood; and discussing the notion of family. In Chapter 3 the resilience literature is reviewed. Since availability of support is a key aspect of resilience, Chapter 4 discusses effective support. Chapter 5 describes methodology, methods, ethical issues and recruitment. The four following chapters explore the experiences of participants in diverse circumstances as they adapt to life with a first baby, presenting their views about how the system of support could more successfully meet the needs of first time parents. These chapters respectively report data pertaining to preparation; the birth and perinatal period; the first three months of parenthood; and the first year. Chapter 10 presents an overview and interpretation of the findings, using the resilience framework mentioned above. The final chapter considers implications of the findings for policy and service delivery.

CHAPTER 2 THE POLICY CONTEXT

This chapter sets the scene by discussing important background conditions that influence the position of first time parents, first describing the policy context, including change in the demography of childbirth in New Zealand and how policy and services currently address needs, then considering the current meaning of ‘family’.

Local landscape of formal and semi-formal support

In New Zealand today the state maintains a system of services and policy measures to assist families in transition to parenthood. Maternity and infant health care is available free. According to the New Zealand College of Midwives website (New Zealand College of Midwives, n.d.), ‘Most women and their families (over 75%) choose a midwife as their LMC⁷’. Childbirth education classes, at which fathers or other ‘birth partners’ are normally welcome, are held regularly in urban areas, less regularly in rural areas. Dwyer (2009) notes that District Health Boards (DHBs) provide most antenatal education in New Zealand, often by contracting out to other providers. The second biggest provider is Parents Centre, a non-profit organisation. There are also independent providers with contracts with DHBs. Midwives are not legally obliged to refer women to childbirth education or recommend it, though many do. Dwyer (2009: 34) found that this typically involves the LMC talking with the woman about ‘whether she had thought of attending antenatal classes and possible options available’. Most first births are in birthing centres or hospitals. In central Auckland, where some participants in my study lived, women who give birth at Auckland Hospital are transferred to Birthcare⁸ after a few hours and stay there for a couple of days. LMCs undertake home visits to monitor the health of mother and child and may be available for support for breastfeeding and other issues. After six weeks LMCs formally ‘hand over’ to a Well Child or Tamariki Ora⁹ service which takes responsibility for monitoring the baby’s development. In some areas Plunket Family Centres, staffed by nurses, karitane (support workers) and kaiawhina (Maori health workers) offer a drop-in service. There are also two toll-free telephone advice services, Plunketline and Healthline, both available all hours to assess problems and provide information and advice.

⁷ LMC denotes lead maternity carer.

⁸ A privately owned maternity care facility.

⁹ Well Child / Tamariki Ora services are offered free to all New Zealand children from birth to five years. They encompass clinical health checks, advice and guidance and health education and promotion. ‘Tamariki Ora’ denotes Well Child services designed by and for Maori people.

While health needs are generally attended to, there is a less comprehensive approach to social aspects of adaptation to parenthood including relationship issues, stress or loneliness. A study of relationship conflict across transition to parenthood (Kluwer & Johnson, 2007: 1102) found that 'relationship distress stemmed from problems that existed before pregnancy rather than from the emergence of distress after pregnancy' so that it might be worthwhile to address problems during pregnancy and thus 'help prevent the exacerbation of relationship distress over the first few years of childrearing'. For couples with relationship problems a national scheme run through the Family Court provides up to six hours of free counselling. Family support social work services were also available in some areas. In two of the areas where participants in my study lived, non-profit agencies provided limited housework and childcare for stressed families with pre-school children. Community organisations provide a varying range of resources that may counteract isolation or provide practical assistance. 'Coffee groups' or playgroups are routinely established by antenatal educators and Plunket as a way of creating a network of support for new mothers.

State-funded Income Support and Tax Credit schemes may assist new parents. At the time of interviewing, paid Parental Leave was available to women who had worked continuously for the same employer for an average of at least ten hours a week in the six months immediately before the baby's expected due date. In some circumstances self-employed people were eligible. Partners were eligible for one or two weeks' unpaid leave if they had worked continuously for their employer for six months or one year respectively. Working For Families is a tax credit package structured to shore up the income of people raising children. In-work tax credit is an additional payment for families in paid work. Parental tax credit, which is to help with the costs of a new baby, is available for the first eight weeks after the baby's birth. Minimum family tax credit is available to families on low wages. Working For Families payments may be made to the parents of a teenage parent rather than the teenage parent. A Sickness Benefit may be paid if a new parent has to stop work or reduce hours worked. People aged eighteen and over who are caring for a child alone are eligible for Domestic Purposes Benefit (DPB). Both before and after the birth of a child Emergency Benefit is sometimes paid to younger parents not in the workforce. Accommodation Supplement may help meet accommodation costs incurred by anyone, in paid employment or otherwise, if they meet certain income and asset tests.

Demography of childbirth

The policy environment outlined above reflects the changing demographical reality of contemporary New Zealand. The median age of women giving birth in New Zealand has been rising since 1972 (New Zealand Health Information Service, n.d.). While the percentage of mothers aged 30 and over has increased steadily since 1978 the number in their twenties has decreased:

In the June 2004 year, women aged 30-34 years had the highest fertility rate (118 births per 1,000 women), followed closely by those aged 25-29 years (112 per 1,000). This is a significant departure from the early 1970s when early marriage and early childbearing were the norm. At that time, the 20-24 year age group was the most common for childbearing, with a fertility rate of over 200 births per 1,000 women. This compares with only 71 per 1,000 in the June 2004 year. Similarly, the current fertility rate for women under 20 years (27 per 1,000) is roughly one-third of the rate in 1972 (69 per 1,000) (New Zealand Health Information Service, n.d.)

As well as having the highest fertility rate in the year to June 2004, women aged 30-34 had the highest number of first babies:

Table 1 Number of births to women having a first baby in year to June 2004

Age group	Under 16	16-19	20-24	25-29	30-34	35-39	40+	Not stated
Number of first births	62	1868	3656	4133	5001	2123	435	2372

Source: Table 3.4, Maternity and Newborn Collection, New Zealand Health Information Service

The MSD publication *New Zealand Families Today* (2004a: 25) notes that women now have fewer children. It presents figures showing that in 1966 the total fertility rate (live births per woman) was 3.4 whereas in 2003 it was 2. The authors posit reasons for the decrease:

Current very low fertility rates and delayed childbearing are caused by factors including investment in prolonged study, workplace demands, and the need for two incomes to support a family...many women are either avoiding pregnancy or are limiting the number of children they have to stay in the labour force. [There may be] a complex interaction between women's

increasing economic independence, active choices about childbearing, and the availability of prospective partners who have similar education and income levels and who are willing to become parents (MSD, 2004a: 25).

Pressure to be in the work force affects timing of childbearing and is an impetus to return to paid employment after having a baby. While returning to work may be for financial reasons it may also be for reasons of status, interaction with other adults and to keep a place on an established career path, often important to older women who have spent over a decade in paid employment and may miss rewards conferred by their work.

From the 1920s until the 1980s it was usual for women to have their first baby by their early twenties. During the baby boom, which began in the mid-1940s, the interval between pregnancies was short (MSD, 2004a). Together, these circumstances meant that cohorts of women were at the same age and stage at roughly the same time. However women who have a first baby in their early twenties are no longer the norm; they are in a category somewhere between 'teenage mothers', perhaps perceived as 'at risk', and 'older mothers', who may wish to explore an established career. Since women having a first baby now span such a wide age range it is much less likely that a first-time mother, whatever her age, will find herself surrounded by peers with small children. Furthermore, increased geographical mobility is characteristic of people in their twenties and thirties (MSD, 2004a) and the New Zealand population is highly mobile internationally (Lunt et al., 2006). Hence women with babies are likely to live at some distance from relatives who might have provided support. Further, for some time families have been getting smaller so the pool of potentially supportive relatives is limited. Compared with earlier decades more older women are now in paid employment so a woman's own mother may be unavailable to support her. Because many women return to work not long after childbirth those choosing not to do so may struggle to find role models who could provide guidance or even peers to provide adult company (Harvey, 2006).

It is interesting to compare the situation of new mothers in New Zealand today with that of a particular cohort of new mothers almost 30 years ago. Park (1982) spent two years researching how stress was dealt with by residents of the Auckland suburb of Pakuranga, then in existence for less than 20 years. Park's work provides a snapshot of mothers in a

particular place and time. It depicts women whose lives were full of people – so much so that they sorted friends and neighbours into categories:

The term “friend” denoted a broad category. Most people used some kind of qualifier when trying to arrive at a well-defined category. Adjectives like “close”, “real”, “good”, and “personal” were employed. Comparisons with kin relationships were made when a person was attempting to describe a “close” friend e.g. “like a sister”, “a mother figure”, “a grandmother”, “like a family to us”...close friendship was like an idealised blood relationship...In their everyday experience, informants found social relationships loosely called friendship were not always easy to sort out. “Acquaintance”, “neighbour”, “friend”, “colleague” all tended to merge into an amorphous bunch (Park, 1982: 99).

As well as being in daily contact with a large group of people who could provide informal support, these Pakuranga women in the 1980s had access to semi-formal support in the form of ‘home help’ and practical assistance at times of illness or incapacity. This was provided through churches or more formally through Social Welfare via Plunket and according to Park (1982: 367) was experienced as helpful:

One woman said “it was just like having a mum in the house”. The work that home helpers did in the house was very important, but equally important was the client’s sense of being looked after. One mother of three children pointed to having a home help when she came home from the obstetric unit as the crucial factor enabling her to breastfeed her new baby. She had been unsuccessful in breastfeeding the two older ones.

Park (1982: 100) found that these Pakuranga women referred to the neighbourhood as their place of work and presented their situation as directly comparable with those in the paid workforce:

Neighbours, mothers in the play group, kindergarten or carpool, the store keepers and tradespeople can then be seen as colleagues and business

acquaintances. A cup of tea with the woman across the road is equivalent to smoko.¹⁰

The experience of women with a first baby in the Pakuranga of a generation ago was of an entirely different order to that of many women in this situation today. There is now less availability of support services, not only of the semi-formal type that Park observed in Pakuranga three decades ago, but also formal support such as well-child services, previously available from Plunket for a longer period of time.

Adapting to life with a first baby may be challenging in the most favourable of circumstances but some families face distressing additional difficulties, including those caused by structural factors such as poverty. Birth is still a somewhat risky event for both mother and baby and medical intervention may be needed in the days or months afterwards. By three months after childbirth, 10 to 20 percent of women have postnatal depression (PND) (Matthey et al., 2004). Many are undiagnosed and untreated (Thio et al., 2006). Others have physical problems. Of the 55,119 women who gave birth in hospital in New Zealand in 2003,¹¹ 7.5 percent were readmitted within three months for treatment for birth-related conditions (New Zealand Health Information Service, 2003).

When confronted by difficulty in any form, first time mothers today are less likely to have ready access to informal support and guidance than women during most of last century. Ability to cope is undermined by the isolation in which many new parents find themselves (Goss, 1998; McAllister, 2003; Harvey, 2006). Participants' experience of support is explored in the fieldwork.

Meaning of family

Demographic change both reflects and influences changing family structure and understanding of the nature of families themselves. For a study with the experience of families at its core the meaning of family is central. Stereotypical family forms are enshrined within societies as normal and desirable. However family is fundamentally a subjective notion rooted in culture and influenced by circumstances. For instance, teenage mothers often continue to live with their own parents (Kalil, 2003). Sometimes people with

¹⁰ Colloquial New Zealand referring to short break from work for tea or a cigarette.

¹¹ First interviews took place in 2005.

no kin or legal relationship to a child may be an essential part of that child's life and considered 'family' (Munford & Sanders, 1999). The western model of family is of course only one of many ways of safeguarding and nurturing family members. Some participants in my study are likely to understand 'family' as the nuclear family while others may have a more expansive notion of the term so the term, so 'family' should be used flexibly, with reference to participants' perspectives. In New Zealand, inclusive understandings of family are normal for Maori and Pacific peoples, with responsibility for well-being of members shared by a larger number of people, potentially giving members access to a wide range of sources of support (Selby, 1994; Tulele, 1994; Atagavaia, 2001; Pohatu, 2003). In a study of Maori, Pacific and Pakeha new parents, the Infant Care Practices Study Team (1999: 245) found that:

Many Pacific and some Maori parents appeared to make the transition into parenthood more easily than other participants and this was probably due to the fact that these parents had close, and often resident, family/whanau support...Amongst all of the Pacific groups participants commented that strong family support for new parents was assumed not only by the parents but also the family. Children are a treasured family member and their wellbeing is the responsibility of all of the family. Female family members, particularly mothers, mothers-in-law, sisters and aunts, provided considerable practical, financial and emotional support for new mothers.

The notion of 'whanau', a Maori term commonly understood as meaning extended family or family group, has been observed to expand in response to the urban environment to partly compensate for 'the fact that whakapapa¹² links are often marked by the separation of distance' (Cram & Pitama; 1999: 149). These authors quote Pita Sharples:

[It is] somewhat natural for Maori people to operate communally in a manner of 'kin whanau' when they settle in a single suburb within a city – even if they originally come from different tribal areas (Cram & Pitama, 1999: 149).

In recent years, increasing diversity of family form has been a feature of western societies (Patterson, 2002a; Walsh, 2002; Beavers & Hampson, 2003; Equal Opportunities

¹² Whakapapa is defined as 'genealogy, genealogical table, lineage, descent' (www.tetaurawhiri.govt.nz).

Commission, 2006) including New Zealand (Munford & Sanders, 2003; MSD, 2004a). The meaning of the term 'family' has been thoroughly debated:

From the middle of last century when it was taken rather unproblematically to mean the nuclear family unit (usually including two adults who were the birth parents of the children in the household who all co-resided in the same physical location), this term and its usage has undergone major challenge (Munford & Sanders, 2003: 4).

Challenge to the nuclear family stereotypical ideal was occasionally vigorous. In a booklet called *Everything a Single Parent Needs To Know*, the Council for the Single Mother and Her Child (1981: 4) scathingly critiqued the notion of family prevailing at that time:

The notion of 'the family' held up so often by politicians, Government Committees and some sociologists is an abstract ideal which society considers desirable and appropriate in human relationships. Until recently, this institution has not been questioned. However, with more information coming to light regarding wife-beating, child abuse, rape and poverty within marriage...it is now fair comment to say that the nuclear family does not suit the needs of thousands of people in New Zealand and in some cases causes untold misery and deprivation. Despite the facts, however, the ideal 'nuclear family' is still upheld as the cornerstone of society and a decision to reject this for an alternative lifestyle seen as a threat to the whole of society.

Fewer families now choose to fit themselves into the traditional nuclear family template, opting instead for 'alternative' lifestyles of diverse kinds and demonstrating their feasibility for raising children successfully. Sole parenting, undertaken by an increasing number of men¹³ as well as women (MSD National Benefit Factsheets 2009), is now so common that it is no longer 'alternative'. The introduction in 1973 of the Domestic Purposes Benefit (DPB) gave sole parents a regular income, however inadequate at times. As a result of separation and re-partnering many children now belong in more than one household. Same

¹³ The percentage of men receiving DPB rose from 9.5 in September 2004 to 12.1 in September 2009 (MSD National Benefit Factsheets, 2009).

sex couples raise children. Hence the Families Commission Act 2003 (Section 10 (2)) defines family broadly:

[A family is] a group of people related by marriage, blood or adoption; an extended family; two or more persons living together as a family; or a whanau or other culturally recognised family group.

Family is a fluid concept, understood differently by people from different backgrounds and changing over time: there are multiple variations on the theme of 'two or more persons living together as a family'. Roles and tasks prescribed by the nuclear family ideal are not always appropriate for new types of family, who rework and reallocate roles and devise different ways of fulfilling their functions, as Silberberg (2001: 57) notes:

The traditional nuclear family is now one of many forms of family in Australian society. There are now nuclear families based on an egalitarian partner relationship, sole parents, blended and stepfamilies and same-sex families. Some of the traditional family practices are in conflict with the values of these alternative family types. These families face the challenge of developing new practices which reflect their alternative values, often without any role models to work from.

Even when families ostensibly match the nuclear family pattern, they may organise themselves differently from the stereotype of Mum looking after children at home, Dad out breadwinning (Summers et al., 1999). Many women now delay childbearing until they are established in a career (Wu & MacNeill, 2002) and often return to their job within weeks or months of childbirth. The role of fathers is also changing. A United Kingdom (UK) study of fathers of babies reported a rapid rise in the proportion of fathers taking more than two weeks off work when a child is born (Smeaton, 2006: 56

The traditional stereotype of a stern and distant father who goes fishing when his children are born and perceives his function primarily as breadwinner, leaving emotional involvement to the mother, bears little relation to reality.

Walsh (2002: 133) comments that families are dealing with unprecedented challenge as the pace of change accelerates:

Over a lengthening family life cycle, children and their parents are likely to move in and out of varied and complex family configurations, each transition posing new adaptational challenges.

However it could be argued that rather than evolving to encompass new diversity the accepted meaning of family is catching up with reality. Diversity in family form is hardly novel. Even in western culture at the height of the nuclear family's pre-eminence family form varied considerably, including stepfamilies of various types and families whose living arrangements included adopted and fostered children or extended family such as grandparents or adult children. In defiance of conventional norms, unmarried mothers did not inevitably relinquish their children to adoption or 'family homes'.¹⁴ Sometimes grandparents helped care for children and rule-bending by child welfare officers enabled some single mothers to keep their children (Dalley, 1998: 217):

Inquiries into ex-nuptial births could lead to a range of assistance to single mothers: finding them work and accommodation, instituting maintenance proceedings, and giving advice on childrearing. Such assistance was non-monetary, although child welfare officers developed ways of aiding women financially, such as 'fostering' their children with them and paying board rates, and invoking the provisions of the Social Security Act 1938 to provide emergency and other benefits.

New Zealand has come a long way since such ploys were resorted to in order to support families who did not match the norm; the state now 'seeks to maximise the ability of all family structures to benefit their members' (MSD, 2004a: 77). However changed demographics and family structure may necessitate new approaches. Recognition that the notion of 'family' is broad makes it important to remember that priorities, needs and aspirations will differ accordingly.

¹⁴ Large houses bought or built by the Child Welfare Division in the 1950s, staffed by a married couple and receiving children as an intermediate step before adoption, fostering or return to family of origin (Dalley, 1998).

CHAPTER 3 DOCUMENTING RESILIENCE: FROM STEEL DOLLS TO PATHWAYS

In the academic literature, the notion of resilience has been used to understand the experience of people who successfully cope with challenging circumstances, including life transitions. In considering the usefulness of the resilience literature for understanding the experience of those in transition to parenthood, it is necessary to review a wide ranging literature, which has been developed for other purposes. In this chapter I trace the evolution of the academic resilience literature from its somewhat unexpected genesis in the fields of developmental psychopathology and risk to its utilisation in practice manuals. I consider the meaning of terms used in the literature in other contexts. The chapter closes by noting key features of the resilience literature that became useful as a frame of reference for analysing data gathered in the course of the fieldwork.

The notion of resilience, defined as 'a dynamic process of positive adaptation despite experiences of adversity or trauma' (Safe Start National Evaluation Team, 2003: 1) is important to my study because it provides a way of thinking about a protracted process of achieving competence after a period of disequilibrium or difficulty. Resilience of this kind is an 'ordinary' concept (Masten & Powell, 2003). A common theme in literature, film and folk tales (Goldstein, 2002) it is widely understood in the vernacular as a potential response to difficulty. 'What doesn't kill you makes you stronger' is a familiar saying.¹⁵ In the academic literature, for the term 'resilience' to be used appropriately there must be evidence of good outcomes in a situation difficult enough to make poor outcomes probable (Cowan et al., 1996; Cicchetti, 2003; Pryor, 2004; Davidson, 2008). Resilience theory is regarded as potentially useful for the design of preventive strategies and policy to improve the odds of good outcomes (Masten & Coatsworth, 1998).

It is now generally accepted that resilience is a process (Hawley & De Haan, 1996; Fraser et al., 1999; Rutter, 1999; Blum et al., 2002; Conger & Conger, 2002; Patterson, 2002b; Cicchetti, 2003; Luthar & Zelazo, 2003). This was not so in the early days of resilience research when resilience was thought of as a characteristic or trait. Resilient children were portrayed as heroic figures, 'invulnerable' or 'invincible' (Werner & Smith, 1982) in the face

¹⁵ While speaking to a class of early childhood education students about my research, I asked them what they understood by resilience and they produced this saying along with others including 'The rougher the weather the deeper the roots' and 'Fair weather doth not a mariner make'.

of adversity, and pictured as 'steel dolls'. Now resilience is regularly explained metaphorically through images of travel: as a pathway or journey (e.g. Hawley, 2000; Kilmer et al., 2001; Walsh, 2002; Duncan et al., 2005; Collins, 2008; Ungar, 2008) or trajectory (e.g. Rutter, 1987). For example:

Family resilience describes the path a family follows as it adapts and prospers in the face of stress, both in the present and over time. Resilient families respond positively to these conditions in unique ways, depending on the context, developmental level, the interactive combination of risk and protective factors, and the family's shared outlook (Hawley & DeHaan, 1996: 293).

Metaphorical definitions of resilience abound. Images of 'bouncing back' (e.g. Hawley & DeHaan, 1996; Butler, 1997; Turner, 2001) or 'rebounding' (e.g. Walsh, 1998; Henderson, 1999; Heiman, 2002; Saleebey, 2002a) suggest an energetic response to adversity and renewed vigour without conveying the time and effort involved in achieving positive outcomes despite adversity. Yet resilience has nothing to do with a 'quick fix': it is a protracted, active process of 'negotiating' (Rutter, 1987; Ungar, 2008) through a hard time. After years of work on resilience, Werner (1999) warned of the pitfall of thinking that resilience can be bestowed upon children. There is no magic wand that practitioners can wave, nor any 'blueprint' to follow (Walsh, 1998). Rather than an involuntary response as implied by images of 'rebounding', resilience is an active process requiring engagement, determination and 'ability to act in a planful way' (Fraser et al., 1999). This process takes time (De Haan et al., 2002).

Resilience was brought into the academic limelight by a series of publications describing Werner's longitudinal study (Werner & Smith, 1982) of all the children born on the Hawaiian island of Kauai in 1955.¹⁶ Of the 698 children in the study about a third were beset by several risk factors and faced cumulative stress (Werner & Smith, 1992; Werner, 1999). Although many in the 'at risk' category developed serious behavioural or learning

¹⁶ Hawaii was still a territory then. Most of its ethnically diverse population were descendents of South-East Asian and European immigrants who came to Hawaii to work on plantations. More than half the children in the cohort grew up in families whose fathers were labourers and mothers had not graduated from high school. A reason for selecting this location was that 'medical, public health, educational and social services compared favorably with most communities of similar size on the U.S. mainland' (Werner & Smith, 1992: 25).

problems at some time during their first two decades, around a third 'succeeded in school, managed home and social life well, and expressed a strong desire to take advantage of whatever opportunities came their way when they finished high school' (Werner & Smith, 1992: 192). These findings were reinforced by findings emerging from Garmezy's work (e.g. Garmezy et al., 1984) in the field of developmental psychology. Garmezy's previous work was on children thought to be at increased risk of mental illness because of prenatal mental illness. Intrigued by findings that many were developing more successfully than predicted, indeed normally, Garmezy established Project Competence to investigate competence in a range of situations deemed to create risk (Garmezy et al., 1984; Masten & Powell, 2003). The results of both studies showed that many children eventually manage to overcome adversity, achieve competence in some aspect of life, avoid the chaotic if not criminal future to which they were thought to be destined and often thrive and succeed in their community and society. This contradicted previous studies that confirmed the prevailing opinion that high-risk children were sure to fail, portraying their developmental course as 'deterministic, inevitably resulting in maladaptive and pathological outcomes' (Cicchetti, 2003: xix). The work of Werner and Garmezy validated an optimistic view of these children by presenting them as full of potential rather than doomed. The hopeful perspective engendered by resilience research has been referred to as a 'sea change' (Masten & Powell, 2003) or 'paradigm shift' (O'Leary, 1998; Wong, 2008).

Since 'resistance to stress in children is relative, not absolute' and 'implies a track record of successful adaptation in the individual who has been exposed to biological risk factors or stressful life events' (Werner & Smith, 1992: 4) Werner replaced the notion of 'invincibility' with 'resilience'. Rather than an inherent quality possessed by individuals to a greater or lesser degree, or the expression of characteristics that together constitute 'resiliency', the term 'resilience' is now understood to refer to a normal developmental process or common pattern of adaptation to a unique set of circumstances (Cicchetti, 2003), the result of interaction with the environment in ways often explained by ecological theory (Walsh, 1998; Waller, 2001; Prilleltensky et al., 2001; Connolly, 2001; Waller, 2001; Duncan et al., 2005). Further, research has repeatedly shown that protective factors that promote resilience in children facing adversity also promote good outcomes in favourable circumstances.

Over time the research evidence convincingly demonstrated that resilience is the product of the complex interaction of an array of individual, environmental and contextual factors (McCubbin et al., 1997; Norman, 2000; Conger & Conger, 2002; Walsh, 2003; Kalil, 2003). It is an active process, requiring people to draw upon resources available to them by making use of their own abilities and engaging assistance (Walsh, 1998; Connolly, 2001; Prillettensky et al., 2001; Waller, 2001; Duncan et al., 2005), 'an ongoing process of garnering resources that enables the individual to negotiate current issues adaptively and provides a foundation for dealing with subsequent challenges' (Yates et al., 2003: 249). It has been the topic of research in a vast range of settings. The following is a tiny sample: hospitalised children (Bolig & Weddle, 1988); adjustment to abortion (Major et al., 1998); minority women (Bachay & Cingel, 1999); urban African American adolescents (Miller et al., 1999); sexually abused women (McClure et al., 2008); immigrant and local youth in Hong Kong (Wong, 2008). While each set of adverse circumstances is particular to a situation as is the set of 'protective factors' available to help put things right (Hawley, 2000), ongoing research has suggested that resilience is essentially 'ordinary' (Masten & Powell, 2003). Each person accesses a unique set of protective factors in a unique way but there is nothing particularly unusual about what they access and how they go about it.

Werner's (1999) writing on resilience, infused with her vision that all children can do well, provided practitioners with reason for hoping for the best rather than expecting the worst and was received as inspirational. There have been enthusiastic efforts to translate research on children's resilience into manuals (e.g. Henderson et al., 1999) and training courses for practitioners.¹⁷ Fretting that the notion of resilience may actually become 'too popular', for 'if something becomes very, very popular it loses its meaning', Werner reminds followers of three of her key findings. First, resilience is the result of the interplay of individual, environmental and situational factors. Second, resilience does not equate to strength: 'It's the going back and forth from vulnerability to resiliency that's actually the essence of the phenomenon' (Werner, 1999: 11) and third, the concept is 'mostly based on children who did it for themselves, with a little informal help by kith and kin'; agency is inherent in resilience. Werner (1999: 19) advises that programmes to boost children's resilience should be carefully designed to meet specific objectives then evaluated to ensure that they 'actually effect lasting positive changes in the behaviours of the individuals, not just in your hearts'.

¹⁷ See Inkpen, 2004.

Protective factors

The pioneers of resilience research noted that many children in their studies did not slide into the unfortunate experiences predicted by their 'at risk' label. Observing that some children 'exposed to poverty, biological risks, and family instability, and reared by parents with little education or serious mental health problems' yet developed into competent and autonomous young adults, Werner & Smith (1982: 3) became intrigued by what it was that broke the connection between risk and poor outcomes accordingly foretold and began to seek the 'roots of their resilience, the sources of their strength'. Thus began the hunt for 'protective factors', conceptualised as guarding against negative consequences of 'at-risk' status (Bowes & Hayes, 1999). Researchers first looked for personal qualities that made children impervious to damage but as research proceeded it became apparent that resilience is also enhanced by external factors. Ongoing research confirmed three sets of protective factors: attributes of children themselves; family qualities; characteristics of the wider social environment (Garmezy, 1991; Fraser et al., 1999; Werner & Johnson, 1999; Luthar et al., 2000; Masten & Powell, 2003).

Individual attributes

Individual factors that promote children's resilience include talents, skills, general intelligence and an engaging personality. This is because a key mechanism underpinning resilience is a positive feedback loop of approval and motivation, leading to increased self-esteem and achievement. Children who present as friendly, bright or talented tend to do well because such qualities 'elicit predominantly positive responses from the environment' (Werner & Johnson, 1999: 261), enhancing a child's sense of self-worth. Qualities that generate positive feedback include athleticism; an engaging 'easy' temperament; intelligence; literacy; and talent or skill valued by the child's family or culture. Proficiency earns respect from peers, increases self-esteem, self-efficacy and confidence and potentially provides solace in the midst of chaos. Faith, not necessarily religious, sustains hope and enables children 'to believe that life, despite everything, made sense and that even the pain they experienced could ultimately be transformed' (Werner, 1999: 17). Communication, problem solving and ability to 'act in a planful way' are all important due to their association with ability to adapt (Fraser et al., 1999). Individual attributes are not so much important in themselves but because they promote competence and self-efficacy and establish a child on a positive trajectory where achievement is rewarded and competence and self-efficacy reinforced.

Family qualities

Protective family qualities include warmth, structure, effective parenting and adults' high expectations of children (Masten & Powell, 2003). A significant factor that 'seems to cut across different cultures, creeds and races' (Werner, 1999: 15) is attachment, which is especially important in infancy (Zeanah & Boris, 2000; Crockenberg & Leerkes, 2000). The attachment bond may be with parents, grandparents, aunts, older siblings or people not genetically related to the child: the important thing is that whoever the child is attached to is a loving, stable feature of the child's life. Fergusson's longitudinal study of 1265 Christchurch children found that strong attachment reduced the incidence of internalising behaviours such as depression, anxiety and suicidal thoughts (Fergusson & Horwood, 2003). Further, the family provides opportunities to 'give something back', learn about reciprocity and develop a sense of belonging and usefulness. According to Werner (1999), encouraging and welcoming a child's contribution to the household engenders lasting willingness to contribute, promoting a sense of being a valued member of a community and generating self-esteem that is grounded in everyday experience.

Supportive systems outside the family

Communities offer scope for developing resilience by providing opportunities to develop talents through clubs or interest groups and functioning as a source of mentors to encourage children's competence and self-efficacy and help them transcend difficulty (Luthar & Zelazo, 2003; Masten & Powell, 2003).¹⁸ By looking beyond appearances and discerning a child's potential, mentors inspire hope by encouraging belief in a positive future. A mentoring relationship can begin early in a child's life (Werner, 1999) perhaps through pre-school centres. It is important that the relationship is sustained long enough for a child to gain confidence. Werner's research suggests self-worth is enhanced by participation in youth groups, church groups, or any cooperative venture where 'you were not just a passive recipient, but where you were called upon to help someone else and you grew up in the process' (Werner, 1999: 17).

The devil in the detail

The categorisation of protective factors was followed by reflections on whether the achievement of good outcomes despite adversity is supported by the same conditions that

¹⁸ This route to resilience is the plot of numerous movies where coaches or teachers become mentors e.g. *Honey* (Higgins & Woodruff, 2003).

support good outcomes in favourable circumstances. Some authors recommend limiting the term 'protective factors' to those that operate in a literally protective way, shielding people from specific effects of particular types of risk (Cassen et al., 2008). A main effects or additive model, on the other hand, indicates that protective factors should be envisaged as 'compensatory' processes, equally beneficial to all (Fergusson & Horwood, 2003). It has been suggested that universally beneficial factors would more accurately be called 'competence-enhancing factors', or 'promotive factors' (Sameroff et al., 2003). Since this debate has not been resolved it is important, for the sake of clarity, to precisely define terms used, as many recommend (e.g. Luthar & Zelazo, 2003).

Many are convinced that ongoing research shows that resilience fits a main effects model, citing evidence that the protective factors that enable 'at-risk' children to succeed are helpful for all (Masten & Coatsworth, 1998; Fergusson & Horwood, 2003): they are 'well-established correlates of doing well in general, under low-adversity as well as high-risk conditions' (Masten & Powell, 2003:13). Consequently the term 'protective factors' is now usually used in its colloquial rather than its technical sense (Luthar & Zelazo, 2003). However, even when protective factors help children to conform to an externally determined 'good outcome' such as academic success, this does not mean that they have escaped unscathed, nor that children who do not meet such standards have failed. It may simply be that researchers are envisaging good outcomes, poor outcomes and protective factors from their own culturally derived point of view. It is also possible that when seeking protective factors researchers overlook some because of preconceived expectations. Luthar and Zelazo (2003: 525) are among authors calling for research to be 'finegrained' and undertaken in a wider range of cultures:

There is a need for greater consideration of cross-cultural variation in resilience processes. The literature on this field (as in developmental psychology more broadly) is singularly lacking in international perspectives, and it will be useful to illuminate the types of risk modifiers that tend to be highly robust across widely disparate cultural contexts and those more idiosyncratic to particular settings.

In some contexts something usually believed to be protective may be detrimental, at least in terms of mainstream understanding of good outcomes. In some contexts resilience may

be associated with behaviour that looks antisocial or destructive to an outside eye (Ungar, 2008). Luthar and Cichetti (2000) point out that while high peer status is typically beneficial for children's overall adaptation, among inner city youth high peer status is associated with repudiating conventionally conforming behaviours, including academic effort. Waller (2001: 294) says that while social support from peers can be a protective factor, it 'might also be a risk factor if the supportive peer group pressures the individual to participate in self-destructive behavior'. Since people may look for role models within their networks of social support, it is possible that destructive patterns of behaviour might be adopted and resilience compromised if available role models are themselves entrapped in a risk chain. Clearly – or rather somewhat confusingly – the devil is in the detail. In order to comprehend or even notice the detail, understanding context is crucial.

Family resilience

As noted in the introduction to this thesis, the MSD has recognised the importance of family resilience, having commissioned a literature review entitled *Family Resilience and Good Child Outcomes* (Kalil, 2003); a research report entitled *Stepfamilies and Resilience*; (Pryor, 2004); and a research report on *Early Childhood Centres and Family Resilience* (Duncan et al., 2005). Interest in family resilience is comparatively recent. At first the family featured in the resilience literature as the 'most proximal environment for an individual's development, exerting a profound, enduring influence for good or ill (Luthar & Zelazo, 2003); or sometimes as the source of problems (Hawley, 2000; Kalil, 2003). When the notion of resilience was applied to families, interest initially focussed on characteristics of families deemed resilient and 'family typologies' (McCubbin & McCubbin, 1988), then 'relational processes' (e.g. Walsh, 1998; 2002; 2003; Canary et al., 2002) deemed helpful in equipping families to overcome adversity. As McCubbin and McCubbin (1988: 247) say:

Research on family resilience was initially characterized by a heavy investment in descriptive research listing those family strengths which authors inferred from family therapists' testimony and questionnaires...Family scientists have turned to theory building and research which move beyond these descriptive accounts, involve tests of the efficacy of these strengths, examine underlying patterns of family functioning referred to as family typologies.

A key finding of the empirical work of McCubbin and McCubbin (1988) was that for families other than white middle-class families, internal strengths appeared to be complemented by community support, service, religious programs, and a sense of belonging or fitting into the community so that 'the emphasis on internal family strengths, which characterizes the current studies on white middle-class families, may not be the most appropriate strategy' (McCubbin & McCubbin, 1988: 253).

There are now three distinguishable perspectives in the family resilience literature; therapeutic; structural; and situation-focussed. Each perspective favours a different type of protective factor. First, the influential literature which emerged from stress and coping theory and family therapy focusses on relational processes as protective factors. The second perspective looks beyond the personal to the influence of structural factors. The third involves applications of the notion of resilience to the situation of families in specific potentially problematic situations, such as coping with the illness or disability of a family member, usually a child (e.g. McCubbin et al., 2002; Patterson, 2002b; Shapiro, 2002; Lee et al., 2004; Lavee, 2005; Ellenwood & Jenkins, 2007). This last strand of the literature places the family at the centre of the discussion and focusses on what families actually experience, what they do and what they find helpful, occasionally venturing further to explore not just what it is that helps but how it helps.

Therapeutic perspective

When the notion of family resilience was recognised as having potential for clinical practice, theoretical work from this perspective soon followed (Hawley & DeHaan, 1996; Hawley, 2000; Patterson, 2002a; 2002b) as did discussion of applications (Walsh, 1996; 2002; 2003; Ellenwood & Jenkins, 2007). In this strand of the literature there is a tendency to conflate family functioning and resilience. 'Healthy family processes' are envisaged both as the method through which families are equipped to tackle difficulties (so the work of the therapist is about strengthening these processes) and the marker of family resilience (because a family with 'healthy' processes will be able to resist the deleterious effects of adversity). Patterson (2002a: 234) distinguishes between 'family functioning', which is 'multidimensional, with several processes characterizing the family unit as a whole such as cohesiveness, flexibility, affective and instrumental communication, behavioral control, and so on' and 'family functions' which are 'important functions that families perform for their members and for society'. Patterson (2002a: 235) provides the following illustration:

A high-quality parent-child relationship appropriate to a child's developmental needs is a prime example of success in fulfilling the nurturance and socialization function. Child abuse or domestic violence would be examples of failure to accomplish this function.

Patterson (2002b: 353) suggests a possible way of assessing family resilience: the degree to which a family is competent in fulfilling one or more of four 'family functions' that centre on: material well-being; protection of vulnerable members; nurturing and self-development; and belonging.

While the ecological model is recognised in this strand of the resilience literature, the importance of context and the impact of other levels of the ecological environment are eclipsed by codes of family functioning derived from clinical research undertaken on a limited range of families, predominantly middle class Americans. The viability of transferring this knowledge to other contexts, or even from unstressed to stressed families in similar contexts, is unproven, as noted by Walsh (2002: 32):

Research on healthy family functioning has provided empirical grounding for assessment to identify key processes that can be fostered in intervention with distressed families...However, most empirical measures have been standardized on white, middle-class, intact families who are not under stress

Walsh's work (1996; 1998; 2002; 2003) is much quoted and clearly highly regarded (e.g. Kalil, 2003). It is from a clinical perspective, targeting 'processes that foster relational resilience as a functional unit' (Walsh, 1996: 262). This family-centric view runs into a dilemma (Walsh, 1996: 269). On the one hand, families and their circumstances are diverse, making it 'imperative to go beyond any one-norm-fits-all model of family functioning'; on the other hand, 'given the unique ecological niche' of each family, it would be impossible, and perhaps unwise, to construct models of family health to fit each situation' (Walsh, 1996: 266). Abandoning the idea of 'a blueprint for any singular model of "the resilient family"' Walsh (1996: 269) recommends that 'our search for family resilience with each family seeks to understand key processes that can strengthen that family's ability to withstand the crises or prolonged stresses they face'. In later work Walsh

elaborates and combines these processes in a framework for clinical practice (2002; 2003) which focuses on adaptation 'around nodal events, including both predictable, normative transitions, such as the birth of a first child, and unexpected or untimely events' (2003: 4). This framework comprises nine 'Keys to Family Resilience', each including subcategories of attitudes and behaviours thought to promote healthy family functioning. Just one, named 'Social and Economic Resources', focusses on engagement with the outside world. Here Walsh (1996: 273) recommends that families 'mobilize kin, social, and community resources'; 'build financial security'; and 'balance work/family strains'. Walsh contends that her framework can prevent problems in that families bolstered by 'psychosocial inoculation' and practised in techniques for good family functioning will be prepared to deal with just about anything that life throws at them. However, she acknowledges that as 'family challenges become more complex' this might be difficult, so that 'complex efforts and social system changes may be required to work out organized solutions and resources, such as adequate family-based healthcare or daycare for children (Walsh, 1996: 273). Walsh envisages a wider range of families than those who attend traditional therapy sessions attending psychosocial inoculation through 'psychosocial education groups'; self-help groups; or flexible arrangements for therapy sessions:

Standard therapeutic contracts of weekly sessions to termination can become more flexible and cost-effective, with intensive work around a crisis, transition or predictable stress point, such as an anniversary of a traumatic loss. Gains can be sustained through periodic check-ups or "booster" sessions. (Walsh, 1996: 277)

Hawley (2000) similarly thinks that families may require 'repeated care'. Hawley and De Haan (1996: 294) indicate that this may be a protracted process since 'therapeutic outcomes are not easily measured in the short term' and 'some families who appear to make remarkable progress in brief therapy may show low levels of resilience over time'. There is dissonance here between the idea of resilience promotion based on sustained skills development and enhanced self-efficacy and 'booster sessions', which might be seen as a prop when families falter. Echoing Walsh's inoculation idea, Patterson (2002a: 239) says that while a strong family may never acquire risk status, reinforcing them against adversity means that 'if ever they should experience a traumatic event, they will be better positioned to successfully adapt to it – to be resilient'. This is reminiscent of the 'steel doll'

notion now refuted in the children's resilience literature. Rather than seeing self-efficacy as linked to achievement by a gradual reinforcing process of gaining confidence grounded in developing skills and acquiring competence, self-efficacy is portrayed as a quality, similar to self-esteem in an individual (Hawley and De Haan, 1996: 290):

Perhaps the most distinct conceptual contribution of the budding family resilience literature is the development of the notion of a family ethos (that is, schema, world view, coherence), which attempts to describe a set of values and attitudes held by a family unit that serves as the lynchpin of resilience.

Appraisal features prominently in the therapeutic literature, underpinning belief in the possibility of change. A plank of Walsh's 'framework for family resilience' (2003) is that resilience is influenced by how a family appraises the situation in which it finds itself, as also suggested by Hawley (2000: 110):

Therapy from a resilience perspective can focus on how a common view of family as a competent entity can be accessed and developed as families seek to overcome external adversity. Fundamentally, this is a question about family identity – who are we, really, when the chips are down and we are facing difficulties? Although this issue is at the core of how a family functions during challenging times, many families have not talked about it and may find it difficult to discuss without an outsider facilitating the conversation.

Although some authors recommend a partnership approach to family therapy rather than a 'one-way transfer of knowledge, expertise and skill from therapist to client' (Allison et al., 2003: 280) it is hard to dilute the power of the therapeutic setting and the expectations it sets up. Almost inevitably the clinician has the role of professional expert with responsibility for directing operations and bringing out the family's self-efficacy, here termed 'mastery' by Patterson (2002a: 245):

Clinicians who believe in a family's inherent capabilities to discover their strengths are in a much better position to facilitate family resilience. Such clinical beliefs contribute to families' acquisition of a sense of mastery, which

is a fundamental building block of protective mechanisms leading to family resilience.

Observing that resilience is understood to be contextual, Hawley and De Haan (1996: 287) acknowledge that family resilience varies with cultural context and that 'a family's capacity to be resilient depends on the fit between their strengths and the circumstances of a particular situation'. Accordingly, they expand their concept of family ethos:

Family schema in many Native American Indian and Hawaiian families is strongly influenced by several factors less prominent in Anglo families, including an emphasis on the group over the individual, a present-time orientation, and a heightened focus on spiritual beliefs and the land...Enculturation, or a close connection to one's roots [is] an important protective factor for Native American youth...Informal support networks [are] a vital resource for African American and Navajo mothers...Thus, outcome criteria for evaluating the resilience of families may depend to some degree on their cultural background. (Hawley & De Haan, 1996: 287).

This raises questions about whether clinicians can work with families whose ethos differs from their own. Also, a clinical approach may not fit with a culturally determined preference for engaging resources through informal support networks. The therapeutic literature is positioned in a Eurocentric clinical setting. While part of an ecological perspective, the macrosystem is usually just the backdrop to therapy, noticed but nonetheless accepted as a given. Authors writing about family resilience from a therapeutic perspective do little more than caution practitioners to remember that clients are affected by circumstances outside their control, recommending that interpersonal and relational processes within the family should be strengthened to better cope with resulting problems. Walsh (1998: 12) goes a little further:

We must be cautious that the concept of resilience is not used in public policy to withhold social supports or maintain inequities, based in the rationale that success or failure is determined by strengths or deficits within individuals and their families, it is not enough to bolster the resilience of at-risk children and

families so that they “can beat the odds”, we must also strive to change the odds.

Structural perspective

‘Changing the odds’ is the focus of the structural perspective discussed below. Drawing a comparison with the public health literature, which suggests that broad preventive strategies are the most effective, Seccombe (2002: 391) echoes Walsh, asking: ‘Should families be taught how to *beat* the odds or should their odds be *changed* by some form of preventative measures?’. Seccombe suggests (2002: 384) that ‘resilience will be enhanced more by keen attention to national economic policies than by focusing upon individual personality characteristics, family attributes, or even unique community features’. Arguing that more good could be done by tackling the causes of poverty than by teaching families coping strategies for managing adversity associated with poverty, Seccombe (2002) calls for resilience promotion through preventive measures at the structural level.

Comprehensive approaches to promoting resilience are sometimes flagged in the literature only to be dismissed as unrealistic. For example, Cowan et al. (1996: 33) flag the idea of reducing adversity through adopting ‘the public health ideal of eliminating risks at the source’ or ‘eliminating swamps that breed malaria-infested mosquitos’. However they claim that it is less feasible to prevent problematic outcomes than it is to reduce the incidence, severity or duration of consequences. They conclude that ‘the best protection for individuals at risk is to help them cope with small doses of the potential risks so that they can become more resilient by dint of their own efforts’ (Cowan et al., 1996: 33). The rather defeatist and puritanical view that it is too difficult to eliminate risk and anyway, a bit of a hard time is good for people, is their interpretation of the ‘inoculation’ analogy.¹⁹

It has been suggested that broad brush preventive strategies could usefully operate in tandem with more targeted approaches, as Orthner et al. (2004: 166) suggest:

There is no question that low-income families need help in acquiring economic assets, and our findings support the potential value of higher incomes and work

¹⁹ Discussed later in this chapter in the section on risk.

hours in strengthening families...However, the value of strengthening relationships should be given equal attention by those who provide support services.

Noting that little attention has been devoted to identifying low-income families' strengths, these authors call for the extension of research to examine particular needs of people of diverse backgrounds. They warn against conflating financial difficulty with relationship problems, which low-income families may or may not have. This is a key point, indicating the importance of understanding context and thinking comprehensively. Failure to discern where problems actually arise 'leads to a deficit-oriented model of family functioning inferred from poor economic strengths' (Orthner et al., 2004: 167). Rather than make assumptions it is vital to identify actual needs. Prilleltensky et al. (2001:150) suggest that the role of social policy is to establish conditions conducive to holistic well-being:

Favorable contexts created by the presence of adequate resources, values, policies and programmes are likely to result in wellness for children and their families...[while] life stressors such as death, illness and transitions descend upon all families, we posit that children and families who have benefited from positive contexts would be able to cope with stressors quite well. Pathways to resilience occur when not all conditions leading to wellness are favourable, but some of them compensate for others...The implication is that interventions should be comprehensive, and that macro interventions should be accompanied by intensive efforts to restore the sense of power and control at the personal level.

The value of a comprehensive approach underpins Middlemiss's (2005) view that collaborative, multi-setting approaches promote children's resilience. Middlemiss suggests that organisations collaborate to plan areas to work on to increase the likelihood of improving outcomes for children and children's progress over time.

A study of early childhood education centres and family resilience (Duncan et al., 2005) exemplifies a comprehensive perspective on resilience. The authors locate the study in place and time in New Zealand in the early 21st century and take the impact of structural factors as given, thus avoiding the possibility of 'blaming the victim'.

The realities of a life of poverty, unemployment, poor housing, and poor nutrition affects the way families interact with children (and consequently children's health and education outcomes). It is also likely to affect parental outcomes, life satisfaction and the ability of families to support children's resilience. The difficult realities of many New Zealand families are much more likely to be the result of social and economic circumstances than any deficiency within the family...The macrosystem is important in this study, as this is the level of beliefs, values and practices within society and its cultures [and] includes the policies and practices that influence family functioning, the provision of EC and other support agencies (Duncan et al., 2005: 8)

These findings suggest that it is not the presence or absence of a particular protective factor that influences family resilience, but rather a particular combination of factors in a specific environment. While respondents in Duncan et al.'s (2005) study frequently made connections between lack of money and feeling depressed and trapped they were diffident about approaching agencies for support because they did not feel 'deserving'. Yet in New Zealand the idea that societal conditions are implicated in people's problems - and may play a part in how they resolve problems - is neither novel nor unfamiliar; although debated and challenged, a sense of collective values and community responsibility has a place in the New Zealand psyche (Dalziel, 1992). Reluctance to seek help may reflect inadequacies in how support is delivered. Applied to the situation of families having a first baby, ideas discussed in this section indicate the worth of a comprehensive approach encompassing a range of strategies aiming to reduce financial strain; meet needs associated with factors such as age group or culture; and pick up potential problems at an early stage so that they can be quickly addressed before they get worse or start a chain of risk. All of the above requires close attention to context because what works in one context may not work in another and what attracts some puts others off. This last issue (the significance of context) is discussed in the next chapter.

Situation focus

Some studies explore what people actually do when faced with a particular type of challenge. One area of inquiry which is relevant to the situation of families adapting to parenthood is the impact of reduced income and financial difficulties generally on

adaptation to change. This intersects with the structural perspective described in the previous section.

While some studies of resilience in families living on a low income indicate that their plight is due to structural factors (e.g. Seccombe, 2002, discussed above) others are reluctant to conclude that this is so. For example, a study of 143 inner city families confirmed the expected link between poverty and disadvantage, in fact finding that 'strikingly high rates of disadvantage demonstrated are higher than were to be expected' (Clark et al., 2000, 81). Finding that the difficulties of these 143 families included poor morale, low self-esteem, limited access to other resources and 'impoverished quality of family relationships' Clark et al. (2000: 82) place responsibility for these troubles with the family:

It could be argued that a dysfunctional family from whatever cause may lack the internal wherewithal either to obtain adequate other material resources or to benefit from them and thereby come to depend upon social welfare... Enabling and empowering individuals to understand and solve their own dilemmas would lead to a boosting of morale and of self-esteem which could then further mitigate some of the adverse effects of living under poverty.

These authors go on to speculate that breaking cycles of disadvantage would require case work, social work counselling or family therapy. However interventions like these are liable to be expensive and may not be accessed by those who need them most.²⁰ Finding that resilience is enhanced by families' confidence in their problem-solving skills and ability to 'pull together', Orthner et al. (2004:166) fret that support to bolster these aspects of family life are beyond many families' reach:

[L]ess economically advantaged families have fewer financial resources at their disposal to purchase relationship counseling or acquire the resources needed to creatively spend free time with each other in activities that can promote their strengths...Programs should be designed for low income families with more limited resources and different life experiences. This may require agencies to help families with child care, transportation, and any fees that are required for accessing support services.

²⁰ The issue of uptake of support is discussed in Chapter 4.

While envisaging the microsystem as both the probable cause of problems and the source of solutions and clinging to the idea that families could escape disadvantage if only they tried harder, Clark et al. (2000: 82) drift towards the need for a comprehensive approach:

The attitude of politicians towards changes in social policy and innovative economic and social measures may be more important as primary preventive measures than any later secondary therapeutic interventions.

In a study of resilience as experienced by rural low-income families, Vandergriff-Avery et al. (2004) found that financial difficulty was the major source of stress for participants and deduced that public assistance to relieve financial stress is a significant protective factor. Emphasising that external sources of support supplement and complement a family's internal strengths, these authors suggest that internal strengths could potentially be fortified by preventive educational programmes, including communication skills courses and parenting classes. Seccombe (2002: 389) puts this bluntly:

What do families need to change their odds of becoming casualties of poverty? Quite simply, they need money. In addition to strong individual attributes, an involved family, and a supportive community, developing sound economic policies designed to strengthen families can go a long way in giving adults and youth the necessary tools to master resiliency.

In their conclusions, Orthner et al. (2004), Vandergriff-Avery et al. (2004), Clark et al. (2000) and Seccombe (2002) all indicate that a comprehensive approach is required to assist families living in poverty.

Studies that focus on families with a vulnerable member who needs care suggest that families' sense of control increases when information and guidance provided by professionals is informative and realistic. The studies also show that families draw on a wide range of sources and types of support, including financial assistance, and that they prefer support that is accessible, user-friendly and 'collaborative' (Patterson, 2002b; Shapiro, 2002) or 'collegial' (McCubbin et al., 2002) rather than directive. Strategies found useful by people in this situation include working as a 'family team' (McCubbin et al., 2002;

Orthner et al., 2004); seeing the possibility of a positive future (Heiman, 2002; Cohen et al., 2002; Shapiro, 2002); active engagement in information seeking (Svavirsdottir & Rayens, 2005); 'finding out what you need to do and then doing the best you can with it' (Cohen et al., 2002: 108) and 'doing something actual or practical' (Heiman, 2002: 169).

Terminology: adversity; risk; 'steeling effects'

This chapter has indicated the diversity of language and thinking that is characteristic of the resilience literature. In this section some of the terminology will be explained more fully. Not only does resilience terminology compress complex ideas into a word or phrase but its use is inconsistent (Blum et al., 2001, Davidson, 2008). The term 'resilience' itself is a case in point: some insist that since resilience is a pattern rather than a trait it is 'prudent to avoid using the term resilient as an adjective for individuals and apply it, instead, to profiles or trajectories' (Luthar & Zelazo, 2003: 513). 'Risk', 'adversity', 'and 'steeling effects' must also be explained. If 'resilience is a dynamic process encompassing positive adaptation within the context of significant adversity' (Luthar et al., 2000: 543), then the level of difficulty that is 'significant' must somehow be demarcated.

Sometimes efforts to clarify terminology only add to confusion. For instance, arguing for greater clarity and consistency in use of terminology, Coleman and Ganong (2002: 556) advise against using 'resiliency', saying that the 'term 'resilience' should always be used when referring to the process or phenomenon of competence despite adversity, with the term 'resiliency' used only when referring to a specific personality trait. Since it is generally agreed that resilience is not a trait but a process, this distinction simply serves to illustrate the importance of clarifying how terminology is being used. Luthar and Cicchetti (2000: 865) explain how inaccurate use of terminology may have far-reaching consequences:

Confusion regarding terminology is a problem that practitioners, like scientists, must guard against. Increasingly there are efforts to develop programs, ostensibly anchored in resilience research, that seek to "foster resiliency in children"...[S]uch intervention efforts...implicitly foster views that if only children were helped to develop "resiliency" they might then withstand all manner of adversities. Like their colleagues in science, practitioners would do well to reframe their foci as fostering resilient trajectories or outcomes rather than resilient children.

Understanding that resilience is a process that takes time, participants in a study of African-American single mothers contextualised the terminology used by the researchers, replacing the term resilience with the colloquialism 'making it', by which they meant 'a process of achieving or approaching success out of unlikely or risky circumstances' and 'an ongoing process punctuated by attainment of goals along the way' (Brodsky, 1999:152). The following sections consider the meaning of 'adversity', 'risk' and associated terms. While there is a tendency to conflate adversity and risk²¹ they are not synonymous.

Adversity

In the early days of resilience research adversity was envisaged as exerting a global and unavoidable malevolent influence on children's lives, setting them on a trajectory leading inevitably to poor outcomes (Werner & Smith, 1882; Garmezy et al., 1984). This separated 'at-risk' children off into a 'doomed to fail' category, branding them as requiring intervention and perhaps thus stigmatising them and creating a self-fulfilling prophecy. Now however it is recognised that many people overcome adversity and go on to succeed.

Chronic stress often features in studies of resilience (e.g. Orthner et al., 2004; Vandergriff-Avery et al., 2004). Others focus on resilience in families coping with 'normative stressors', these being events or transitions that are common and predictable and often experienced as stressful or disruptive (e.g. Conger & Conger, 2002; Walsh, 2003). The birth of a first child is one such transition (Cowan et al., 1996). Stress should be comprehended holistically because it is 'a process, a complex set of changing conditions that have a history and a future, rather than a short-term, single stimulus' (Lavee et al., 1985: 812). A key point is that any kind of adversity is worse if it occurs in combination with another, as discussed later in this chapter. For example, people stressed by poverty are more likely to be derailed by further problems than more affluent peers.

Risk

Risk is a probability statement about the likelihood of negative outcomes (Bowes & Hayes, 1999; Fraser et al., 1999) and has been defined as the presence of factors and processes that make such outcomes more likely (Duncan et al., 2005). However the connection between a risk factor and a negative outcome is not one of cause and effect. Different risk

²¹ As when Luthar and Cicchetti (2000: 858) say that 'adversity (or risk) typically encompasses negative life circumstances that are known to be statistically associated with adjustment difficulties'

factors have been found to produce the same negative results (Sameroff et al., 2003). Risk factors 'elevate the odds for many types of problems and disorders' (Fraser et al., 1999: 32) but the counterbalancing beneficial effect of 'protective factors', discussed below, means that some people do not succumb to the detrimental effects of risk factors beleaguering them.

Addressing the question of what constitutes risk, Patterson (2002a) identifies two perspectives in the literature. The first is a 'hard line' view, implicit in how Masten and Coatsworth (1998: 206) explain 'significant threat':

To identify resilience, two judgements are required: first, that there has been a significant threat to the individual, typically indexed by high risk status (e.g. born in poverty to a single parent who has not finished high school) or exposure to severe adversity or trauma (e.g. family violence, war, death of a parent); and second that the quality of adaptation or development is good.

In the second perspective the vicissitudes of life in general are viewed as sufficiently challenging to create risk, so that anyone who functions competently can be considered resilient (Walsh 1998; Benard 1999). Some authors say that daily minor stressors provide a more powerful prediction of psychological or physical symptoms than apparently traumatic circumstances (Reding & Wijnberg, 2001; Canary et al., 2002). 'Daily hassles' may outweigh a person's capacity to cope (Patterson, 2002a) as much as 'major transitions' like transition to parenthood (2003b). Patterson (2002a) believes that the 'significant risk' perspective emerged from research on populations deemed at risk whereas the 'life-as-risk' perspective was developed by practitioners (therapists and clinicians) who were interested in a new approach to intervention focussing on strengths rather than deficits. Patterson (2002b) believes that researchers still tend to favour the former view, expecting that a proportion of respondents will experience poor outcomes, while practitioners see adversity as ubiquitous but believe that good outcomes are possible for everyone. However, since this practice-oriented perspective on risk tends to conceive of solutions focussed on the microsystem, it suggests that people must simply learn to better cope with a situation that might in fact be ameliorated by strategies at the community or societal level.

Identified risk factors for children are many and various (Middlemiss, 2005). Some studies focus on children whose well-being is obviously compromised, such as maltreated children (e.g. Bolger & Patterson, 2003) or children suffering illness and hospitalisation (e.g. Bolig & Weddle, 1988). Sometimes a developmental stage or transition is viewed as adversity (Luthar & Cicchetti, 2000), adolescence being a case in point (Arrington & Wilson, 2000; Conger & Conger, 2002). Some authors observe that the well-being of children growing up in generally favourable circumstances may be derailed by common events like divorce (Luthar & Zelazo, 2003; Hetherington & Elmore 2003). Having noted evidence of adjustment difficulties among suburban, relatively affluent youth typically thought of as being at 'low risk', Luthar and Cicchetti (2000: 878) maintain that it is important to 'guard against narrow, stereotypical conceptions of which subgroups of children or families should be considered 'at risk' for various negative outcomes' and resist preconceived notions about which children 'need' interventions to promote well-being.

Being blinkered by one's own cultural and professional assumptions about what constitutes risk can lead to failure to understand the realities of a particular context, pathologising behaviour that is acceptable in that context or imposing values that are inappropriate (Silberberg, 2001). Waller (2001: 294) explains:

Life circumstances that are normative in nondominant sociocultural contexts may be mistakenly considered by middle class European-American researchers to be pathogenic risk factors. Viewing the person/risk factor relationship as separate from the cultural context can have the unfortunate consequence of leading mainstream researchers to pathologise whole populations. Catterall (1998) termed this 'risk by association', that is, 'the tendency in academic and professional discourse to equate risk with membership in many of a number of disadvantaged societal groups.

A view of risk as an indelible label imprinted on certain groups lingers in the resilience literature. For example, Kalil (2003) seems to endorse the view that teenage parenthood, sole parenthood and low socioeconomic status are circumstances that automatically confer risk status on children. This is a deficit perspective rather than the strengths perspective claimed and celebrated in the resilience literature. While such circumstances constitute an underlying layer of difficulty that may exacerbate other difficulties

encountered, this perspective is unhelpful, for two reasons. First, it stigmatises people, thus, it could be argued, adding to the adversity with which they must struggle. Second, it is inaccurate. For example, in a review of research published in the US and UK between 1981 and 2000 on social influences on teenage pregnancy, Bonell (2004: 256) warns against conflating cause and consequences:

While there is plenty of evidence of harm in terms of low socioeconomic well-being and prospects being experienced by teenage parents and their children, this cannot be regarded as a direct and inevitable effect of pregnancy or motherhood. Rather, it is one mediated by, and contingent on, how society responds to teenage mothers and their children via health and social care, education, training and welfare provision.

Addressing the question of how 'significant' risk must be for a good outcome to be deemed evidence of resilience Patterson (2002a) presents her Family Adjustment and Adaptation Response (FAAR) Model to show how stress is created as much by 'daily hassles' (minor disruptions of day-to-day life) as anything else. This model describes how families balance demands with capabilities to arrive at a level of adjustment or adaptation. Demands include unexpected stressful events, unresolved tensions and daily hassles. Capabilities include 'tangible and psychosocial resources (what the family *has*) and coping behaviours (what the family *does*)' (Patterson, 2002b: 350). A family's response is influenced by appraisal of demands and capabilities and how they see their family in relation to outside systems. When demands outweigh capabilities families experience crisis, which 'can lead to a discontinuity in the family's trajectory of functioning, either in the direction of improved functioning or poorer functioning' (Patterson, 2002b: 351). Although couched in technical terminology, this is a commonsense notion. In seeing adversity as everything from life transitions to 'daily hassles', and picturing them as piling up and outweighing capacity to cope, Patterson (2002a) might be said to domesticate the notions of risk and resilience, bringing them down to earth to resonate with families' everyday experience. Because families in crisis are 'unstable and disorganised and often more open to interventions and programs that will facilitate their return to balanced functioning' (Patterson 2002a: 240) thinks that 'a very hopeful and optimistic perspective for policy makers and practitioners would be considering ways to support families in crisis who have not yet built a repertoire of protective factors'. Reflecting the US context of her work, she makes a plea for more

resources to be made available for therapy, affixing a postscript about what might be done to prevent problems in the first place:

From a policy point of view, it would be much more cost effective to insure [sic] that there are adequate resources in the ecological context to facilitate the development of protective processes within families that enable them to satisfactorily accomplish their core functions. Reducing the ecological risks that undermine accomplishment of family functions also is important work for public policy makers. These strategies enhance the health of families at the population level (Patterson, 2002a: 245).

Patterson's (2002a) description of the experience of adversity suggests a general shape for a comprehensive set of strategies designed to promote family resilience. On one hand, policy, programmes and services are required to stop difficulties accumulating, thus averting problems; on the other hand, for those already caught in a cascade of risk, in the manner described in the next section, or teetering on the brink, targeted services are required to reorient them.

Risk chains and cascades

Cumulative risk has been described as the 'clustering effect of normative and nonnormative events' (Lavee et al., 1986). It may result in the demoralising phenomenon of 'risk chains' (Smokowski, 1998; Rutter, 1999) or 'cascade effects' (Masten & Powell, 2003). In layman's terms this simply means that one bad thing leads to another. Waller (2001) uses the word 'pervasive' to express how risk factors tend to accumulate in people's lives, significantly increasing the likelihood of poor outcomes. This is a widely recognised phenomenon (Rutter et al., 1995; Fraser et al., 1999; Luthar & Cicchetti, 2000; Patterson, 2002b; Seecombe, 2002; Walsh, 2003; Jaffee et al., 2007). Researchers have long been aware of the strain resulting from 'accumulation of demands that stem from current as well as previous, unresolved family life changes' (Lavee et al., 1985: 822). As Masten and Powell (2003: 7) explain:

Risk factors more typically co-occur with other risk factors, usually encompass a sequence of stressful events rather than a single event, and often pile up in the lives of children over time.

Clark et al. (2000: 77) found that 'families suffering more types of environmental disadvantage are more likely also to be dysfunctional in each domain of family life'. The power of this phenomenon is partly due to how accumulating problems makes people feel. Reviewing how the social work literature describes the situation of impoverished single mothers by whom 'life is lived in terms of the minute, recurring stressors of day-to-day survival', Reding and Wijnberg (2001) warn practitioners against making assumptions that this kind of stress is trivial and contend that a context-specific combination of factors determines whether stressors 'build to an image of their lives and their destinies as being hopeless or hopeful' (Reding & Wijnberg, 2001: 345). They state that the sources of stress and how it might be remedied is revealed only by sensitive, open-minded inquiry into the detail of their lives. Reporting results of their longitudinal study of rural Iowa families affected by a severe economic downturn, Conger and Conger (2002: 363) provide an illustration of a risk chain:

[Economic] pressures involve psychologically meaningful events and conditions within the life of the family, such as the inability to purchase basic necessities like adequate food and medical care, that result from economic hardship and that impinge on the emotional health and ongoing relationships of parents.

Once positioned on a slippery slope like this it is very hard to get off. For people so entrapped, it becomes increasingly difficult to achieve positive outcomes. The impact of each problem is increased by the presence of others (Waller, 2001). Furthermore, at high levels of risk it is hard to access protective factors, or there may in effect be none to access (Fraser et al., 1999). A situation like this may approach the irrevocable; it has been suggested that high levels of cumulative stress may derail even the most adaptable individuals (Hetherington & Blechman, 1996: vii) and that in the face of overwhelming risk all will eventually succumb (Waller, 2001). However the powerful negative force of chain effects is counterbalanced by 'protective chains' which establish people on positive trajectories and are equally powerful in their momentum towards good outcomes rather than bad. The term 'protective chain' denotes that success breeds success; achievement, however minor, enhances confidence and the optimistic attitude that motivates people to take action rather than passively await the next problem. This encourages the

development of information-seeking and problem-solving skills that underpin self-efficacy. This upward cycle, suggesting that adversity can have a strengthening effect, is amplified by the notions of 'steeling effects', 'inoculation' and 'turning points'.

Protective chains, steeling effects, inoculation, turning points

It could be argued that the optimism engendered by the notion of 'protective chains' is what makes resilience so popular with practitioners; they can visualise future good outcomes if only it is possible to get a child, young person or family established on a positive trajectory. Yet setting someone on a positive trajectory is not enough. Resilience requires active engagement with problems and, often, access to resources and support of various kinds, material, practical or emotional.

A mechanism behind protective chains is what is referred to as 'steeling effects' (Rutter, 1999) or 'inoculation' (McMillen, 1999), comparable to immunization (Hetherington & Blechman, 1996). This metaphor suggests that protection 'resides not in the evasion of risk, but successful engagement with it' (Rutter, 1987: 318). Correspondingly, moderate stress strengthens competence; if a challenge is successfully met it helps prepare people for the next one. Coping with adversity and developing resilience is thus a tough but potentially enriching learning process (Saleebey, 2002b) involving sustained personal development resulting from acquiring coping skills. Early success, however small, engenders renewed resolve and effort and, eventually, sustained, generalised competence. Thus people who overcome adversity can reach and even surpass their pre-crisis level of functioning, emerging from a hard time with capacities that they might not have otherwise developed (Boss, 1992; Carver, 1998; O'Leary, 1998; Rutter, 1999; Hawley, 2000; Conger & Conger, 2002; Patterson, 2002a; 2002b; Waller, 2001; Walsh, 1998; 1996; 2002; 2003; Fredriksson et al., 2003b; Lavee, 2005; McLure et al., 2008). Saleebey (2002a: 11) proclaims:

Resilience is not the cheerful disregard of one's difficult and traumatic life experiences; neither is it the naïve discounting of life's pains. It is, rather, the ability to bear up in spite of these ordeals...Resilience is a process – the continuing growth and articulation of capacities, knowledge, insight and virtues derived through meeting the demands and challenges of one's world, however chastening.

This phenomenon has limits. It is the result of 'being challenged just enough to encourage the development of new capabilities but not so much that the system is overwhelmed by the demands' (Patterson, 2002a: 239). Rutter (1987: 326) says:

Protection may lie in the "steeling" qualities that derive from successful coping with the hazards when the exposure is of a type and degree that is manageable in the context of the child's capacities and social situation.

The nub of the notion of 'turning points' is that engaging with a new experience, change or transition can result in marked and possibly permanent positive change in lifestyle or even life course, as Rutter (1987: 328) explains:

Transition to work, marriage and parenting all provide further possible turning points whereby success in the form of personal relationships or task accomplishment may change the life course onto a more adaptive trajectory.

This notion is highly relevant to families adapting to life with a baby. It suggests that there is opportunity around the birth of a first child for families to engage in a process of sustained positive change that will stand them, their child and subsequent children in good stead. Individual circumstances make it more or less likely that challenge will produce competence and confidence rather than collapse so it is important to ensure that relevant support is available to people experiencing turning points.²² When well-being is already compromised by personal or environmental factors people are more susceptible to being harmed by adversity. This is 'vulnerability' (Fraser et al., 1999; Luthar & Cicchetti, 2000). Vulnerability increases people's chances of becoming so embroiled in a downward cycle of adversity or 'cumulative risk' that it becomes too hard to extricate themselves. This makes the availability of effective support crucial:

Maintaining optimal parenting is difficult enough under normal life circumstances; to do this in the face of stressors such as depression or homelessness is clearly noteworthy and must eventuate from additional

²² Support is the subject of Chapter 4.

positive influences (e.g. support from family or friends, high personal ego strength, or availability of mental health services (Luthar & Zelazo, 2003: 520).

A problem with discussing adversity is that something experienced as merely annoying by one person may overwhelm another. Subjectivity gets in the way of neat categorisation or measurement of adversity. While 'risk by association' may attribute risk where none exists, the converse is to underestimate difficult circumstances because they seem 'normal' or dismiss the impact of 'daily hassles' (Patterson, 2002a) because they seem trivial or because those affected are in apparently favourable circumstances. As Patterson says (2002a: 239): 'practitioners and policy makers should concern themselves with strengthening family capabilities to successfully manage whatever sources of stress they may encounter'.

For clarity, I note my own use of terminology. I use the word 'difficulty' to mean something experienced as challenging or testing and requiring effort to resolve, but not necessarily causing undue anxiety or distress; 'adversity' to mean conditions likely to cause problems, that may in turn become risk factors; 'problems' to mean difficulties causing distress, destructive change or inability to achieve outcomes considered desirable; 'risk factors' as problems implicated in risk; and 'risk' to mean probability of poor outcomes. This categorisation of hard times are stages on a continuum of risk and competence along which people may move in either direction, either towards resilience, which Rutter (1987: 316) called the 'positive pole', or in the other direction, where they may find themselves overwhelmed by a cascade of risk. It is common to use the term resilience to describe successfully getting through hard times of various types, including normal life transitions as well as sudden crises. This reflects the understanding that resilience is essentially an 'ordinary' phenomenon (Masten & Powell, 1998), a common process of getting through a challenging time and emerging with increased competence. In the literature the term is commonly used to describe how people manage this in a range of difficult situations²³.

Competence and good outcomes

In reviewing studies of children's resilience, Masten and Powell (2003: 7) state that competence is conceptualised differently in different studies, from 'simply an absence of

²³ See Chapter 3.

disorder or mental health problems to a focus on competence in developmental tasks'. In their study of resilience in maltreated children, Jaffee et al. (2007, 232) state that a consensus view of resilience is emerging that 'does not require that youth excel; rather, it requires that youth function at least as well as the average child who has not been exposed to adversity'. Competence indicative of resilience is thus positioned at the moderate end of a continuum spanning 'the mere absence of emotional or behavioural maladjustment' (Luthar & Cicchetti, 2000: 858) and spectacular success or 'supernormal functioning' (Rutter, 1999). At the dazzling end, 'superstar patients or families' (Rolland, 2003) are celebrated as models of resilience, as when Bachay and Cingel (1999) cite Oprah Winfrey as an example, or when Deloris Jordan, mother of basketball player Michael Jordan, received the Chicago University Center for Family Health Inaugural Family Resilience Award in 1998 (www-news.uchicago.edu). Examples of this kind set the bar far too high. In keeping with resilience being an 'ordinary' concept, competence is more usefully envisaged as ordinary achievement, such as ability to function well at school, interact appropriately with peers and regulate behavior (Jaffee et al., 2007). Masten and Coatsworth (1998: 206) take a similar view:

[Competence is] a pattern of effective adaptation in the environment, either broadly defined in terms of reasonable success with major developmental tasks expected for a person of a given age and gender in the context of his or her culture, society and time, or more narrowly defined in terms of specific domains of achievement, such as academics, peer acceptance or athletics.

As well as what might be called mundane good outcomes, or 'doing OK' (Masten & Powell, 2003), there is a strand of the literature that extols 'thriving', where challenge is seen as the impetus for achievement that surpasses previous levels of competence resulting in newly developed skills, increased knowledge, self-reliance and sustained positive self-appraisal grounded in achievement (Calhoun & Tedeschi, 1998; Ickoviks & Park, 1998). O'Leary (1998) contends that if challenge is successfully met it helps prepare people for future difficulty. Thriving shares ground with notions of steeling effects, discussed above, and with 'learned optimism', as expounded by Bandura (1977). The literature on thriving prompts reflection on three aspects of resilience. First, it reinforces the notion of a continuum of outcomes encompassing 'habituation; 'doing OK', sustained competence; growth and outstanding success. Second, it indicates that doing well is influenced by

feeling that doing well is possible. Third, it reiterates that a hard time can ultimately be a 'good' thing, creating momentum for change. Explaining that thriving is most likely when initial success is experienced when stress is potentially overwhelming, Carver (1998) adds to the list of benefits; personal relations are strengthened as a result of finding that help is readily available or that significant others can be counted on. Thriving is associated with availability of effective supportive resources to turn the experience to good account.

The issue of who judges 'good' adaptation is a salient point. Ungar (2008) says that outcomes assumed to indicate competence are often western-based, emphasising individual and relational factors typical of mainstream populations and their definitions of healthy functioning and lacking sensitivity to cultural factors that influence how resilience is defined by different populations. Masten and Coatsworth (1998: 207) explain:

Deciding whether a child is competent can be difficult when a child lives in a cultural or community context that differs markedly from the larger society in which the community or cultural group is embedded...It is important that policymakers and those who intend to intervene in children's lives remember that families in a given community may have different values and expectations for competence.

Ungar (2008: 221) advises that 'to avoid hegemony in how we characterize successful development and good coping strategies' it is essential to understand the context in which resources to nurture resilience are to be found. Boyd-Franklin (2003) says that in order to evaluate what is normal in a family's development, clinicians and researchers must explore the larger social context in which the family lives; when working with families of different racial or socioeconomic background than themselves they must pay particular attention to strengths and survival skills that enable families to cope in their particular situation. In these circumstances it may take time to establish sufficient trust for people to confide what is really going on. Some achievements are universally important, such as attachment to caregivers and developmental milestones; some are culturally or historically specific markers of competence; and some, such as academic success, are important in many cultures but not all. Masten and Coatsworth (1998) believe that it is both valid and necessary that a broad range of outcomes count as 'good'. The importance of context is one of three key themes in the resilience literature. The others are the role of self-efficacy

in how competence develops and the need to see the big picture; the discussion now turns to these three themes.

Context

It has been noted that resilience research is predominantly European-American (Walsh, 1998; Arrington & Wilson, 2000; Patterson, 2002b; Collins, 2008; Ungar, 2008) and thus not necessarily transferable to other contexts. Culturally endorsed values and behaviours are internalised (Ryan & Deci, 2000); expectations are culturally determined and achievement socially sanctioned (O'Leary, 1998). A case in point is conceptualisation of self. While an independent, autonomous self is typical of Western culture, even in the US with its individualistic ethos there are cultural groups, such as Dine people (Waller & Patterson, 2002), who experience self as 'ensembled' or inter-connected, as do people of Eastern cultures including China, Japan and Korea (Hobfall et al., 2002). People endowed with a sense of ensembled self can benefit from communal mastery (Hobfall et al., 2002), which privileges collaborative problem-solving and goal attainment over competition or 'going it alone'. Considering the experiences of youth of diverse cultures, Arrington and Wilson (2000) propose that resilience should be examined in reference to subjective experience comprising an 'inventory of resources' and a 'biography of success'. Resilience would then be inferred when people exceed expectations warranted by their background, culture, class, circumstances, the community to which they belong and its norms and expectations.

Self-efficacy

It is suggested in the literature that by encouraging hope and facilitating determined action and 'planful competence' (Fraser et al., 1999) self-efficacy promotes sustained good outcomes, underpinning 'a well established feeling of one's own worth as a person together with a confidence and conviction that one can cope successfully with life's challenges' (Rutter, 1987: 327). Self-efficacy helps explain how people become established on an upward rather than a downward spiral. Bandura (1977: 195) describes how success breeds success and turns expectations from pessimistic to optimistic:

Successes raise mastery expectations; repeated failures lower them, particularly if the mishaps occur early in the course of events. After strong efficacy expectations are developed through repeated success, the negative

impact of repeated failures is likely to be reduced...Once established, enhanced self-efficacy tends to generalize to other situations in which performance was self-debilitated by preoccupation with personal inadequacies.

An optimistic attitude and positive self-appraisal determine whether people will even try to cope with difficulty, how much effort they expend and how long they will persist (Bandura, 1977; Carver, 1998; MacMillen, 1999; Collins, 2008). If people appraise problems as potentially resolvable they are more likely to attempt to find solutions (Boss, 1992; Chang, 1998; Folkman & Moskowitz, 2000; Bandura, 2004) and more likely to be successful (Fredriksson et al., 2003b). In turn, successful outcomes reinforce optimism. Self-efficacy is closely linked with agency, which is characterised by belief that positive change is possible and involves 'acts done intentionally that reflect an individual's perception that they are exercising influence over what they do' (Jones & Prinz, 2005: 342) thus counteracting powerlessness. Bachay and Cingel (1999: 172) report that when asked to provide advice for a hypothetical 13-year-old daughter, participants in their study of minority women who had overcome adversity 'communicated their solid sense of agency'. The reported experience of families with a vulnerable member who needs care, referred to above in the section entitled 'Situation Focus', backs up the importance of a 'solid sense of agency' in achieving competence in a difficult situation.

The big picture

Bandura (2004: 159) sees human agency as encompassing collective agency enacted through social systems:

The quality of health in a nation is a social matter, not just a personal one. It requires changing the practices of social systems that impair health rather than just changing the habits of individuals. We do not lack sound policy prescriptions in the field of health. What is lacking is the collective efficacy to realize them...People do not operate as isolates. They work together to improve the quality of their lives. Their shared belief in their collective efficacy to accomplish social change plays a key role in the policy and public health approaches to health promotion and disease prevention.

Bronfenbrenner's ecological model is implicit here. As explained by Bronfenbrenner (1977: 514) and paraphrased below 'the ecological environment is conceived topologically as a nested arrangement of structures, each contained within the next'. The microsystem is the complex of relations between a person and environment in an immediate setting containing that person. The mesosystem comprises interrelations among major settings containing the person. The exosystem comprises other social structures, formal and informal, that do not contain the person but impinge upon or encompass the settings that do contain the person and thereby influence, delimit or determine what goes on there. These structures encompass the major institutions of society as they operate at a concrete local level. The macrosystem refers to overarching institutional patterns of a culture or subculture, such as economic, social, educational, legal, and political systems. These are expressed in the micro-, meso- and exosystems and are conceived not only in structural terms but as carriers of information and ideology that endow meaning and motivation to agencies, social networks, roles, activities, and their interrelations. As an example of this, Bronfenbrenner (1977: 515) uses the status accorded families raising children:

What place or priority children and those responsible for their care have in such macrosystems is of special importance in determining how a child and his or her caretakers are treated and interact with each other in different types of settings.

In the resilience field an ecological perspective is often claimed (e.g. Fraser et al., 1999; Waller, 2001; Blum et al., 2002; Walsh, 1996; 1998). For example, Walsh (2003: 3) says that 'the family, peer group, community resources, school or work settings, and other social systems can be seen as nested contexts for nurturing and reinforcing resilience'. Yet the lens through which remedies are explored is usually directed at the microsystem. Juby and Rycroft (2004: 581) write about applying 'ecological/transactional theory, which considers the interactional relationship between individuals and their environment' but confine recommendations about macrolevel change to suggesting that social workers use their knowledge of 'the dynamics that exist in resilient families' to lobby for 'preventative programs or treatments for...poverty-stricken families that do not have the skills and attributes necessary to maintain healthy family lives' (Juby & Rycroft, 2004: 587). Surmising that it is because the concept of resilience originated in the disciplines of

psychiatry and developmental psychology that most studies of resilience and poverty focus on the individual, Waller (2001: 294) calls for a broad view:

The ecosystemic perspective suggests that protective influences can be introduced into a person's life through any relationship in any part of the ecosystem (personal attributes, family strengths, a high-quality recreation program, social policies promoting education etc)...For many individuals, families and communities understanding resilience requires analysis of the impact of oppression.

However, it is one thing to analyse the impact of oppression but quite another to make changes that will be of practical benefit. Calling for policy that will promote resilience by addressing poverty directly (e.g. tax changes; increasing the minimum wage) and challenging interpretations of the ecological perspective that focus on individuals Seccombe (2002: 390) discerns the legacy of the American dream:

The ecosystemic perspective may acknowledge structural factors but it does not give centre stage to the role that national and state-wide economic policy must play in strengthening families. It continues to reflect US cultural values that individuals are primarily responsible for their own plight and that reliance on Government to redistribute wealth is un-American or antithetical to our core values.

The American dream is of doubtful relevance to people who do not live there; strategies for promoting resilience in that context may simply not work elsewhere. Yet influential literature in the field incorporates this ethos: Werner (1999) extols 'going it alone' as the 'wonderful optimism' of America and Walsh (2003) admires 'rugged individualism'. Clearly surveying the big picture means taking a deliberately context-specific view of problems and solutions at every level.

With a view to considering implications for policy and service delivery the fieldwork for this study explores factors that new parents in New Zealand consider relevant to dealing with challenges inherent in adapting to parenthood. From my reading of the resilience literature I have developed a conceptual framework that is used in Chapter 10 to consider

participants' experiences of adapting to parenthood and considering what helped or hindered them as they overcame difficulties and attained competence. This framework incorporates the following key elements:

- Resilience is a process of developing competence in response to challenges, thus demonstrating ability to get through a difficult time.
- Resilience is compromised by accumulation of difficulties, which may become a downward spiral from which it is hard to escape.
- A life event or transition may be experienced as a turning point, altering a trajectory of risk to one of resilience.
- Resilience is the result of resources that operate at all levels of a person's environment, from the personal and interpersonal to the structural and attitudinal.
- A key mechanism underpinning resilience is the development of self-efficacy and agency, envisaged as ability to find a way to overcome difficulties. This enables people to acquire skills useful not only for current problem solving but also in the future.
- Resilience is influenced by contextually specific factors.

Exploring what families with a first baby find helpful or unhelpful as they adapt to parenthood makes it possible to consider how the support system might be changed to ensure that families can readily access what they need to adapt successfully. This entails formal and informal support. The next chapter discusses support.

CHAPTER 4 SUPPORT

Transition to parenthood is commonly challenging. As families in this situation encounter challenges, it is usual for them to draw upon their own strengths, their personal networks of support and supportive resources available to them in their environment. Rather than examining personal qualities or intrafamily processes that might contribute towards resilience, this study focusses on the contribution of resources in the community, particularly the support system provided or funded by the state, in order to answer the research question 'What are the implications for policy and service delivery?'. This support system comprises formal and semi-formal support services and a range of tax credit and income support mechanisms, described later in this chapter. As noted in the introduction to this thesis, this is the support system that can be altered to more closely match needs.

This chapter draws upon the literature on support in order to lay a foundation for understanding types of support found helpful by participants and clarifying types of support wished for. This is important for answering the research questions 'What was the experience of first time parents in a range of circumstances in New Zealand today as they adapted to life with a baby?' and 'What factors did a diverse set of first time parents experience as helpful or unhelpful in dealing with challenges encountered during transition to parenthood?' While the study focusses on formal and semi-formal support, understanding the nature of informal support provided by family members and friends is also relevant, in that helpful aspects of informal support could potentially be incorporated in formal and semi-formal support. We need to understand the whole support system as it is experienced to determine what external supports are needed and how they should be provided to respond to the specific needs of individual parents. To be in a position to answer the research question 'What are the implications for policy and service delivery?' it is essential to comprehend the details of how participants experience support, hear their views on what works well and draw out their ideas about what might work better in helping families to develop resilience and avert the possibility of sliding into a cascade of risk where they are engulfed in problems.

As noted in Chapter 2, in New Zealand the state is involved in providing a system of support for families in transition to parenthood. Services available to everyone having a

baby include antenatal education and free health care during pregnancy and childbirth and free maternal and infant health care during the first six weeks afterwards. For the next three years parents have the option of using Well Child services available through a range of providers, including the long-established organisation Plunket and several providers of Tamariki Ora services. In addition, semi-formal support may be available in the form of services provided by non-profit parenting organisations, such as Parents Centre; through La Leche, an organisation dedicated to breastfeeding support; or coffee groups and play groups, often provided by Well Child services.

A motivation for my study is to produce knowledge that might in some way be used to enhance this support system. Hence the study is predominantly concerned with the provision of formal and semi-formal support. This is because formal support is the result of policy decisions and subsequent implementation and could potentially be adjusted to cater for actual needs and problems of families in transition to parenthood. Semi-formal support is often provided by agencies who receive funding through contracts with government departments or from philanthropic trusts and increased understanding of actual needs might enable such agencies to distribute funding in ways that more closely match needs. While new parents may benefit from informal support from family and friends, the availability of such support differs widely from family to family. The way in which it is provided is idiosyncratic, a personal matter, and it is hard to see how such support might generally be enhanced, or even influenced.

Reinforcement of the view that it is difficult to enhance informal support is provided by the findings of the Supporting Parents research initiative, a themed research project funded by the UK Department of Health (Quinton, 2004). The researchers hoped to discover untapped reservoirs of informal support that might be mobilised to help parents. However they were disappointed in this regard; if parents had informal support available to them it was apparently their first port of call. There appeared to be little scope for rallying further support from this source.

I am interested in hearing about what made informal support work well for participants in my study because it might be possible to incorporate aspects of helpful informal support into formal and semi-formal support in order to better meet the needs of potential users.

This is also true of strategies that first time parents themselves use to cope; these could perhaps be included with advice offered by formal and semi-formal support providers.

Having discussed types and sources of support, I consider engagement with support and the usefulness of the notions of navigation and negotiation (Ungar, 2008) for considering how support might be made more relevant to the requirements of a wider cross-section of families with a first baby. I discuss effectiveness of support, noting that a key element that appears to make support work well is the quality of the relationship between provider and user of support, something long understood in the discipline of social work. The potential problem of a surfeit of support and the difficulty of managing this is briefly addressed. Then I describe what the literature says about support needs of families having a first baby. Finally I reflect on how knowledge about the nature of support and its potential effect on the development of competence and resilience is useful for informing the design of interview schedules for the fieldwork for this study.

Support: 'Complex to assess, to get right and to deliver'

Introducing the collection of research studies conducted in the UK under the banner 'Supporting Parents', Quinton (2004: 22) highlights a facet of the study:

Support, even a good piece of ordinary social action, is complex to assess, to get right and to deliver. This is especially apparent when it comes to supporting parenting, because of the balance required between the neglect of family problems and intrusion into family life, not to mention differences in individual and cultural ideas of what satisfactory parenting is, how and when this needs support and who should decide that.

Types of support are categorised as formal, semi-formal or informal.²⁴ Formal support is provision of services that require expertise or professional knowledge. Semi-formal support includes community and self-help groups, either run by formal organisations or by group members themselves. Examples are baby and toddler groups, women's support groups and groups that cater for specific needs or give advice for specific problems. Informal support is received through personal networks and includes comfort, advice and

²⁴ The term 'social support' is used in the literature both as a generic term, referring to interpersonal aspects of support, and as a synonym for informal support.

practical assistance to help recipients get by from day to day. Quinton (2004: 93) explains that 'alongside the categorization of sources of support runs a second classification organized according to the kind of support provided'. Kinds of support include emotional support or comfort; practical help; and resources, including financial assistance. What Quinton calls the 'policy context' is important. This aspect of the exosystem controls provision of tax allowances and income support benefits; universal and targeted support services; and regulates the availability of assistance for those affected by serious family problems such as family violence. In New Zealand, the state child protection agency Child, Youth and Family works under national legislation and non-profit sector agencies providing preventive services (e.g. family support organisations) and remedial services (e.g. Refuge) are largely dependent on Government funding.

It is usually said that informal sources provide emotional support; practical help (e.g. childcare) and material resources (e.g. passing on or lending baby equipment) while formal services provide expert services and dispense specialist knowledge. Semi-formal support lies somewhere between. However several issues muddy the waters here - appearances may belie reality. Formal support, normally professional, may be experienced as so helpful that people seek emotional support through this means (Quinton, 2004). Conversely formal support may be experienced as so intimidating, even threatening, that those who need it most may be reluctant to use it. Also, specialist knowledge is not the sole preserve of formal services, but may be held and provided by knowledgeable individuals or groups that could not be classed as formal either in structure or accreditation but who are experts in a particular field. Breastfeeding support groups, for example, may be as informative and helpful as professional lactation consultants. A significant issue here is that use of semi-formal support may be restricted to certain groups who 'fit in' and are not too overwhelmed by pressing problems to put time and effort into accessing this type of support and perhaps integrating into groups.

Informal support is sometimes assumed to be both available and easy to use, but may be neither. People may simply have no network of support, be loath to admit that they need help, or fear that their independence will be compromised. Seeking support often involves turning to a relative or friend to have sense made of an experience or to derive comfort. Doing so successfully means identifying people who can act as prudent confidantes or positive role models (Polk, 1997) but making a poor choice can have distressing or even

destructive consequences if bad advice is accepted or a confidence is betrayed. Being part of a social network can be a mixed blessing. In general terms, informal support is experienced as responsive and flexible but tends to include some sense of reciprocity, sometimes veering towards obligation, so that 'even with close family, where a kind of trade in support might be less calculated, the receiving of support sometimes involves a trade with independence' (Quinton, 2004: 182). While this is part of the web of relationships that tie people together it may lead to 'social debts' (Pilisuk & Parks, 1981), a sense of interpersonal obligation, or required repayment for a history of past help, may be a source of problems rather than assistance if those involved feel that the balance of give and take is out of kilter, or if support comes with strings attached that recipients resent or do not understand.

Isolation is an issue for many families. A study of American low-income families (Orthner et al., 2004) found that although informal support is an area of potential strength it was 'uneven' across the families who took part in the study. Fewer than half the participants said that they had friends or family to whom they could turn in times of significant need. Observing that this lack of social connections is not unique to the poor and is increasingly characteristic of American families, the authors ponder why. With regard to low-income families, they speculate that the family and friends of low-income families might also be struggling. Writing about New Zealand, Connolly and Doolan (2007) say that in the past new parents had more support because child-rearing responsibilities were shared across generations. While intergenerational caring is still more common in Maori households, they too may be 'alienated from whanau, hapu, iwi, and be without the compensatory effects of any alternative nurturing systems of support' (Connolly & Doolan, 2007: 106).

One of the functions of formal and semi-formal support is to link families into networks of informal or social support (Duncan et al., 2005). For example, childbirth educators and Well Child providers establish coffee groups for new mothers, who then continue the organisation of their group themselves. Activating support is also an aspect of social work practice, as Munford and Sanders (1999: 23) say:

We recognise that agency support is one of a number of resources that a family/client will use to resolve issues. This type of support can often form a

pivot or catalyst for the creation of change and the identification of additional resources which may be of value to the family.

High levels of social support have been found to be associated with general life satisfaction, reduced stress and positive parenting outcomes.

Adequate and positive social support plays an important role in parenting and in providing a buffer to stressors experienced by families...Further, the presence of social isolation, a lack of social supports and a high rate of negative relationships with and attitudes to available networks, have been identified as contributing to the risk of child abuse (Hardy & Darlington, 2008: 252).

Mothers whose interaction with kin and social service providers is negative have been found to be more likely to become stuck in negative childcare practices (Schilmoeller & Baranowski, 1991). Yet families may simply have no access to the kind of support they need. It is far from true that every family has informal sources of support to which to turn in time of need, whether this is because they do not live close to those they would turn to, because of unresolved relationship problems or because they simply do not have anyone in their life fitting this description. With regard to formal or semi-formal sources of support, they may simply be unaware of what is available or what is available may not match their needs. This dissonance is compounded if formal and semi-formal services are perceived as off-putting, intimidating or 'not for people like them'. Willingness and ability to get out there and seek out support equates to a form of agency. However whether people are motivated to do this is also affected by the nature of what is available and how it is presented. Hence a key factor in the utilisation of support is engagement.

Engagement

What seems to matter most in the usefulness of support is not its existence as such but how it is experienced. Rutter (1987: 317) criticised a propensity in the literature to debate the 'buffering effect of social support' while failing to recognise that the protective effect of support lies in the process rather than the variable. The point is that unless support is provided in a way that suits potential recipients they will not fully benefit from that support and may even resist or reject it. This explains something that is perplexing and frustrating

for service providers, policy makers and others interested in promoting beneficial change: namely a common scenario where resources are apparently available but only a subsection of the population who might be expected to use them actually does, and then in a limited way. For example, a review of parenting programmes in New Zealand highlights low rates of engagement and retention (Hendriks & Balakrishnan, 2005). Important resources, provided in ways intended to be universally beneficial, may in fact thwart people's intention to benefit from them or fail to attract people who might use them if they could see the point. The ideas of navigation and negotiation, expounded by Ungar (2008) in relation to children and young people, are pertinent to the landscape of support for families having a first baby in New Zealand. Cognisant that certain psychological needs and processes (e.g. self-efficacy; attachment; social support) are common to people from diverse cultures and backgrounds, Ungar highlights the wide variation in how different subsections of populations see the world and live their lives. Navigation refers both to capacity to seek support (personal agency) and to the availability of the support sought. 'The child seeking self-esteem...requires access to experiences and relationships that build that self-esteem. One can only navigate towards what is available and easily accessed' (Ungar, 2008: 225). Negotiation refers to adjustment in the nature of resources, style of delivery and expectations about their purpose to take account of background and culture:

[T]he child may be able to navigate his or her way to school and access appropriate educational experiences tailored to his or her level of study. However, if that education is provided in ways that are culturally less meaningful to that student, with outcomes that are likely not realizable such as a good job or advancement to university (due to the child's poverty or experience of racial discrimination) then we might say that the child's resilience remains contingent upon his or her negotiation for education and a place in society that is more responsive to his or her context and cultural realities (Ungar, 2008: 225).

Patterson (2002a) observes that a family's resilience is associated with opportunities or risks in their environment so that from a policy point of view it would be cost effective to ensure that there are 'adequate resources in the ecological context to facilitate families' ability to satisfactorily accomplish their core functions' (Patterson, 2002a: 245). A key word

here is 'adequate'. However sophisticated or well-funded a support strategy is, it will not promote competence if it does not mesh with the circumstances of people it is supposed to assist – if its nature and style have not been negotiated to suit the context. What may be lacking is a forum where negotiation might take place.

It has been suggested that to counteract insularity and promote wellbeing service providers could usefully expand the scope of their service provision to encompass interaction with extended family members, especially grandmothers, or other key potential supporters, in the services provided through home visiting programmes or other programmes for families with young children. The idea is that this would enhance consistent support for mothers (Schilmoeller & Baranowski, 1991; McCurdy, 2005) as these supporters would be aware of the information or advice that parents had been given and could step in to help out in a way that meshed with the messages being imparted by the programme. This represents a way of reinforcing and strengthening existing informal support, in a way not addressed in the Supporting Parents study (Quinton, 2004). It is worth noting, however, that members of a social network may all be struggling; the duty of providing support in specific, possibly unfamiliar ways may put pressure on people who are trying to cope with their own difficulties (Rutter et al., 1995).

Further options for increasing availability of support hinge on enhancing semi-formal or formal support. This too is not straightforward. Finding that parents who used semi-formal support the most were those with higher incomes and with a better range of supportive resources already, Quinton (2004) concluded that it takes energy for a parent to insert semi-formal support into their lives. Studies of support have highlighted qualities that make support effective in terms of both attracting people and making engagement worth the effort.

Effectiveness

The literature indicates that features of support that make it effective are the quality of the relationship between the giver and receiver of support and the provision of authoritative, useful guidance (Quinton, 2004). Relationship is fundamental:

It was clear from many of the studies that support from services is not just a question of giving help in a piecemeal way. The effectiveness of support and

its ability to maintain the relationship elements that are so important are improved if support is seen as a process. If relationships are right from the start, then parents feel better about the help they are getting and are more likely to stay engaged with the service (Quinton, 2004: 192).

A key aspect of relationships that make support effective is the conveying of respect (Beeman, 1997). More than thirty years ago Cobb (1976: 300) surmised that the mechanism underpinning social support which is 'protective against the health consequences of life stress', is information in the sense of messages about worth and competence rather than facts or advice, and that information of this kind makes the recipient of support feel cared for, esteemed and valued and creates a sense of belonging to a network of mutual obligation. Cobb (1976: 11) speculates that this is because 'emotional support and a sense of belonging might provide the climate in which self-identity changes can most readily take place' thus making a change in role easier. According to Cobb (1976) feeling valued by others encourages people to go out and attempt to master a problem, thus promoting self-efficacy. The core benefit of support thus lies in the power of relationship to make people feel better about themselves and about their capacity to get through a hard time. This understanding of the way support functions has since been substantiated (Quinton, 2004).

The Supporting Parents project found that 'relationships between individuals lie at the heart of support' (Quinton, 2004: 24) and that it is through relationship that benefits of support are absorbed into families' lives. Support is valued when families perceive providers as respectful and knowledgeable, interested in their situation but not intrusive. The findings of a study exploring how families at risk of 'family breakdown' in North Wales responded to two contrasting configurations of services (Statham & Holtermann, 2004) showed that participants appreciated practical support, especially childcare, but that benefits did not last beyond the withdrawal of services. Many participants commented that the social workers who arranged the services did not treat them as individuals, appeared not to have time for them, did not understand the extent of their difficulties, did not keep them informed and generally failed to make them feel valued. Further, families could not see the point of some of the services organised for them. They felt 'taken over' by the social workers when they would rather have been listened to and supported to devise solutions that were relevant to their lives. Summing up the Supporting Parents project,

Quinton (2004: 78) says that families value the expertise of formal services but want them to incorporate the kind of relationships that are a key aspect of informal support:

Parents...liked the services they used to be practical, professional and well organized. But they also wanted them to pay attention to their own view of what they wanted, to be responsive to them and to treat them as equals. In the case of formal services the sense of balance and equality cannot come through the parents giving something back to the service. Rather it comes from the service being respectful to parents and treating them as experts on their own needs so that they feel that they are partners in problem solving.

Authoritative, practical advice and guidance, delivered in ways experienced as collegial, was important to participants in the Supporting Parents project (Quinton, 2004). Similarly, participants in a New Zealand study of the role of early childhood education in family resilience (Duncan et al., 2005) typically saw the role of agencies as providing reliable information and access to resources that enabled them to become more self-determining and better able to meet the needs of their own family. Commenting on the results of the Supporting Families studies, Quinton (2004) says that families were anxious to preserve their autonomy. Those most worried about this were the most vulnerable families, who feared that by seeking formal support they would be perceived as unable to cope. The low rate of voluntary use of formal support may have been connected to fear of being 'taken over' by the authorities. Yet families who used formal support found it helpful. Perhaps the ways in which formal support was offered simply did not appeal to potential users.

To cope with a new set of circumstances people often need to learn new skills and change their behaviour. The literature indicates that successful provision of support in such circumstances is less about instruction than about facilitating understanding. Recipients of formal support want to be treated more as colleagues or partners than as beneficiaries of expert knowledge, preferring to be informed and offered options to being instructed or directed. While they may comply with behaviour that is required of them and apparently do as they are told because of fearing the consequences of not doing so or to avoid guilt or to look good, they will only fully integrate new behaviours if they are supported to do so in ways that allow them 'to feel competent, related and autonomous' (Ryan & Deci, 2000: 73). Support that privileges autonomy can have powerful, long term effects:

To integrate a regulation [required new behaviour] people must grasp its meaning and synthesize that meaning with respect to their other goals and values. Such deep, holistic processing is facilitated by a sense of choice, volition, and freedom from excessive external pressure toward behaving or thinking a certain way. In this sense, support for autonomy allows individuals to actively transform values into their own (Ryan & Deci, 2000: 73).

Another important factor in converting support into a catalyst for sustained good outcomes is positive feedback about capability and competence. As Duncan et al. (2005) and others writing about resilience point out (e.g. Goldstein, 2002) this kind of attitude is intrinsic to the strengths perspective on social work practice. Also, a partnership model of practice is a key aspect of family support approaches (Munford & Sanders, 1999; Dunst, 2003; Scott & O'Neill, 2003) and was identified as important in a New Zealand study of early childhood education centres and family resilience (Duncan et al., 2005: 14):

It is unlikely that change will be achieved if professionals are unable to connect with parents within their everyday life contexts. It is also unlikely that change will be successfully achieved with a top down 'expert to parent' approach. A partnership approach is much more likely to be effective.

The literature indicates that to be optimally effective supportive resources must be provided in ways that make them easily accessible to families who might benefit from them and in a style that conveys collegiality and promotes self-efficacy. Strengths-based and family support models reflect attitudes and ideas in tune with this approach, advocating access to material resources as well as promoting self-determination, competence and self-efficacy. Saleebey (2002b: 12) reflects on the gulf between the collegial style that he recommends as fitting strengths-based social work practice and the detached, directive style traditionally adopted by some practitioners, who may exacerbate clients' powerlessness by imposing their own theories over clients' accounts and ideas, by using assessment in an interrogative style and by engaging in 'self-protective manoeuvres' such as scepticism:

When we work together with clients we become their agents, their consultants, stakeholders with them in mutually crafted projects. This requires

us to be open to negotiation and to appreciate the authenticity of the views and aspirations of those with whom we collaborate. Our voices may have to be quieted so that we can give voice to our clients. Comfortably ensconced in the expert role, we may have great difficulty assuming such a conjoint posture (Saleebey, 2002b: 12).

Messages about reliable information and respectful delivery apply across the landscape of support. Just as it is important that families with a first baby know about Well Child services and feel respected by their staff, it is important that those eligible for DPB or Working For Families Tax Credit know about their entitlements and how to make a claim and feel respected by staff of relevant agencies. Suggestions of disrespect or disdain may cause families to shy away from using resources, or, if they do use them, cause them to feel that they are failing because they have to use them rather than succeeding because they have managed to access a potential solution to a problem. These issues mean that interviews should canvas participants' experiences of how support is delivered.

Managing support

In some situations the problem is not so much one of absence of support but of a bewildering array of resources and services. For example, parents of pre-school children may receive informal support from friends, family and the community at large as well as various types of semi-formal and formal support such as parent education, home-visiting programmes, information services, health and social service professional contact, or institution-based support such as early childhood education centres (Duncan et al., 2005). It may be true, as these authors surmise, that differences in family resilience are influenced by differences in 'access to and effective use of family and non-family social support networks...that can provide families with opportunities to gain material and economic resources and knowledge and skills' (Duncan et al., 2005: 2) but interacting with many support providers can be exhausting. If information and guidance dispensed is inconsistent, families may be confused rather than enlightened in their efforts to resolve problems. Families who are seriously stressed by multiple problems are the most likely to find themselves with the additional problem of dealing with multiple agencies.

Inter-agency collaboration is often mooted as a way of addressing a profusion of support. For example, in their study of forty Welsh families with high needs, Statham and

Holtermann (2004) found that many had involvement with multiple services of diverse types but that this did little to address their underlying problems, such as ill-health, relationship difficulties and especially drug abuse or financial problems. These authors call for a broad, cross-agency approach to addressing social exclusion. However there is a risk here that families will feel that their problems have been taken out of their hands by a collection of agencies, compromising their sense of self-efficacy. Statham and Holtermann (2004: 161) found that families perceived a negative aspect of receiving help as 'not being kept informed, and feeling that things were happening 'behind their backs''. Strengthening Families operates in New Zealand as a method of problem-solving through meetings that assemble all the agencies involved in a family's situation in the presence of the family. The intention is to ensure that families get the services they need in the most efficient way. The most recent review of the programme (MSD, 2004b) did not examine how families themselves experience Strengthening Families but an earlier review (Oliver & Young, 2001: 23), for which families were interviewed, indicates that the programme was experienced as increasing feelings of powerlessness. As well as not knowing what to expect, people worried about being ridiculed or attacked during the meeting. Grounded in previous experience, these fears were justified: 'for some, these kinds of anxieties became reality at some stage of the meeting' (Young et al., 2001: 23). This kind of experience is hardly likely to promote self-efficacy and resilience. A different approach to collaboration is suggested by Middlemiss (2005). This is not so much about meeting to discuss individual cases as about communication and planning to promote a co-ordinated, helpful system:

These collaborations could incorporate joint organizational meetings in which agencies work together to identify possible areas of collaboration and areas of need for the families in their communities...work together to bridge services and thus make the community and therapeutic sources of protection easier to access for parents and children (Middlemiss, 2005: 91).

A collaborative effort of this kind would facilitate negotiation, in Ungar's (2008) sense of the word, of support designed to meet diverse needs of all who might need to use them, not just a select few.

Transition to parenthood is a major life change involving a completely new set of challenges, emotional and physical as well as material and practical (Wilkins, 2006; Kluwer

& Johnson, 2007). Support is normally required to help smooth the path of people in this situation. However, as the literature reviewed in this section suggests, providers of formal and semi-formal support may need to evaluate whether the way in which they deliver support actually has the results intended, even when the aim is as simple as the teaching of a skill. If the intention is broader in scope, to assist families to adapt to parenthood and develop sustained competence, then it is even more important that the mode of delivery of a service or programme is carefully considered. Specifically, the process may be as important as the content. This feature of support is explored in the fieldwork. Another key issue to be explored in the fieldwork is the scope of potentially problematic aspects of adaptation to parenthood, which range from the universal, principally the challenging nature of childbirth and the perinatal period and the support consequently needed at this time, to the demographic, such as becoming a parent at a very young age. There is also a range of possible misfortunes that may befall infants and their families, including medical problems and emotional issues. While acknowledging the joy that new parents and their families may feel and the excitement with which a first baby may be welcomed into a family, it is only by exploring difficulties that it is possible to discern how the support system might better respond to actual needs.

Support for transition to parenthood

Even when all goes smoothly, formal support through the health system is essential to safe pregnancy and childbirth. Although childbirth is not now anywhere near as dangerous as it once was in developed societies, either mother or baby may still be affected by medical complications. Breastfeeding is often problematic (Caldwell et al., 1998; Hendriks, 2001; Ingram et al., 2002). Further, a first birth brings changes in roles, responsibilities and relationships (Mercer, 1995; Infant Care Practices Study Team, 1999; Cappuccini & Cochrane, 2000; Figs, 2000; Gjerdingen, 2000; Aiken, 2006). Life is suddenly dominated by the baby's needs (Dalla & Gamble, 1997; Ahlborg & Strandmark, 2001). Family members, fathers especially, find themselves with an unfamiliar role to which they must quickly adapt (Freed et al., 1992; Matthey & Barnett, 1999; Von Klitzing et al., 1999). Broken sleep and anxiety about a baby's health and development are usual in the first few weeks. Inability to soothe a fretful infant can result in a new and unsettling type of helplessness. The difficulty of transition to parenthood was an unexpected finding of research on professionally led 'couples groups' around the time of the birth of a first child.

Since participants were not recruited on the basis of any risk factors, the researchers (Cowan et al., 1996: 30) were taken aback by high levels of stress reported:

Many were surprised at how many serious stressors and how much unexpected strain they have been contending with, and, frankly, so were we...It would be tragic if the real difficulties families face as they attempt to raise young children were to be ignored on the assumption that help is needed only by those in more traditionally high-risk samples.

Unfortunately, believing that only 'at risk' families 'should' need help can deter families from revealing problems, far less seeking support. Women feel that they should measure up to an unrealistic 'perfect mother' image (Choi et al., 2005). This may 'prove problematic to first-time mothers in particular, who have to reconcile the gap between their idealised expectations and the lived reality of mothering' (Shelton & Johnson, 2006: 317). 'Idealised expectations' are shaped by popular culture. According to an editor of *Little Treasures*,²⁵ an upbeat representation of parenting is preferred and expected: 'Traditionally we wrap even negative stories so that they promise something positive' (Duggan, 2003:9). Reporting a study for which women were interviewed two to five weeks after giving birth, Runquist (2007: 35) says that many believed that they could 'do it all just days after childbirth' and concludes that 'women live in a context that does not provide information about the postpartum healing process nor the amount of time and rest that healing requires'. Coupled with total responsibility for a helpless infant, the physical effects of childbearing make women vulnerable to self-doubt and emotional upset (Figes, 2000). Pregnancy, birth and lactation affect energy levels, self-image and emotions (Fredriksson et al., 2003a) but perfectly groomed celebrities are regularly pictured with cute newborns in popular women's magazines. To emulate this some women consider or actually undergo plastic surgery (Shipman & Donnelly, 2007). While this is extreme, change in self-image and role that new mothers experience may amount to a loss of former identity (Cronin, 2002; Wilkins, 2006; Shelton & Johnson, 2006). Couple relationships may be strained during this time. In their study of relationship conflict across transition to parenthood, Kluwer and Johnson (2007: 1102) found that 'relationship distress stemmed from problems that existed before pregnancy rather than from the emergence of distress after pregnancy',

²⁵ *Little Treasures*, a magazine for parents of preschoolers, is published by a nappy company of the same name.

suggesting that addressing relationship problems during pregnancy might 'help prevent the exacerbation of relationship distress over the first few years of childrearing'.

Teenage parenthood is often seen as something to be prevented. However, while data from the Christchurch Health and Development Study suggests that early motherhood puts women at risk for 'educational underachievement and poorer economic circumstances' (Boden et al., 2008: 151), there are indications that 'linkages between early motherhood and later mental health difficulties can largely be accounted for by childhood, family, and related circumstances that occurred prior to parenthood'. In reviewing literature on teenage parenthood, both Bonell (2004) and Corcoran (1998) suggest that concern about teenage pregnancy is largely economic, reflecting ideas about minimising 'welfare dependency' (Corcoran 198: 53). According to Bonell (2004: 266), poor outcomes are 'socially mediated, and are especially affected by the degree of state support in terms of income, childcare and educational provision'. Corcoran concludes that short-term spending on comprehensive programmes to support teenage parents can have far-reaching benefits. For instance, young mothers aspire to continue education but many cannot find a suitable way of doing so (Hill et al., 2005). If aspirations are blocked by lack of available resources young parents are more likely to feel hopeless (Brosh et al., 2007). Young mothers who attend teenage parent units (TPUs) in secondary schools feel supported (Education Review Office, 2007) and have opportunities to learn childcare skills (Collins, 2006) and their employment prospects improve.

The needs of teenage fathers in New Zealand are not well understood, far less catered for (McCurdy, 2004). One study found that while initially 'the recency of their unencumbered adolescence attenuated their best wishes to father appropriately...each engaged in the struggle to ascertain an identity as father' (Frewin et al., 2007: 166). Reviewing the literature on adolescent fathers, Dudley (2007: 173) observes that although stereotyped as uncaring and uninvolved, 'some are just the opposite - fathering is an essential part of their lives'. Cutrona et al. (1998: 384) call for programmes designed to involve fathers of infants born to adolescent mothers, including education on child development and parenting and 'two key content areas: stress management and relationship management'.

Rather than being inevitably detrimental, for many teenagers transition to parenthood is a turning point (Rutter, 1987; 1999) catalysing beneficial change in attitudes and life style. A

study of the beliefs, attitudes and values of young parents confirms that transition to parenthood is a 'window of opportunity' for positive change (Dornig et al., 2009). Black and Ford-Gilboe (2004: 359) conclude that 'some young women experience personal growth' as a result of early parenthood. As reflected in the title: 'If it wasn't for my baby I don't know where I'd be', Collins' study (2004) of New Zealand teenage mothers showed that parenthood instigated change for the better for many. Following up this study Collins found that many 'defy stereotypes of teenage mothers' (2008: 1). An Australian study of teenage mothers reports that although participants were aware of being judged and condemned they were able to hold to a 'consoling plot' in which they saw themselves as good mothers and endeavoured to live up to their own expectations (Kirkman et al., 2001).

Towards fieldwork

In New Zealand there is a system of support for families having a first baby. I am interested in how this system of support influences the resilience of families adapting to life with a baby. Resilience theory indicates that how people cope at the beginning of a new phase of life may lead to a wide divergence in outcome. This suggests that a key function of formal and semi-formal support provided during transition to parenthood is to help new parents become established on a positive rather than a negative trajectory.

Based on the understanding that resilience refers to a common process of experiencing difficulty, learning new coping strategies and developing self-efficacy, the literature points to areas of experience that it is important to explore with first time parents in order to fully comprehend how they overcome difficulties and attain competence in their new roles. While some families will have to deal with far more problems than others, so that for them high quality formal and semi-formal support will have a key role in facilitating successful adaptation and preventing problems further down the track, all families may benefit from such support in getting off to a good start in the role of parent and thus getting their children off to a good start as well. In preparing for fieldwork with a focus on how support contributes to the resilience of first time parents in New Zealand, knowledge about how support has been found to be experienced by people in the role of parent prompts exploration of these areas during interviews. My reading of the literature on this topic suggests that the ideas of respect and reliability provide useful background knowledge to contribute to an informed approach to interviewing people currently experiencing transition to parenthood. Support may be counterproductive if recipients feel alienated or

disconnected from providers of support; if they feel they ought not to need support; or if support is experienced as demanding, boring, disparaging or irrelevant (Quinton, 2004). Studies conducted with parents (e.g. Quinton, 2004; Duncan et al., 2005) indicate that what parents require from support is that it is reliable, trustworthy, and that it helps them become more capable of fulfilling family functions, thereby helping to build resilience.

Connecting resilience to support

Extensive literature on individual resilience indicates that support available in the environment enables children and young people to make use of their aptitudes, talents and willingness to participate in their community, thus helping to build their competence, and self-efficacy, so that they become adept at managing difficulties, finding solutions to problems and taking advantage of opportunities that arise. This process establishes them on an upward trajectory manifesting resilience and steers them well away from the cascade of risk that can overwhelm those less fortunate in this respect.

The literature on how support may contribute to family resilience is not nearly so well-developed. Rather, despite allusions to families being situated within an ecological context, there is a tendency, especially in the therapeutic strand of the literature, to focus on families as entities and on their internal functioning rather than on how they interact with the environment. There are several problems with this approach. The first is the problem of how families who do not have 'healthy' family processes can acquire them. Altering family processes appears to be a time-consuming matter requiring intensive therapeutic work and possibly 'booster sessions'. This is simply unrealistic for families in transition to parenthood, for reasons that include their preoccupation with pregnancy, childbirth and the baby; financial outlay at a time when income is normally reduced; and being busy with a new baby's routine of feeding and sleep, which is commonly unpredictable and likely to be very tiring for new parents. Secondly, the therapeutic literature is based on a set of families whose situation and context are not necessarily comparable to families living in a different context. Thirdly, this literature focusses on family functioning rather than on functions, such as ensuring economic and emotional well-being and protection, that families perform in providing for themselves and taking a place in society. It is my contention that the latter is a more evident gauge of family resilience, just as competence in key life tasks is seen as a gauge of individual resilience. It is in relation to these functions that this thesis explores the contribution of support to family resilience.

Two examples drawn from the resilience literature illustrate the connection between resilience and support. One strand of the family resilience literature indicates that financial strain and its effects is a significant source of stress and adversity, making the role of income support strategies potentially important. Another strand indicates that parents in the situation of caring for a vulnerable family member appreciate information, guidance or assistance that is presented in a collegial manner.

This study explores the experience of families having a first baby in New Zealand, focusing on environmental factors that may compromise or enhance their resilience and paying particular attention to implications for policy and service provision. Messages from the general resilience literature, listed at the end of Chapter 3, constitute a set of 'sensitising concepts' (Patton, 1990) or factors to bear in mind during interviewing and analysis. The literature on support is also drawn upon on this respect, particularly its indication that the effectiveness of support is associated with its being experienced as respectful and reliable. With a view to undertaking interviews for this study, the literature on support suggested that as well as encouraging reflection on types of support across the range of potential sources, interviews needed to allow participants to reflect on the relationship between themselves and providers of support and on the dimension of how delivery of support made them feel, especially whether they feel demeaned or belittled in any way as opposed to feeling respected and strengthened.

The aim of ensuring that participants felt able to discuss all the variations in their experience of adaptation to parenthood meant that the style of interviews should be flexible rather than tightly controlled, following where participants chose to take the discussion rather than working through a list of questions. A flexible style encouraged participants to describe their experience in their own way and raise issues important to them. Exploring adaptation to parenthood in as much depth as possible allows a comparison to be made, at the analysis stage, between, on the one hand, what the literature suggests is to be expected or likely to be helpful; and on the other hand, what actually happens, how it was experienced and what really was helpful.

People experiencing a major life transition can be seen as poised between risk and resilience. For my study of how people experience transition to parenthood, including how

support may help them veer away from risk and towards resilience, interviews needed to create space for exploring whether participants experience anything akin to a 'cascade of difficulty' or a 'protective chain'. Encouraging discussion of changes in lifestyle was also important in order to give participants the chance to reflect on any altered attitudes or behaviour that might indicate that they experienced transition to parenthood as akin to what Rutter (1987) calls a turning point. It was important to encourage participants' reflection on factors that seem to be protective at all levels of the ecological context, from the personal to the structural, thus making it possible to explore a wide range of types of support received and wished for. Since the literature suggests that resilience is associated with self-efficacy, interviews needed to explore how participants have coped with any difficulties and whether support they received was experienced as helping or hindering self-efficacy. In the next chapter I consider methodology and methods to facilitate this broad approach.

Chapter 5 Methodology and methods

This chapter describes the qualitative nature of the study and my use of narrative inquiry to explore the experience of first time parents in diverse circumstances in New Zealand and seek to answer the research questions, which are:

What was the experience of first time parents in a range of circumstances in New Zealand today as they adapted to life with a baby?

What factors did a diverse set of first time parents experience as helpful or unhelpful as they dealt with challenges encountered during transition to parenthood?

What are the implications for policy and service delivery?

Methodology, methods, ethical issues, reflexivity and analysis are discussed in this chapter. Consideration of implications of participants' experience for policy and service delivery, as a prelude to the further step of making recommendations, is consistent with an orientation towards social justice (Galambos, 2008) and human rights (Centre for Human Rights, 1994; Ife, 2008) and reinforced by Flyvberg's (2001) argument that exploring situations in detail enables researchers to propose change.

Methodology

Qualitative methodologies, which privilege meanings and interpretations, are suited to: gaining understanding of a respondent's world (Sarantakos, 1993; Denzin & Lincoln, 2008); exploring the needs and experiences of current and potential service users (Ritchie & Spenser, 1994); and, according to Massey et al. (1998: 340), may explain how differences in outcome are contextually mediated:

Qualitative work offers a way to take seriously the influence context has on experience and meaning...Not only can participants in a qualitative study tell us if they felt, believed or acted in a certain way, but they can also describe *why* – what influenced their feelings, beliefs or decisions. Further, they can

articulate the limits built into their situations. We can then investigate how they experienced the opportunities and constraints of the adversity of interest. What limits did they confront? What choices did they perceive they had?

My study positions people experiencing transition to parenthood as the experts on that experience, exploring their experiences of support and gathering their views about how the support system might be improved. Knowledge produced by the study is, as I see it, a collective endeavour and a collective product, including not only participants interviewed, but other people with whom the research was discussed as it progressed and yet others with whom it will be discussed as I attempt to use it to contribute to beneficial change.

Qualitative methods are ‘particularly useful to develop in-depth, rich, and nuanced accounts of the lived experience of research participants’ (Dornig et al., 2009: 52); have the capacity to explore processes over time and the mechanisms underlying the risk-resilience relationship (Davidson, 2008); and can reinforce advocacy in the policy field (Shaw, 2003). Schoenberg et al. (2007: 9) concur:

The privileges that qualitative researchers derive from their “up close and personal” approaches provide critical insights for policy planning, appropriate service provision, and optimal provider and client/patient communication.

This use of the term ‘up close and personal’ graphically conveys how important it is that researchers engage with participants in ways that enable participants to fully articulate needs, met and unmet, in the context of their daily lives.

Methodology has been conceptualised in two ways (Sarantakos, 1993; Seale et al., 2004): in an abstract way, ‘in conjunction with distinctive, unidimensional and mutually exclusive theoretical principles’ (Sarantakos, 1993: 32); and in a practical way, where methodology equates to research model. Van Manen (1990: 27) distinguishes between methodology as ‘philosophic framework, the fundamental assumptions and characteristics of a human science perspective’ and methodology as ‘technique’. Seale et al. (2004: 7, 8) see methodology as having a ‘political’ role, helping ‘to legitimate and elevate a discipline or practice among other enterprises or social practices’ and a ‘procedural’ role, helping to ‘frame a research topic and to guide researchers in concrete terms during the whole

process of producing knowledge'. The 'political' role provides an epistemological foundation, or a way of reinforcing validity by considering 'how we can know certain things, and what counts as legitimate knowledge' (Tolich & Davidson, 1999: 23); the 'procedural' role establishes congruence between the investigative aims of the study and methods used to achieve them.

Looking first at how methodology relates to 'philosophical framework' (van Manen, 1990: 27), my study is within the 'interpretive' paradigm (Sarantakos, 1993; Tappan, 1997), which conceptualises reality as 'what people see it to be' (Sarantakos, 1993: 35) and is thus concerned with subjective meaning: 'The baseline assumption is that the human individual is a conscious agent who is the most knowledgeable expert on his or her life' (Astedt-Kurki & Heikinnen, 1994: 418). Subjective meaning is central to hermeneutic phenomenology, which is 'concerned with the life world or human experience as it is lived' (Lavery, 2003: 7). Researchers working from this perspective must painstakingly attend to the detail of what they find out from those whose experience they are exploring, as Lavery (2003: 7) recommends:

The focus is toward illuminating details and seemingly trivial aspects within experience that may be taken for granted in our lives, with a goal of creating meaning and achieving a sense of understanding.

A focus on detail is also strongly recommended by Flyvbjerg (2001) as vital if researchers are to be in a strong enough position to take an informed stance on how their findings can be put to practical use to achieve change for the better.

Hermeneutic phenomenology supports an approach to research that takes account of context (Charalambous et al., 2008), which is understood to influence resilience (Ungar, 2008). From the perspective of hermeneutic phenomenology, people understand the world in ways determined by their background and culture (Lavery, 2003); 'humans are embedded in their world to such an extent that subjective experiences are inextricably linked with social, cultural, and political contexts' (Lopez and Willis, 2004: 729). Many research studies in the field of nursing have been based in hermeneutic phenomenology, which has been found valuable (Charalambous et al., 2009; Draucker, 1999) for enhancing understanding of 'the lived, contextual realities and concerns of the clients for whom

nurses provide care' (Lopez & Willis, 2004: 726) and has produced results that are culturally relevant, respectful of the social realities of participants and contextually grounded in daily living and practical concerns (Annels, 1996). Hermeneutic phenomenology holds that it is important to remember that researchers, just as much as research participants, understand the world in ways created, influenced and possibly distorted by their own background and culture. Researchers approach their studies with their own understandings and expectations (Lopez & Willis, 2004; Charalambous et al., 2008). Indeed, it is this knowledge base that makes it possible to make a start, and proceed, towards understanding others. According to Tappan (1997: 649) this means that 'there is no such thing as nonpositional understanding'.

Interpretation must take as its starting point the historical and psychological reality of the lived experience both of the subject whose expression of experience is being interpreted, and of the interpreter herself...An interpreter understands by constant reference to *her own perspective*, which shapes her understanding of the world based on her own expectations, preconceptions, biases, and assumptions...Her methodological task, therefore, is not to immerse herself completely in the experience of the subject (which, needless to say, is impossible). Rather, it is to search for ways in which she can interact with the text in order to increase her understanding of the subject's experience, based, at least in part, on her own experience.

It is important to remember that 'every encounter involves an interpretation influenced by 'historicality'. Historicality, described as 'a person's history or background', includes 'what a culture gives a person from birth and is handed down, presenting ways of understanding the world' (Lavery, 2003: 9). Hermeneutic phenomenology recognises that it is impossible for interpreters to extricate themselves from sociohistorically acquired traditions and prejudgements; research offers a view that is inevitably mediated by the researcher's interpretation (Liamputtong & Ezzy, 2005). Throughout this study I was aware that my background is very different from all of the participants and that this requires the exercise of vigilance lest my own 'historicality' obscure or overwhelm that of participants. On reflection, I do not think this occurred. Rather, I was repeatedly surprised by what I heard from participants. I felt privileged to learn about their lives. Articulately, and often with humour, they conveyed very directly what it was like for them to learn to cope with their

new roles and responsibilities. This is mirrored in the stories and quotations that are the substance of Chapters 6 - 9.

The complex dynamics involved in interpretation is explained by the 'hermeneutic circle', a metaphor for a process that begins with a 'vague and tentative notion' or 'an anticipation of meaning' (Cohen et al., 2000: 72) and becomes more substantial as parts of the text are understood in relation to the whole, in turn informing understanding of the whole. The hermeneutic circle is a continuous process, involving movement back and forth between the whole and the parts: 'Hermeneutic reflection, preunderstanding, interpretation, and understanding are involved in every step the researchers take in the process of research' (Lindholm et al., 2003: 142). As the fieldwork progressed I refrained from asking leading questions and, by listening to tapes after interviews, checked that the focus remained on inviting participants to explore their own experience and that I was not indicating what my own views might be. Similar vigilance was constantly in my mind when analysing transcripts, as described later in this chapter. Where a theme began to materialise, that is, when successive participants mentioned a particular experience or topic, I encouraged exploration of this topic in following interviews in the same set of interviews. For example, it was so common for participants to mention food when speaking of the days after childbirth that, if this were not raised by a participant, I mentioned noticing that previous participants had talked about food. This evoked stories about hospital food, gratitude for gifts of food, or experiences of shopping for food.

While openness to participants' experience is critical to research from the perspective of hermeneutic phenomenology, as is the researcher's awareness of her own experience and response, it is accepted that 'presuppositions or expert knowledge on the part of the researcher are valuable guides to inquiry and, in fact, make the inquiry a meaningful undertaking' (Lopez & Willis, 2004: 729). As we try to make sense of the world our perceptions are inevitably influenced by existing ideas (Mitchell & Cody, 1993). This set of ideas includes theories, which, as Gilgun (2006: 438) explains, 'illuminate for researchers what might be important to study and thus provide sensitizing functions', or, in Patton's (1990) phrase, 'sensitising concepts' Astedt-Kurki and Heikkinen (1994: 419) observe that 'The interview themes for a research study are usually derived from a certain theory or frame of reference that is relevant to the main issue of concern in the study'. For example,

Robinson's (1994) narrative study of sexually abused girls was informed by literature on delinquency; girl offenders; and abuse, especially sexual abuse.

It is because of its ubiquity in discussions of how people manage to achieve competence after a period of difficulty or disequilibrium that I drew on the resilience literature for 'sensitising concepts' (Patton, 1990) for studying how first time parents in New Zealand successfully adapt to life with a baby and for a 'frame of reference' (Astedt-Kurki & Heikkinen, 1994) or organising concept for considering the findings. Reviewing this literature indicated that support is a key factor in promoting resilience, so literature on supporting parents was reviewed in order to discover how support of this kind is conceptualised and considered. This literature helped shape my approach to both data collection and to analysis. In line with Padgett's (2009: 102) counsel that 'qualitative studies do not take place in an intellectual vacuum; theories and concepts are used to inform but not constrain', interviews were informed by what the literature indicated might be important, but yet were flexible, exploring ideas introduced by participants. Open questions encouraged participants to respond in ways that were relevant to them. Participants were encouraged to reflect on what the support they received actually meant to them so that at the analysis stage it would be possible to consider whether services and strategies that might be expected to promote resilience in fact did so, or if something else was more important to participants. While helpful in comprehending the structure of service provision, the support literature did not prefigure participants' notion of the ideal service provision scenario, which turned out to be largely about choice.

In the second sense alluded to at the start of this section, methodology is 'the theory behind the method, including the study of what method one should use and why' (van Manen, 1990: 27). In this role methodology functions as a coherent plan, a grand design for operationalising a study, and has been explained as follows:

[Methodology is] the strategy, plan of action, process, or design lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcomes (Crotty, 1998: 3).

Two very important aspects of my study were, first, following participants' experiences over a period of time to recognise that resilience is a process that develops over time, and

second, ensuring that participants' experience was 'revealed to us in such a fashion that we are now able to grasp the nature and significance of this experience in a hitherto unseen way' (van Manen, 1990: 39). Tappan (1997) explains that for experiences to be available for interpretation they must be expressed. Expressions in this sense are symbolic representations of experience, through text, image, dance or music, that make subjective experiences available for interpretation by others. Quoting Ricoeur, who said that 'interpretation is the hinge between language and lived experience', Charalambous et al. (2008: 640) note that 'this is especially so with research interviews...where lived experience is expressed through language then transcribed into a text and interpreted'. This is central to narrative inquiry. According to Polkinghorne (1988: 125) 'narrative is a primary scheme by means of which hermeneutical meaningfulness is manifested'.

Narrative inquiry

Early in my thinking about studying resilience in families adapting to parenthood I became convinced that the most natural way to find out about their experiences of the system of support available to them was to ask them to tell me about it from their own point of view. This view was affirmed when I came upon Sandelowski's view (1991: 162):

Because lives are understood as and shaped by narratives, narrative approaches to inquiry parallel the ways individuals inquire about experience...and, in a sense, naturalize (or remove some of the artifice from) the research process.

Maines (1993: 20) observes that 'stories and storytelling are ubiquitous and that most if not all societal activities could not take place without narratives'. A narrative approach has been recommended for exploring a respondent's own "take" on their resilience:

Personal narratives may illuminate protective factors (active or latent) in parts of a respondent's ecosystem that might not be readily apparent to researchers. For example, a child's stress may be buffered by the continuing ripple effect of a nurturing, supportive teacher years after the child was actually in that teacher's class. Subjective, narrative accounts are also useful because of the dynamic nature of both risk and protective factors, and because a given individual moves back and forth along the resilience-vulnerability continuum (Waller, 2001: 295)

Observing that ‘telling stories about past events seems to be a universal human activity’, Riessman (1993: 3) says that narrative is ‘talk organised around consequential events’ where ‘a teller in a conversation takes a listener into a past time or “world” and recapitulates what happened then to make a point, often a moral one’. The following description of narrative inquiry resonated with my thinking:

Narrative inquiry is a way of understanding experience. It is a collaboration between researcher and participants, over time, in a place or series of places, and in social interaction with milieus. An inquirer enters this matrix in the midst and progresses in the same spirit, concluding the inquiry still in the midst of living and telling, reliving and retelling, the stories of the experiences that make up people’s lives (Clandinin & Connelly, 2000: 20).

Narrative approaches take account of context, viewing self and identity as connected to social, historical, political and cultural contexts (Smith & Sparkes, 2008). Narrative inquiry is flexible, as Stanley (2008: 436) explains:

Narrative inquiry provides a methodology, a set of broad procedural ideas and concepts, rather than a pre-set method or specified technique, and it encourages responsiveness to the dynamics of the research context.

Narrative inquiry underpins the design of a methodology for my study that privileges what participants communicate about their experiences (their ‘expressions’) and is flexible enough to suit their circumstances. In my study the salience of participants’ views is illuminated by the stories they told. Riessman says (2008:187) that a narrative is ‘not simply a report of events’ but rather ‘one articulation told from a point of view that seeks to persuade others to see events in a similar way’. It is intriguing that the word ‘telling’ is a synonym for ‘forceful’ or ‘powerful’. Participants’ narratives were energized by the realities of their lives and are telling in this sense of the word. Encouraging participants to express their views in their own terms provided a mechanism for including their voices directly in later dissemination of the results of the study in order to advocate for change.²⁶

²⁶ Table 3, Appendix 2

Methods

Riessman (1994: 68) notes that 'the telling of personal narratives is common in research interviews' and that, if not interrupted by standardised questions, participants 'will hold the floor for lengthy turns'. This is much more likely if participants feel comfortable; it requires establishing a relationship that will create a sense of safety and an atmosphere that facilitates 'conversations with a purpose' (Jarrett, 1992: 177) and encourages reflection. Cohen et al.(2002: 178) explain successful interviewing as interaction that elicits 'participants' feelings and thoughts about their past experiences, and assists them in reflection, making it possible for new meaning to emerge and be articulated'.

Depth interviews have been described as 'an entranceway to narrative understanding'. (Miller & Crabtree, 2004: 200). The depth interview is 'designed to generate narratives that focus on fairly specific research questions' (Miller & Crabtree, 2004: 188). Open, direct questions are used to do this. Aiming for a collaborative approach to constructing meaning (Mishler, 1986; Riessman, 2008), this method goes some way towards neutralising power differentials (Ife, 2008). Miller and Crabtree (2004, 196) explain that in a depth interview 'the researcher, not the research guide, is the research instrument' and that:

The interviewer's role is to assume a low profile but encouraging stance, to put the informant at ease, to acknowledge the value of the information and assign competence to the interviewee, to take on the role of the respondent...and to reinforce the continuance of the conversation – to facilitate improvisational storytelling.

I found that being an 'instrument' of this kind is challenging and demanding, requiring sensitive attention to what is happening during interviews. Listening to tapes soon after interviews helped me monitor whether I was staying focussed in this respect and notice any lapses so that I could do better in subsequent interviews. Miller and Crabtree (2004:) advise that during depth interviews interviewers should show enthusiasm and interest; be non-judgmental, flexible and empathic; beware of forgetting previous answers and avoid condescension. I did my best to do all of this and ensure participants felt free to go beyond conventional notions of life with a first baby as portrayed in the media²⁷ and tell me about the realities, including any 'gap between their idealised expectations and the lived reality of

²⁷ Discussed in Chapter 4.

mothering' (Shelton & Johnson, 2006: 317). I invited participants to tell their stories in their own way (Munford & Sanders, 2003), using active listening to show my interest in their experience and encourage reflection on feelings as well as discussion of what participants found helpful and what they thought would be helpful for people adapting to parenthood. I used paraphrasing to check my understanding of what I was told. I found that pauses, met with attentive silence, were sometimes a prelude to stories. A principle of the human rights perspective on social work is to avoid perpetuating power differentials in social work practice and research (Ife, 2008). While interviews were conducted as conversations, I was always aware that the conversation was in a way 'staged' and that power relations were still inherent in the situation. To mitigate this somewhat, at each interview I overtly referred to what I planned to do with the information participants provided. I set the tone of interviews by first and foremost explaining the study as motivated by my interest in improvement in the support system for families with a first baby, asking participants to help me understand the experience of people in this situation by telling me about their own experience and inviting them to join me in considering strategies for helping more families negotiate this transition more successfully. This view of participants as holders of knowledge about the experience of transition to parenthood in New Zealand was conveyed to them in written information given to them and repeated verbally before each interview.

A significant challenge of the interview process was that participants came from very different backgrounds. While an 'outsider' in the context of their lives, I was I think perceived, in Sultana's phrase (2007: 379), as an 'acceptable outsider doing 'useful' research'. My concern with being utterly respectful did not fully equalise my relationships with participants. Some, as the saying goes, were more equal than others; as an educated Pakeha woman I was much more 'like' some of the participants than others. It is possible that hearing that I have children meant that rather than perceiving me solely in the role of researcher, participants talked to me as another mother, fostering a deeper level of interaction. However, this was very different with older participants compared with younger ones, some of whom were the same age as my own daughter at the time. My approach varied accordingly; when I told participants something of my background when introducing myself I tended to mention my own children to older participants, whereas with teenage participants I mentioned my children's friends' new babies. This seemed to help make the interview situation more natural, perhaps by indicating that I had at least some inkling of the realities of life with a baby.

Throughout the research I reflected on how interviews might impact on participants. Visiting them at home meant that I was meeting them 'on their own territory' and, as well as being more convenient and comfortable for them, may have symbolically communicated a willingness to enter their worlds. I think that this, together with timing interviews to suit participants and always allowing plenty of time so there was never any rush, added to participants' sense that I was there to consult them, that I valued their knowledge and views and that I was grateful for their willingness to make themselves available to me. I was invariably made welcome in participants' homes, which included farm cottages, upmarket city houses and suburban rented houses. Interviews were often interrupted by babies needing attention and by callers, including participants' friends or relatives. I took my cue from participants at such times and often found myself holding the baby. Given how busy participants were, and conscious of the need to limit my interference in their lives, it was inappropriate to involve them more heavily in research design and analysis. However, in taking up the dual role of reporter and narrator, I ensured that their views on what worked and was needed to support the experience of having a first baby were central to the research findings.

Reflecting on the fieldwork, I think that my background in family support social work, which I mentioned to participants, helped them feel comfortable by suggesting that I would not be shocked by anything that they chose to reveal. However, I was at the time conscious that this background might lead me to steer the conversation towards areas not raised by participants or to infer more than was intended from what they said, so I monitored my own response to what participants were saying and held my own views in check. I believe, however, that my ability to stay in the researcher role was reinforced by my having departed to work outside social work several years before the interviews took place. Where I think that my professional experience of interviewing families under stress was useful was that it prepared me to notice nonverbal cues and follow up issues of concern. On two occasions I provided participants with information to assist them with problems. Knowing that the impetus for my research was practical as well as exploratory, participants readily volunteered ideas for improvement in service provision. My statement that I would preserve participants' confidentiality unless I believed that someone was at risk or unwell was accepted as the safety measure it was intended to be.

To take account of the nature of resilience as a process that takes time (De Haan et al, 2002) I undertook three sets of interviews: within five weeks of a baby's due date; when babies were around three months old; and close to each baby's first birthday. While I offered to come to their homes, I invited them to suggest alternative venues. For the majority of interviews I visited participants' homes. Of first interviews, however, two took place in birthing centres following prenatal appointments, one in a café, two in participants' parents' homes and one in a residential facility for teenage mothers. Interview guides,²⁸ prepared for each set of interviews, contained questions designed to elicit information about participants' experiences relevant to the research questions. I expected that some participants might not wish to be interviewed three times, especially if they returned to work. In fact the attrition rate was low. After the first interview one participant went to live overseas and another employed a nanny and went straight back to work, declining a second interview. After the second interview I lost track of three more. Anna, who was in an apparently stable relationship with a much older man, moved 'up north' and I was unable to contact her. Maya, according to her flatmate, had gone into Refuge to escape her baby's father, with whom she had never wanted to live. I could find no trace of Zoe, whose relationship with her baby's father was shaky when I first met her (although apparently stable when I interviewed her the second time).

Two informal exercises were used as tools to kindle discussion and reflection. In the second interview an eco-mapping exercise²⁹ was used to gain some understanding of participants' perceived networks of support. I provided participants with drawing materials and invited them to draw a simple diagram, with themselves represented as a circle at the centre of other circles representing, first, people whom they saw as part of their social network, and secondly any people or organisations that they saw as current or potential sources of support. They were asked to use various types of lines, for example, dashed to represent a tentative link with a source of support, zig-zag to represent any tension between themselves and another person, or a thick line to indicate a strong connection. This exercise was used as a tool for encouraging reflection and discussion of support found helpful or wished for and it sparked stories and comments about perceptions of relationships with potential sources of support. In the third interview a simple scaling technique was used to invoke reflection on achievement in the family functions³⁰ which

²⁸ Appendix 7.

²⁹ Described further at the start of Chapter 6.

³⁰ Economic well-being; nurturance of vulnerable members; personal development; belonging, discussed

Patterson (2002) argues are indicative of family resilience. The scaling exercise, adapted from a technique used in strengths-based practice (De Jong, & Miller, 1995; Turnell & Edwards, 1999), involved simply asking participants to rate themselves from 1- 5 across the family functions of material well-being; protection of vulnerable members; nurturing and self-development; and sense of belonging.³¹ This proved a non-threatening way of launching detailed narratives about difficulties overcome, thus enabling participants to discuss what they did to overcome these difficulties, the kind of support they received or the kind they wished for. Most participants cheerfully awarded themselves a 4 or 5 for all functions. Economic well-being was often a 4. When participants thought a 3 or less appropriate for one or more functions, aspects of their family life were seriously awry; their resilience was definitely compromised.

Recruitment

I aimed to recruit participants spanning the age range of first time parents and as diverse as possible (Patton, 1990; Seidman, 2006). This promised to produce the kind of data I was seeking; that is, 'high-quality, detailed descriptions of each case, which are important for documenting uniqueness' and 'important shared patterns that cut across cases'. Going by Patton's advice (1990: 172). Miller and Crabtree (2004: 191) state that for a study using depth interviews 'respondents should be selected so as to maximize the richness of the information pertinent to the research question...the sampling strategy should be purposeful and not random'. The sample included 27 women, aged from 16 to 40 and in widely different circumstances.³² Three were immigrants (from Europe), four were Maori and two had Pacific heritage. Both of the latter were born in New Zealand; one did not identify with the Pacific aspect of her background. Since it seemed probable that participants' circumstances would vary with urban and rural residence, participants were recruited in two urban areas (within Auckland but with different demographic profiles) and two areas north of Auckland (a semi-rural area within 90 kilometres of Auckland and a rural area about 200 kilometres from Auckland).

Transition to parenthood presents challenges for all families and difficulties for many so I resolved to explore the experience of participants in diverse circumstances

later in this chapter.

³¹ Discussed later in this chapter.

³² See Table 2, Appendix 1. Of the 27 women interviewed in late pregnancy, 25 were available for a second interview around 3 months after the birth of their child and 23 were interviewed again around the time of the baby's first birthday. Two were unavailable for this third interview.

without prejudging whether they were 'at risk' in some way, thus avoiding 'risk by association'.³³ Representation of diversity was curtailed by the logistics of one person undertaking a series of three qualitative interviews. This made anything but a small sample unrealistic. Stories and views presented in the findings chapters can be no more than indicative of circumstances encountered and support received by first time parents in New Zealand. Recognising this limitation of the study, I hoped to produce 'informative' research (Schoenberg et al., 2007: 11) in that a study that 'employs a limited number of cases with rich contextual data and no pretensions of generalizability may be particularly informative for the specific research question being addressed'.

Encouraging participants to direct the conversation meant that a wide range of topics was discussed in some depth. A whole thesis could have been written about the nature, membership and function of coffee groups. Nonetheless, the narratives provide some insight into what life with a first baby is like for people going through the same life transition in different circumstances. The findings chapters report the words of people who literally knew what they were talking about and whose views about improvement in the support system for families with a first baby emerged from their own experience and that of peers. Hence the study provides well-grounded starting points for taking a closer look at topics important to first time parents.

My first attempt at recruitment, by means of a flyer on GPs' notice boards (with Information Sheets available for anyone interested)³⁴ had met with no success whatsoever. My next strategy was to contact an urban midwifery team and ask them if they would pass flyers and information sheets on to women using their services. One midwife suggested that I contact a local childbirth educator, who offered to ask her current class if they would be open to my talking to them about the research at the beginning of a class. Since they were happy for me to do so I spoke briefly about the research at the beginning of the following class and left information sheets, including my contact details. This resulted in five participants contacting me, all of whom were in their thirties. The childbirth educator gave me contact details for another childbirth educator in a different part of the city and the same approach was used at her class, with similar results although a more diverse range of participants, but none younger than mid twenties. To recruit younger participants I

³³ Discussed in Chapter 3.

³⁴ See Appendix 4.

contacted several midwives. Often the midwife would say something along the lines of 'I've got a couple at the moment who might be interested'. Approximately one in two actually were interested. Permission for me to contact these women was established through an intermediary consent form³⁵ with the purpose of allowing the midwife to pass on the woman's contact details so that I could then contact them. This strategy resulted in midwives' providing contact details of twelve participants, mostly teenagers. By this time I was missing only women in their early to mid-twenties. The gap was filled by asking midwives to tell women in this age group about the project.

My intention was to interview women first, then, through them, recruit 'significant others', especially their partners. This was done by means of a Significant Others Information Sheet and Consent Form.³⁶ Twelve interviews were formally arranged by this means. In all but two instances, significant others were interviewed in the presence of the original participant. Jack became depressed after the baby's birth and Fay thought that he would express his views more freely if she were not present; Kent was interviewed with his mother with whom he and the baby were living after Dawn left to live with a friend. Occasionally interviews with significant others turned into dialogues with the original participant contributing too. On several occasions, partners, parents or friends happened to arrive during an interview and were invited by participants to join the conversation, which they occasionally did in an informal way. All interviews were taped, with a standard clause in the Information Sheet indicating participants' right to stop the tape. This was requested on two occasions, once during a first interview when a participant wished to talk about something in her own background 'off the record' and once during a second interview when a participant wanted to discuss a relative's situation that was worrying her.

Ethical issues

Ethical approval for the study was obtained from Massey University and the Northern X Regional Ethics Committee.³⁷ Ethical issues were considered and addressed before and during the fieldwork. For reasons connected to this, some events and experiences had to be described in a modified way in the reporting and analysis of findings. For example, sometimes participants spoke of events that reflected very negatively on others and it was inappropriate to report this verbatim. Also, to protect participants' privacy and avoid stirring

³⁵ See Appendix 6.

³⁶ See Appendices 5 and 6.

³⁷ See Appendix 3.

up any residual pain, the full detail of particularly stressful events and circumstances is not reported in the findings chapter. This was an aspect of the partnership developed with participants and something on which I constantly reflected during the fieldwork process and while analysing the transcripts. Including the 'gory details'³⁸ of experiences that might still cause emotional pain would have been a breach of the understanding established with participants about the purpose of the study and the use to which their narratives would be put. Although no physical risk to participants in this study was foreseen, there was a possibility that discussing their circumstances might be in some way upsetting. I was aware that the conversations at the heart of the interview process might instigate reflection on events or circumstances about which participants were unhappy, perhaps exacerbating discontent or frustration. There was also a possibility that pondering their own experience as parents might trigger thoughts of their own experience of being parented. To mitigate any problems, I resolved to conduct interviews with scrupulous attention to active listening skills and I watched for body language indicating distress. I researched sources of support in each of the geographical areas where I planned to interview participants and prepared a list, including contact details, for each area. I took copies of this list³⁹ with me to interviews so that if participants expressed or demonstrated a need for support I would be able to refer them to appropriate support.

Participants were assured that their anonymity would be protected. To fulfil this obligation details that might potentially identify participants have been omitted or mentioned in a modified way in the reporting chapters. Tapes and other materials produced during interviews were kept securely locked in a filing cabinet at my home. Consent forms were securely stored separately. Transcripts were stored on my personal computer under password protection and were accessible to no-one else. All names have been changed. Unless a significant other took part in the study, in which case a pseudonym is used, partners' names are represented as [Partner] and all babies' names are represented as [Baby]. Some participants in fact referred to their child as 'Baby'. Although neither Maori nor Pacific participants were specifically sought, my aim of recruiting participants of diverse background meant that I expected that some would be of Maori or Pacific descent, in which case I undertook to seek advice about interviewing them. When I did so I was advised by both cultural advisors that since women had volunteered to take part in the study having heard me talk about it (via childbirth education classes or expressing interest

³⁸ The term 'gory details' is in fact a literal description of some of the detail of participants' stories.

³⁹ See Appendix 8.

to a midwife and requesting that I phone them), I should proceed as with other participants, being careful to observe practices like removing shoes and accepting hospitality if offered (which it was). Two participants were European immigrants.

Reflexivity

Reflexivity is concerned with the need for researchers to locate themselves in their work, considering how their biography and opinions may influence the research and monitoring the effect of the research experience on themselves. Elliott (2005: 153) suggests that reflexivity 'might be understood as a heightened awareness of the self, acting in the social world' or 'the tendency critically to examine and analytically to reflect upon the nature of research and the role of the researcher in carrying out and writing up empirical work'. Either way, it is by concentrating on how personal interests and standpoints affect the research process that the researcher is able to actively and consciously construct interpretations of experiences in the field and question how these interpretations arise. Thus reflexivity provides insight - both into the topic of study and also into how that insight is generated. The researcher may thus become a channel of communication through whom a 'narrative structure unfolds' (Bott, 2010: 160). Elliott (2005:155) issues a warning:

[I]t should be acknowledged that 'unfettered reflexivity' risks diverting all attention away from the subjects and subject matter of the research and onto the researcher. The aim is therefore for researchers not simply to provide their readers with confessional accounts of their experiences of conducting research, but rather to produce an analytical discussion of how their own theoretical and biographical perspective might impact on their relationships with research subjects, their interpretation of research evidence, and the form in which the research is presented.

Reflexivity is relevant throughout a research study, influencing the relationship between interviewer and interviewee (Tappan, 1997) and encompassing a process of 'interweaving levels of theoretical analysis as a type of theoretical reflexivity' (Fook, 2002: 91). Rubin and Rubin (2005: 31) discuss the importance of self-reflection for handling the experience of hearing participants express views that are dissonant with the researcher's own.

Rather than pretend that interviewers come into the situation with no biases and can listen to answers without sifting them through their own experiences and cultural lenses, the responsive interviewing model argues that researchers need to continually examine their own understandings and reactions.

This I found challenging at times, especially when some participants mentioned their opposition to the repeal of Section 59 of the Crimes Act (which removed the defence of reasonable force for adults accused of assaulting a child, but was widely referred to as 'banning smacking' and perceived as removing parents' 'rights' to 'discipline' children). My own stance on this matter was strongly in favour of repeal. I was also occasionally surprised by what seemed like racist comments (for example, a casual allusion to previous tenants of a participant's rented house) or taken aback by the vehemence of some participants' views, or indeed the level of difficulty they were experiencing.

As well as being a key aspect of fieldwork, reflexivity is important during data analysis, at which stage consulting with others helps researchers examine how their ideas evolve (Starks & Trinidad, 2007). Reflexivity is also while writing about a study (Elliott, 2005). As Cresswell (2007: 179) says:

How we write is a reflection of our own interpretation based on the cultural, social, gender, class, and personal politics that we bring to research. All writing is "positioned" within a stance.

To process my response to what I was finding out and monitor how my own stance might influence interpretation, I incorporated reflexive strategies into my thinking throughout the fieldwork, analysis and writing phases of the study. After each interview I noted my responses.⁴⁰ I regularly discussed the study, especially with my supervisors, but also with Plunket nurses, parents of babies, midwives, social workers and counsellors and, between second and third interviews, with the Chief Executive of the New Zealand College of Midwives and the director of a residential facility for teenage mothers. I was fortunate to be

⁴⁰ Third interviews took place at a time of public debate about the repeal of Section 59 of the Crimes Act, intended to remove the defence of 'reasonable force' in maltreatment cases, but interpreted by many as denying parents the right to 'correct' children in a way seen as their parental right, or indeed duty. Twice I was momentarily taken aback by what Frost and Hogget (2008) call 'disagreement' between the values of researcher and participant. This was when participants expressed their conviction that smacking young children is a valid and useful parenting technique – by no means my own view. At these times a reflexive approach was particularly helpful.

able to talk regularly with a cultural advisor, who generously shared with me her profound knowledge of the potential impact of research on the researched; helped me understand how my 'researcher' role might be perceived by participants; and encouraged a collegial, down to earth approach to interviewing that genuinely privileged participants' experience and conveyed respect for them as experts on their own situation. I spoke publicly about the research as it proceeded. I delivered lectures to, and invited questions from, two groups of early childhood education students; I was guest speaker at an early childhood forum; and I presented papers at training sessions and conferences,⁴¹ where questions and conversations about my work were stimulating and sometimes challenging. This was particularly true of the *Meaning of Motherhood* conference, held while I was interpreting the data, where I was closely questioned about the provisional results of the study.

My personal politics influenced my choice of topic as well as the methodology and methods used to study it. Raised in a working class Scottish family in an industrial town that suffered from a downturn in shipbuilding while I was a child, from an early age I witnessed the struggles that families go through and became aware of the impact of poverty. This instilled in me an abiding interest in social justice and led me to social work as a career. I now consider myself to have a Scottish-Pakeha world view, having lived in a rural area north of Auckland since 1986 and having been fortunate enough to be included in wananga on marae while working in community social work. During the fieldwork phase I was alert to the danger of being a 'cultural tourist', a trap that Smith (1999) warns non-Maori researchers to be careful of when conducting research involving Maori. In fact I found that this warning was germane throughout the fieldwork generally since the background and circumstances of all participants differed from my own in many ways. This issue was kept current in my mind, and I think avoided, by extensive discussion with a cultural advisor. My experience of parenting three children, one of whom has a chronic illness, contributes to some degree to my interest in parenting, resilience and the role of support in developing competence in the parenting role. All three of my children are now young adults. My own experience of adaptation to parenthood was not particularly stressful and did not have a significant influence on my choice of this subject for this thesis; it is my professional background, which includes 15 years managing a community-based semi-rural family support agency, that was the impetus for undertaking the study,

⁴¹ Including the SPEaR Conference (2006), the Plunket Centennial Conference (2007), the BRCS Colloquium (2008) and the Meaning of Motherhood Conference, organised by the Centre for Attachment (2009).

specifically my experience of working with people who were under severe stress and were struggling to parent their children safely. It was this that chiefly channelled my interest towards the possibility of improving the chances of new parents getting off to a good start in the parenting role.

Analysis

A reflexive approach to analysis requires that 'the researcher starts by acknowledging his or her perspective in relation to the evidence collected' (Elliot, 2005: 158). As noted earlier, my study was motivated by hopes of building knowledge to advocate for beneficial change for families experiencing transition to parenthood by consulting people currently in this situation as experts on how support could be more useful, appropriate and accessible. Munford and Sanders (2003: 2) propose using research for this purpose:

Often we talk about generating new information which can help to reshape state policies that have developed from limited understandings of the realities in which most families live. Research can also feed into the development of new styles of practice and new theoretical formulations on which practice is based.

Essentially this is what I hope eventually to do, using whatever avenues I can to report participants' families' experiences and views and drawing on my social work background to consider how state policies could be reshaped and 'new styles of practice' developed and implemented to promote resilience in families with a first baby in ways that suit them. In this sense the study has a social justice orientation; it is intended to support equity in availability of services and resources (Galambos, 2008). I hope to disseminate the findings of the study in ways that underpin change that will better promote the resilience of a wide range of families having a first baby.

According to Reissman and Quinney (2005: 393) a key aspect of analysing narrative in the context of research is paying 'attention to how the facts got assembled *that* way. For whom was this story constructed, how was it made, and for what purpose?' The stories that participants told were undoubtedly influenced by the study's purpose, which participants were aware of. In this respect knowledge generated by the study is a collective product, referencing the perspectives of participants who took time to reflect on adaptation to

parenthood and thoughtfully offered ideas for beneficial change. From my perspective, the study began a conversation about support in which participants are included via their recorded words. It is their words, directly reflecting their experience and encapsulating their ideas, that could potentially inform beneficial change in the system of support. This had implications for analysis, in that themes are drawn directly from participants' narratives, focussing on what they said about support, and for presentation, in that clarity was a key consideration. For example, utterances such as 'umm' and 'err', included in some reproductions of speech in reporting of narrative studies, were not included lest they would distract readers from the point being made or the feeling being expressed.

The aim of creating channels through which participants' views might inform strategies for enhancing resilience during transition to parenthood is reinforced by Flyvbjerg's (2001) contemporary interpretation of *phronesis*, an Aristotelian concept translated as 'practical wisdom', and, according to Flyvbjerg, facilitating the construction of a foundation for social research that takes account of values, underpins social commentary and promotes action and practice that is relevant, just and ethical. Flyvbjerg's approach addresses 'a current concern of qualitative research' (Denzin & Lincoln, 2008: 3) which is, 'to connect qualitative research to the hopes, needs, goals, and promises of a free democratic society'. Flyvbjerg (2001: 132) asserts that the development of social research is restricted because researchers 'tend to work with problems in which the answer to the question "If you are wrong about this, who will notice?" is "Nobody"'. This is the antithesis of research based on *phronesis*, which cultivates ongoing debate in society. The completion of a study incorporating *phronesis* is not the end of the researcher's involvement in issues addressed by the research; because it is important that people do indeed notice researchers must consciously invite responses by talking about research, welcoming comments and disseminating findings widely so that they may be discussed, challenged and used. This helps the researcher stay grounded in reality rather than going off down a theoretical track that may mean little to research participants. For researchers working from this perspective, being comfortably sequestered in an 'ivory tower' is simply not an option; they are expected to take a position based on judgements made as the study proceeds, thus linking social science to real problems.

In Aristotle's words, reported by Flyvbjerg (2001: 2), *phronesis* is 'a true state, reasoned, and capable of action with regard to things that are good or bad for man'. In order for

'good' and 'bad' to have meaning Flyvbjerg introduces the concept of power into his discussion of phronesis. Power is envisaged as a 'dense net of omnipresent relations' (Flyvbjerg, 2001: 131); it can be hard to see what is really going on. Power is discerned by examining whose values and interests are served and who gains or loses from a given state of affairs. Essentially, research from this perspective aims to get to the bottom of a situation and take action for the benefit of marginalised or under-resourced groups. This is accomplished by focussing on the contextual realities or detail of people's lives, bearing in mind the questions: Where are we going? Is it desirable? What should be done? Flyvbjerg's approach shares common ground with that outlined by Munford and Sanders (2003: 5) who are interested in 'embedded research', or research that 'works through relationships with participants and other key stakeholders and which is therefore accountable to a wide audience that reaches beyond research funders and the academic community'. Munford and Sanders argue that researchers should consider the question 'Who will benefit?' and explore their work's potential for positive impact.

It has been argued that research and practice in the social work field should feature a clearly articulated value position privileging human rights (Ife, 2008). Like Flyvbjerg (2001), Ife (2008) recommends an approach to research that illuminates issues of human rights in order to promote debate and action to create beneficial change. A human rights perspective maintains that it is possible for social research to incorporate values and promote action and practice that is relevant, just and ethical:

There is a strong tradition in social work of identifying a core value position for the profession...social work writers have consistently emphasised the importance of this value base; social work is not seen as a neutral, objective or value-free activity, but rather as work which is grounded in values and which makes no apology for adopting partisan stances on a range of questions (Ife, 2008: 8).

My stance is that every child has a right to the kind of care that protects their optimal development; and that the state has a role in ensuring that families' ability to do this is not so compromised by problems that children are neglected or ill-treated. In my view, this means that the state has a responsibility to support families in ways that enable them to develop resilience. This is reflected in New Zealand's commitment to promoting family

resilience, protecting infant development and upholding the Universal Declaration of Human Rights, of which Article 25 is particularly relevant. As well as stating that everyone has a right to a standard of living adequate for health and well-being, Article 25 includes this clause: 'Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection'. Neglecting to attend to this responsibility, or failure to carry it out well, means that some families flounder; some will slither inexorably towards inundation by a cascade of risk.

My study frames Flyvbjerg's (2001) question 'Where are we going?' in terms of the direction taken by the support system and its resulting capacity to promote resilience; gauges the desirability of this direction by exploring families' experience in the light of a framework derived from the literature; and presents families' views as essential input to dialogue about what should be done differently. The selection of a broad sample is a way of bringing into view diverse experiences of transition to parenthood and access to support. Powerlessness is here conceptualised as lack of influence over how support is provided, resulting in what amounts to exclusion from support as a result of not fully benefiting from the current structure of the support system; in this context, 'power' is about having some influence over 'what is desirable' and what should be done.

Narrative has potential to clarify process and meaning and produce both understanding and explanation. Explaining the importance of gathering detail so that knowledge about the subject of study gradually emerges and coalesces, Flyvbjerg (2001: 86) recommends narrative as 'perhaps our fundamental form for making sense of experience' and as a way of reaching a point where the researcher has sufficient knowledge to make recommendations. A focus on everyday detail is particularly apt for understanding what life is like for families adapting to parenthood because it is this that characterises life with a baby, a situation that involves repeatedly performing small tasks. Yet research participants may feel that everyday detail is too trivial to mention, as Daly (1992: 5) suggests:

Although some aspects of family experience are deliberately hidden from researchers, other aspects of this experience are hidden simply because of their apparent mundaneness. Routine, repetitive aspects of family roles and relationships can be so much a part of taken-for-granted daily life that

participants may not see them as important. Qualitative research is one way to take the obvious (and therefore the hidden) and bring it to light.

Detailed knowledge acquired in this way provides the substance of the story that the author of a research report tells. If this knowledge is firmly grounded in the detail of people's lives, this gives an author a platform for speaking out.

Polkinghorne (1988: 18) notes that narrative understanding is 'one of two modes of cognitive functioning, together with the logico-scientific mode' and suggests that 'we conceive our own and others' behaviour within the narrative framework, and through it recognise the effects our planned actions can have on desired goals'. Narratives convey meaning by means of plot, which transforms a listing of events 'into a schematic whole by highlighting and recognising the contribution that certain events make to the development and outcome of the story' (Polkinghorne, 1988: 19). Salmon (Salmon & Riessman, 2008: 78) explains that 'a fundamental criterion of narrative is surely contingency. Whatever the content, stories demand the consequential linking of events or ideas'. Sandelowski (1991: 162) concurs:

Narratives are generally understood to include a temporal ordering of events and an effort to make something out of those events: to render, or to signify, the experiences of persons-in-flux in a personally and culturally coherent, plausible manner.

Polkinghorne (1988: 19) reinforces the centrality of sequencing and consequence in the construction of a narrative:

By inclusion in a narratively generated story, particular actions take on significance as having contributed to a completed episode. In this sense, narrative can retrospectively alter the meaning of events after the final outcome is known. For example, the significance of an instance of running out of gas can become understood in the light of friendship that subsequently develops with the person who stopped to help.

According to Riessman and Quinney (2005: 394), sequence and consequence are the essential factors that distinguish narrative from other forms of discourse: 'events are selected, organized, connected and evaluated as meaningful for a particular audience'. A story has meaning in the context of the narrative of which it forms part and in turn contributes depth to the narrative as a whole. Stories are much more than lists of events or chronicles. Riessman (2008: 9) says that 'Narratives invite us as listeners, readers and viewers to enter the perspective of the narrator'. Stories explain something important to the narrator, illustrate a point or convey a feeling or, as Riessman (1993: 3) says, express 'a sense of a deviation. Narratives specialize in the forging of links between the ideal and real, self and society'. This last quality of narratives creates room for expressing any dissonance experienced by participants between the ideal 'perfect mother' image and the everyday detail of life with a baby. It is by entering the perspective of the narrator and understanding this detail that participants' experience of coping with a first baby in New Zealand today can be understood, and this level of understanding in turn makes it possible to understand the types of support that are experienced as 'the right help at the right time' (MSD, 2005: 75) or, alternatively, the type of need that the system does not meet.

Reserving 'narrative' for the entire product of an interview, which becomes part of a set of narratives across which themes may be distinguished and within which stories are embedded, I use 'story' to refer to episodes described by participants (with themselves or others as protagonists) in order to illustrate experience or make a point. Notwithstanding that 'story' and 'narrative' are used as synonymous in this quote, Denzin (1989: 37) puts my understanding of 'story' in a nutshell:

A 'narrative' is a *story* that tells a sequence of events that are significant for the *narrator* and his or her *audience*. A narrative as a story has a plot, a beginning, a middle and an end. It has an internal logic that makes sense to the narrator. A narrative relates events in a temporal, causal sequence. Every narrative describes a sequence of events that have happened. Hence narratives are temporal productions.

The stories included in the results chapters were selected to illustrate what was important to participants and thus contextualise their views about support. Stories exemplify and

crystallise themes, which are usually described under a heading that is a phrase used by one or more participants.

In telling a story a narrator has an audience in mind. As Denzin says in the quotation above, a story has significance for both narrator and audience. Riessman and Quinney (2005: 394) concur: the construction of a story is shaped by intention to make it 'meaningful for a particular audience'. Narratives produced during my study were shaped by my focus on enhancing the system of support for families with a first baby. The Information Sheet and my verbal reminder at the beginning of each interview informed participants that this was the focus of the study; while their immediate audience was me, sitting in their lounge, kitchen or garden with my tape recorder, participants knew there was also potentially a wider audience who might be influenced by what they said. The potential audience is broad, including practitioners, policy makers, funders, perhaps politicians, and also families adapting to parenthood, reached perhaps via magazines for parents of young children or via the newsletters or websites of Well Child providers and organisations like Parents Centre. Participants were informed of my intentions at the start of the study and reminded at the start of each interview. In telling stories about people they knew as well as about themselves they demonstrated their interest in explaining what happens to new parents; their ideas for change were informed by the immediacy of their knowledge of the circumstances of friends and acquaintances.

Participants' narratives reflect the complexity of adaptation to parenthood and contain an abundance of stories. Many express a keen sense of beginning a new phase of life. Some stories from the first interview express anticipation and apprehension concurrently. Later stories about difficulties experienced are tempered by hope, humour and a degree of resignation. Even when circumstances were difficult, the tone is often upbeat. The stories in the results chapters were selected to illustrate what was important to women interviewed and thus contextualise their views about support. They normally make a point or have a moral. They provide vantage points from which to survey the landscape of support for families having a first baby in New Zealand, making it possible to discern gaps or pinpoint inadequacies. In a context of fiscal control, where supportive strategies are inevitably rationed, Flyvbjerg's (2001) question 'Who gains and who loses?' is perhaps better framed as 'Who gets a good deal and who misses out?'

Since competence is the sign of resilience, a problem to be solved for the study was how to gauge competence. While 'resilience is a multidimensional construct, the definition of which is negotiated between individuals and their communities' (Ungar, 2008: 219), professionals interested in resilience tend to belong to a comparatively narrow socioeconomic band; their notion of family competence is liable to be different to that of their clients, patients or respondents. The therapeutic strand of the literature equates competence with 'healthy family functioning' (Walsh, 2003) but this is contextually suspect; family functioning, and what it means in terms of how families organise themselves and their affairs, will differ according to cultural background, values and expectations, as will the number and range of people included as family members and what accordingly is expected of them:

Desired amount of emotional connectedness varies significantly between and within families at different ages and stages of life as well as among different cultural groups...Among African American families, intergenerational connections among women often are stronger than couple bonds...[Among] native Hawaiians...success is valued only when one is part of a group, rarely as a form of individual achievement. In contrast, the dominant European American culture emphasizes...competitiveness and individual success. This cultural norm is frequently learned and carried out in the family. Adolescents, for example, are encouraged to be separate from their parent; health and education systems frequently advocate for their autonomy. (Patterson, 2002a: 240).

A more flexible option for gauging competence is the notion of 'family functions'. Observing that there are many views about what constitutes 'success' when the term is applied to families, the MSD (2004a: 8) suggests assessing success by considering whether families are in a position to carry out 'core functions...at the heart of our community, and our sense of ourselves' and lists core family functions common in New Zealand as: nurturing, socialisation and protection of children; maintaining and improving the wellbeing of family members by providing emotional and material support psychological "anchorage" of adults and children by way of affection, companionship and a sense of belonging and identity; passing on culture, knowledge, values, obligations and property from one generation to the next.

This set of family functions is similar to Patterson's (2002a) list of functions performed by families for their members and for society. These are: material well-being; protection of vulnerable members; nurturing and self-development; sense of belonging. In Patterson's view (2002a: 354) resilience can be assessed by fulfilment of these functions although 'the way these functions are accomplished 'will reflect incredible diversity'. The terms of all these functions are broad enough to allow families to self-define successful outcomes within general parameters, offering a more context-neutral way of gauging competence than expecting families to comply with any predetermined model of family functioning. Looking to functions rather than functioning as the marker of competence allows for diverse ways of achieving resilience and is less prone to cultural pitfalls than attempting to assess family functioning.

For families adapting to life with a baby, acquiring expertise in this function of protection of vulnerable members is a key task. However, the other functions are also relevant. Disruption in the smooth operation of family functions is likely; new ways of fulfilling them may be required. For instance, material well-being is affected by a new mother giving up work, even temporarily; relationships are altered by the advent of a totally dependent baby; plans for self-development may need to be put on hold; sense of belonging must shift to accommodate new responsibilities. Competence in this situation must thus be conceptualised broadly. Focussing on functions turns attention to a range of ways in which competence might be facilitated and promoted, such as through improving the availability and relevance of community support services or through reducing the impact of adversity through sensitive and carefully planned policy design and implementation.

Process of analysis

I transcribed all interviews myself, verbatim. Soon after the interview I listened to an interview tape in its entirety. This enabled me to hear the cadences and rhythms that characterised each speaker's oral style and to note the entrance and exit talk used to introduce and conclude stories. I next transcribed the interview, then 'parsed' it as described below. As more interviews were completed, listened to and transcribed I began to notice themes, which I distinguished by means of colour coding in tandem with the 'labelling' process described below.

Alternating close reading of transcripts with repeated listening to tapes enabled me to consider the context in which stories were told, aiding reflection on whether a story could be interpreted differently (Fook, 1996). I found that I became attuned to the oral style of each voice. Stories can be described as passages with recognisable boundaries and coherence (Mishler, 1986; 1995). Riessman (1993: 58) says that 'entrance and exit talk' is a way of identifying the beginnings and endings of stories within a body of text. Some stories were obviously sequential, like Abby's,⁴² about not having a midwife because of multiple moves from one place to another. In Mishler's (1986) terms, this story begins with an orientation, moves into 'a resolution and ends with the coda: 'I'd like my *own* midwife, one that will stay'. Some participants used obvious entrance and exit talk. Dean's phrase 'I'll give you a classic example...'⁴³ is in fact a 'classic example' of entrance talk and he neatly ties off his story with a point: 'There could be better communication'. However, narrators do not always neatly circumscribe a story. Rather, stories sometimes coalesce as narrators reflect. Becoming familiar with the style of each narrator meant that I began to hear how stories were embedded in their talk. Although neatly circumscribed, Dean's story also exemplifies how stories sometimes evolved as participants spoke. Dean was the protagonist of the story he told, it was prompted by recalling a woman whose needs were not met because staff could not communicate with her. While some stories emerged spontaneously, as did Tania's story about a friend who pretended all was well while actually suffering from depression,⁴⁴ others were produced in answer to interview schedule questions. Lucy's story about turning the tables on her dad⁴⁵ was in direct response to the question 'How have you found life with a baby compared to how you imagined it?'

In narrative inquiry, analysis of text is linked to transcription. Some authors depict inquirers' presence in conversations by including their words. Some include inarticulate sounds (e.g. mm; uh; err) made by either inquirer or narrator, or indicate pauses, sometimes noting length of pauses. Riessman (2008: 37-39) does all of the above except note pause length, in representing a conversation about a miscarriage. It seems to me that this so prominently displays the operation of the analyst's mind that it is a distraction from what is actually said; the sense takes second place. Since my focus was on content rather than linguistic structure I chose to highlight the content of what participants wanted to

⁴² See Chapter 6

⁴³ See Chapter 6

⁴⁴ See Chapter 7

⁴⁵ See Chapter 6

communicate rather than how they did so. In the results chapters I simplified representation of participants' speech, as do Fine and Weis (1998). My decision to treat transcripts as 'a straightforward path to meaning' (Riessman, 1993: 69) was to reinforce the power of what participants said and was grounded in respectful recognition that participants quite literally knew what they were talking about. This approach prioritises the 'told' (informants' reports of events and experiences) rather than 'the telling' (Riessman, 2008) (how meaning is articulated).

Notwithstanding my interest in simplicity of representation, as part of analysis I used a process similar to Gee's (1991) to 'parse' transcripts, a technique that involves, as Riessman (2008: 33) explains, 'listening carefully to how a narrative is actually spoken with pauses and pitch glides (subtle falls in the pitch of the voice)' to detect lines (a sequence of words comprising an idea unit) that form stanzas (groups of lines with similar content that are separated by pauses and shifts in pitch). Since emphasis was often crucial to meaning, italics are used in the reporting chapters to indicate emphasis. Gee's rather literary approach to analysis is shared by Polkinghorne (1988) who highlights use of figurative speech. During interviews I noticed that figurative speech was used by many participants to concentrate meaning. Many of the chapter and section headings are typical figures of speech and other expressions (e.g. 'In the deep end') used by participants. Stories were selected to representatively illustrate what was important to participants and contextualise their views about support. Results chapters contain not only stories but comments or 'quotations', in the sense of 'a phrase or passage from a book, poem, play, etc., remembered and spoken, esp. to illustrate succinctly or support a point or an argument'.⁴⁶ They are included for this very reason - that they make a point.

A potential problem with narrative inquiry is loss of data within the general narrative, often seen as outside the story structures (McCance et al., 2001). To avoid this, in the initial stages of data analysis for their study of caring in nursing, McCance et al. undertook a content analysis across all transcripts. To include non-storied content I used a form of thematic analysis, which Riessman (2008: 53) says is 'arguably, the most straightforward and appealing in applied settings'. Where I disagree with Riessman (2008) is in her opinion that in thematic analysis attention is fixed on content to the point that audience, context and purpose are overshadowed. Participants were aware that a purpose of my

⁴⁶ Collins English Dictionary, 2003

study is to contribute to change for the better; my intention to channel their views to people in a position to facilitate such change means that the potential audience is wide. Despite the provisos just noted, Riessman's (2008: 54) explanation of a thematic approach to interpretation explains my own approach:

Data are interpreted in light of thematics developed by the investigator (influenced by prior and emergent theory, the concrete purpose of an investigation, the data themselves, political commitments, and other factors). There is minimal focus on *how* a narrative is spoken, on structures of speech a narrator selects, audience (real or imagined) or complexities of transcription.

As well as identifying stories that represented common experiences, I distinguished themes by building on my initial system of identifying phrases commonly used by participants. My process of analysis was similar to that engaged in by Hopfer and Clippard (2011: 267) in their thematic analysis of college students' narratives, where they used 'tagging' to pinpoint 'meaningful segments of their material that are relevant to the purpose of the study', then 'labelled' these segment, then compared and contrasted segments to identify themes emerging from their data:

Unifying ideas were identified based on recurrent ideas and repeated phrases or key words expressed in the data. These were categorized into meaningful groups based on heightened consensus or agreement about an idea across participants and/or by the intensity with which the idea was expressed (e.g., emotional tone and intensity) (Hopfer & Clippard, 2011: 267).

I marked quotations and stories containing recurrent ideas, often expressed in similar or even the same words by different participants, relating to their experiences of transition to parenthood and their descriptions of informal, semi-formal and formal support received. Listing these quotations and stories enabled me to discern 'unifying ideas', then sort them into 'meaningful groups' (Hopfer & Clippard, 2011) and categorise them as themes. Like Hopfer and Clippard, I found that 'labels' or headings for themes emerged directly from the text. For example, I used orange text to note where participants spoke of their own, or others', experiences of breastfeeding; how they learned; how easy or hard they found it;

what surprised them; why they gave up; or how they overcame problems. A participant's inadvertent pun, 'consumed by breastfeeding', became the heading for the theme of breastfeeding.

In interpreting texts produced in the course of research the researcher takes up the role of narrator (Riessman, 2008), telling a 'meta-story' (Larsson & Sjoblom, 2009). In the four reporting chapters which now follow I move into this role, interleaving participants' stories and quotations with discussion. Chapter 6 reports interviews conducted in the six weeks or so before the birth of a first baby. Results of the second interview, approximately three months after the birth of a first child, are reported in Chapters 7 and 8, respectively focussing on the birth and the first few days and on the first three months. Chapter 9 explores participants' reflections at the end of the first year of parenthood. Throughout the process of interviewing, transcription and analysis I was conscious of Flyvbjerg's (2001) notion that paying attention to detail is a key aspect of research aiming to promote relevant, just action. I welcomed discussion of what Daly (1992) calls the 'everyday detail' of participants' experience and found that it was this detail that slowly built a picture of the practical realities of adapting to life with a first baby.

CHAPTER 6 'READY OR NOT': PREPARING FOR PARENTHOOD

The women recruited for the study were diverse. They ranged in age from 16 to 40.⁴⁷ About a third lived in urban areas, a third in the country and a third in suburban areas outside Auckland. Some lived in rented accommodation with a bare minimum of possessions; others in homes that they owned, where beautifully decorated, fully equipped nurseries were ready for the baby. Visiting participants' homes involved considerable travel, and, in some of the outlying areas especially, occasional difficulty in locating participants' homes, sometimes due to turning down the wrong end of loop roads, sometimes to making the wrong turn at un-signposted crossroads.

First interviews focussed on exploring participants' experiences of preparation for childbirth and for life with a baby, but I had two additional aims in mind. First, I wanted to acknowledge their importance in that they could contribute first-hand knowledge about adaptation to life with a baby and what might help or hinder that process. I told each participant a little about my background, referring to my Scottish origins, to my twenty years' residence in a rural part of New Zealand and to my three children, all young adults. I mentioned my social work background and my consequent knowledge of problems commonly faced by families. I stressed how careful I would be to preserve confidentiality, with the proviso that I would take appropriate action if I thought someone was at risk. This was part of achieving the second aim, which was to maximise participants' sense that they could tell me anything and I would handle what they told me carefully. Success in this respect is indicated by the topics that participants chose to raise. Even in these first interviews some spoke about aspects of their lives that they would be unlikely to mention to someone with whom they felt uncomfortable; they spoke of past sexual abuse; abortions; childhood experiences of being fought over by warring parents; being picked up by Police as a teenage runaway; and the experience of being deserted, including by the participant's own father or mother in the past or by her baby's father recently.

Generally, first interviews were characterised by excitement fused with trepidation. Although 'looking forward to meeting the baby', as Karen said, many participants were apprehensive about childbirth. Some mused about whether they would 'be a good mum';

⁴⁷ See Table 2, Appendix 1

sometimes because they had 'always been good at everything' and fretted about doing so in their new role, sometimes because they or their partners had themselves had difficult times as children, as Abby (aged 19) and Kim (aged 18) certainly had. Both were resolved to safeguard their own babies from anything similar:

Abby If me and my partner break up I'm never going to do what my mum did – custody battles, court cases. I was quite young when I was taken away from my mum. My dad just turned up to my school and said we're going down to [Town] so I couldn't say goodbye or anything. So if me and my partner ever break up I'm going to think of [Baby] only, no fights or anything. He can see her whenever he wants. It's not going to happen, but you know I'd never wish upon a kid to go through what some kids have gone through. I was one of those kids actually - if I had one parent with each hand, they'd pull it.

Kim Because of what me and my partner have been through we know what not to do and what to do. My mum died when I was five. CYF got involved, we got put with relatives because my dad's sister made a false accusation. My dad committed suicide the following year. When I was thirteen I ran away because I was always getting a hiding and I didn't like getting hidings. And my partner's parents are split up, he was always stuck in the middle between the arguments and he'd have to listen to his mum crying and listen to his dad. So me and him made a pact that if we're going to keep this baby we're going to stay together, no matter what, until it's old enough to move out. And once it's moved out if we still feel that we want to split up, we'll split up. Because it really hurts, you know, that's what got him depressed. Me and him just decided, we're going to stay in a relationship, we've made this pact that we will not split up. If we have problems we'll go to a counsellor.

Themes from this first set of narratives were consistent across the range of participants. Many headings used for themes and sub-themes are phrases used by participants, signalled as such by quote marks. The themes are: emotional support and learning; a sense of not being fully prepared or ready ('not too sure'); nesting; relationship change ('a pressure cooker situation') and financial insecurity ('watching the money') which included working harder and saving; and using paid parental leave, income support and tax credits.

Emotional support and learning

Transition to life with a baby is an emotional time for new parents and others close to them. While emotional support could be experienced as overwhelming, being 'made a fuss of' was appreciated. Abby, for example, said 'My partner's sisters have just taken me under their wing. They took me out to dinner one night, told me 'You've gotta eat''. Less helpfully, acquaintances implied that Abby's life was 'more or less over'. Some participants found themselves at the centre of general excitement:

Tania My mum can't wait. She's so excited, I think she's more excited than I am. She rings me up, she goes: 'Oh, I'm so excited, I'll come round and hang out with you and look after the baby, you can go and have a sleep or something'.

Some worried about being inundated by well-meaning visitors, and would have agreed with Julie who said: 'The kind of ideal thing would be someone to fend them off, so we can have peace and quiet'. Ria explained her situation:

Ria I kind of expect everything to change. The relationship with his family - well, it's already changed, they're so excited about it it's not really containable. It's changed in that it's got more difficult. Hopefully it might change again and get easier. They're coming on Boxing Day whether I like it or not, so I said 'Fine, you can clean up the house when you get here, you can bring your food and you can clean up when you leave'. Mum's helping a lot with the over-support, Mum's pointing out that it's particularly hard for me being over-supported because of my over-independence, so [Partner's] mother and myself, it's a two-way thing.

While not exactly emotional support, a sense of being valued was felt by participants whose employers were accommodating about their return to work:

Clare I've taken a full year's leave. I've indicated that I'd quite like to come back part-time after seven or eight months. They're completely cool with that. They said 'Yeah right, come and talk to us when you're ready to come back. We know what you're thinking, but we're OK if you don't come back'. I'm feeling some pressure to go back because two months ago I applied for a promotion within my team and despite the fact that I'm obviously not going to be around to take it up they gave it

to me, they're holding it open. So I feel some need to go back and take up that job at some point. They're really supportive. If it doesn't work out that way, that's fine. I expect I'll go back part time and see whether I want to work up to full time or not.

Dee My boss wants me to go back. He has actually told me that when I go back I'll be getting a pay rise. I'm hoping to stay off DPB if I can. Maybe I'll get some child support from my baby's father. Then I'll just go back to work.

In preparing for childbirth participants relied heavily on their LMC, especially when she was committed to both providing antenatal care and delivering the baby. While maternal health care provided by midwives is formal support by professionals with significant responsibility for the health and safety of women and babies, participants' narratives suggest that the support they received from this source often encompassed key qualities of social support in that it transmitted encouraging messages about worth and competence, posited by Cobb (1976) as the underlying mechanism of social support. Participants learned a lot from their LMCs. Antenatal classes were described as 'fantastic' for some participants but as 'nothing you couldn't get out of a book' by others. Information, provided in abundance by friends and relatives, was seen as not always entirely reliable. This section includes sub-themes: gathering information; the relationship with the LMC; and antenatal education.

'Hearing stories'

Many participants were repeatedly told stories about other women's experiences of childbirth, from relatively easy to harrowing. While some of the more gruesome stories were deemed 'too much detail' this was a significant source of information about childbirth; hearing about different experiences seemed to create a mindset of acceptance that anything could happen, a kind of precursor to self-efficacy in terms of accepting that 'you just deal with it':

Celia I've heard the stories - from my mum, other mothers as well. It's funny, it's gone from one extreme to the other, where the experiences have just been - well, too much detail, rather - really difficult births, the whole labour thing. And then I've heard about others who've had quite an easy time. So there's some preconceptions on my part, where they put a lot of emphasis on the whole pain issue. And I'm like, well, that's part and parcel of it, you just deal with it.

'My own midwife'

Most participants had regular contact with a midwife. Participants who said 'I've got my own midwife' did so in a tone of thankfulness and expressed feelings of being understood and cared for. The relationship was comforting and comfortable. The midwife was a trusted advisor, a real asset. Midwives were clearly skilled in relationship building, incorporating a wide range of communication techniques in their interaction with participants, treating them as equals and building their confidence in ability to handle childbirth. Midwives evidently made themselves easily accessible. Rae, for example, was comfortable enough with her midwife to be able to 'give her a call and ask her things'.

Ange My midwife, she's been amazing actually, just really relaxed and open to anything. She doesn't push a particular way, whatever her preference is. It doesn't matter to her at all what her preference is, she doesn't even tell me her preference - it's all about me, and what I want. It's really, really nice. And also she's been a midwife for quite a number of years now, she's very experienced. She's great.

Fay: I've got a lovely midwife. She's just been incredibly supportive, she's been amazing. We're really lucky. She just has a very strong belief that I'm more than capable of doing it. She spends time with us, her visits are at least an hour long. She's looking at it not just as a medical thing. She's a massage therapist as well so I've had some massages with her. I feel so spoilt. She's just incredibly respectful of what I want, what I say. She gives me heaps of information.

Participants' narratives suggest that midwives carefully handled specific needs and often managed to engage partners too. Zoe, whose relationship with her baby's father was tenuous, said: 'He comes to all my midwife appointments'. Ria, who worried about having too many family visitors after her baby was born, discussed this with midwives at the local rural birthing centre with the result that she could say "they're quite ready for little signals" that she needed them to intervene so she could have peace and quiet. Some of the older participants had recognised the importance of the 'right' midwife at an early stage, seen that 'choosing an LMC is a whole journey', had 'asked around' and been exacting in their selection: they had done what they could to find a proficient midwife, then could relax:

Ria I'm a bit of a structured, organised, read all the books kind of person, but strangely enough about the birthing plan I've just gone 'Phew, it'll happen'. But I was very careful about choosing my midwives. I was very careful about choosing them and their philosophy. I went through a few because I was with my GP in Auckland, who happened to be with one of the last obstetric gangs around. So I was with them for a while. I spent a bit of time looking around, effectively interviewing midwives, and then started finding the women around who've had babies and asking them.

Studying women's self-efficacy in the context of childbearing, Brown (1998: 99) refers to this kind of relationship as 'affiliation' and found that when women did not feel affiliated with health professionals they were 'less apt to consider the information relevant or credible and more likely to disregard the information exchanged'. Karen spoke highly of a free service, recommended by her GP, through which she was 'matched' with a midwife with whom she felt comfortable. This matching process seems likely to enhance affiliation. Many of the women who took part in my study were able to choose their midwife. However, this was not the case for women in other parts of the country at the time. In their Position Paper on Maternity (2006: 9) the Royal New Zealand College of General Practitioners stated: 'There have been numerous accounts of pregnant women finding difficulty in locating a midwife to act as LMC'. ⁴⁸A comment made by Beth, who had recently shifted from an area where midwives were in short supply, suggests that overloaded midwives may struggle to provide the reliable care that participants in my study appreciated:

Beth My last midwife was a bit of a nightmare. She just wasn't available. I was pregnant before and I had a miscarriage. She was OK with that but if she had a few births in one week she'd ring up to say she can't make it. But my midwife, the one I've got now, she goes out of her way to make sure she makes the appointments.

Abby, who had also shifted but had not yet managed to find a new midwife, was living at her mother's house when I first met her. She explained her situation:

Abby We've moved eight times in the past ten months for [Partner's] work. I couldn't really settle, you know? Even in one town we lived in three houses in two months.

⁴⁸ See Appendix 9.

Up north I unpacked every box because I thought this was where we were going to stay. But I was wrong about that. I'm starting to get the hang of being organised – just expect the unexpected. I got to see the whole of the North Island pretty much, that's one way of looking at it. We're just waiting for a nice house. Because we were on a farm we had dogs, I had to let all my dogs go last week. So the stress on me is just huge at the moment. I just want to get into a house now and stay there. I did have a nice midwife up north, only saw her twice though. I've got an appointment with a midwife tomorrow. I'd like my *own* midwife, one that will stay.

Many participants had a midwife recommended by a friend. This made women feel part of a network and helped establish trust in the midwife:

Dawn For the birth we're going to North Shore hospital. Just in case something happens – I just feel more safe there. My midwife is really good, she's lovely. She was my friend's midwife as well. She recommended her.

Participants' accounts of care received from their 'own' midwife suggests that this option was preferred to alternative arrangements experienced by those had a 'community midwife' for antenatal checks but did not know who would deliver the baby: whoever was 'duty midwife' at the hospital at the time would do so. Cheung (2002) found that having information that allows choice and perceived control about childbearing is linked with subsequent emotional well-being. Participants with their 'own' midwives evidently talked at length with them about arrangements for the birth, hopes, preferences and contingency plans, so that the plan for the birth evolved and they felt they were in control of what would happen, and 'safe'. An important aspect of the birth plan was choosing who would be present. Some planned to have friends there as well as their partner, mother or other family members.⁴⁹ Clare had opted to have an obstetrician deliver her baby. Although she felt 'very well looked after' by the obstetrician, she had not yet had 'the birth plan session' and had not had the opportunity to repeatedly talk over details of the plan for the birth, as her friends had with their midwives, thereby enhancing their sense of being prepared. Clare said that if she had another child she would choose a midwife. Rather oddly given that they embraced the opportunity to plan the birth, several were unclear about how long they would stay in a hospital or birthing centre. Ange had the following impression:

⁴⁹ In this respect times have definitely changed since the 1960s, when parents struggled for fathers to have the right to be present at the birth of a baby (Dobbie, 1990).

Ange People stay at Waitakere up to four days. That's the standard stay, [Midwife] says. The good thing is you check into the room and you come back to it after you have the baby. You don't have to shift, which I really prefer. At Auckland after two to four hours you pack your bag and either go across to Birthcare or go home. A friend of mine, she had her baby at Waitakere, she said it was fantastic.

When her baby was born Ange found that the 'standard stay' she expected was not standard after all and that 'already after two days they were pressuring me to leave'. This was disappointing as she had anticipated having time to focus on herself and the baby before returning home to a house full of visiting relatives.

'Nothing you couldn't get out of a book'

For some participants antenatal education was either unavailable or so inconvenient that they did not attend. Anna and her partner, both Maori, said that they preferred to 'get advice from family'. Rural women were more likely to miss out; when they did attend, spin-off benefits of antenatal education such as the opportunity to establish friendships with others with similar interests and at the same life stage, thereby finding a place in a supportive network, were not available in the same way. This was partly because some classes were offered over a single weekend, not conducive to the gradual process of getting to know others that was sometimes an aspect of urban classes, and partly because attendees were very mixed in terms of age, socioeconomic group and interests.

Ria There's a bit of a shortage of women to make friends with. Because it's rural it's not like in the cities - my girlfriends had these wonderful classes with all these people they've become close friends with because they're all the same stage. They were talking about setting up a coffee group from our class but I don't think it's going to happen because it hasn't so far, and you know one of the couples were a Brethren couple, they're closed religion, they'd never join, and then there were only four others. And quite an age range and quite different. So I don't think that one will fly.

In rural areas childbirth educators were accommodating, providing one-off sessions for those unable to attend a class. While appreciated, this was experienced as a bit rushed and of course did not offer the social benefits of a class.

Celia The lady offered to come to the house. No-one else is due around the same time so there's no class – no chance for us to meet other couples expecting a baby around the same time.

Cara I wanted to go to an antenatal class but there was a bit of a muck-up actually. There weren't enough people to make the class up and I didn't hear back until after the next one started. I had a crash course, two hours last night. She came round and went over different options for pain relief, just real basics. I've bought a couple of books and she gave us some books. She gave a book for fathers to [Partner], which we thought was really good. I'm a bit disappointed that I haven't done a proper antenatal class because someone was saying 'Did they show [Partner] how to massage your back?' and I was like 'No, there was no time for that'.

Most of the younger participants mentioned feeling uncomfortable and out of place at antenatal classes, so much so that rather than a boon, attendance became a problem, demanding persistence and determination. It was certainly not the catalyst of a network of connections. While the educator at Amy's class was probably trying to encourage participants to get to know one another by means of 'group things', this did not work for Amy and her partner, aged 19 and 26.

Amy I just got put off, the way they sort of looked at me. I wasn't much younger than some of them but I might have looked a lot younger, and [Partner] too, though he was roughly the same age as the other guys. So it was so uncomfortable – like they wouldn't talk to us, or interact. There were group things, but even then. There wasn't much age difference but they judge you as if you were 15 or something.

While interviewing participants I heard numerous stories about navigating to a resource only to find it was unsuited to the needs of people who might use it. The following dialogue illustrates:

Gary We went to three classes and then decided to wag.

Tania: It was a waste of time, there was nothing that books couldn't tell you, or friends. My sister has three kids and all my friends have babies so what they had told me pretty much covered it.

Gary: The antenatal classes were almost inconvenient really. It was at night, after I'd done a long day at work...

Tania: ...and I was working...

Gary: ...and Tania was working. It was kind of a burden...

Tania: ...and I had sore feet...

Gary: ...and we went to three or four of them I think and we started driving to the class and we went 'Nah, we won't go tonight, so we can get takeaways'. Instead of going, we'd go out for dinner, we'd go to the beach.

Moran and Ghate (2005) observe that robust evaluation is required to understand what constitutes a culturally sensitive programme and how this impacts on recruitment, retention and ultimately on outcomes. This applies to antenatal education. Ungar's (2008) concept of navigation and negotiation⁵⁰ suggests that it is no good having motivation to seek support and willingness to navigate there if the support available causes discomfort or anxiety, thereby impeding the development of resilience. The issue here is about making sure that the service suits potential users' needs. Although not mentioned by participants, kaupapa Maori antenatal education is an area where further negotiation may be required. Reporting Maori SIDS⁵¹ research on the needs of Maori women in relation to antenatal education and services, de Joux (n.d.:2) says that 'many Maori women see no need to learn how to have a baby', depending rather on whanau for information and support. If they were to attend antenatal classes it would be to meet others, share experiences, learn from other women, learn from older women and listen to stories of traditional practices.

⁵⁰ Discussed in Chapter 3.

⁵¹ Māori SIDS is an organisation aiming to prevent SUDI (delivering national and regional services aiming to prevent SUDI (Sudden Unexpected Death in Infancy). Māori SIDS focusses on education, research and co-ordination I(www.maorisids.org.nz).

Many of the Maori women interviewed were adamant that traditional practices and customs should be reintroduced and incorporated in any programmes that were developed...They felt their spiritual needs were not met and that had an impact on their decision to continue classes...If Maori women are getting information via whanau and friends [it may be] based on medical procedures from past birthing practices [when] breastfeeding was discouraged [or] sleeping baby on the tummy was the recommended position...The concept of educating the woman only and maybe the partner is not realistic when in the whanau environment she may be one of several members of the whanau that are responsible for the care and support of the baby.

It is interesting that several participants later mentioned a need for information for family members that in their context would correspond to 'wider whanau'. They envisaged such information as including the change in recommended infant care practices that de Joux (n.d.) refers to above and also information in the form of tips for new grandparents about the type of practical support, such as meals and assistance with shopping, that might be particularly helpful to new parents in the first days and weeks. Applying Ungar's (2008) ideas suggests that participants in my study were keen to navigate to supportive resources but often found that the kind of support that would meet their needs had not been negotiated. For example, with regard to antenatal education my study produced similar results to a study which found that women who attended antenatal education wanted to 'meet people like me', while non-attenders thought classes were not for 'people like them' and 'expressed fears of being looked down on' (Cliff & Deery, 2000: 143)

'Not too sure'

Opportunities to learn about infant care, breastfeeding or generally coping after the birth were sketchy to say the least. Participants had only vague ideas about services that would be available. Abby, for example said 'I think you can get a car seat from Plunket. I think you can take your baby for checks, not too sure'. Most said that if they needed advice they would turn to family or friends, described and quoted as authoritative sources of first-hand, practical information:

Beth I can't see me going to Plunket for anything. I don't really see the point when my sister knows so much.

Julie My mum knows so much about babies and children, I feel that in some ways that is the perfect service, but I don't want to take advantage of it, or for her to be at my beck and call twenty four hours a day.

Amy, aged 19, had several friends of similar age with at least one child. It was from them that she saw herself seeking guidance. She said 'None of my friends go to Plunket' but did not know why this was so. Yet participants were evidently interested in learning about life with a baby. For some, this had a practical aspect:

Dawn My friend said she just learned on the way. She said as soon as you have your baby you have mother instincts, you just know what to do straight away. You know if they're hungry, or if they need their nappy changed. You just pick up little things like that. She said it's not that hard, you just get used to it. With breastfeeding, I'll just see how it goes. She said some women get quite sore. I didn't know you could breastfeed wrong. The first time I held a newborn was a month ago - my friend's baby, she lives quite close to us. When I'm by myself she'll come over and show me what to do. My mum just had her baby a few weeks ago so I went to my mum's for a couple of days, picked up a lot of things about how to look after a baby. I've learned so much about babies already. So that when my baby comes I know I'll be a good mum. I've read lots of books.

Lucy's parents arranged something similar, clearly anxious to ensure that she understood what life with a baby entails.

Lucy I've had no experience with babies. I got sent to my cousin's when my parents found out that I was pregnant so I could look after her four-week-old son for two weeks and I had to sleep in the room and get up when he got up and change him.

Learning about breastfeeding was mentioned by only a handful of participants, including Dawn, who discussed breastfeeding with friends, and Ange, who was able to attend a two-hour course, booked by her midwife, about 'what to expect, showing techniques'. Although

many participants attended antenatal classes, which normally include discussion of breastfeeding, they experienced classes as focussed on childbirth. For example, Cheryl said 'There's not much on the actual baby. There should be more. They didn't really talk about that, about five minutes only'. During the second interview Jan said that while her antenatal class covered 'care of the baby, bathing' what she found she actually needed was information on settling a distraught baby. At Roz's class the educator spent time on infant care but Roz rejected this information as 'too by the book'. Only one participant attended an antenatal class which went into any depth about relationship issues commonly experienced by new parents. At one class participants were simply warned that many couples separate in the year following the birth of a first baby; ways of preventing this were either not mentioned or not remembered. Not a single participant recalled information or advice about postnatal depression. Interaction with the LMC was also at this time focussed on preparing for the birth, as described in the section on midwives below. The narrow focus of information received from formal sources is surprising. While preparing for childbirth was important to them, participants also wanted information about afterwards. Most put time and energy into learning about life with a baby as well as about pregnancy and childbirth. Almost all mentioned reading books, purchased, borrowed or received as gifts. Some were reading voraciously. Tom said: 'The antenatal classes were mostly about the birth but I read up about it, I read the books she was reading'. Karen researched alternative approaches to baby care. Only Ria mentioned current semi-formal support:

Ria The first Tuesday of every month there's a Plunket coffee group and that's for - well, there's some mums there, their kids have grown up and gone and they still pop along. And that's quite big. And I'm being I think recruited onto the Plunket Committee because my mum's mate's on it. I went to one meeting already. They're very sort of accepting, and my cousin is in that group as well.

While many participants sought information, they apparently did not find as much as they needed. In the second interview several participants said that they wished that they had absorbed more information before finding themselves utterly responsible for a tiny baby. Participants had minimal opportunity to begin to learn skills or prepare to process change they were about to experience (Reece, 1995; Hawkins et al., 2008). Dawn's idea that she 'would pick up little things' certainly did not prepare her to deal with the postnatal depression she experienced. Any information she may have been given clearly was not

enough to help her seek support when she began to experience symptoms. Dawn's problems, described in Chapter 9, bring another issue to the fore: that of information for fathers. In the final interview Dawn's partner (by then ex-partner) Kent, aged 19, said that he wished he had been given information about 'things to look out for, little signs'. He believed that this would have enabled him to pick up Dawn's depression earlier:

Kent If I'd had a chance to go to a class I would have gone, yeah. I didn't even know about them. I suppose Dawn probably did but she never mentioned anything. If your partner's having a baby you should know as much as possible. Meet other parents on their way to have a baby as well.

Reinforcing prospective fathers' ability to support their partners is important. Zelenko et al. (2001: 276) found that 'young women who report less support by the father of the baby are more distressed and unhappy'. However, some men were initially somewhat stunned by the weight of responsibility they found themselves carrying. This was compounded by confusion and feelings of helplessness. The following comments are typical:

Julie I do think that a lot of men have never had much to do with babies. And I think that's quite difficult for them. A lot of women don't nowadays as well. Our guy friends come round and there's only one that'll hold [Baby]. The rest of them are a bit scared of [Baby]. I just think, you know, maybe some hands on. One baby got brought into the antenatal class for a bath, which was nice, but I thought maybe more babies could have got brought in to show the men, get them to demonstrate, enjoy it. Just to show how to change a nappy. It's a different thing, I think, being told than being shown. Couples came in and talked about the birth, how the birth was for them, but they didn't talk about after the baby was born.

Zac Being a parent, it's a great role that I didn't know anything about, that I only had opinions about but no practical experience. If you don't have children it's hard for you to be an expert at it.

The topic of preparation for life with the baby prompted participants to reflect on whether during pregnancy prospective parents are in a frame of mind to absorb information about how to look after a baby or deal with problems. A first birth is a unique experience, a big

event emotionally and physically; antenatal education is a chance to manage apprehension about the birth, beyond which it is hard to see. Furthermore, it is clearly tricky to pitch information about how to cope after the birth in a way that engages a wide range of prospective parents. Roz's experience of disagreeing with the educator is one example. Another is a comment made by Maya, who was staying at a residential facility which aims to equip pregnant teenagers for parenthood: 'I've learned some stuff, but the level's not high enough'.

'Nesting'

In getting ready for the baby participants were accumulating baby clothes and equipment. Gifts and loans of needed items were made and received in a spirit of comradeship. In rural areas, this kind of support was traditional:

Ria There's this travelling case of maternity clothes that goes round the community but because I'm pretty small most things are miles too big, but it makes them gloriously comfortable. I've got a T shirt that a friend of my mum's gave birth in.

With younger participants it was common for prospective grandparents to buy a new cot, pushchair or car seat for the baby. This was a significant gesture of support, indicating acceptance. Teenage parents have to handle the reaction of their own parents who may be shocked (Allen & Bourke Dowling, 1998; Auckland Women's Centre, 2004), suddenly finding themselves concerned not only with an adolescent child but also a grandchild (Dalla & Gamble, 1997). 'Accelerated role transitions' resulting from teenage pregnancy 'may have direct implications for identified normal intergenerational and family relations' (Caldwell et al., 1998: 395), impacting on younger siblings of teenage parents as well as their parents (East, 1999). The gift of a major item was interpreted as meaning that prospective grandparents were willing to accept the baby and their new role and thus had emotional connotations, not always articulated but certainly present. It was, as Cobb inferred in 1976, 'information' in the sense of messages about being cared for, esteemed and valued, here representing the family rallying round young parents and contributing to a budding sense of being capable of moving into the role of parent, thus preparing the way for resilience. It has been noted elsewhere that a teenage pregnancy can have positive influences on family dynamics and function as a catalyst for repairing family relationships (Reeves, 2006), offering opportunities for fractured families to regroup to some extent. Kim

and Jon, as well as living with his mother, were given a cot by Kim's adoptive mother and a car for Kim by his father, who was separated from his mother. The car was a thoughtful gift for a potentially isolated teenage mother; it encouraged Kim to pass her driving test and enabled her to get around her rural area. This extended family continued to collectively support the young couple. In contrast, Abby's mother presented her with a large quantity of second hand items, including two pushchairs, which Abby experienced as demeaning and annoying. Informal support sometimes took the form of promised practical support, which seemed to help participants envisage the future, indicating that life as they knew it could continue, for example being able to work while relatives cared for the baby:

Ange My mother-in-law very kindly volunteered to be an on-call grandmother – any time. I'm like 'Can you sign that please?' She's very happy to slow her work down, she's very happy to enter into the occasion, which is great.

Material support was important not only from a practical point of view, helping financially, but also was a form of emotional support, symbolising recognition of role change.

'A pressure cooker situation'

While younger participants experienced more relationship instability than did older ones, this may be due as much to short duration of relationships or unplanned pregnancies as to age. All eight teenagers were having 'a surprise baby'. Three only realised at four or five months; another was 'too scared to do anything about thinking I was pregnant' so that she too was past four months when the pregnancy was confirmed. One of the 20-year-olds had planned her pregnancy but was deserted by her partner. The strain on a relationship of an unexpected pregnancy in the context of a short-term relationship is illustrated by the situation of Fay and Jack, who were in their mid thirties.

Fay It's important not to make assumptions about what it's going to be like or each other's roles will be. That's when problems can come up. When you've got a baby that needs a lot of time and attention it's maybe not the time to start addressing those things. So before we went to the Family Court counsellor we talked about our own upbringings, our expectations, what we perceive a mother's role to be and a father's role to be, about our own personal fears. Because at the beginning we both

felt that we were in a real pressure cooker situation because I was pregnant and we both wanted the baby but it was a new relationship, six months or something.

Fay here implicitly recognises something observed by Summers et al. (1999: 291) which is that background and culture strongly influences perceptions of the parent role. However, this couple perhaps did not fully benefit from counselling. Family Court counselling has a limited timeframe and Fay and Jack had to travel to sessions. When their entitlement to free sessions ran out their attendance became erratic. After a year or so, having struggled through a series of problems, they separated. Despite serious relationship problems Maya was not interested in counselling. Nor was Zoe, whom I met at a birthing unit where she had a prenatal appointment. Her baby's father was there and I was able to talk with them both, during which time Zoe explained the situation:

Zoe With the relationship there are already some problems – we've got the idea that each of us will be able to go out with mates and the other will look after baby. We wouldn't use counselling - I'd rather we talked it through ourselves. I'm the sort of person people come to for help and advice.

In pondering imminent parenthood four women told me about traumatic issues in their own childhood, including issues that had affected relationships with their parents. The partners of another two had experienced similar issues. To deal with these historic issues one woman was currently attending counselling, another planned to do so and another had already addressed an issue that 'shook her world view' and felt that it no longer affected her emotionally: 'I had one counselling session, it helped reframe it. It was enormously helpful to get that objective point of view'. Others felt no need of support in this respect. While Kim's childhood and early teenage years were very hard, her informal adoption into a loving substitute family was clearly a source of strength and stability; she expressed no worries about her capacity to be a good mother, quite the opposite in fact. However, men in this situation were reported to be wondered about their capacity to 'be a good father'.

Ange He's already had a few little run-ins with himself, during the pregnancy, just facing the fact the he's going to become a father, and will he be able to be a good father or will he just copy behaviour from his father, what he saw until he was a teenager. But he's been doing some really amazing work on himself, with mentoring.

‘Watching the money’

While there were obvious differences of degree in financial strain expected or currently faced, getting by financially caused general concern. Most participants expected a reduction in income. Many were already taking action to forestall problems by controlling spending or by prospective fathers working longer hours. Older participants established in well-paid jobs had to make a tough decision about whether they were willing to forgo a considerable chunk of income and potentially slip a rung or two on their career ladder. Some had been ‘very career focussed’ and were relinquishing what Ria called ‘a divine salary’ - also, they were realising, they missed interesting work and a role conferring status. Clare found herself still in two minds. Even for Karen, who was keenly anticipating motherhood, the change was dramatic.

Clare I think it will be really, really different. I've gone from thinking ‘Oh my god, my life will change in all sorts of horrible ways, horrible isolation ways, it'll be a life full of drudgery. Do I really want that?’ - to ‘I'm really looking forward to it’, concentrating on what's happening now and what's coming. I think it will actually force me to slow down and reprioritise and that is something that I can afford to do. I work a long day at the moment, even now I'm working till seven. I'm so over that. It can be hard during the day. It comes from being part of a team, being responsible for the work. To some extent I think if you get paid really well you can't really complain but I'm pretty well over it. I do think one thing that I may struggle with, or that worries me a wee bit, is that loss of identity. A huge part of my image of myself is Clare the successful [professional]. So stepping away from that – in some ways I can't wait to because I find that quite a confining role - but also I'm like ‘Oh my god, well, what will I be? Clare the absolutely fascinating mother?’ I don't know. So I'm kind of aware of that. This girlfriend of mine has done a similar thing and felt – well, interesting when you've gone back to work and feel, actually, a kind of loss of confidence professionally because you don't feel on top of your game so much - and in fact don't care as much, it's not a priority.

Karen I've recently given up work having worked for the last 20 odd years in various careers. So the first week was quite a transition. I didn't know what to do with myself. And of course there's this busy mind and body that wants to keep going.

The nature of Ange's business enabled her to envisage that she would 'just take the baby along' when circumstances allowed. Other self-employed women planned to return to work in the near future and were considering arrangements to make this possible, such as employing a nanny, organising regular childcare with a family member or engaging in 'negotiation about the balance to be struck between cash and care' (O'Brien, 2004: 13).

Ria I want to make sure we don't end up getting too limited, remembering we've got options. Because in my profession I can step back into work in a second and it's very well paid. I don't know that [Partner] sees that the same. He feels a bit over-responsible I think. I've said I can step back into it in a second even if that means we have to rent and move to Auckland, I'll do a six month contract. He's like 'I wouldn't want to do that'. But I want to stay focussed on freedom and options and flexibility and not just stay here for the next thirty years, being skint, being stuck.

Younger participants usually had no spare money at all. Paradoxically this gave them more freedom to plan to be a 'full-time mum' rather than return to paid work; the balance between a boring, low-paid job and being at home with the baby was weighted on the side of time with the baby.

'Working harder', 'Saving up'

Self-reliance was a feature of discussions of income and money. Several described the action they had planned or taken to reduce outgoings or save for what they needed. Even where money was tight, no actual financial problems were mentioned at this stage. Many of the circumstances associated with taking on responsibility for a new baby are totally new to first time parents but financial strain is a familiar source of potential difficulty; many participants were clearly skilled in averting or dealing with problems in this respect and were weighing up their options:

Cheryl I'm one of those people who when it comes to finances I need to know exactly where the money's going and I need to have everything written down. I need to know. At the moment I've got the next eight weeks sorted and I'm not looking beyond that. Soon as I've finished that eight weeks, then I'll be stressed out for the next week, while I sort that out, get the next two months sorted. As long as I know, I can budget. If I knew my mortgage was going to be paid, every month – I mean I

know it's going to be paid but at the moment it's my maternity leave paying that - once that's gone I'm going to have to take another \$600 a month out of [Partner's] wages. If I could ask for something it would be the financial security to know that I didn't have to return to work and that I could actually be there and be a mum for my child. That would be the biggest thing. I really am not into childcare as such.

For younger participants, simply having somewhere comfortable to live and being able to create a home was a pressing issue, sometimes problematic. Current accommodation situations were often temporary. Several were staying with their own parents to save money but wanted to move into their own place when the baby was born, if not before, keen to establish their independence and begin family life as a nuclear family. Dawn, for example, living with her partner at his mother's house, said: 'We just thought we'd save up more money, then we'll move out'. Younger participants had to think and act strategically to provide themselves with what they needed.

Zoe I was five months pregnant when I found out. I was living with my mum in West Auckland. I was doing cleaning work, high range. I found this house [in semi-rural area] and I moved in. Sometimes [Baby's father] stays. But there's no bus, I don't have my restricted and I'm not interested in learning. I might move closer to town.

Dee, who was no longer in a relationship with her baby's father, was saving hard while living with her parents.

Dee I've managed over the last four months to save quite a lot. If I need it it's there. My ex-partner tried to get my hours cut at work and get me on DPB. But I just refused. It's nah, if you're not gonna be there I'm gonna do it myself. He might support the baby through Child Support, maybe not. We haven't fully discussed it yet.

One couple in their late twenties, both of Pacific descent, were living with the woman's family while saving for a house, an arrangement that worked well for all concerned and was still working well when the baby was a year old.

In first interviews women already spoke of their partners' feeling more responsibility for the financial well-being of the family, working longer hours or planning to do so.

Ria We've had a bit of financial pressure, one business closing, one not earning. A business in its first year shouldn't really have to be supporting three people so there's that pressure. [Partner's] got a lot of pressure because he's got to work quite long hours to make this happen yet he's not a work hard ethic person, he's a family person. So the hours he's doing now, if he has to do that after the baby that will be very stressful for him. It won't be his priority, it's not his values. What's rescued us a little bit is he's now got [part-time contract work]. And when we get round to planting our vege garden it's a very sustainable life style. There's lots of options for a sustainable lifestyle here.

Some had the security of knowing that they could get help from family members if necessary. One of these was Cara, who also fortuitously had a lodger able to provide useful information:

Cara Financially it will be hard. I do get Maternity Leave, we get about \$290 a week for 14 weeks, so – it's going to be hard. Our lodger works for WINZ. He's good at letting us know. We can probably get top-ups on [Partner's] wage. So it's gonna be really hard, mortgages are hideous in Auckland. But we're quite prepared to take a change of lifestyle. We don't go out drinking or anything like that anyway. So nothing's going to change majorly. Cheaper cuts of steak – no more eye fillet! I'm actually quite looking forward to that aspect of it – to sit down and look at what we've got. But we're quite happy. And both [Partner's] parents and my parents have said if we need help financially they'll help us out.

Many participants were unclear about how tax credit and income support schemes like Working For Families might assist them and tended to rely on informal sources of information (friends and colleagues mainly) for information . However, participants were much clearer about eligibility for Parental Leave.

Paid Parental Leave

Women eligible for Parental Leave were looking forward to spending time as a 'full-time mum' before returning to work. Cara saw this as enabling herself and her partner to adapt to their new roles.

Cara What I'm looking forward to is that it's the next stage in life really. I'm giving up work. I'm taking seven months leave. Even just that is quite exciting in itself. [Partner] works from home. It's like we're going into something together. I think if he was going to be going off to work each day, probably like most guys do, it might be quite a different feeling. But I'm really looking forward to it because I know we're going to be going through it completely together. Although I probably am a little bit scared through my lack of experience I think our situation is really, really good and we're lucky we can both be here.

If participants did not qualify for Parental Leave this added tension to their forward planning, more sharply felt if they had worked for an employer for only a few weeks short of the number that would have made them eligible, so that they felt almost cheated.

Income Support and tax credit

Younger participants were currently receiving Sickness Benefit or Unemployment Benefit. This was a vital source of income, a lifeline for women in short-term relationships while they sorted their situation out, including negotiating the impact of the pregnancy on the relationship, finding somewhere to live and organising how they would generally cope.

Abby I'll just probably go on Sickness Benefit soon. I do miss working because I'm an independent person. We are quite stuck for money to actually get into a house. But I'm on Unemployment now. I think I will stop when the baby's born, I'll go on Sickness and then I'll stop when the baby's born. Because I've opened up another account, just to put a little bit away for her. It's so expensive.

Maya, wary of living with her baby's father, fully intended to live on DPB, which for her offered protection as well as financial support. Her forebodings were clearly prudent as she later needed Refuge help to ensure the safety of herself and her baby.

Given that the women had evident skills in money management and showed no lack of initiative or creativity in planning how they would cope financially it seems odd that they were so vague about tax credit schemes or other assistance, suggesting that these were not publicised in ways that reached all who might benefit. Dawn noted there is little

information on TV about financial support. Only Amy spontaneously mentioned Working For Families (calling it Family Support) at this stage.

Amy We'll manage. We've cut down a lot of stuff. And I've paid off everything. I've got Maternity Leave. And there's Family Support but I don't know much about it.

When prompted about Working For Families, Cheryl said that she had noticed information about Parental Tax Credit on the Parental Leave Form. Since not all participants were eligible for Parental Leave many would not have seen this. Several who knew people who did not qualify for Working For Families said that they assumed that they would not qualify either and had not bothered to look into this option. Dawn had heard that it was possible to get 'a \$1000 baby grant' from WINZ (this may have been a Special Needs grant or possibly Parental Tax Credit). Informal support appeared to be often more confusing than informative with regard to financial assistance.

Dawn's comment about lack of information on TV highlights the issue of participants' general lack of information about tax credit and income support schemes. People already receiving a Benefit usually found Work and Income staff helpful and got all they were entitled to; people in paid work tended to assume they would not be entitled, did not want to apply or were put off by not understanding the regulations, for example for Parental Tax Credit. Prospective fathers were beginning to feel pressured to work long hours to compensate for the drop in income normal at this time. That families found themselves worrying about financial wellbeing at this time is of concern because financial strain is a pervasive source of problems for families, exacerbating other difficulties encountered.

'Ready or not'?

Participants were keen to lay the groundwork for being a 'good mum' but had few avenues to do so apart from reading or talking with relatives or friends with babies. However, they apparently more often discussed childbirth rather than childcare. Hearing the stories of others who had experienced childbirth seemed to function as a way of preparing the mind. Later interviews with new fathers suggest that this applied to them too.

Apart from support from midwives, formal support, including antenatal education, was accessed by only a proportion of participants, not all of whom found it easy or comfortable

to use. Some participants were unable to attend an antenatal education class because none was available. Although an inner city class attended by one participant appeared to be useful to people of diverse ethnicity, in general antenatal education did not appear to attract or engage a range of families. There are gaps in formal support pertaining to learning how to care for a baby and manage relationship issues and other likely changes. Even participants' knowledge of Well Child services was hazy. Later interviews show that participants were taken aback by the realities of life with a baby. Roz raised the issue of how men could be better prepared, an issue that requires deeper consideration than is possible through my study. While appreciating the educator's efforts to give prospective fathers the chance to talk about 'men's stuff' by occasionally separating them off, Roz thought this unsuccessful, mainly because 'it would be better to have a bloke for the blokes'. Studies have shown that the father's role is rarely discussed during pregnancy and men do not get enough support to prepare for parenthood (Fredriksson et al., 2003a). As reported in subsequent chapters, men often felt at sea in terms of their new role and sometimes irrelevant and helpless. Hardly conducive to self-efficacy, in some cases this may lead to resentment. The narratives from the first set of interviews suggested that in the weeks before the birth of their child participants were simply waiting to 'meet the baby' but had little idea of what this would mean to them. What it meant is the topic of the next chapter.

CHAPTER 7 'MEETING THE BABY': CHILDBIRTH AND THE FIRST FEW DAYS

The second set of interviews took place when babies were around three months old. Again I found myself out on the road. I had envisaged being able to find participants' homes more easily this time round but several had moved to a different house since the previous interview; more than once it was with relief that I spotted baby clothes hung out to dry after at last locating the right house. In the previous set of interviews participants had expressed their eagerness to 'meet the baby'. Now I had the chance to do so. Interviews were usually preceded by admiring or interacting with him or her. Towards the start of second interviews I invited participants to draw a picture or diagram of sources of support available to them,⁵² a form of ecomap representing how they felt about support received from that source. This was simply a tool to ease them into thinking and talking about support and seemed to be something they became quite interested in doing. While they were busy with this, I often found myself holding and entertaining the baby.

Results of this set of interviews are presented in two chapters because participants' narratives indicated that they saw the three months since the birth as comprising two phases or stages. The first related to the birth and the few days following. The second involved adapting to the role of parent and the concomitant responsibilities. The former is the focus of this chapter. In relation to this phase, not surprisingly, formal support from health professionals, including midwives and the staff of maternity facilities, featured strongly. As well as general recognition of the value of caring, competent support at the birth, significant themes from this set of interviews are: consternation at the brevity of the interlude of 'being looked after' while coping with the trials of being 'consumed by breastfeeding' (in the apt phrase used unconsciously by one participant) before being 'thrown in the deep end' and thrust onto a 'steep learning curve'. This chapter includes insights from later interviews with partners of women interviewed. As background, the chapter begins with a discussion of support for novice parents.

Novice parents

So that it soon becomes possible to manage new roles and the inevitable period of disequilibrium is not prolonged, families with a first baby need access to resources. New

⁵² As described in Chapter 5.

mothers must quickly become proficient in 'maternal skills' (Pridham & Chang, 1992). Warren (2005) found that appraisal support, or positive feedback about developing competence as a mother, had a stronger association with new mothers' confidence than information, practical assistance or emotional support. Reviewing studies of breastfeeding support for adolescent mothers, Moran et al. (2007) found appraisal support to be a key factor in their success. Confident parenting at one year after delivery was found by Reece (1995) to be associated with positive self-evaluation at one and three months. Brage Hudson et al. (2001) explain that infant care self-efficacy is a form of self-efficacy developed through experience, encouragement and modelling and that parenting satisfaction is enhanced by high self-efficacy in terms of the ability to master parenting tasks, parent effectively and establish and maintain relationships. They note that 'active participation of fathers in infant care may result in increased infant care self-efficacy and parenting satisfaction' (2001:42) and that 'the common practice of focusing on mothers' parenting concerns during parent education classes may not adequately prepare fathers to cope with the transition to parenthood' (Brage Hudson et al., 2001: 42).

Satisfaction with the parenting role is important at an early stage because early parental caregiving patterns tend to persist and influence how parents interact with their children over time. Based on their study of 44 couples transitioning to parenthood Brage Hudson et al. (2001) consider that fathers find it harder to develop infant care self-efficacy because they have less time to do so. As well as recommending that fathers be encouraged to take paternity leave if possible, they make many suggestions for action to engage fathers, including encouraging new fathers to participate in hospital teaching sessions facilitated by fathers experienced in the parenting role so that they could model infant care tasks, such as bathing. They suggest that these sessions encourage small group discussion to assist fathers to share and express feelings with other fathers so that 'feelings of relief might occur when fathers realize that they are not the only individuals experiencing difficulty during the transition to parenthood' (Brage Hudson et al., 2001: 42). They recommend the inclusion of research-based educational content about parenthood to provide new parents with a realistic picture and advise that sessions be arranged to suit fathers' work schedules. They suggest that mothers should be encouraged to involve fathers in baby care 'when fathers return home from work' (Brage Hudson et al., 2001: 42). It is tempting to leap in with solutions. However, if a goal of service provision is to enhance resilience it is essential to frame strategies in ways that not only resolve problems but enhance self-

efficacy. Rather than making assumptions (for example, that fathers work regular hours) strategies must reflect understanding of families' circumstances. Assumptions are liable to obscure the realities of a situation being studied.

The birth

Of the 25 women interviewed more than once, five gave birth in a birthing centre and 19 in a hospital. Six of the latter then returned to a local birthing centre, having been transferred from there to a hospital for specialist care. The four who gave birth at Auckland Hospital transferred to Birthcare, as is normal practice at this hospital. Two had planned a home birth but Karen was advised by her midwife to go to hospital. Fay's home birth turned out to be an ordeal. All the women except Fay felt that they received a high standard of care, wherever they were, during labour and delivery. Several expressed appreciation of the maternity care system. Those with their 'own' midwife were full of praise:

Jess I love the fact that you have the same midwife all the way through. It's just wonderful. Because it's such a huge part of your life and it's personal and you actually get to develop a relationship with your midwife. I had the most amazing midwife, lots of connections and stuff like that. I think if I had any issues she would definitely have put me in the right direction. About ten seconds after he was born [Partner] proclaimed that that wasn't too bad and we could have another one! He was on Cloud Nine.

During labour twenty two women were supported by the baby's father. Maya did not want her baby's father there. Julie's partner just missed the birth as he was delayed overseas. Her mother was there. As well as having her mother with her, Dee was supported by text by an ex-boyfriend. She later got back together with this man, and, despite difficulties, was still involved with him when I visited her after a year. For fathers and other supporters it was an 'amazing' experience, 'a buzz', apparently strengthening bonds.

Kim Jon delivered him. Told me when to push, cut the cord and everything. The midwife ended up telling him, 'You should become a midwife yourself - you're really good at it'. He was really emotional that night, he was very happy with himself, he said he'd never ever cried happy tears before. And Jon's mother actually said to me she didn't think it was possible to love another child as much as she loved her own kids

but [Baby's] like her own, she just can't help that feeling. She was very excited that I let her come in. She said 'It was so good to be able to be in with you'. And it was good for me to have someone that's been through it. She was able to calm Jon down. I think she knew that he was starting to get on my nerves. It was getting to the point where I was just about to start to swear at him and she was like, 'Oh Jon, you don't know what it's like'.

Gary I was just interested, because it was such an easy birth. I had my little pack, with my lunch in it. It was good. I was able to help Tania with the towels and bits and pieces. It doesn't really gross me out, that sort of thing - I think because of my hunting background I'm used to a bit of action like that. It was not too bad. In fact it was just amazing. I took my shirt off and we had skin to skin. It was quite daunting at first but we'd bonded.

Childbirth and self-efficacy

Narratives from the second interviews indicate that midwives enhanced participants' sense of self-efficacy about childbirth, self-efficacy being an integral element of resilience. When cared for during childbirth by midwives with whom women felt safe, they felt able to 'just do what had to be done' even when complications occurred. Women who had a strong working relationship with their LMC trusted the LMC's judgement, so that even when the birth did not go according to plan they felt they had done their best under the circumstances, consistent with the positive attitude that underpins resilience and with the saying 'what doesn't kill you makes you stronger' - which several participants used. When fathers felt that they could be helpful, as Jon and Gary did, they felt valued rather than feeling like the invisible man (see below in this chapter). One woman's story provides a converse example. Fay carefully planned a home birth with a midwife with whom she had developed a close, trusting relationship. This midwife had to stop practising shortly before Fay's due date and Fay found the replacement 'completely different, chaotic, missed a lot of visits, turned up late, disclosed a lot of personal things that were not appropriate'. Fay described the birth as harrowing for all present, including her partner and his parents. She felt that she 'lost control'. She suffered a debilitating injury from which she took weeks to recover, eventually requiring specialist care. This meant that the early days with the baby were a struggle. This may have contributed to the depression experienced by her partner

and may have had something to do with the couple's relationship problems, which eventually led to their separation.

The 'invisible man'

Although most men interviewed recalled the birth as 'a buzz' some felt 'spare' in the delivery room and unwelcome afterwards. Matt made the comment below in the course of explaining his disappointment that he could do little for his baby at first. Dean was still indignant about a scolding he got for taking his baby out of the hospital ward, a story related as an illustration of his low opinion of communication at the hospital:

Matt It kind of starts in hospital. You're an invisible man at the hospital. For the nurses, the doctors, the guy's invisible. Which is fine. But it kind of starts there, for the next six months. You know, I think it's fine at the hospital, because they've got a little area for dads, to make sandwiches and stuff like that. But if somebody lets you know ahead of time, that that's how it's going to be, that would be quite a bit nicer. At the antenatal class, or something like that. So you don't think that they're being really rude to you. Because the nurses and doctors are actually really rude – not so much rude but they won't even acknowledge that you're talking, and saying stuff – it's all about the woman, it has to be. But I think if in the antenatal class that's kind of brought up, you know, 'Don't feel bad because you're not getting any attention'.

Dean There was no continuity of staff, nobody seemed to follow on. There was an Asian woman in the ward. They couldn't seem to communicate with her. I'll give you a classic example. When we were checking out Celia was really tired so I picked up [Baby] and went downstairs to pick up her script so we could leave. And the matron or whoever it was went absolutely off at me that I'd taken the baby out of the ward. Yet there's no signage, no one had said anything to me about that. All that I did was walk out with her, down in the lift to the pharmacy, then back up again. I was gone five minutes. I can understand their mythology over it but there was just no signage. But there's signs on the walls saying get out by 11 o'clock type scenario, so we were ready to go. So that sort of thing I found quite draining. Liability, I understand it, but I wouldn't think of that because I don't need to think that way. And at times you'd walk round with the baby, and there would be ten blokes, cruising round with their babies, just chilling, you know, which I thought was quite

cool. So that experience was quite interesting. I just thought there could have been better communication between the shifts about what's going on.

Both the above comments were about hospital care. Birthing centres were experienced by some men as welcoming in that they were able to stay there for long periods of time, kept informed about what was going on, and, in some instances, instructed in baby care, including being able to practise bathing the baby. Hospital staff may not have time to involve men in this way. Roz, who had her baby in a hospital, felt that the needs of new fathers were overlooked there and support should be offered to men by men. Amy, who gave birth in a birthing centre, also thought that more could be done to encourage father involvement:

Roz I reckon they should have males going round in the hospital to talk to fathers. You know, so it's not 'Hey fathers, come into a room with all these strange people, so we can tell you about how to be a father' - just have a random male, it could be even people who are volunteers, just going to talk, like, 'Come and have a coffee'.

Amy I think *they* might need a bit more help sometimes, the fathers might need another man to help them. OK, you've got the nurses that are girls, ladies, they should have men ones, just to help fathers be fathers.

For one young couple, hospital care was essential and deeply appreciated. Their baby spent time in the neonatal unit after sustaining a birth injury. During this time Abby and Tom found hospital staff informative and John spent a lot of time there:

Abby It was so cute at the hospital, he did the whole proud daddy thing. All the daddies were doing the 'walk the hallway'. He'd come back and say, 'I just met a dad, we talked about this and that'. John liked the fridge [snacks for fathers], yes, he never wanted to leave.

'Consumed by breastfeeding'

Along with many of the participants, I find it hard to see how first time mothers are expected to learn the complex skill of breastfeeding with practically no one to call upon for help. While midwives assist with breastfeeding while visiting women at home, they are not

necessarily there when a woman needs assistance. Compared with hospital staff, birthing centre staff apparently spent much more time with women to help them develop breastfeeding expertise. Participants who had not been in a birthing centre complained of receiving inconsistent advice from hospital staff, leading to confusion and delaying success.

Although she felt well looked after in the birthing centre where she went after going home from hospital, Kim had by then got off on the wrong track with breastfeeding. Her early difficulties continued and eventually she stopped altogether when her baby got used to a bottle while she had mastitis. Although all the women wanted to breastfeed, several found it much more difficult than foreseen and four found it just too hard to continue for more than a few days or weeks. Dee, for example, gave up because at six weeks old her baby still needed feeding every couple of hours. Fay felt bitter and Tania continued to struggle:

Fay I really struggled with breastfeeding at first. It really hurts. I felt really betrayed, really betrayed, like, why don't women share this with each other, it's like this secret, and then afterwards they can't wait to share it.

Tania I just kept thinking 'Oh this can't be happening, it can't be this hard, I just don't want to do it any more'. But now that I've done it, like it took me two weeks to get it sorted and the pain to go away and then it was comfortable and now I think 'Oh I'm so glad I've stuck to it'. It would have been so easy just to say I don't want to do this anymore. At three weeks she was going through a growth spurt and I didn't know, and she was hungry, hungry all the time, and I thought she's obviously not getting something, but my midwife told me 'Oh no, she's fine, she's just going through a bit of a growth spurt'. But things like that, I think that there should be minor warnings, just to know that at three weeks expect a growth spurt

Some women found that seeking advice only added to their problems because advice provided was inconsistent:

Jan The midwife said 'Feed both sides for twenty minutes', but La Leche, when I rang, said: 'Feed one side so he gets the hindmilk'. It's confusing. La Leche was going to

send me out information but she never did, she wasn't focussed, she was talking to her child or a dog while on the phone to me.

Cara learned correct positioning for breastfeeding only after weeks of stress culminating in an abscess that required hospital treatment, then visits by a district nurse. She attributed her problems to inconsistent advice early on.

Cara One thing I really hadn't thought about was breastfeeding. That was my biggest nightmare, right from the start. He just wasn't latching on. Every time it was time to feed, my stomach would just go into an anxious knot. I just had no appetite. In those first two weeks I lost most of my pregnancy weight. And I was tired because I was feeding him very two hours. I'm a really light sleeper so if something's bothering me I can't sleep. Everyone would say 'When he's having a sleep during the day go and have a sleep'. But I'd lie in bed and I'd just be thinking about things. So I got really run down. I just did not know the whole breastfeeding thing would be such a mission. One thing I found when we were at the birthing centre, each nurse that came in had a different way of getting the baby to feed. It was confusing. It's hard also when you've got a midwife, with timing. Because often she'd come around and he'd actually be asleep. What happened is I got an abscess, so I ended up in hospital over Waitangi weekend, which just added to the whole hideousness of it. I didn't know I had an abscess. I was totally unaware that could happen. Because I was tired and run down I thought I had flu. Maybe if I had gone to antenatal classes I would have known. I tried to call the Auckland La Leche numbers but I couldn't get in touch with anyone. But I got the South Island lady. I was just ringing all the numbers I could find. In the end I went to hospital to see a lactation consultant and they took one look at it and said 'Oh dear.' I had to go over to North Shore because the hospital didn't have the facilities to deal with it. I sat in that emergency room all night, being exhausted, by myself, just sitting there. It was Friday night as well so there were all these drunks coming in, it was just hideous, hideous. I was *this* close to giving up breastfeeding and Mum said to me 'You know, people breastfeed with just one breast'. I think Mum's encouragement is what kept me going. When I think back to it, that whole six weeks, I was just consumed by breastfeeding. After the abscess I employed a professional lactation consultant, Plunket suggested her. It was well worth it. Looking back I think I was

quite a stress bucket really. I always felt I didn't have enough milk and it's an awful feeling. That continually was on my mind, it was a real stress for me. I was just so desperate I would have paid anything. It was about \$160, so worth it. This woman was just so straightforward. She was just miles better than anyone else.

Jess, who became so ill with mastitis that she 'couldn't get out of bed', thought that women should be warned and given advice about mastitis. She suggested that information about support for various potential problems be presented to women before leaving maternity care. However, for those who leave within a matter of hours it would be difficult to find time for this. Jess qualified her thoughts on this topic, recalling that some information was presented at her antenatal class but that it had gone over her head at that time:

Jess I didn't know about the Plunket Centre, like that they've got a lactation consultant. They kind of went into that at the antenatal class, but I think you're in that kind of thing when you think 'I won't need it'. And especially when it's your first baby, all you can think about is labour and delivery and what it's going to be like. Everything else is kind of secondary.

Support for breastfeeding

Almost all of the women struggled at first with breastfeeding and wished they had received more support to acquire this skill. Breastfeeding is promoted as best for babies⁵³ but breastfeeding problems may be troublesome and debilitating (as reported further in the next chapter). Apart from its avowed benefits, breastfeeding competence is an emblematic sign of transition to motherhood. As well as averting problems, support to develop this competence at an early stage may promote the optimistic attitude that promotes self-efficacy, creating the reinforcing effect on competence generally that is a key mechanism underpinning resilience.

Being 'looked after'

At the time of the second set of interviews, the Parenting Council⁵⁴ was publicly advocating for women to be able, should they wish, to spend longer being cared for in a facility like a birthing unit (Willis, 2006). Many participants in my study had envisaged being 'looked

⁵³ See, for example, Ministry of Health breastfeeding campaign, referenced in Bibliography

⁵⁴ Coalition of five parenting organisations aiming to engender a shift in the New Zealand environment from a situation where 'virtually all the parenting resources are focused on late intervention...to one in which the parenting role is valued and seen as worth proactively resourcing' (Parents Centres New Zealand).

after' in the first few days of parenting, but instead found the reality of looking after a newborn baby to be a huge responsibility to which they had to immediately adjust. Their pre-childbirth expectation that they would simply go off home and be able to cope was viewed as ludicrously unrealistic.

Karen There's so much healing to do and so much relationship change. If you look at other cultures they have a six week confinement, and a lot of them, you know, they lie about and they have their mothers do everything in the household, and they get to know their babies. And you see, we get up and leave hospital the same day and then think that we can run our household and get to know our babies and carry on as if nothing had happened. I was quite determined not to put myself through that.

Others shared Karen's belief that taking responsibility for a baby's well-being means that much must be learned in a short space of time and so women need to be nurtured so that they can do this well. Many were surprised to find that they were expected to take the baby home before they felt they had recovered, far less become competent in infant care. They had apparently imagined that they would be looked after at the facility where they gave birth for much longer than is normally the case. Some who could afford it paid for extra time at a maternity facility to ensure that they felt confident enough to go home.

Rae I was surprised about it all – I thought you went to the hospital and you stayed there for as long as you needed and then you finally went home when you were OK. But they kick you out after a couple of hours and then you go down to Birthcare and then they kick you out after three days, or three nights. And if you get there before eight o'clock in the morning they count it as a night.

Jess I'll tell you one thing - I wasn't thinking about how bad I would feel after having him, like just having run a marathon or something, worse, very knocked over. Even with the stitches, you're not comfortable and you're trying to breastfeed and that's not comfortable either. You're trying to sit down and breastfeed and neither's comfortable and you think: 'Will I ever be comfortable again?' That kind of thing surprised me - the whole time through you're just thinking about having this baby at the end, you think about the labour, you don't actually think about what it's going to be like afterwards. I hadn't thought that I'd feel rubbish, that's the thing I wasn't

ready for, well it didn't actually occur to me. I stayed three nights in a private room. They said: 'It would probably be best for you to stay another night'. It meant when we came home we were both really confident because we'd had a good night.

Warren (2005) says that the introduction of early discharge ignored the value of 'lying in', including opportunities to be supported by other women, rest and be nurtured. Participants lucky enough to find themselves in a rural birthing centre felt welcome until they were 'ready to leave' - which was actually quite soon because they received helpful, consistent coaching. According to Beth, 'it was like being on holiday, I got waited on hand and foot, it was wonderful'. Some birthing centres warmly invited women to bring the baby back for a visit later on. Birthing centre staff took care to ensure that Dawn, aged 17, felt supported:

Dawn I've never had little brothers or sisters so I didn't know much about coping when I first had her. But they taught me heaps at the Birthing Centre. They just gave me little talks early in the morning about breastfeeding properly, and soothing her, and the best way if you can't bring her wind up and you don't know what to do. They did most of that stuff early in the morning, Kent wasn't there. And they wrote me this big list of things, you know, all the things to calm her down, like turn the vacuum cleaner on, they had a photocopied list of things like that. They gave me the Plunket number and I think I've got a pamphlet somewhere about a free service for housework and that. They gave me heaps of pamphlets to take home.

Unfortunately, although the respectful encouragement of staff helped Dawn feel confident about taking her baby home, her sense of being respected was dented by what might seem like a minor incident as she waited to be collected, but which nonetheless upset Dawn's equilibrium and was recalled with chagrin.

Kent They kicked you out, eh, Hon?

Dawn I was going to stay there till Friday but I wanted to come home on Thursday. And there was this cleaner lady, she was quite rude. Kent's mum was an hour late for picking me up. And the cleaner, she told me to get out of my room, and I thought that was quite rude. So I just waited in the waiting room for a bit. Kent's mum, she wasn't that long. But everything else at the birthing centre was good.

The 'personal touch' was a key factor in making birthing centres so popular - as well as food that was appetising and plentiful. Food featured prominently in recollections of the early days. Women who have just given birth are not ill, but rather have gone through strenuous physical endeavour and need extra sustenance for breastfeeding. Many saw food as signifying care, part of feeling nurtured emotionally as well as nutritionally. Ange gratefully recalled her mother-in-law bringing 'a big casserole pot every time she came over in the first few weeks' and Tania's mother-in-law filled their freezer with 'heaps of frozen dinners'. Hospital food was not popular however:

Tania It was like meals on wheels, such a big help in the first three weeks because I still kind of didn't really know what I was doing - trying to get dinner sorted was the last thing on my mind. It was a major help.

Dean The food at the hospital was crap, absolutely disgusting. I knew that the second night when I turned up with food and I was surrounded by about 20 other blokes with takeaways. The hospital had white bread and all that sort of stuff. In this day and age it's crazy to be feeding people that stuff, especially mums.

Not being given breakfast was the last straw that drove Kim, who was 18, to leave hospital and go home, too early as it turned out.

Kim I got up the next morning and I didn't get that much to eat. The midwife ordered me breakfast but I only got a piece of bread and a glass of milk. But no, it was all right because I knew I'd just got to get out of that hospital. It was just too enclosed for my liking. I had [Baby] on the breast for a little while but no-one showed me how to put him on properly. I called the midwife and she told me it probably wasn't the wisest idea to go home after you've had a baby but I was just so sick of hospitals I just didn't want to be there any more and I went home, which wasn't the right thing to do, so I rang up the next day and asked if I could go to the birthing unit and I ended up there which was really good because I had all the support I needed. I thought I'd have to go out in three days but she said no, I could stay as long as I need to stay, until I'm ready to leave. Jon was allowed to stay. It was really good

actually. And the food was good, better than [Hospital] food. I stayed in there nearly a whole week. You get a lot of help in [rural birthing centre], I really liked it there.

When a woman was looked after in a way that enabled her to focus on the baby, this time was remembered as 'special'. Comments about birthing centre staff contrasted with comments about hospitals, where staff were perceived as impersonal, uninterested, and 'cold'. Hospital hustle and bustle was disturbing when what was craved was peace and quiet. Participants felt that they were taking up space required for the next woman, occupying a bed that staff wanted them to vacate as soon as possible - well before they were ready. It was only Ange's assertiveness, reinforced by her midwife, that made it possible for her to stay in the hospital until she felt strong enough to leave:

Ange I just felt really uneasy leaving the hospital with all these stitches. I told them 'Even if it seems to you I'm fine I'm actually not'. But they asked each day 'Are you ready to go home yet?' Then they said 'If you want to stay on we'll move you to a multiple room'. But the nice thing about being there was being able to focus on myself and the baby. I hadn't ever changed a nappy. I probably would have been very happy to have been there for a week, yeah, just easing into everything. Because I knew as soon as I went home I wouldn't rest as much. Even if they tell you, you know, 'You stay in bed and everyone will do everything for you', welcome to the real world, it's not happening.

Julie I found the nurses quite cold. I buzzed them and said 'There's something wrong with [Baby], he's spilled up mucous all over himself' and I didn't have a change of clothes for him, and all she did was come in, change him and leave. They were kind of uninterested. Except in the morning there was a nice midwife. The night-time ones were very cold. I felt quite scared, to tell you the truth. I found them cold, and I felt really sorry because the girl that shared a room with me, she couldn't get her little baby to stop crying, she'd keep buzzing the nurse and the nurse would go 'Oh, you've got to learn how to do this'. It was very sad. I thought 'I want to go home, I want to go home *now*'.

In birthing centres participants felt genuinely cared for. Anna, who was 16, found the hospital and the birthing centre experience vastly different. In the birthing centre she was able to have members of her whanau with her:

Anna When I was in hospital having Baby they wanted me to stay there but I didn't want to. Yeah. Because we were not allowed to have partners or anybody with us from eight o'clock and I get quite lonely. I went to the birthing unit and I stayed there three days and got used to breastfeeding.

The first few days after childbirth are crucial for learning to breastfeed, which, many participants found 'does *not* come naturally', as Cara said. As well as resulting in women giving up breastfeeding, known to be much the best option for babies, incorrect breastfeeding technique can have injurious consequences for women, examples of which appear in the 'Breastfeeding' section below. Participants found that a few peaceful days in a birthing centre helped get breastfeeding comfortably established before venturing home. There was also time to learn other skills. Tania was one of the lucky ones in this respect.

Tania I stayed at [Hospital] overnight then went to the birthing centre. We did breastfeeding, learning to bath her, which was really good. It was just so helpful. And they were just so nice to me. I almost didn't want to go home. Gary spent all the time at the birthing centre with me. He came up every day and stayed really late. He actually bathed her when we were there. One thing I really wasn't prepared for though, was the breastfeeding, I was there for four days, just for my breastfeeding. I found it really hard. I just had no idea what I was doing. Whenever I needed to feed her I would call a midwife and they were more than happy to help, even all through the night. I don't think you should go straight home. It's just nice to have people around who know what they're doing - and I didn't, I had no idea. It's so traumatizing, like you feel like you've been run over by a bus, twice, everything's sore, it's just so traumatising. There's no point in rushing back home just for the sake of it. It's there and it's available, you might as well make the most of it.

Gary I think that is what the birthing centre does, it does the transition from being a new mum and being naïve to being prepared, feeling confident to look after your own baby. You can control the visitors too. You get so many people wanting to come

and see you. And you don't want to. You want to try and get used to having your new baby. People that want to come and visit you, they think they're helping but they're so not. They're only there to hold the new baby and the whole novelty of it, but they're not actually helping.

Julie, who had her baby at the same hospital as Tania but did not spend any time in a birthing centre, still 'didn't know what to do' when she got home:

Julie I bathed him when I got home. Nobody showed me how. My mum was saying 'I'm not quite sure what to do because when you came home you were two weeks old'. Mum kept ringing my friend, who'd just had a baby, she's got two kids now, and asking her. And [Baby] wouldn't feed. He slept for a really long time. So we rang our midwife. She had had three births the night that [Baby] was born and two the next day so she hadn't slept for however long but she came round anyway. She told me I had to strip him off, it was really hot, and we had to squeeze the milk onto a teaspoon and teaspoon feed him. But it was quite scary because he wouldn't wake up and I didn't know what to do really.

A 'steep learning curve'

Lack of time to learn essential skills for caring for a baby was something that many participants spoke of. Breastfeeding was by far the most challenging of these skills. Celia explained that while in hospital 'there was no continuity of staff, nobody seemed to follow on as far as the practice side of it, the feeding'. Birthing centres gave women a sense of being looked after, of being 'special', and provided helpful coaching, appreciated by participants whatever their age. Although in the first few days men realised that at this stage 'it's all about the woman', it helped them feel 'part of the team' if they were treated respectfully, even more so if they were given some instruction and guided practice in infant care and had time to ask questions. This promoted a sense of self-efficacy and a feeling of being of some use to their baby, and to their partner, a feeling which for some was instigated when they were able to help out in some useful way at the birth. When a woman was in a comfortable birthing centre for a few days both new parents had time to get used to a level of change that they could now understand better. Birthing centres catered for particular needs of participants, for example 'fending off' visitors, which is what some participants wanted, or else welcoming whanau, which others wanted. Although the

neonatal intensive care unit at one hospital provided sensitive support, hospitals seemed to have little flexibility in accommodating new parents, far less meeting particular needs linked to background or circumstances. While neonatal unit staff apparently recognised that parents of babies there would be anxious and so consciously looked after both parents, perhaps it should be recognised that all novice parents are anxious and somewhat bewildered and need a bit of looking after.

Informal support was also important, especially, in the early days at home with the baby, having relatives or friends who were experienced parents available to provide guidance or reassurance or sometimes take action to find a solution to a problem.

‘In the deep end’

Going home with the baby was experienced by most participants as being thrown ‘in the deep end’. A general need for more support than they got is inherent in quotations about the first few days and weeks. For example:

Amy Maybe when you first come home a nurse or someone could come with you, even for a couple of hours. I found that was a bit weird, coming from the birthing unit to here. Some people have their partners around but [Partner] couldn’t stay, he had to go back to work, so he just picked me up, dropped me off, and like ‘Oh my god, there’s not actually anyone here’.

Tania The first couple of weeks I thought ‘Oh my god it would just be so much easier to get up and go to work’. I just thought ‘Where’s the day gone? It’s dinner time and I’ve done nothing’. Even now [three months later] it’s like that sometimes. And then other days I’m just so motivated and I get through the washing and vacuuming, the housework and everything, and then we can go out.

Gary From my point of view there was nothing I could do, I’m pretty much helpless apart from helping change and bath and bits and pieces, it was pretty hard to help out. Tania felt totally responsible for [Baby].

Tania I was just her lifeline. Some days I wanted to get away from her but I couldn’t because Gary was working. A lot of my friends haven’t coped when they got home.

Gary They've foundered because they've gone from hospital and having all these people there straight home to having nothing, partner's gone back to work and they're there all alone, left in the deep end.

Speaking of the first few days, almost all participants expressed some sense of feeling at a complete loss. Formal support from midwives was a stable source of advice and reassurance but was not always available. The relationship with the LMC, still evidently conveying confidence in participants' coping skills, seems to be a type of support that was consistently conducive to fostering participants' resilience. This relationship made it easy for participants to ring midwives for advice and help. The exception that proves this rule was Fay's situation, where her relationship with a trusted midwife was disrupted and she completely lost trust in the replacement.

The demands of baby care on women had not been comprehended by fathers beforehand. Those keen to be a 'hands-on dad' found that this was not actually realistic just then, especially if the woman was breastfeeding. This stage of the baby's continued dependence on the mother has been referred to in popular parenting literature as 'the fourth trimester' (e.g. Einhorn, 2001). Men who talked to me about this ongoing dependence, or whose partners passed on their feelings, would have liked to be warned about it rather than thinking that their active fathering would begin at the big event of the birth. Instead they found themselves still supporting their partners. Although they did so willingly they would have preferred to know that this would be the case.

Many participants received considerable emotional and material support from family and friends. Informal support of this kind, especially when family were staying, was a mixed blessing, being supremely helpful for some, distinctly unhelpful for others, for some a mix of both. Some received reassurance and instruction in infant care from these sources. Some found that people they thought could help were not actually confident about what to do. The mothers of women in the study were often a source of strength but not always a source of practical advice because the methods they had used were different to those that new parents now are advised to use, as Col explains:

Col In general, I suppose you ask your parents for advice. One of the best things was when Cara's parents came and stayed. Because you just don't know. I would imagine it must be really hard if you don't have those supports. It's mainly family really. It's quite funny, my mum got her old Plunket book out, from when I was a baby. And she said sometimes in the afternoon you give a baby water and orange juice, which you don't now, so that's possibly a drawback with parents because they're doing something they did 30 years ago. You learn it on the go. I've always wondered why there's no real good book about it. I suppose every baby's different. I wonder if chucking you in the deep end is the best way to learn. But at the same time, there's no manual.

Practical support in the household was helpful:

Anna When I first came home it was hard, the two hour wakenings were hard. Other family members showed us how to bath her and stuff like that, when we come home. They all came down to the hospital. Then they wanted to stay up here with us for the week. It was good, it was helpful.

Jess Mum just did stuff around the house, like making meals. She didn't really do much with the baby apart from giving him a bath. There wasn't really much help we needed with that, it was more just that it was nice for her to do that, but it was a great help to have her around the house, and the meals and things. It was nice.

Others did not share this experience of live-in family as supportive:

Ange We had family staying from overseas, we didn't have any time to ourselves. That was pretty challenging. I would have liked them to take care of their own lives, be more independent. I kept saying 'Just do everything like you would at home, don't worry about things'. My mum did clean the windows, a bit of cleaning, but she didn't cook or things like that. Or if they prepared lunch they prepared it for themselves because they didn't know whether [Partner] and I wanted to eat - if we were not quite there at that exact minute they wouldn't go out of their way to find out and it's like 'Where's *my* lunch?' I think to a degree they didn't want to interfere, that's what maybe held them back. Everyone burped him, cleaned his nappies and

stuff so I was only on night duty. But it still did my head in. It's like OK, you change his nappy but I'd much rather you went to the supermarket to buy food. Every time I looked in the fridge there was just emptiness. It was the last thing I wanted to do, race out to the supermarket. I was just basically on the jump all the time for the baby and anything else that came in between didn't go down very well. Sometimes [Partner] would make conversation, comments, and I'd just burst into tears and he'd say: 'Why are you so grumpy?' I was very short tempered. I didn't have enough time and space to do what I felt I needed to do. Everyone just kept wanting things from me. The demands were more than I could cope with really.

Cheryl Mum intended to stay but her father was sick. I found my cousin to be more of a hindrance than a help. All she ever wanted was to play with Baby. I would have wanted her to take the household worries off me so I could play with Baby, so I could get to know her. It actually pissed me off a bit cos Mum paid her \$400. It would have been nice if rather than me having to tell her what to do my cousin just looked to see what needed doing.

Looking back, some women realised that they had learned from family members by osmosis:

Clare My mum kind of modelled what to do in the sense that certainly in the early days when I didn't really know what to do she'd come in and just kind of do it, like she'd soothe him. She wouldn't say 'What shall we do Clare?' I think if you're a woman watching your mother do that, you learn.

While some families rallied round new parents, creating a sense of security, Abby and her mother had a major row, of which she offered the following analysis.

Abby She wanted me and [Partner] to break up I think and she wanted me to live there with the baby and I think I would have gone crazy if I lived there. This house was helped by her to get and she even pulled that one on me. 'Oh, I helped you get this house'. Oh my god. She's just gone on about money and everything, whatever money she helped us with. It's just crazy man. So everything she does for me, I have to go 'Oh, cool'. You have to be nice to her one hundred per cent. We're not

talking pots of money here, she just helped us move. She drops in now but she comes with all this crap - and when you turn it down! We've thrown away, oh, crap, stuff she's got at op shops, off the road.

Well-meaning visitors could be experienced as demanding:

Tania I think for me it was just emotionally draining. Like feeding her, I just had no energy whatsoever and all I wanted to do was sleep. And I'd just get to sleep and there would be a knock at the door. And then I'd just get to sleep again and she'd wake up, and I'd think 'Oh would you just shut up'.

Midwives continued to provide highly valued guidance, advice, and information and some emotional support when they visited. The only problem was that they were not always there when needed.

Many men had done what they could to prepare. For example Tom said 'I'd read up about it. I read the books she was reading'. However, Col spoke for many when he said that new parents lack obvious, authoritative, easily accessible sources of information. The books that he and Cara had read had 'been for pregnancy only'. He had himself 'googled things', and they found the magazine 'Little Treasures' helpful. He made a few suggestions about provision of information:

Col It would be good if they said 'Babies will quite possibly do this and this and this, it's quite normal'. That would be reassuring. I guess if you were given a little list or something that would probably be quite helpful, like these are things that you could do. So it's there. Being guys you tend to think of the solution. What probably wouldn't be silly is to have a class before the birth, then a bit of a top up, at six or seven weeks, just one session, you could have a whole lot of questions. It seems weird - I would never say people are hesitant to give advice but it's not like people are totally forthcoming with it. Really you're just craving for any information. You're not necessarily going to react to everything you're told but it's good to have a whole lot of different ideas.

'Where's the manual?'

If new parents are to be in position to develop self-efficacy from the start of their life with a baby they need to be given opportunities to acquire skills. Rather than feeling equipped with skills required most participants spoke as though what they had done was 'muddle through'. However, it appears that at least some of them actually were given information about looking after a baby: several later mentioned that they had been given quantities of pamphlets, which they 'put away in a drawer and forgot about'. For example, Julie said: 'My midwife gave me a bag just full of all these pamphlets. But I only managed to read through it just the other day'. Apparently this means of conveying information did not help much. Wignall (2005: 35) observes that 'ideally new dads would like to have a 'Fathering Manual' that they could refer to when they come across a problem'. This is exactly what Col suggested.

Participants felt more confident when they spent more than a day or two in a maternity facility where they had the opportunity to develop some initial competence in baby care, or when they had helpful family members easily available to advise and reassure. Midwives were helpful but only intermittently available (although clearly doing their best to help, possibly at the cost of putting strain on themselves). Sometimes relatives keen to offer support were unable to help out in ways that were actually useful because they did not know how recommended parenting techniques have changed and so were drawing on out of date information. Since new parents had been provided with only minimal information or training in current infant care, sometimes this did more harm than good by increasing confusion. Wilkins (2006: 175) found that conflicting advice and information overload may 'evoke feelings of panic and helplessness'. A few participants suggested that potential supporters somehow need to be brought up to speed with current infant care practice and how they might help out: 'a pamphlet for grandparents, what they could do to help, what advice is given these days'. This might have averted a few arguments, for example about the best sleeping position. Many participants saw a need for more home visits by midwives or other friendly health professionals or paraprofessionals.

Despite feeling thrown in the deep end, however, there was at least someone to call on when about to sink. Participants aware of the situation for new parents in other countries expressed thankfulness for the New Zealand system. For example, Celia contrasted her own situation with that of a close friend who had recently had a first baby in the US:

Celia In the US it's all very, very technological. There's no personal type of foundation or relationship. It's all just very 'OK you've had the baby, off you go'. And now she's at home with Baby, no-one comes to see her, no-one follows up on her progress, how she's doing with breastfeeding. They told her to 'do this, do that' but there's just nothing else, she has no support.

The question of how to make sure new parents know what they need to know is intriguing. A key problem is when and how to provide this information:

Rae The antenatal classes were good in terms of your pregnancy and labour and all that kind of thing. I guess there could be more of a focus on when you have the baby but I can understand why it's like that because when you're a first time mother you're so focused on what the labour's going to be like, because you don't know. You do think about afterwards, but I can see why they focus on the labour.

Before the birth the focus is on the birth, afterwards new parents are living in a blur of adaptation to broken sleep and fitting the baby's needs into their lives.

First steps on a pathway to family resilience

'You don't know' was a phrase used repeatedly by women and their partners about their experience of the early days of parenthood. The repeated use of this phrase or something similar indicates a striking lack of the information required to develop self-efficacy.

Feelings of utter bewilderment were common when first at home with the baby. Being so unprepared is likely to lead to feelings of helplessness, the antithesis of self-efficacy.

Participants in my study conveyed the strong feeling that 'forewarned is forearmed' - and the equally strong impression that they were singularly lacking in information they needed; authoritative, reliable information is a key issue for adaptation to parenthood.

CHAPTER 8 'THE CONSTANTNESS OF IT': THE FIRST THREE MONTHS

This chapter reports on how participants interviewed when their babies were around three months old were finding life with the baby on a day to day basis, what they found helpful and what they would have liked in terms of support. Difficulties of one kind or another were described by all participants. Some difficulties were almost universal, such as the unexpected 'constantness of it' that gives this chapter its title. Other difficulties were idiosyncratic. Whatever the source of difficulties, ability to resolve them and develop competence and resilience was frequently spoken of in relation to support received⁵⁵, or felt to be lacking.

The chapter begins with some general discussion of the process of adaptation to parenthood and how participants coped. 'The constantness of it' resonates through participants' narratives about this time. This phrase signifies their absorption in an unrelenting new routine marked by chronic tiredness and '24/7' responsibility. This is the theme that emerged most strongly and consistently from the transcripts. Other themes include the uncertainty involved in learning to parent ('You just don't know'); isolation ('Nobody cares what I do with my day'); financial strain ('Reining in spending'); fretting about paid employment ('Out of the haze'); role and relationship change ('A life-changing experience') and concern about being a competent and 'good' parent ('Doing it right'). These themes overlap but are presented under separate headings for clarity. This chapter presents data about one of the two phases that were the focus of second interviews, which took place when babies were around three months old. The other phase, childbirth and the first few days, is reported in Chapter 7.

In these early days some participants had considerable support from family members; some found this a godsend, others found it annoying at times. Some, however, especially those who were immigrants, had no support of this kind. Ecomaps completed during second interviews pointed to different understandings of 'family', from the mother and baby dyad to various configurations of extended family:

⁵⁵ Kim's story, recounted later in this chapter, shows how helpful her midwife's support was in giving her the confidence to get to grips with a problem encountered while living at her partner's mother's home and the effect of this on activating further support from family members, enabling this very young couple to take charge of their situation and resolve a number of problems in a way strongly signaling resilience, as indicated by their constructive response to a later problem, when Jon's contract with his employer was unfairly terminated.

Karen [Baby's] godmother is like family, that's [Partner's] ex-wife actually. We're all fabulously kind of connected. Her and I used to flat together. We see her on a weekly basis because she's very close to [Baby] and has to see him, she has to have her fix. So family happens in a different sort of way.

Transition to motherhood is a challenging process, physically and psychologically, and takes time, as Pridham & Chang (1992: 204) explain:

[Transition to motherhood] is a process of personal and interpersonal change that occurs as a woman assumes material tasks and appraises herself as a mother...This transition continues until infant care and parenting issues no longer seem unfamiliar or predictable. Transition is best studied in a developmentally coherent time period. During the first three months, mutual regulation of biological rhythms is a pervasive developmental task that organizes the major activities of mother and infant.

By the second interview women who were breastfeeding had either adjusted to its demands or given up, often as a result of being beset by painful conditions that are quite common. The effects of pregnancy and lactation on body image and self-concept were a 'shock' for some participants. They had expected to be 'back to normal' after the birth, confirming Mercer's (1995: 112) statement that 'women expect their bodies to quickly resume their prepregnant condition'). In fact motherhood can have a profound effect on the sense of self (The Infant Care Practices Study Team, 1999; Wilkins, 2006).

Julie I was used to doing lots of sport and I assumed that as soon as [Baby] was born I'd be able to do all those things, like go the gym and do all that kind of stuff, but I just couldn't take it, with the sleepless nights. I just can't. I was quite upset about that at first. And I was upset about the stretch marks.

Tania Mum had given me some money for my birthday so I thought 'I'll buy some new clothes'. But my body had changed so much, I was just shocked at how much it had changed. I didn't feel like it was that different but when I tried on clothes, sizes that were one up, they just did not fit. And I was just so sad, I felt so depressed, I

just walked out of the shop and started crying to my mum and said 'I can't believe this' and she said, 'It's only three weeks since you had a baby you know'.

Family members had an important role in providing this kind of down to earth reassurance and advice. Also, networking through family was often how participants, especially young ones, found accommodation and work. Talking about relationships, participants noted shifts in roles and tasks - and that 'society makes it all about the mother'. Several men were disappointed that their role as a 'hands-on dad' was effectively postponed; they found that there was little they could do for the baby straight away. Some had friends who reassured them that this phase would pass. Otherwise men had little chance to process emotional changes they went through. Some said that prospective fathers should be given information about how they might feel and tips about action they could usefully take:

Dean I think that when you do your whole antenatal thing they should get right into the financial aspects, the planning – how to make your house safe, we didn't even know what to buy. And I don't think there is a lot of information about the emotional track, the highs and lows. And I think the other thing too is that a lot of guys I know, my best friend, he stays home and looks after the children, his wife is the executive, she's away two or three nights a week. So there's a classic example of the whole situation changing.

Jack One of the conversations I had with a friend of mine, he did warn me, he found he didn't connect with his little girl straight away, it wasn't until she was a bit older and could start communicating back with him that he started to become involved. And I think that was helpful to know. I mean because as a father you don't have that physical connection like the mother has. Until he started communicating with me a lot more I felt that it was just him and mum, and then me. I did kind of feel a little bit like I wasn't connecting with him like I wanted to, but now he's very interactive, me and him have this special bond that even Fay says that she can't recreate. If there was a group that I could have gone to - I'm sure there is, but it's a matter of finding it. And then also I wasn't in a space where I wanted to be around people. My parents were fairly helpful but there's only so much they could do. I guess I didn't really realise what sort of situation I was in until I'd come through it. I wasn't able to go, 'Wow, man, I'm just not dealing with this, I need to go and talk to someone and

get it off my chest', that was one of the last things. It was just 'I need to get through this. I need to stop [Baby] from crying, I need to be able to deal with Fay and Fay's not well'. You know there were just all these things I've gotta do, I've now gotta get money for the both of us. And there was work I needed to do. I was just dealing with it day by day. It was books and friends mainly that I got my support from.

Ria and Brad discussed this when I visited to interview Brad:

Ria I don't know, I don't think Brad gets any support, as a parent.

Brad Yeah, it's not set up for that. But I get my support. Not really my mum, Mum's more interested in [Baby]. Like when I'm at my friend's [male] we talk about family. And another good friend of mine, always asks 'How's the family, how's [Baby]?' and even him just asking 'How's [Baby]?' kind of makes you go, 'Oh she's good', you talk about it a bit so it's roundabout support. Not direct support but just talking about what it's like to have a family. Blokes usually make jokes about their wife – sorry - but blokes talk about their baby. When I talk to my friends you don't actually talk about what it's like to be a dad, ever. Whereas women would, mums probably would go to coffee groups, say what it's like to be a mum. Whereas guys will be like 'How's the baby?' 'Good, he cried last night'. 'Oh sweet. What did you do?' You know, it's kind of different. I see my friend and we have a little bit more of a heart to heart about what it's like to be a dad. But he's my best mate. He's just great with kids. So yeah, I suppose that's where the support comes from. Just talking about, almost, how cool it is to have a kid, versus the problems of having a kid.

Rae mentioned ways in which new fathers might get this kind of supportive interaction:

Rae I've got some friends, their antenatal class has been good for the fathers, because the women meet for coffee group, and the men meet for beer group. They go out once a week, one evening a week for a beer. And our coffee group decided to have a barbecue on a Saturday because all the dads hadn't met the other babies. So it was quite nice for the dads.

Except for a very few participants who chose to attend counselling either to address relationship issues or past problems, most participants had little opportunity to process relationship change or personal issues concomitant with new roles. Informal support from family sometimes enabled new parents to have time together 'as a couple' and some also occasionally organised this by paying a nanny or babysitter. However, the focus on the baby that characterised the first three months was intensified by how formal support centred on monitoring the baby's health, the primary job of the Well Child provider. In terms of adaptation to a new role, semi-formal support did not appear to function in the way imagined by Brad as a place for women to discuss 'what it's like to be a mum'. Rather a coffee group was just something to do, to 'say hello'. Formal support for dealing with relationship change and developing competence in the family functions of nurturing and self-development is simply not in evidence; formal support concentrates on protecting vulnerable family members, mainly the baby, and on financial assistance. The other two family functions, (self-development; sense of belonging) appear to be outside the scope of formal support.

'The constantness of it'

Surprise was common at how much time it takes to care for one little baby. Tania noted how time seemed to fly:

Tania: I could just sit here all day and play with her sometimes. And then I look and think 'Oh, I'm still in my pyjamas and it's lunchtime'. And if I'm hanging the washing out I've got to come in and see her.

Several participants described their daily routine as 'relentless':

Jess It's very busy. I was prepared for him to be time consuming but I don't think you can actually appreciate until you've got one, the constantness of it. It's more constant than I expected. I think because we're in the position where we don't have any family around it makes it a bit harder because we don't really get a break from it. But I really enjoy looking after him. The day seems to go so quickly.

Roz There's parts of during the day when it's a bit much. I mean it's really nice to feel like you're needed by somebody all the time but sometimes it's just you need a bit

of space. And then when your partner comes home you're kind of 'Get away from me, take the baby and go away'.

The situation of participants living with their own parents was somewhat easier in this respect, although sometimes presenting challenges depending on expectations. Kent and Dawn were living with Kent's mother and younger sister.

Kent They don't overhelp, like if they know we're OK they won't bother. If we say we need help they lend a hand. If we say no they just give us our own space.

Dawn They always offer. Sometimes Kent's mum, if she knows we're tired, she'll get up in the morning and feed [Baby]. If we want to go out for a smoke they'll look after her.

Leah and her partner were living with Leah's family:

Leah Mum and Dad are happy to have us here. [Baby's] the centre of everyone's world. There is an overload, like you get so much help, especially from your family, but in terms of giving back we all sort of chip in and muck in. I mean they want to help, they want to be involved in her upbringing, so even if we didn't want them to help they would.

Lucy, aged 16, was living with her parents. Her baby's father, aged 15, lived nearby with his mother but spent a lot of time with Lucy, who had primary responsibility for the baby:

Lucy Mum tries to help but I just want to be able to ask for help, like she sort of tells me I need it. She's like 'Oh, give me [Baby] so you can have a rest'. I'd like to ask her if she could take him for a while so I could have a rest. I probably *do* need a rest but it just annoys me that she tells me that I need help. I'd just like to be able to ask her for help instead of being told sort of thing. I know she's only trying to help but it just annoys me.

Kim, living with her partner's mother and sister, faced an awkward situation and found her midwife's support invaluable; taking the midwife's advice put her in a frame of mind where

she was able to deal with the problem. Generally, like other younger participants, Kim thought that young people have no idea what having a baby means:

Kim When we were living with his mum it got to the point we actually were rowing. I felt I couldn't talk to his mum, she didn't understand me at that time. Just being around his family too much, I felt like I was suffocating. I was missing my family. You know, 'I want my mum and dad, I want my family to talk to'. Because I couldn't talk to my family I turned to my midwife. She listened, she didn't butt in. She listened first, then she gave me advice. She didn't pressure me or try to force me, either I took her advice or I didn't, it was up to me, she left it me. I said 'What would she do?' She said 'I'd have break'. So I went to my family for a week – which [Partner] didn't agree with - but I said 'I need my space, I'm sick of your family. I don't want to lose my temper, I don't want to say anything I will regret'. I stayed with my mum and dad for a week, that's what I needed. When we were with his mum I think he just relied on his mum and sister too much, he didn't have to be at home to help me because his mum was there. And that got me down quite a bit cos I had to rely on her. Then she said to me 'I'm not being mean or anything but I think you both need to move out' and I was just like 'Oh my God, that's exactly what I was thinking'. She wasn't being stink by booting us out or anything but she saw the dependence on her and she didn't want that. It was really good, me and her had a talk and then we brought [Partner] in and had a bit of a talk. He wasn't very happy, I think he felt we were ganging up on him. But I talked to him by myself, I said 'We're not ganging up on you or anything, it's just, you know, you're relying on your mum'. But it worked out good in the end, me and him went out looking for places and he rang his dad and it was his dad that found the lady that owns this house and got us to rent it and it's been good...I don't regret having him, but you realise how much you're missing out on, like you don't get work experience, you don't get that independence where you just go somewhere without no worries, or go to a friend's house and stay out late. I think that's why you should wait. That way by the time you're 21 you could be saving up for a house, or a car or something like that, anything. I don't regret having him at my age, or anything that I've been through with him, but I think young people should wait. If I was to give advice to a young couple that said 'We're thinking of having a baby, what do you think?' I'd say to them 'No, I don't think you should have a baby, it's a great gift, it's just wonderful, it changes your whole world,

but I think you should wait'. Because then you can get everything before your baby out of your way that you want to do then just relax the rest of the way, have a kid then and not have to worry about what you missed out on.

In this set of interviews it became obvious that in fact participants in general had previously had little idea of what life with a baby normally involves. Jan did not at first realise that what she was going through was unusual, so did not seek help:

Jan It was hours to settle him, between five and nine kind of thing. And cat-napping, only 40 minutes during the day, feeding every hour and a half. The best way I can describe what I felt in those eight weeks was it was unrelenting. Enjoyable too but not like when he started to get older and more settled and interact with you, you sort of felt he was becoming a little person and appreciating what you were doing rather than you just being on autopilot and never having any time for yourself. It was just take, take, take kind of thing. There were times when we tried to let him cry but we couldn't sit through it for more than 15 minutes. There was a difference between him just crying and a point when he was absolutely beside himself. To me he was getting so worked up that he just wouldn't sleep so I'd go in then. There were times when I had to leave him to cry for a while because I was getting so frustrated and angry - which surprised me, I didn't think I'd ever - I thought I'd understand that he was just upset. But I got frustrated - sometimes his eyes would just be closing, he'd be peaceful, I'd think 'Well done' - then he'd go again. The housework just didn't get done. [Partner] would come home and find the floor half mopped or I'd tried to bake some cookies, they were half done. He didn't care, it was quite funny. I was a bit frustrated but I realised there was nothing I could do about it. I couldn't cook dinners. He would have to come home from work and cook. There were times when we didn't really eat dinner together, we'd have to do it in shifts, one of us would be rocking [Baby], keeping him occupied. My friends had talked to me about the witching hour, we just figured it was normal. It didn't cross my mind to call Plunket, I just thought it was one of those things. They did come, I can't remember now, at the usual times, six, eight weeks. I think I would have talked to her about it. It's a blur. I never went to the Family Centre where I've heard you can spend the day and they try and work out what might help. I would think that taking him to a Centre would be totally different for him so he probably

wouldn't do what he does at home. So I never pursued going there to help with sleeping but I think if a Plunket person could come to you, be here and actually see what he's like in his own environment and potentially talk you through, OK, he's doing this, and just give you some suggestions.

As in a UK study of antenatal education (Cliff & Deery, 2000: 142) participants found that classes had 'not prepared them for the emotional and psychological aspects of first time motherhood'. Reviewing nine qualitative studies, Nelson (2003: 476) concludes that 'a proactive, honest, reality-based approach aimed at altering maternal expectations of the postpartum could be directed at counteracting the feelings of inadequacy often experienced by new mothers'. It is this kind of 'reality-based' approach that is required if strategies for resilience promotion are to have any real hope of success. Insufficient understanding of the realities of life with a baby will quite likely make new parents feel that difficulties normally encountered are in fact particular to them; that they are not coping as well as others. Feeling like a failure is counterproductive to resilience and may become a contributing factor to a chain of risk. If it seems that everyone else easily adapts to life with a baby, problems can be seen as failure and families may disguise their difficulties. A story Tania told provides an example:

Tania A lot of people won't say what's going on, like a friend of mine with a six week old boy, she came across really confident, doing really well, and 'Oh I can't see you today because I'm busy' or 'I've got to go out'. But when we actually stopped in to see them for the first time, the dad, he was up, the mum was still in bed. And basically, just from the comments he was making, she's not coping. Just trying to put this whole big façade up, that everything's OK. It's like everyone always carries on as normal but behind closed doors it's not actually OK. She couldn't even get out of bed, she was just so tired. She'd told him if he left the house that day then don't bother coming back. Because he'd been away, fishing or something. You want to try and help them, but they don't want it. She wasn't interested.

Ideally, fathers as well as mothers would be prepared for the emotional and psychological aspects of adaptation to parenthood. The topic of parenting education in schools was raised. Some thought, like Amy, that 'classes in schools wouldn't go down too well'; that

young people would 'take no notice'. Others thought school a 'sensible' setting for education about parenthood, especially if linked to contraceptive advice:

Abby Send young mums into schools, that would actually be quite sensible, it would be quite cool. Because young people think we keep nagging about contraception. Then they're like 'Oh yay, you're having a baby', you know, all that sort of stuff, but it's not like that, your life changes dramatically, man. You can't have the same friends you did have if you're doing drugs, you know, you can't have them, you've got to be a role model for your little one. It's a 24/7 job.

Kent They should teach it in schools, for sure. I mean it's hard, coming from a freedom life to having a baby. You're responsible. Some people think it's quite easy. It's not.

When talking about the first few weeks it was common for participants to say something along the lines of what Cara said: 'I didn't want to really leave the house. It was a major for me to take the baby out'. Shopping was unexpectedly problematic.

Karen I took him shopping once and look, they couldn't get me out of that supermarket fast enough. I didn't know how to strap him into the trolley - with the car seats you can stick them in the trolley if you've got the right kind of car seat but I didn't know how to do that so I didn't know what to do with him. He was too little to put in those hard toddler seats so I stuck him *in* the trolley with all the groceries. And some kind lady came up and said 'Do you know that you can just hook those straps over?' which was terribly kind of her. Somebody had to carry my groceries out and pack them in my car because he just went *nuts* because it was too stimulating - loud, cold, bright, it's awful. He's fine now. I don't know how people do it. I guess a lot of husbands shop in the evening now that supermarkets are open. The thought of *having* to go to the supermarket – I wouldn't like that.

Broken sleep meant feeling constantly being on duty. Participants gradually tuned into the baby's sleep and feeding patterns but for those breastfeeding especially this could be, as Celia said, 'pretty tiring', or as Cara said, 'really full on, *really* full on, especially the lack of sleep'. Enough sleep made other adjustments easier, but worry was nonetheless common:

Zoe I have to admit that sometimes it's been hard. Sometimes it's been hard, sometimes it's been easy, but I suppose that's just being a mother and learning new things. Lack of sleep, that's the main thing. What I always do now is every morning he's up for an hour then he goes for a morning nap and I try to get him down for an afternoon nap, and now he knows. I don't mind six a.m. as long as I've had a good eight hours sleep.

Leah I had to adjust to the sleep deprivation. It's the unknown that's stressful I suppose, like when she's crying and I don't know why I always worry that something's wrong with her and I think 'Do I ring, is it serious enough to ring someone or not?'

Julie [Partner] rang Plunketline one day. [Partner] takes him to the doctor all the time. I don't know how many times he's taken him to the doctor because he was rubbing his ear.

The narratives suggest that participants were unprepared for the '24/7 job' of caring for a baby. Few were forewarned by watching relatives or peers go through this phase, as might have happened if families lived in closer proximity to relatives or in a neighbourhood like the Pakuranga of the seventies (Park, 1982) where new parents were surrounded by peers who acted as role models and had a range of supports available if they encountered particularly hard times. Rather, most got through by drawing on personal resources. Younger participants had family on hand to help, as did some others, but some had little support of any kind. Any pre-birth advice about adapting to life with the baby was either so minimal it was of little help or had not been absorbed; current formal support was 'more about the baby'. As discussed below, participants found that Well Child services were exactly that, 'just for weighing and measuring, that kind of thing', much less interested in parents' needs than LMCs had been. Jan's narrative (this section, above) illustrates how she and her partner used humour and 'teamwork' to get through what was a very difficult time indeed, 'a blur', when Jan was exhausted and her ability to reach out for help was compromised. Jan's partner willingly and effectively stepped in, did what he could and helped her maintain her equilibrium, so that it is quite possible that the resilience of this particular family was strengthened by going through this difficult time. Jan's story eventually had a happy ending as her sleepless, distraught infant turned out to be an active, sociable, inquisitive child, so that at one year old he 'loved daycare' and she could

work part-time with no qualms. However, it is easy to see how powerless new parents might feel in this situation, how frustration and exhaustion could manifest as anger against a partner or a baby. Jan's suggestion of a 'Plunket person' spending time with the family in the home is noteworthy. Even if a baby's problems are physiological and little can be done, at least families would feel that they were doing all they could, and their efforts recognised, instead of feeling powerless.

'You just don't know'

In the first six weeks midwives were a vital source of support, especially advice when worried. The close relationship with a midwife was missed when responsibility for monitoring the baby's progress was handed over to a Plunket nurse, perceived as 'there for the baby'. Amy spoke for many: 'Suddenly you go from having this midwife really focused on you to no-one. I felt that a bit'. According to Dawn's ex-partner's mother (whom I talked with when the baby was a year old after Dawn had left her partner and baby) 'Dawn really missed her midwife' when she stopped visiting and never fully engaged with Plunket. Plunket was the only Well Child provider mentioned. Some Plunket nurses were 'fantastic'; others 'useless' or 'rigid':

Fay I didn't agree with the Plunket philosophy, it was really undermining of what I was doing. So the next time [the nurse visited] I told her 'Nine o'clock he feeds, 12 o'clock he feeds. I just lied to her. She said: 'Is he sleeping through the night?' and I said 'Perfect' and she said 'I love it when parents listen'.

Several said that rather than consulting Plunket they would 'go to family first':

Tania My family are just always there if I have a question. I can ring them up and ask them, especially my sister, she's got three, all under five, so she knows the most what's good and what's not these days. I think the hardest part is you just don't know, just little things. Like when [Baby] started just spitting and blowing bubbles. And I thought 'There's something wrong, is that normal?' So I rang my sister and said 'There must be something wrong, she's frothing at the mouth and blowing bubbles', and my sister said - well, at first she said 'She's got rabies, take her to the doctor' - but then she said 'I'm just joking, she's found her tongue, they do that'.

Beth If I start to lose the plot I just get on the phone to Mum. Doesn't matter if it's three o'clock in the morning - not that I'd ring her then but she'd be here in a flash. I'll ring her up and say 'Is this normal? Is she being a pain in the bum, or is she just being normal?' If I get angry with her or something.

Julie She's available any time, I don't feel bad about ringing her up at twelve o'clock and going '[Baby's] not going to sleep'. She gives suggestions. I remember [Baby] just wouldn't stop crying and Mum just said 'Try and sing to him'. And we sang to him for about a minute and he just went to sleep.

Plunketline and Healthline were often a first port of call:

Clare They were good, but I think they sit there with screens in front of them and they enter in symptoms or whatever's going on and you don't really feel that you're talking to anyone who's got any real experience of it if it's not medical, if you want ideas about how to get them to sleep a bit longer or something like that.

For those who lived near a Plunket Family Centre this was a much appreciated source of support, information and guidance. For Rae, it was the key factor in her baby getting the medical attention he needed:

Rae The Plunket Family Centre is just round the corner. My midwife recommended it so I went quite early on, at first because they have a sleeping video you can watch. Then they started helping me with the feeding for him. They're the ones that were the most helpful when we were starting to sort out what was wrong with him and no-one really knew. We'd seen paediatricians and they said no problem and that was quite frustrating because we knew there was something wrong, we just didn't know what it was. He got quite sick one day and the nurse round there, she's been very good, she said take him to Starship. They were genuinely concerned. It wasn't until after he was much better that one of the nurses said to me 'We've all been very worried about [Baby], we've all had sleepless nights over him'. I was going round there every week, a couple of times a week sometimes, and they were great. It was just so handy. I still go and see them once a week just to get him weighed. We spent five weeks trying to work out what was wrong with him. He was never

really unhappy, he'd always smile at you and laugh so I was never really worried. I'd seen a couple of paediatricians and they'd said 'It's fine, there's a lot of babies that do this and suddenly they just come right'. So you kind of just think, well, one day that will happen. But it never happened. They did tests and things to check it wasn't anything obvious. It was a bit stressful when he was in hospital and they were doing tests for brain tumours and things like that. It could easily have been a major. The time to wait for the diagnosis was frustrating when we were in hospital. They said he's going to have a CAT scan so we couldn't feed him for four hours beforehand so that was quite stressful because he woke up and he was hungry, he was just screaming, you couldn't do anything. Then it got cancelled. Then the next day they said the same, so we went through the same thing again and it got cancelled. That got really frustrating. And then we didn't get the results for a long time. We were just waiting. The whole time we were there we were just waiting for results. I don't know, there seemed to be a lack of communication a lot of the time, between the staff, and that got very frustrating because no-one seemed to know what was going on. And so we just ended up waiting round, didn't we [Baby]? We didn't get the results for several weeks. There was only one neurological radiologist or whatever and we had to wait for them to have a look. It was quite nice when we found out that there actually was something, a bit of a relief really. The Plunket Centre was good. They cared. It wasn't just like we were the next case - we were Rae and [Baby] and they were genuinely interested in his welfare.

It was perhaps the more relaxed atmosphere that enabled Family Centre staff to get to know Rae and pick up the fact that there really was something wrong with her baby.

Family Centres were several times compared favourably to other Plunket services:

Clare You can go and have a snooze, they're lovely, very practical, very non-judgemental, they're lovely, lovely, I feel I should have used them more actually. But the nurse who visits, she's six months away from retiring, she gives quite out of date advice, she's very much 'you must do this, you must do that'.

Cara I went to the Plunket Family Centre for a day. [Midwife] put me on to it. You could spend the whole day there. I learned about sleeping patterns. I didn't really know the importance of babies having regular sleep. There were three of us and one

nurse. You can relax there. And just ask questions throughout the day. Nice. Because often when you have your Plunket session they operate on quite a tight schedule and often you go there and you leave and you think 'Oh I didn't ask this or this'. At the Centre you've got the whole day.

The drop-in aspect of Family Centres made it easier for busy fathers to go there. In one rural area the birthing centre provided similar ongoing formal support in an informal style.

Ria I bumped into [midwife] in the supermarket last week - they give you a bit of free advice there, asking you about this and that - in the middle of the supermarket! 'You must visit', they're always saying, 'Come in, come in'.

Twice the handover from midwife to Plunket did not happen as it is supposed to:

Julie It's actually quite awful, my midwife didn't refer me to Plunket. So I didn't know what you kind of did. I rang the clinic up the road and it was always the answer machine, she's obviously not there all the time, the Plunket nurse. I thought 'Oh OK, well maybe that's what you do, leave a message'. Well I didn't know what to do so I just took [Baby] to the GP I go to. I was having trouble with him sleeping and I thought I wonder if she knows what to do, she was kind of the first person I thought of. So she organised Plunket for me. So I didn't have any of that Plunket contact when [Baby] was a newborn. I don't even know what's supposed to happen because it never happened to me. The midwife said 'You're going to go to Plunket aren't you?' and I said 'Yes' and that was kind of all that was ever said. Maybe the midwife should be a bit more onto it with that. A check after a month? A call to see how you're going, how's Plunket going? Because it is quite weird that someone you've kind of seen every day and that you've been through something so important with, all of a sudden they're gone. It's like 'Oh that's right, I was just another person'. Now I go to Plunket for checkups at the dates in the book. Sometimes it feels rushed. By the time she's checked him and weighed him and talked about his things it's kind of like 'OK then' and the next family comes in.

Jess I had some issues with the transition between my midwife and Plunket. I seem to have got left out of the loop. So I kind of floundered for a little while. There were

things that I was worrying about and I was phoning my midwife and the midwife was like 'Look, that's an issue for Plunket' but I hadn't heard from Plunket so I didn't actually know where to go. And then even when the Plunket nurse came to the house, I didn't really know about the Family Centre and the fact that I could go and just drop in. I actually didn't know what Plunket was about and what the service was – that might be because I'm not Kiwi and I've not been brought up with Plunket. Maybe people assume you know. I just didn't realise that the support was really there. It took a few phone calls because then whenever I spoke to someone it was obviously a receptionist and she would say all the nurses are out on lunch or something. But I just kept phoning them.

Down to earth informal support in the form of practical assistance and reassurance was a boon at in the first three months, whether minding the baby so new parents could shop unencumbered, babysitting so they could go out as a couple or helping out in other ways. Some participants were in a position to pay for such help. Clare had found a nanny who could look after the baby a couple of nights a month so she and her husband could go out. What seemed to be most appreciated here was flexibility. However, empathy expressed in practical ways was also important. When Beth moved to a new house it was not just the practical support that Beth valued, but the way her family had thought about what would be most helpful to her and smoothed her way:

Beth [Baby] was six weeks old when we shifted and I thought it was gonna be an absolute nightmare, and you know it was a bit, but as I was cleaning out the last house I didn't realise my sister was here unpacking everything. That afternoon we came in and our whole bedroom was done up, the kitchen was unpacked, and Mum had cooked us a stew.

Tania's description of her aunt's composed assistance apparently triggered thoughts of other support she valued from her mother. This was a form of 'appraisal support' (Warren, 2005):⁵⁶

Tania There were a couple of nights when she was having a growth spurt that I could have just given her away. She just cried and cried. Every time I put her down she'd

⁵⁶ See Chapter 4.

scream and I'd pick her up and think 'Oh I've got things to do I can't hold you all the time'. It was such a good help during the day to ring my auntie and say 'Could you please come and watch her? I'm so tired I'm a zombie'. I could go to the end of the house and have a good sleep without being disturbed. My auntie, she comes round, she offers to do all the housework, which I've usually mostly done. She's not full on and in your face so it's really good, but I know that if I really do need her I can just ring and ask her. My mum said to me yesterday actually, she said 'You know, I was a bit concerned when you were pregnant cos I thought 'Oh no, how will you cope?' But I'm really amazed at how well you're doing, and I'm just so proud'. It made me feel really good. She said 'You might think I'm being stupid but I might as well tell you'. It was really nice to hear that. She thought I'd have to ring her all the time and ask for help and she was just amazed that I just took to it so well.

Celia also received appraisal support from her mother, as well as advice, though it was long distance:

Celia Mum's overseas but she's on tap. She wants me to get a webcam. She's like 'How's my little angel doing?' and she'll give advice and also validate what I've already done. Making me feel I'm on the right track.

However, receiving appraisal support did not appear to be the norm:

Ria One thing I find is that everybody criticises you, nobody tells you you're doing well. Like I'm doing *everything* wrong, particularly with attached parenting - you know, 'You'll spoil her, she'll never get in a routine, you're cuddling her too much', and then they say stuff like 'You're really lucky, you've got an angel of a baby'. I find that the mothers from that next generation that are supportive confess that they did it too, my mum did, they just lied to their Plunket nurse, 'Oh yes we're leaving her crying to make her sleep - like, not!' When I say everyone's critical, there are a few close people that are positive, like a friend of mine the other day, she's never actually said anything positive until she said 'Did you know that you'd be so good at it?' So I said 'You're saying I'm good at it?' The midwives and the Plunket nurse, those are the only people that say it, and the friend the other day accidentally. My girlfriend, who's a bit younger and has a new baby, I was with her the other day,

I'm just loading her with praise, because I know how I'm missing it and how I'm worth it. You see I'm good at my job, I'm used to being told that.

A striking finding of this study is the paucity of formal support and authoritative information available to families with a first baby. Furthermore, the impression created by participants' narratives is that the formal support they got was hit and miss – some were lucky enough to benefit from sensitive, responsive support that was the crucial factor in enabling them to resolve a problem (examples being support that Kim received from her midwife and Rae through a Plunket Family Centre) but others 'got left out of the loop' altogether.

Relationships established between participants and LMC midwives appear to be conducive to participants' seeking support. It was Kim's midwife's willingness to take time to actively listen and understand that enabled her to advise Kim wisely. When 'handed over' many participants missed the personal, authoritative, easily available support that LMC midwives evidently provide. Plunket visits did not replace this, probably because of restrictions on nurses' time, but perhaps also because the Plunket nurse image has an 'expert' dimension which some nurses emphasised in preference to acting as consultants to new parents and offering options; a practice shown in the literature to not only reinforce self-efficacy but also to establish willingness to make good use of available support.

Because they had practically no opportunity to develop parental self-efficacy before being confronted with the reality of responsibilities of parenthood most participants felt ill-equipped and often at 'at sea' and 'at a loss'. Interestingly, younger participants were less likely to feel like this, tending rather to take the new situation in their stride. I suspect there are a combination of reasons for this, including not having the kind of idealised notions expressed by older participants; fretting less about being a 'perfect mother'; and feeling that the parent role enhanced rather than diminished their status. New parents who do not have access to informal support from knowledgeable family members or peers, or access to a friendly Plunket Family Centre, carry all the responsibility themselves. Telephone health lines provide quick access to advice when worried but cannot provide the personal support wished for, and certainly cannot act as role models. Looking at this situation from the downside of resilience, as it were, this establishes conditions for a chain of risk, with no-one on hand to notice, far less intervene. This is a concern inherent in a third theme in this set of interviews, that of isolation.

'Nobody cares what I do with my day'

Most of the women interviewed spent a lot of time alone with the baby. For example:

Julie: Occasionally I spend the day without seeing Mum or anyone and I'm kind of 'Oh, this isn't very fun' [sic] so I plan something.

In nuclear households with a new baby, social isolation and loneliness have long been common (Rankin, 1988; Mercer, 1995) but now that more mothers of young children work full time it is even harder for new mothers to find congenial company in the daytime (Harvey, 2007). This is perhaps a self-perpetuating phenomenon; if lonely and bored, women may return to work earlier than they otherwise would have, then there is one less new mother for others to interact with. Women interviewed were very aware of potential isolation:

Clare The lack of getting out and about and doing what I want to do for myself I've found quite difficult. I don't know whether it's isolation or being on your own with the baby. Especially when he was about two or three months old I'd get up in the morning and think 'What am I going to do with my day? Nobody cares what I do with my day'. When you work in an office you have somewhere to turn up to every day, you have meetings, people to meet, places to go. That kind of suddenly stopped and I found that really hard.

Cara Even when [Husband] goes away for a whole day and I'm here by myself, the thought of that every day, just myself and Bubs, would drive me mad. It makes me realise how good it is having someone to talk to, knowing that you've got that bit of support if you suddenly have to go and do something. It makes me realise how much of an achievement it is to be raising children on your own. Even being at home by yourself all day must be hard.

Isolation was felt poignantly by two participants from overseas. Jess, who had visited her family overseas, now knew what she was missing. Fay was homesick and had found herself pondering what home meant to her:

Jess When we went home I was able to leave [Baby] with my mum and pop out to the shops. I was like 'Oh, I couldn't just leave him here, could I?' And they were like 'Please do, please do'. It hadn't actually even occurred to me that I could do that. And that was just nice because I literally only had a couple of things to do, but to take him it's like you have to make sure you've got everything ready, get the pram or whatever and go, and then you've got to unload the pram, get him in. I mean, he's not an inconvenience, but you know, just the convenience of having someone, when you know you're only going for a couple of things. And we went out a couple of nights, my mum and dad babysat, and he was fine. We knew he'd be fine. My mum sent me a text to say 'He's fine, don't worry'. I speak to my parents and my brother on the phone and my husband's sister - they're not physically here but I still find it supportive. I can email my mum, even if I've got a moan or something.

Fay Because I know I'm going back home I'm not searching for support here. People I've got history with, that I don't have to start from the beginning with, people that you've known for years, they can look at you and know how you're feeling without you having to say, you can be absolutely yourself - that's what I've been missing. It's been hard because I think pregnancy and childbirth is the one time when you need to be fully yourself and express yourself. Things would have definitely been easier for me if I had had that familiar support. It's a connection to me, whereas you can quite easily get lost because you give yourself so totally to your child, which, you know, you need to, but also you need to retain yourself. I thought of that when I was putting the washing out.

During a later interview Fay explained that support from family was indeed what she needed:

Fay I had a conversation with my brother on the phone and I was in tears. I'd never felt particularly close to him but he just said all the things that made me feel better. I wasn't expecting it to come from him. He lent me the fare to go home. With hindsight, I would have done things very differently, I would have gone home to have [Baby]. Just for the familiarity. A big thing was the respect, there was a lot of respect for the way that I wanted to look after [Baby]. My brother's living with my mum at the moment. I'd get up in the morning and he'd be getting ready for work

and he'd play with [Baby] straight away so I could get his bottle. I could relax because I knew when I needed to be busy doing things [Baby] was well taken care of. My brother took him for walks. By the time I left he was going on days out with my brother or my mum. And I wasn't worried. It was all very fluid. Because we were all living in the house together that allowed a close relationship to establish, they saw every side of him, it allowed that trust to build up. It was exactly what I needed.

Groups for new mothers, usually 'coffee groups' organised through antenatal groups or sometimes Plunket, were a way for some women to find company, such as Ria who found her group 'great, an opportunity to ask a few questions because they've all got older children'. However, finding friendship this way was rare. Fay tried a La Leche breastfeeding support group but found it too 'middle class' and decided 'I don't think this is for me really'. Ange joined a coffee group organised by 'a local mum' but found that of the 10 women there 'literally every single one in the group, I would never otherwise meet, ever, in my life. It's a forced situation' and so attended only occasionally 'just to say hello'. She contrasted this with ongoing friendship with a couple met at her antenatal class, where over several weeks people had 'got to know each other a little bit' in a more natural way. However, not everyone even had easy access to a coffee group:

Julie The antenatal class have a coffee group and I was invited but it's miles away so I just thought there's no point. There's a Plunket one as well, but I missed out on that too because I missed out on Plunket. I think there are probably things out there, systems out there, but I just kind of slipped through the Plunket ones.

Zoe They were going to start up a young mums' group up here but it's never happened. And it should really because there are a lot of young mums out there that do get quite depressed, that need to get out of the house. I see a lot of young mums with babies, and there's nothing really for them, no. I would go if there was one, I would go and have a look, just for the sake of [Baby] as well. It could explain a lot of information, what help we can get. Like financial and stuff, what financial help we can we get. Just stuff like that. Speakers that come in. For first time mums that don't know what to do, how to hold babies and bath them, practical stuff.

For some participants the effort to go out seemed hardly worth it, although being invited by someone who was showing an interest was a motivating factor

Karen If I hadn't had [Partner] at home, I probably would have been more motivated to get out and join a new mothers group. I had an aversion to leaving the property for a while. I think it would have been good if there had been a structure in place for our antenatal group to keep meeting because it would have made us do it. It tends to be something that drops off the radar. Two women in my Pilates group who have children, one of them's got twins for goodness sake, toddlers, and a new baby, and she managed to get to Pilates at three months. Well I'm sorry, I didn't. I only had one baby and I couldn't *imagine* how anyone could get to Pilates at 9.30 on a Friday morning. But my teacher kept ringing to see how I was - not to get me to come back, she just really wanted to know how I was getting on. Last Friday I thought 'Well, I'll go and see them, why am I thinking I can't? It'll be the best thing for me, to get there'. You would only need a sliver of depression or sleep deprivation and you wouldn't be motivated to do that. I haven't suffered either and I still haven't been motivated. The self-motivated thing's quite hard, especially if you're trying to fit in three loads of washing.

There were few avenues for developing any sense of collegiality as a parent or even for finding companionship. For example, the 'young mums' group' to which Zoe looked forward never eventuated. Viewing parenting as directly comparable to other work, a phenomenon documented by Park (1982) in Pakuranga, is evidently no longer current. New mothers are no longer surrounded by others viewed as colleagues. It may be that a sense of mothering as important work has been eroded. For women interviewed, opportunities to pick up information and acquire parental self-efficacy by learning from peers or others who might act as mentors or role models were limited, or in effect nonexistent. With fewer mothers around to interact with, the informal learning opportunities observed by Park, including role-modeling and coaching, are no longer available to most women. The only reported example of a coffee group functioning in this way was Ria's rural Plunket group, which gave her access to women of whom she 'could ask a few questions'; normally, however, coffee groups are composed of first time mothers who are all new to parenting. The upshot is that parenthood is now a private matter. Very little was available to participants to increase their parenting competence or counteract isolation, a

somewhat worrying finding as isolation may exacerbate any depressive tendencies (Cade, 2005). It may be that formal or semi-formal support could somehow fill this gap.

‘Reining in spending’

Many participants worried about money. While comparatively well off, those on incomes above the threshold for Working For Families usually had high outgoings:

Jess We spent money probably a bit frivolously, when we wanted something we bought it - and then having [Baby], and all the things that go along with having him, cots and prams. Ideally I would like to own our own home. We are getting there, but it’s slowly but surely rather than fast.

Rae It has been a challenge going onto one income. We’ve had to rein in [Partner’s] spending a lot. Before we had to be careful but if we wanted to go out for a meal or something like that it wasn’t a problem. But now we don’t do that, we have to think about where we’re spending our money. We could spend it all quite easily.

For those who were eligible, Parental Leave was a godsend:

Cheryl The money at the moment I’m trying not to focus on. I’m a bit scared of all that, but at the moment I’m just trying to not think. Until the Maternity Leave finishes we’re all right. And then we’ll go and see what has to be done. If I knew my mortgage was going to be paid, every month – I mean I know it’s going to be paid, but at the moment it’s my Maternity Leave paying that. So once that’s gone I’m going to have to take another \$600 a month out of my husband’s wages.

Financial support

Working For Families was helpful but some were loathe to apply or had difficulty applying. For example, since Jack was self-employed, Fay and Jack needed financial records to prove eligibility. A friend had offered to do Jack’s accounts but their completion was held up for some reason. For most participants coping financially required careful budgeting. Many received material support in some way from family, as Leah did. Karen’s approach was unusual in that she did not even investigate state support, but other couples chose to relinquish income for the sake of time with the baby:

Leah I have to really budget. We're on family assistance now. It's all based on the partner's salary and he recently got a raise so it's going to come down a wee bit - but that's OK. I guess it would have been harder, but being at home with Mum and Dad we're saving a lot of money. Like right now we're saving up so we can get a place of our own so Mum and Dad's support is really helpful.

Karen We've been absolutely broke, that's been one of our stresses. I was the major wage earner. So that has been difficult. But when you're at home with a baby you don't really spend much. I haven't even looked at what I'm entitled to Benefit wise, we just didn't want to go there really. I did get Parental Leave for about three months - longer would have been super. I've chosen not to go back to work, I've got a year's maternity leave and I probably won't go back to what I was doing. In many people's terms we've gone down a bad financial track - we had money available in a flexible mortgage account and we've just used it. I don't know how any mother would be ready to go back to work at three months, you're only just coming out of the haze, really, you *are* in a haze, those three months, it's such a huge adjustment phase. I personally couldn't leave my baby, but I would say, only maybe at five months it might be physically, mentally, emotionally healthy. You've just got a handle on your household, you've got a handle on your emotions again. I think your hormones have settled down by that stage. You feel more yourself.

Women on DPB found WINZ staff helpful. Maya, for example, said 'WINZ have been good to me'. This support was essential when she had to evade her threatening ex-partner.

Zoe I budget really carefully. We get Family Assistance now. The thing that I hate is that some people just scam the system and that's wrong because then we all miss out. And we should be told what we're entitled to, not kept a secret. I absolutely loved the WINZ office I used to go to. The lady that I had was really cool. She just told me what I was entitled to.

Dee I went in there and saw if I was entitled to anything. I actually already had a case manager. When I first had [Baby] I thought she'll be a bit horrible and that, cos every time she's been on the reception desk and I've gone in, me and her always

sort of argued. But she actually was quite nice, sort of asked me how often I work and I said I only do like one day a week, one day in three weeks or something. She was quite understanding and said 'How come you don't work more?' and I said 'Well, when I'm at work I miss [Baby]. The first year, all her milestones'. So she wrote down on the computer, 'Finding it hard to be a full-time mum and work'.

Two fathers were made redundant, causing huge stress due to the weight of responsibility each felt for providing for his partner and baby. Men felt pressure to work long hours, constraining time with the baby. Work/life balance was already an issue, especially when one or both partners were self-employed:

Ria Today I'm on the phone making sales calls with her in the front pack. If I work the pay for one day equals three days of his part time job. So the deal is, look at it as a family unit, cut down the part-time time. I did my first two days two weeks ago. He looked after her, he can do it because it pays for six days of his working. That's what we're moving to. But we're in this time of getting enough lined up because we're both self-employed, it's never exactly guaranteed. We were going to look at whacking a bit on the mortgage. I'm like: 'Oh, we've got to build a balcony once she walks, let's use that maternity money', and [Partner] who used to be crap with money and illogical is now being the sane rational one, he says 'No, let's put that in the bank. If we need to we'll stick a bit of plywood around so she doesn't fall off'.

Participants' narratives indicate that support provided through income support and tax policy definitely is a strategy for reducing stress and consequently risk. However, when a family's financial position situation was not straightforward enough to easily meet criteria this was a source of strain. Even when there were no such barriers, lack of information was an issue. Participants were unclear about both availability and eligibility; several did not access support to which they were eligible for some time. For example, Amy said: 'Family Assistance has helped a *lot*. Wish I'd known about it a bit earlier though'. The Benefit system was of considerable help to all who qualified for it, making it possible for women in difficult situations to 'get things sorted', as Zoe put it. Participants reported that Work and Income staff were respectful and helpful. In this way staff contributed to families' resilience by making them feel comfortable about claiming Benefits and conveying positive affirmation of the parenting role - in what seems to be quite an unusual way when

compared with attitudes apparently prevalent in society as a whole and evident in the attitude of some employers, as noted below.

‘Out of the haze’

A few participants, especially the self-employed, were already back in paid work. Others were considering this. Not surprisingly, money was a pressing reason. However, other reasons were mentioned too: disliking financial dependence; craving adult company; missing status conferred by a career; concern about keeping a toehold on a career ladder.

Tania I think once I've stopped breastfeeding I would like to maybe work a couple of nights a week. It would just give me *my* piece of money. I've been working all this time and now I have to say to him I'm going to spend this much at the shopping and I just feel really strange because I'm used to having *my* money. It would just give me my bit of freedom.

Rae I don't want to be away from work too long. It's the kind of thing you can lose touch with, so I don't really want to lose touch for too long. And plus, just to get a bit more adult contact and conversation.

Going back to work was a double-edged sword – a solution to some problems, a problem in itself because of wishing to be with the baby and the problem of acceptable childcare. Most were reluctant to leave their baby; some had no intention of returning to paid work:

Cara I love being at home. I was really concerned about how I would deal with not being in the workforce - but not a problem. The day goes so fast. I feel like we were fairly late to start, I'm 34 now, so I feel I've done my career, I'm ready to be a mum. I'm prepared to take out 10 years out of my life to focus on that really.

Some noted changes in how employers treated them. Both Dee, who worked as a waitress, and Clare, who approached her employer about returning to legal work part-time, felt undervalued by managers who did not know their track record:

Dee I went back to work a month early because they asked me to go in, they were a bit stuck. We had new bosses. I was asked to go in and sort of show the new boss

what I could really do, 'cos I went in there and asked if I could start back and he didn't really want me to go back to work sort of thing. But I went back and proved my point that I can work, that I knew what I was doing. I asked for one day a week but they never gave it to me, they just call me up when they're a bit busy. When I first went back, these new bosses, they wanted me to work five days a week but I told them that I couldn't work five days a week because I was determined to spend time with [Baby], especially in her first year.

Clare The most stressful thing for me has been the big lifestyle change, dealing with work and accepting, kind of grieving, that my career is on a bit of a hiatus. But now I've accepted that and embraced it. I've felt I've given quite a lot up and really missed it. Yes, it's a bit funny when you've got a career that you take seriously. My employer was not as supportive as I hoped. There's a new manager who doesn't know me. When I rang him just to keep in touch he told me that he was offering me flexibility. He said 'If you want to come back part-time we'll give you some work that is not time-critical'. He was utterly patronising. So the way I'm dealing with it is that I'll worry about it in a few months. I'll probably go back part-time, do it his way, because I don't really feel like buying a big fight over it.

Clare gratefully mentioned how her family helped 'keep things in perspective', quoting her sister who said 'Oh for god's sake Clare, chill out, your career isn't everything'.

Back to the workforce

Returning to paid work was an ambivalent experience. For some participants it was a step on the 'journey a family takes as it adapts and prospers in the face of stress' (Hawley & De Haan, 1996: 293). This turned out to be a very big step. Wishing to stay in control of a career, protect financial well-being or feel self-reliant financially, several participants investigated returning to paid work but found that employers' attitudes to working mothers were not as enlightened as they had imagined. This is a barrier to feeling in control, a key element in the development of resilience – actually employers were in control. If participants did return to work, most found that leaving the baby was more difficult than expected; they were well and truly confronted with the realities of work/life balance and all the consequent effects on relationships, already under some strain simply from the changes instigated by the arrival of a child, as described below.

'A life-changing experience'

In their study of first-time parents' relationships Ahlborg and Strandmark (2001) found that 'the baby was the focus of attention'. Cappucchini and Cochrane (2000: 189) state that 'the success of negotiations within this close personal relationship may be central to the future of the new family'. The experiences of participants in my study bear these statements out. Celia said 'Our main focus now is [Baby]. Most of the stuff we do or eat or go to is around her'. Many were aware that their relationship took second place to the focus on the baby:

Tom You'll definitely find your relationship changes because the husband is no longer the centre of the wife's attention, it's as simple as that, they're no longer the be all and end all, the baby is, and no matter how much the mum thinks it's not going to be, it is. You can't help it.

Couples had to learn to balance their new roles and responsibilities as parents with their own needs. It helped when family were available to babysit. Dee's new partner's parents helped in this way, becoming extra grandparents:

Dee If we want time either his parents or Mum will come and pick her up and we get quality time together. Either my parents or his have her for the weekend.

For some the baby's arrival strengthened their relationship rather than causing problems they had half expected. Something mentioned as a key relationship factor was a 'team' approach. This helped Jan and her partner cope with their chronically unsettled baby. Feeling that her partner was working harder than ever to support them all, Tania's version of a team approach meant that she always attended to the baby at night.

Jan I guess I can see how it can potentially drive a couple apart or bring them together. Like it's brought us together, it always would. But it's all about the child and not necessarily about you two for a while. I can see if you didn't have a strong relationship how hard it could be. [Partner] would never say 'I've been working all day', he'd quite happily cook while I did the bathing. He just got in and helped with whatever needed helping, kind of thing, which made it easier for me because I

haven't had to tell him anything to do. It's working together rather than having defined roles about who does what. Even though it's been a life changing experience we've tried to adapt [Baby] into it. Our family is the three of us. We've been a team since we got married and now we've got a new member.

Tania He gets up quite early to go to work, like at six o'clock, so we get up too and have the last feed and then by the time I'm finished he can play with her for half an hour. It works out really well and she smiles and he doesn't want to go to work.

Gelling as a team was not the experience of Fay and her partner Jack, who later separated. Fay lamented what she saw as Jack's inability to take on the responsibilities associated with fatherhood: 'He's found it difficult to let go of the single life he had before'.

'Doing it right'

Just as the 'core category' emerging from a study (Wilkins, 2006: 173) of the support needs of first-time mothers was 'doing it right' or a 'need to carry out their role safely and effectively', 'doing the right thing', and doing it well, was very important for participants. 'Doing it right' required a steep and fast learning curve, without the benefit of consistent, comprehensive information and training.

Overall, while midwives, Plunket and telephone help lines were important sources of information, participants mostly drew on their own personal and family resources to cope with the demands of the first few weeks. Informal support was in fact preferred by many, especially after the handover from LMC to Well Child provider. For those with access, drop-in services were a boon, offering non-threatening, nonjudgemental professional advice and easy access to information. While technically formal support, participants described support provided at Plunket Family Centres, and at one rural birthing centre too, in terms that suggest that it felt like informal support – it was personal and friendly. Plunket Family Centres evidently conveyed appraisal support authentically, thus encouraging participants to repeat visits. Occasionally individual Plunket nurses gave positive feedback but otherwise participants received very little appraisal support. There was an obvious gap in support for acquiring information and skills required to develop parental self-efficacy. At a structural level, parental leave, Benefits and tax credit schemes were essential supports for families who would otherwise have seriously struggled, (or in fact actually did struggle

because they were ineligible for Working For Families as they were unable to prove their income). However, finding out about these sources of support was somewhat hit and miss. The role of these types of support in enhancing participants' resilience is considered in Chapter 10 in relation to the frame of reference derived from the resilience literature.

CHAPTER 9 THE WORK/LIFE BALANCING ACT: THE FIRST YEAR

Final interviews were challenged by attempts by mobile, vocal one-year-olds to join in, attract attention or closely investigate me or my tape recorder. During one interview it was discovered that the baby had removed my wallet from my bag and was adeptly unpacking it under the table. Another interview was completed by means of holding the tape recorder above my head out of reach of a particularly interested baby, who resisted being distracted by anything else, despite the best efforts of his mother and myself.

Reflecting on the first year of life with a baby, participants marvelled at the magnitude of the change they had experienced. Long past the bewilderment of the first few weeks and the occasional turmoil of the first three months, it was as though participants' new roles now fitted them, even though they might not always be 'in charge'. Most felt that they were doing well in terms of the core family functions of economic well-being, protection, nurturance and self-development, indicating that they were developing competence and resilience. Yet not all was well. Two women had postnatal depression and one couple had separated. Themes from the third set of interviews include seeking advice ('Asking questions'); gender issues ('Still the division of labour'); feeling connected; work/life balance ('I've just got to think what I actually want to do'); and a sense of achievement in adapting to being parents ('The next level').

Three reflections begin this chapter. The two women quoted first, respectively the oldest and youngest participant, say much the same thing about having imagined the 'little baby' but not the active toddler, perhaps indicating widespread unfamiliarity with what parenting is actually like:

Karen I don't think you have any idea. I don't even know if I had a realistic conscious thought about it. I used to say things, flippantly, like 'I'll be sitting under my peach trees with my baby kicking on a rug'. And then I thought I guess I'll have a toddler running round the back garden one day. I never thought any more than that. I never thought it would be difficult, having a toddler and then trying to get the lawn mower out. Or trying to get the wheel barrow from the other side of the fence, with a toddler, and how am I going to do that? How he slows things down. All my jobs

that I want to do, I have to give them up because I can't always do them with him. So I don't think I really had any idea. I struggle with him being sometimes such a full on kid, like he's into everything. You don't think about the baby at a year old, you think about the little baby, all the little baby things. We go to someone's house and it's just a nightmare, it's the most un-relaxing, stressful thing. I feel I present myself as the most harried, tortured mother. I have a little bit of the looking good thing, you know, 'How am I presenting myself with my first child?' You become the caregiver. Oh gosh, you're so vulnerable to other people's opinions. Whatever age you are, it's still all new, the learning curve is still in front of you.

Lucy I didn't really know what it would be like. I don't think I thought past the baby stage to when he would be playing. Now he's up all the time. He's learned to push the button on the copier. My dad used to come home and say 'You haven't done anything today'. And then he spent a day with him and I went 'What have you done today?' and he goes 'Oh, I had to put him to sleep and he kept waking up, and I had to feed him'. And I said 'See how I feel?' and he said 'Yeah, I understand now'. I think having a baby young is harder in a way, but not harder as in looking after him. I guess it's hard that you lose the teenage years. That's about it.

Jess You've got no idea, have you? Absolutely no idea what it's like until you've got one. And nobody can possibly tell you, you've just got to be there and learn for yourself. It's a lot harder than you ever think it's going to be, a lot, lot harder. I think you have this kind of - well I did anyway - you just have a rose tinted spectacle view of what it's going to be like. You know that kids are hard and all the rest of it, but it's the whole being 24/7. When they're grumpy, when they're teething and they're grumpy you know that they're teething and that they're in pain but it's really hard for you not to get grumpy with them. And you can't reason with them. He's not a good eater and it's so frustrating. What's worse is that he'll eat something one day and I'll think 'Fantastic, I've found something he likes' then the next day he won't even look at it. Things like that, it just sounds really trivial, but it's hard when you're dealing with it day in day out because you just don't have any control over it. I think that's the thing, you just completely lose control. I wasn't expecting that complete loss of control. I think you think that you're going to be in charge, but you're absolutely not.

You think that you're going to be the mother and you're going to be in charge, but guess who is! I think you've just got to learn that the hard way.

'Asking questions'

While no longer 'floundering in the deep end' participants still occasionally needed information or support when a baby reached a milestone or sleeping or eating patterns changed. The worst moments were when a baby was hurt or ill:

Amy When he's sick I just stress. I've got no clue. I panic. I ring Mum. I ring my friend - she's got two kids, she knows basically everything. She gives a couple of ideas and I try them. I ring Plunketline but sometimes you have to wait a bit. He fell off his changing table even though he was strapped in. I bent down to pick up his clothes and he just fell. I felt *worse* when I went to the doctor's, I thought 'What are they going to think? I dropped my baby!' I took him, just to check, and he was fine. And they were nice.

Leah [Baby] was just burning up. I wasn't sure what to do, like I didn't want to panic and rush off to the hospital. So I made a few phone calls, to my mum and [Partner's] grandfather. I said 'I don't want to look like an idiot and drive her straight to emergency for a fever'. They said 'Just take her to the doctor'.

Karen On my own with a very sick baby I felt really isolated all of a sudden. I'm a [health professional], I'd thought I could tough it out, but I just couldn't, I had to take him to the doctor. I couldn't find my keys, I just felt a bit panicked.

Health professionals and some family members were praised as calming and helpful at such times. GPs were 'fantastic' and 'wonderful'. Phonelines were still often used, found helpful and perceived as reliable, something that was very important to participants. The best aspect of phonelines was fast reassurance. Several participants said 'They never take long to call back'. One or two mentioned using the internet to find information:

Dean Because we're in a small town the bulk of the information I get is on the net. When I want to find something about where she is, her stage, or about the health problems, I go straight on the net.

Plunket was a common source of information and advice about day-to-day care, but whether this was useful, or indeed used, depended on the relationship established with nurses, who often seemed 'rushed' so that the kind of talk that would get to the heart of a problem was seldom possible. Several participants felt like Tania, who said: 'The Plunket nurse only asks about the baby, they don't care about the mother'. Leah had a particularly accommodating Plunket nurse:

Leah She still visits. I don't ask why. She asks if I want her to come over. I'm like 'That would be nice'. Everything she does, she asks 'Is that OK, do you want me to do this or that?' She goes by my lead. She says how well we're doing.

How women felt about Plunket seems to be linked to the time the nurse could spend with them, the type of relationship built; and whether options were presented by the nurse, so that the mother felt in charge. Jan felt 'brushed off' by when, exhausted and desperate, she sought help:

Amy Plunket are good when you go there. But I haven't been for months. I've seen three different Plunket ladies. They don't tell you what to do - they give you ideas, which is good. I don't like being told 'do this, do that'. They say 'try this or try that'. They give you many ideas. I wish they did it a bit more frequently, every two months or so - you're only there for about five minutes. Well you can be there longer if you're asking questions and that. But all I want to know is how he's doing, what he measures sort of thing, just to quickly drop him in the little weighing machine - he's a little waste disposal, if you keep feeding him he'll keep eating. I've tried going down there to get him weighed but either they're closed or they're busy with appointments. They say come back, but I do and they can't do it or something.

Jan He wasn't putting on much weight. The Plunket nurse wasn't too concerned but at the end of the visit said 'Try the Family Centre'. I rang and they made suggestions that I didn't feel comfortable with, that just seemed quite ridiculous to me, and said 'Get back to us in a week'. What I wanted was to actually go in and them sort of see what was going on, spend some time there. I didn't feel welcomed.

When participants did not like a Plunket nurse it was usually because they thought her 'bossy', 'cold' or 'directive'. While she saw the potential value of 'a chat', Clare simply wanted information she could use, presented in a straightforward manner:

Clare The nurse in our area, she's going to retire at the end of this year, she's just quite bossy, directive, talks a lot about herself and her grandchildren - which is lovely, but I have a life, I didn't go to see the Plunket lady to spend an hour chatting. It's quite possibly something that other people would think was wonderful. But I haven't got time. I don't really want to hear about her grandchildren. She asked a lot of questions about me but told me all about her. And just a bit old-fashioned, you know, there's one way of doing things. But having said that, I did use her as a sounding board. I always asked questions and sort of got information. I think she'd see where I was going and give out the standard advice. I do think Plunket has a real place, with home visits. If they come for a chat that might be all you want.

Cara was pragmatic about Plunket:

Cara I've heard a lot of people saying 'Oh don't worry about Plunket'. And I think so many people take Plunket the wrong way. I mean they have to have a set of guidelines. It's up to you to just be flexible with what they say.

Beth relied on her family and her GP:

Beth: My sister said the Plunket lady was absolutely useless, never turned up when she said she would, [Sister] knew more than her. I've worked in childcare, Plunket won't tell me anything I don't know. There's no point in finding time to go there. But the doctor's good, awesome with babies, a country doctor, not like city doctors, you're in and out, they don't give a stuff. He actually cares, gives you time.

Some participants spoke of paragons of Plunket nurses. Karen's Plunket nurse praised both the baby and Karen, who said: 'She says 'He's a beautiful baby, you're doing well'. We enjoy that'. Both Lucy and Ria felt that the nurse genuinely cared:

Lucy The Plunket nurse is really nice, she's got nice manners. She just talks, asks how I'm feeling, always has plenty of time. She's good, if something comes up and I can't make it, she rearranges everything. Sometimes she comes here to the house.

Ria The Plunket nurse has been great. It's that nonjudgemental positive regard, very much on your side, telling you how well you're doing. Some of my friends have had nightmares of nurses saying 'Don't go and do this or that'. Just bossy and negative stuff. I know it's hard because there are times when you could be doing things wrong and Plunket might need to help you but they could still do that in a friendly way, give people options. I think that the helpful, supportive Plunket nurse versus the little Nazi Plunket nurse makes a dramatic difference. Plunket is this big mechanism that's set up for everyone. The attitude of the Plunket nurse is a massive thing I think.

Some were in a position to make comparisons. Tania, for example, found the nurse in one area 'a lot more friendly, talked to you about yourself rather than weighing the baby, sending you on your way' and Ange spoke of an experience which clearly still rankled:

Ange The first Plunket nurse we had, she was wonderful, even when giving advice she didn't put a negative slant on things. She moved on and now there's another one. And she's a little bit hard. I don't feel comfortable any more. The first one really showed a lot of interest but the second one, she's fairly, you know, just official. She goes through her tick the box list, there's nothing personal there at all. She doesn't seem to engage. I took him there a couple of months ago. She wanted him to sit on the floor but he was still sleeping heaps in the morning, he was tired. He could already sit but of course when he's tired, it's 'Stuff you, I don't want to sit'. So I tried to sit him and straight away he was on his tummy, grizzling, and she was like 'Oh, there must be something wrong with his back, I want you to go to your health professional and get it checked out. Every baby by this age must be able to sit'. I was like 'Excuse me?' I was just like 'What?' I said 'He actually can sit perfectly well, he's just tired. What's the difference between you not wanting to do something if somebody says you have to and you just saying you don't want to, and him?' And she's like 'Oh, but he's a baby. He should sit when you sit him up'. And I'm like 'He's got a will of his own'. We were supposed to go there yesterday but he's got a

bit of nappy rash at the moment so I postponed because I don't want to listen to that sort of thing again. And I feel really bad that I'm thinking that.

Fay You know when it's your first baby I suppose it's dependent on who you fall in with as to the way you're guided and the ideas that you take on. My mindset was to have him sleeping in the bed and that was encouraged by [Partner's] mum and our midwife. We looked into and it felt right to us at the time so any ideas other than that, we saw as not us. Looking back, Plunket was giving good advice but the way she presented her belief, the method she advised, was not in keeping with our philosophy. She said 'You're making a rod for your own back'. And there was truth in that but it was very much black and white. With hindsight I think we did it for too long and then we had a period of about a month when we transferred him into the cot when it was just a nightmare because he wasn't sleeping well because he was used to sleeping with us. But equally I would never leave him to cry. I just found it really hard, there was no one sort of presenting to me, saying 'Here are the options, the advantages and the disadvantages'.

Roz was one of two women, both in their twenties, who saw Plunket advice as counter to an instinctual form of parenting passed on through families. Both were scathing about recommendations for foods babies should not eat.

Roz Plunket have been quite good but I don't agree with a lot of what they say, they seem to change their minds every five minutes. I mean a lot of it is based on studies, but that's only a small percentage of the population. A friend of mine follows everything Plunket says, everything is by the book. They don't really give you that leeway, I call them Nazis actually. They need to make it clear that it's your gut instinct – although some people don't have it. I just go by what my grandma says. All her kids are all right.

Rae The actual Plunket nurse that we're assigned, I don't go to her. When she first came round, when [Baby] was sick, she was quite rushed all the time and didn't ever really seem concerned. I don't know, I just didn't gell with her. She said that he had thrush when he didn't and that made me think 'Does she really know what she's talking about?' If you want that bit of reassurance you can go to the Plunket

Centre and it's free. I think it's the people there that make it. A couple of the nurses there have been Plunket nurses for ever. They don't judge you, they just try and help you. I feel they've been around for ever so they should know. With my midwife when he was first born I was quite concerned that he should be in a routine and she was like 'Oh well, just let him do what he wants', but I kind of like positive suggestions, the advice, to feel like I was doing something. I quite like that.

Sometimes Plunket assistance made a dramatic difference:

Julie [Baby] didn't sleep, at all. We'd be up all night with him. Plunket helped a lot with that. My mum wasn't a very good help because I was a bad sleeper as well. But [Partner's] mum was a big help. She just said 'He's a big boy now. He's full, he's not wet, you've just got to leave him to cry'. And so - because I didn't trust her - I went to the Plunket Family Centre. I went to this course about sleeping and basically the lady checked out [Baby], she said 'Look, he just needs to be left to cry, he just thinks it would be fun to have a game, at twelve o'clock at night or something'. So after that I trusted [Partner's] mum. We'd already tried going in every ten minutes but he's quite a determined little person so he stands up in his cot and waits for you to come in. And then he started throwing toys at the door. I thought it was him falling out to start with so I'd run in and there'd be these couple of stunned toys on the floor. So I had to move everything away from his cot. And then he headbanged for a while and that was absolutely horrifying. So my dad came and foamed everything. I've had a *lot* of support with the whole sleeping thing. So in the end we just left him. One night he cried for five hours straight. She prepared us, the Plunket nurse, she said 'Get out some good DVDs'. We slept on the couch so we could hear him and had his baby monitor right there cos I was terrified. But she'd said 'Don't you go in', and I'd be like 'I'm going in, I can't stand this anymore' and [Partner] was like 'No you're not'. But that really helped. It took four nights. The second night was the worst then after that he got the idea that we weren't going in. In the morning I'd go in and go 'Hi, how's it going?' I was back at work, I just had to get some sleep.

Supportive Plunket nurses could reinforce a developing sense of parental self-efficacy. Kim explains her views on what happens when young parents' efforts are not validated.

Kim What doesn't work is when people tell you how to bring your baby up. What p's me off a lot about people is, when young people first have babies, older parents with experience, they say 'Back in my day, this is how we did it', or 'Do it like this, you don't do it like that'. And so you're wrong all the time. That's not what a new mother needs to hear, they don't wanna be hearing, you know, you're doing this wrong, you're doing that wrong. Even though they don't mean to make it sound so mean, in the new mother's head it's 'Oh my God I'm a bad mum'. That's how I reckon postnatal depression starts. [Adults] aren't *trying* to make them all afraid or trying to make them feel down on themselves, they don't think how it feels. [Partner's] family, when I first had [Baby] was trying to tell me how to do it. But my mum said 'He's your son. If you want to do things your way, you do it your way, bub'. That made me feel a lot better, hearing it from my mum, because my mum had her babies at a young age. And I asked the Plunket nurse. And next time when my mother-in-law [interfered] and she goes 'Did you ask the Plunket nurse?' I said 'Yes, I did, she said it's all right'. She made out 'Oh I knew that kind of thing', which p'd me off too, I was just like 'whatever' because she started being real nice. At least she could have admitted she was in the wrong.

Friends could be a helpful source of advice, especially for older participants. Jess, for example, said, 'Friends with kids a bit older, it's good to get advice from them. They've been there done that, they know what you're going through. However, Amy, aged 19, found that friends her own age, some with two or three children, ridiculed her parenting style:

Amy Some people call him the bubble boy. They say he's not experiencing the outside world, he's in a bubble, because I don't like him around people drinking or smoking. When [Partner's] brother comes I make sure he smokes right down the driveway. Some of my friends smoke and drink around their own kids. Smoking and holding a kid, to me that's a big no-no. They press my buttons about that so I just go on the rampage at them, blurt stuff out. I say 'Every parent's different, it's your child, not mine, [Baby's] my child, not yours. Everyone's different. He's not missing out on anything, he's just not taking in toxins'. My mum and dad never smoked. I talked to

Mum about it – she was horrified. My friend's parents don't seem to mind if she's smoking holding the baby.

Plunket

The ubiquity of Plunket in participants' narratives reflects the reality that Plunket was their main source of formal support. No other Well Child provider was involved with any participant. Plunket clearly has a key role in supporting transition to parenthood so how this role is undertaken is crucial. Quotations presented above indicate the kind of support that enhanced parental self-efficacy (warm, authoritative, collegial, offering options) and the kind that did not (cold, bossy, directive, rigid). Accessibility was an issue for some participants. There was a vast difference between dropping in at a Plunket Family Centre and turning up at a clinic to find the nurse busy with other mothers, attended to individually in a limited time. The chance to talk to someone in depth was the idea for improving support most frequently mentioned throughout second and third interviews.⁵⁷

'Still the division of labour'

It seems that while mothers found themselves very quickly learning skills, there is little that fathers can do for a baby at first. Fathers came into their own when the baby began to interact. The quotations below are representative:

Zac Once the reality hits it's kind of swim or drown really. It's probably the traditional role since the industrial revolution that the man goes out to hunt the dollar, but recently there's been this whole development of both parents working. In our antenatal group women would say they'd just be away from work for two or three weeks and then go back. Straight into childcare or nannies. But I think it's important to allow time to take the shift on. As a parent, it's a great role that I didn't know anything about - that I only had opinions about, no practical experience. If you don't have children it's hard for you to be an expert at it. So I think allowing oneself time to grow into the role, taking things a bit slower. Its like cherishing a good meal - give yourself time for the cooking, the eating, nice glass of wine, there's a depth of experience available that is not available in a fast food outlet. I'd probably say that I do feel empowered by the decision to be a father and that I have natural abilities

⁵⁷ See Table 3, Appendix 2

within me that I would not necessarily be credited with easily. But they're there, instincts, aptitudes, that give me the self-esteem that I can handle this.

Brad As a father you go 'But it's not about me, it's about the baby and it's about Mum, she's the primary caregiver'. And that's the thing, you kind of end up going 'Hm, it's still the division of labour, I'm out at work, she's to feed and be around with the baby all the time'. It's just the way it is.

Cara I still find I probably do most of the looking after. But [Partner] definitely has found it easier to interact with [Baby] since the sitting stage.

Clare and Matt had a conversation about this.

Matt The first four months are actually hard because you can't add any value, from the dad's perspective. But after six months it gets so much better. I found it really frustrating, the first six months, but it gets better. Before that, it's 'I can't feed him' - I can wash him or something, but you know, there's no bonding going on, you find you're just supporting the mum. You kind of want to be there with the baby but you're not doing much. For the dad, the first three or four months, it's just change a nappy, there's not much you're actually doing. It's after that, that's when your role kind of comes in. I think a really good message for dads is that it actually gets much better after, like, four months. My friend [male] and I have talked about how it's harder for the guy to adjust to the crying at first. Mums seem to find it a bit easier. Guys take a couple of weeks, before you really get so the crying just doesn't get on your nerves. It's harder for guys to kind of deal with it. Or just get used to it, not feel anxious, absolutely helpless.

Clare I wonder if that's a gender thing. I mean if [Baby] was crying and I was exhausted, I'd just be sitting there and I'd be crying, because I was so tired, but you actually felt quite angry at him.

Matt During the whole pregnancy there's the two of you, there's all these messages, you're both in it together. And then the baby comes - and it's the two of *them*, mum and baby, and you just kind of, well, make dinner, wash dishes. You know, you

build up this thing that you're in it together, then all of a sudden you can't actually add anything. And some dads don't particularly want to be a father. You know, the dads from our antenatal group met, and three quarters are over the moon, but a couple of others, you know, you can tell that they're not really involved in it.

'Becoming a father'

In suggesting that men become fathers rather more slowly than women become mothers, participants' narratives reflect the findings of other research. Reviewing literature on the 'process of transformation from man to father', Vehvilainen-Julkunen and Liukkonen (1998: 11) note three stages: initial acceptance and enthusiasm; struggle to gain the status of parent from partner, family, friends and society; fitting the role of father into the personality. In their own study of 137 new fathers they found that some men want more information and encouragement in handling the baby. Observing that father-infant interaction appears to develop differently from mother-infant interaction, Von Klitzing et al. (1999: 233) found that a precondition for the development of good father-infant relationship was associated with the capacity of both parents to anticipate a 'triadic relationship with an essential contribution from the father'.

'Feeling connected'

Most participants seemed to move into a 'give and take' position in their social network. Earlier they had been on the receiving end of support: now they sometimes helped someone else. Interaction with others at a similar stage sometimes evolved into mutually supportive friendships characterised by reciprocity and including childminding, cheerfully provided; invitations; outings; emotional support; and information sharing. Reciprocity was a feature of family networks, with the balance weighted towards family members helping new parents - often babysitting, with the reward being simply time with the baby:

Cheryl What keeps families on track is other family members. That's huge, having someone to help. People don't turn to people outside. When it's family like your mum you know they're not going to judge you, you know you can be completely honest. If I'm worried about anything I can ask one of my aunties or my mum. My family's very much if anyone needs help all they have to do is ask. I don't get asked, well I help my grandad but he doesn't ask, Mum asks. I help my mum and my mum helps me. Sometimes, on the odd occasion, he'll come and stay here

because he needs full care or I go there. If Mum's broke and needs twenty bucks we'll give it to her and if we need twenty bucks she'll give it to us. If we want to go and visit her and we can't afford to she'll pay for us to come up. We're very close to Mum. She rings more or less every day. If I've got a problem with her being around when I don't want her to be I can just say 'Mum, get out of my face'.

Ria The parents-in-law, the first six months was more stress than help because of them wanting to visit all the time. But now they're helpful. They just do anything to have time with her. And that's going to help more and more as she gets older. It would certainly help if we have another one.

Karen Support is somebody rocking up with a dinner cooked, or coming to just sit with the baby so I can go and have a massage or tidy the back yard. That's what I think support is. It hasn't happened like that. But then the other day there was another mother here with children and [Baby's] godmother came for lunch. And she suddenly said 'I'll go and make lunch' and came out with this gourmet lunch for us and she said 'Well, we women who don't have children must support the women who do'. Gems like that occur.

Reflecting on their own need for support in the early days, some supported others:

Clare The thing I'll do for my cousin, which is what [Nanny] did for me, is give her the odd hour or two when she can just go for a sleep, that kind of in-home little break.

Karen Not enough people tell you you're doing well, people don't do it. I went and saw a friend the other day, her baby's four months. I really was aware of telling her how well she was doing. Because I realised nobody did that for me. People are doing it now but not right in those early months, when you kind of feel you're in this fog and it's all a bit weird and your hormones are going crazy.

Two participants belonged to coffee groups that had attracted women with similar interests. As well as providing company, these groups now functioned as an information-

sharing mechanism. The area in which Jan lived was the only one where many young families lived in close proximity, as in the Pakuranga of the seventies.⁵⁸

Jan We've got a coffee group, we've been together since the kids were brand new and we meet every week. There's ten or thirteen of us, pretty much at least seven every week. We bounce things off one another quite a bit. I was speaking to one of them a little while ago about [Baby] being really unsettled with his sleep and I told her what I'd read and she said 'I was having the same issues and I rang Plunket and they said 'He's too old for that now, it doesn't work, if you keep going back they just think 'Oh, she's back'. You just have to leave them'.

Although coffee groups are potentially a way to counteract isolation they did not always meet a woman's need for company:

Abby I have my antenatal coffee group. We see each other once a month sort of thing. They're all working so I can't just go and see them. We had a barbecue on Sunday for the coffee group people. Last Friday I met these mums off the internet. There's about four of us living near so we met up. That was very crazy, because I just didn't know who I was meeting. It was just weird, like say if you met a guy off the internet, it's no different, you get that feeling, you're like 'Who are we looking for?' I saw one girl cos we were meant to meet by this place and we sat there talking but the others were over just a little way over from us. I'd be the youngest, the girl I met first the second youngest and the other two were middle aged. I'll meet them again but I will never meet again offline, on the internet sort of thing, cos it just felt really weird. I'd rather stick to my coffee group friends and wait a month.

Tania tried a local coffee group but found that 'all the mums had three or four children, no money, were pregnant again - I didn't fit'. Her inability to find adult interaction was a contributing factor in her decision to seek part-time work. 'Not fitting' in some way was a repeated refrain in this set of interviews:

Kim I've been going to baby group, Mainly Music.⁵⁹ Basically I know everyone there already. I don't go a lot, they're mainly older mums in their thirties. I don't have very

⁵⁸ As described in Chapter 1 (Park, 1982).

much in common with them - not that I don't like them, they're different from what I've experienced. It's hard to kind of relate to some of them.

Julie I found it hard to find peers because a lot of the girls I found around my age, that have children, kind of left school really young. I made friends again with a girl I was at school with but who left school at fifteen and has two older children and one the same age as [Baby]. Once a week we go to her house or she comes here. We can chat about our kids and stuff but other than that we don't really have much in common, at all. And my other friend down the road's just had a baby, so we go and see her sometimes, but to start with I was kind of like 'Well, what am I going to do?' That's why I'd like to go back to uni – I find it difficult being away.

Jess, Karen, Fay and Abby were among a few with no plans to return to paid work as yet. Rae was thinking about work but keen to get out and about meanwhile. It was evident that persistence was required to find something interesting to do. Clare, who had enjoyed taking her baby to story time at the library, said: 'I think if you try out a couple of different activities, you'll find somebody you can kind of bond with, at least talk to'. Now that Clare was back at work the nanny was taking the baby to story time. Playgroups and Playcentre were seen as places to find company and to extend parenting skills. However, the commitment required by Playcentre did not suit everyone:

Jess I really like the idea of Playcentre. I like the idea of being there when he's learning new things and doing new things. I think Playcentre might be quite good because you do courses, you're quite involved in it as well. That has its downside for some people but I think in a way it would actually be good because you're developing your skills as well, it would be new things for me to learn.

Karen We go to playgrounds, but the mothers at playgrounds don't really talk to each other, it's quite strange. We've started at Plunket playgroup, we've been to one. I met a nice mum too and so the next week she came here with her children and we had a nice day in the back garden. We'll have a look at Playcentre soon.

⁵⁹ A programme run through churches for parents and preschoolers.

Rae Around here they seem to be cliquey a little bit. Everyone's in their own little group. I've thought about going to Playcentre. But you have to commit to two mornings a week and one morning you're on duty so you have to get there early. He's still having a morning sleep so I might wait till he's down to one. We still have our antenatal group coffee group, that's quite good. It's worked out quite well, we had quite a diverse group. There's only about five of us now. We're seeing quite a lot of each other soon because it's all the birthdays. We go along to playgroups and things but he's sort of just getting to the age where he's only just old enough. We get on with one couple from antenatal class, I see her a couple of times a week, talk to her every day. And there are courses run by Plunket that I'll go to.

In some rural areas there were more opportunities than in urban areas. Rural coffee groups apparently functioned as a kind of gateway into community life.

Ria I feel that things are there if you need it, for example courses on parenting that I will get around to doing but I've been too busy and I haven't really felt I've needed them. If I was suffering with anger or whatever, if I didn't have the skills to manage basic finance, there's so much stuff that actually is there. But I think maybe part of it is finding out. I don't know that all mums would have the skills or the network to find out. Only very recently I discovered - I probably would have found it more useful earlier - Mainly Music, but we've only been twice. And also the church have a coffee morning that I've hosted once and gone to once but I've only just discovered it recently. I'm not a churchy type. But they're inclusive. Next week we have a mums' pamper night. That would be unheard of, with my city girlfriends, to have a pamper evening that didn't have wine. It's different. I respect them in different ways. I think urban women go to coffee groups and don't relate. We have a Plunket coffee morning and I'm on the committee, I do car seats. Feeling connected to the older generation is a help with connecting to the area. The mums groups you could sort of join anyway but possibly I wasn't nervous. Yes it's helped, being in my small town, and it would have helped if anything had gone wrong or it had been a really hard year. I have all of my mum's friends, and my godparents, all of those people to draw on.

Mainly Music seemed to be widely available, easy to attend and to cater for a wide range of people. As well as courses run through community groups or Plunket, libraries featured. Fay, also in a rural area, now had a weekly schedule: 'Playgroup on a Monday, Tuesday story time at the library and on Wednesday, Playcentre'. Clare, living in the city, said that her nanny took the baby to story time at the library where there was 'a bunch of other mothers and nannies'. Beth had hardly been going out at all. Suffering back pain and PND, she relied on her family for company as well as support:

Beth It's a bit hard being stuck out here in the middle of nowhere not knowing anyone. There's a girl at the shop we talk to, she's just had a baby. But I haven't seen her for weeks. There's a parents group one day a month – but these things are on when [Baby] needs to go to sleep and have bottles. And then walking down there, when my back's so sore. If they reminded me it was on, there was transport and stuff like that, absolutely I'd go. But next Tuesday I'm going to start taking her to Mainly Music down at the church.

While most participants attempted to find a place in a social network, whether learning to drive, however reluctantly, or hunting down possible options for learning skills and finding congenial companionship, Beth was seeing no-one but her family. She was living in a new area and had not felt able to get out and meet people. Her problems appeared to be compounding in the way described in the resilience literature. She was suffering back pain and depression, her relationship with her partner was now 'not too good' and he too was depressed. While Beth had a very supportive family keeping an eye on her and helping her out, there must be countless others whose problems are neither noted nor addressed. Jan's reflections on earlier days, when her now sociable baby cried for hours on end, show how sheer exhaustion might cause isolation:

Jan When he was screaming and wouldn't go to sleep the worst was when I'd keep going in and he'd keep screaming. I'd feel like 'I'm here to help you and you're not relaxing, you're not listening to me', I got more and more agitated. So then I'd just have to walk out and leave him for a while because I was just getting really agitated by him seemingly not calming with what I thought he wanted, which was me going back in. So, it was just - letting him cry. Then both grandparents said 'Oh, it's not nice for him to cry before he goes to sleep' so that kind of made us feel guilty. So

we got out of the habit of doing that and started patting him. And then because it got to the point where it wouldn't take long to pat him, we thought, 'Oh well it's easier'. Then it got to taking a long time and we were back to square one. When I had to get things done, if something was happening that day and I had to do this, this and this, that would be a situation when I'd get more stressed. But not now - if I had to be out of the house by a certain time and he wouldn't sleep and I still had to shower I'd just go and shower. It's hard because a lot of other women say 'Oh I feel really bad when he cries' and I don't sometimes. Sometimes I just walk around going, 'Well, he's just going to have to live', and I'm quite rigid with that. And I think 'Where did that come from? Very harsh, but he does have to live.

For those new to a rural area the extent of community interest could be surprising:

Dean For us it was really strange, we shop in [rural town] and we had people in the stores giving us gifts. We talk to them, but you don't expect them to stop you down the street after you've had a baby and give you a gift. We had to do the big walk up the shops and show everybody. The café where we have coffee, we probably go in there maybe once every two weeks, and every time I go in those girls ask 'How's Celia, how's the baby?' It's amazing. You can see how you get into that culture - one of them, an older lady, her daughter's about to have a baby, and I'm like 'How's your daughter?'

The environment was not always conducive to getting around with a baby. City roads were hard to negotiate with a pushchair. Ange said 'When we go for a walk, we drive in the car, then go for a walk'. Men felt that 'the system is set up for mothers'. Brad said: 'There's no coffee group for dads. And the spacious toilets with changing tables are on the women's side'. For younger mothers, a significant step in dealing with isolation was learning to drive and getting at least a restricted licence. This not only enabled them to get out and about but made it easier to do paid work.

Participants described a process of finding a balance between independence and interconnectedness. Some agreed with the saying 'it takes a village to raise a child'; others were not so sure. Julie said: '[Partner] doesn't like help from people because he thinks that

when he's achieved something on his own, he's achieved it' but others revelled in having informal support more or less on tap:

Abby There's a house here, and then four steps and there's another house, his brother's in there, and his mum and three sisters next door. There's two houses next to each other. It's just down the road. And I have a best friend that would drop everything and do anything for me. I've got quite a bit of support.

Belonging

An optimal balance involved satisfactory interaction with family and with people in the community, resulting in a sense of belonging. This was made visible at the first birthday party, for many participants a significant event apparently functioning as an assembly of the network of family and friends around the baby, sometimes quite large gatherings; at Cheryl's baby's party there were 'maybe 40 adults, 15 kids'. The first birthday was a time when those without family nearby were conscious of their absence. Although 'rituals' are accorded importance in the therapeutic strand of the family resilience literature (e.g. Walsh, 1998) the first birthday party was one of only two intimations of what might be called ritual.⁶⁰

'I've just got to think what I actually want to do'

Musing on balancing paid work with time with the baby, participants raised issues of identity, childcare, money and attachment. In common with several of the younger women, Amy, who said 'I've just got to think what I actually want to do', was considering upskilling rather than returning to paid work. Several participants were by now working part-time. Finding an acceptable childcare solution could be challenging: some gave up. Others devised resourceful arrangements. Lucy, as well as studying by correspondence, was working part time at the same place as her mother on a different shift, passing the baby to her mother as she began work and her mother left. Julie was able to take her baby when working part-time at a creche run by her mother. Roz was not so fortunate:

Roz I've only been back at work for a couple of months and I'm looking at another day, we need the money. It was hard because [Baby's] not in my class. Most parents take their child to preschool and leave but I had to hear him being distraught all day

⁶⁰ The other was mentioned as a milestone by younger, lower-income participants only. It involved the purchase of large formal photographs of the baby from a widely advertised company specialising in this.

and I couldn't go to him. It was awful, I was in tears, you know. He's all right now, he loves it now. I'm starting studies again in April. Part-time work, part-time study. I don't want to stress myself out by missing out on him. Going to work was stressful at first but we've kind of worked out our little routine now. [Partner] picks [Baby] up on his way back from work because I don't finish till 6.30, so by the time I get home he's fed and bathed and either in bed or ready for bed.

A few participants had chosen to be 'a full-time mum'. The only downside from Leah's point of view was the difficulty of saving for a house, but living with her parents meant that she and her partner could still 'put small amounts away'.

Jess I haven't gone back to work. I did think about it, I got offered part-time work when he was only about six months. But I just decided it was too early. It was only twelve hours a week and I wouldn't have thought twice if I was at home and I could leave him with his grandparents but I didn't really want to be putting him into daycare when I didn't have to. It would have been for selfish reasons, not for him. We're lucky because my husband's got a really good salary, I wouldn't ever profess to being on the breadline or anything but it's still been different, you spend according to what you're getting in, we've still had to adjust since I stopped working. And then buying a house - Auckland's a nightmare.

Kim All my friends say to me, 'Why don't you put [Baby] in daycare, get yourself a job?', and I'm like 'No way', and they say 'Why not?' I say 'I don't want to be leaving my baby, I want to teach him all the things, give him his lunch. I want to see him take his first steps. I want to be there for a while'. I've got, what, three years that I can spend with him, by myself. I'm not going to get that again. Once he gets into school, that's when they don't want to be with Mum, they don't want to stay home. I love being at home. I just think that people who put a child in daycare, it's kind of lazy. I'm not saying all of them, I'm just saying some, you know, don't want to do the whole changing nappies thing, they'd rather be socialising at work with friends and what not. As for me, I'd rather hear him say his first sentence, I don't want him to say it to some stranger at playschool or some centre thing. I want to be the one that hears it, jealous as it may sound.

Cheryl I've thought about studying nursing, childcare even, but I'm not ready. I want to be a full-time mum. I'm not with the whole childcare thing. I have no problem with family looking after her, but not childcare. If it's my family looking after her they'll instil the morals and values that I have. At childcare there's such a variety of people, not just one person looking after her. She won't get the morals and values that I believe in for her. This is the most important time of her life, the most developmental, and the most she's ever going to actually want us. After this she's going to become Miss Independent. I'd rather enjoy this time than waste it. I mean, money's not important for me. As long as we've got our health and happiness I can go without things. Why would I want to get away from her?

Karen, currently working a few hours per week at home on 'a no-brainer that I can stop and start', said 'there's not a bit of career mindedness in me at the moment'. Recently briefly tempted by being offered some interesting work, she rejected this as it meant having the baby looked after by someone else. Rae was also working just a few hours.

Rae I'm only doing very, very part-time, five hours a week, working from home when he's asleep. If I wanted to do more I'd really have to organise some sort of care for him and it probably wouldn't be worth it. There is some pressure on, to do a bit more. I mean, [Baby's] getting to the age where I might start looking at doing something. My preference would be for his grandmother to have him. But I don't know whether she wants to or whether she's got time. She doesn't work but she seems very busy, doing stuff, doing her own thing. She's said she'll look after him one afternoon a week at this stage, which is fine, it would probably work out all right. So I've been trying to instigate that as a regular thing but we haven't really got into it yet. I tried to organise it but she already had appointments booked. Employing someone wouldn't be worth it. As long as we've got enough money to be able to do the things we want to do, and be able to eat, have a house and look after ourselves. I mean it's nice to have a lot more money, but if you don't, well I don't think it's necessary. We don't actually save any money but we get by. We can't obviously go away for holidays every year. It's more I worry about not earning. I just feel that I should be earning, because I always have. It takes quite a bit of getting used to.

Women who worked at home had to be particularly good at juggling tasks. Ria, who was just beginning to resume work in her own business, explained her situation.

Ria I'm just starting to get back into work. Mostly at home but if I have to go to a meeting she just comes along. The thing that still frustrates me is I can spend an entire day, don't sit down, and it's gone. As soon as she's asleep I'll do a clean- up, maybe a tenth of the GST, make a few calls, do a few loads of washing, do what she needs and suddenly it's the end of the day and I haven't had a break and I haven't even finished the GST. And I haven't done my assignment for my course, that I've had for months and it's due next week. A lot of what I've been doing hasn't been much of a commitment. It's now it's getting harder, where I'm trying to help with [Partner's] business and I'm trying to work.

Ange now found it impossible to work with a mobile and active baby in tow:

Ange Occasionally I get a bit behind with work. I'll probably get a nanny, two mornings even, where I can get my head down and do things without being constantly interrupted – which is fine, he's a baby. You know I wouldn't be happy not working either. If I didn't do anything else but him I'd feel absolutely miserable. I'd turn into a vegetable in a way. I have to have contact with people, have challenges. I mean, he is a challenge, but, well, I see it with one of my friends, she did quite a corporate job before she had her baby and the little one is five months now and she doesn't do anything else but coffee groups, music things, yoga things, every day of the week is designed around the baby. It would do my head in.

Childcare that met their requirements and standards was the key type of support that participants needed if they were to return to work. Another factor was employers' flexibility, experienced as a form of positive regard. Roz, for example, found her boss supportive when her child was sick. 'I've had to have time off work but she's been so good about it, she completely understands'. If a woman felt her employer valued her skills this encouraged her both to return to work and to remain. Otherwise women were discouraged from making the considerable effort required. What Clare missed when she returned to work was respect for her competence, which she was sure that her previous manager would have communicated to her but his replacement did not:

Clare There was a time when it felt very dark, three or four weeks, when I felt teary, depressed. My family would be saying how beautiful [Baby] was and I'd be thinking 'Actually, it's a shitload of work'. It's finding the balance long-term. Going from a working woman to a mum, just kind of feeling bored and lonely, it felt like a loss – and I felt like I'd lost it! I was surprised at how difficult that was for me. I talked to [Partner], and friends, lots of sympathetic people, and then I made the choice to go back part-time and that has been really good for me. The company has been very flexible, brilliant, whatever I've asked for - but on a one-on-one level I think my manager has struggled with it, he's found it a bit difficult. I suspect that often happens, from people that I've talked to. Everything on the surface goes really well but actually making it happen day to day is different. So I don't feel I can complain but it hasn't been a total success. And now I'm actually at the stage that I'd rather be at home. I'm working four days - four days the manager can think of you as a real person, three days and I'm a 'part-time mum'. I think I might have got the balance a little bit wrong, I might go back to three days.

For participants in my study work/life balance was intertwined with successful fulfilment of the family functions of economic wellbeing, nurturance, self-development and protection. The right balance here was different for each. According to Stephens (2004: 90) 'Work is where women go to make and find meaning, to have mastery and control and regain an "identity" that has purportedly been lost'. However, for participants in my study the dimension of role was important. Some prioritised the role of 'mother' and saw returning to paid work as relinquishing that role; for others this role incurred loss of previous status conferred by employment. Ability to control whether and how much they worked was key to participants' feeling that they were finding a way through the challenges of the first year with the baby; making arrangements that were right for them was essential to their sense of self-efficacy. There were problems in this respect if their environment did not offer childcare that suited their background and values, whereupon returning to paid work was in itself a source of problems. Cara's description of the process she went through illustrates this issue and introduces the equally difficult issue of financial strain, discussed in the next section:

Cara I originally was going back to work, they created a three day a week position for me. At seven months I decided not to. I started thinking it might be financially worthwhile to go back and I started looking into daycares but I felt he was too young, also the feeding issue, he wouldn't take a bottle. The daycare was very nice but I had this funny feeling, I just didn't want to. And then I found out we were entitled to money from the Government, which we didn't know. It wasn't till three months after it had been introduced my sister said 'Are you getting this? I'm sure you're entitled to it'. And I was just 'Wow'. We were so stoked. So I just threw away the job, just quit, and that was a huge relief. Also financially it wasn't worth it, with the cost of travel, the cost of daycare. The Working For Families benefits we get are better than if I were to work. I think they're introducing very heavily subsidised daycare for three days a week. I think something needs to change with the cost of daycare to get parents back to work if they want to go back. It's much, much better staying at home. I would probably be tempted to go back just to get that interaction with adults. But if you send your baby to daycare you have to deal with the sickness, the kids get sick all the time and that's a hard one too. Parents can't afford to take the time off, they still have to pay for the daycare so they send their kids anyway, probably knowing that they're not well, and they infect all the other kids. I do have days when I sort of miss work, I had quite a neat group of work friends. We do keep in touch but it's not like before. But I love being at home, especially now that he's a bit more fun and he's getting his own little personality.

Financial strain sent several women back to work, usually part-time. Those on a low income or Benefit found that 'every \$5 counts'.

Abby There's been the odd time when the cupboard has been quite bare, but we've fed [Baby], we've used the money for her [when] the bills got on top of us. But the bills are important, like the roof over our head, and the power. John took a week unpaid leave when we were in hospital. So we were a bit down on money but it had to be done. It was all right because it was only a week. We got a bit grumpy cos we hadn't had the nutrition. Otherwise we'd just go over to his sister's for dinner sort of thing. Most of the time we just manage to get by. It's just a matter of doing it.

Those in a high income bracket usually had high outgoings. Those in the middle found that eligibility for Working For Families meant that returning to work made little difference financially. Working part-time meant 'prioritising' or 'cutting back'. Some fathers were still working very long hours and aware of the 'opportunity costs' in missing out on family time. As at the time of the second interview, participants relied heavily on their own resourcefulness to make ends meet:

Roz There's been times when we haven't been able to pay things, our rent and stuff, that's been pretty stressful. [Partner's] car's broken down so he's got mine. That's been stressful, trying get the money to get things fixed. The other day I had to take [Baby] to the hospital and my sister had to take me. It's a bit of a pain. I was actually quite stressed out about it, I was down for a couple of days. But my parents were worse off when they had all us kids, they've survived, so I just think it's something I'll look back on and it's going to make me stronger, it's not the end of the world. [Partner] gets stressed out, but then it's 'Oh, it doesn't matter, we've got a roof over our heads'. Going back to work has helped, definitely. We only had maternity leave for five weeks, although we do get Accommodation Supplement from WINZ and that's pretty good. And Working For Families. I just budget a lot. I keep all my paperwork and if I have to ring about something I write down everything I've said to that person.

Some in effect bought time with the baby. Karen said 'We actually didn't pay our mortgage I guess, our flexible mortgage paid our mortgage if you get what I mean'. Ria and Brad used savings:

Ria It's certainly made me think about people that genuinely have nothing to draw on, family, investment money, nothing. [Partner's] had clients not paying, jobs going wrong, so cash flow has been massively stressful. You end up cutting into your investments. We're so much luckier than so many because we've got investments to cut into, but still, you don't want to cut into your future. We say it's stressful but we've got the credit card limit, we can go and buy a bottle of wine, if we're down, feeling a bit guilty because we shouldn't. Living in the country has helped. It means that you have time, no commuting. I feel so much more for people who have \$300 coming a week, \$360 expenses so they can't even afford to go to the doctor.

Living on a Benefit or ACC was challenging. For Cheryl and Tom this was exacerbated by the fact that Tom's older child had recently gone to live with Tom's ex-partner so Tom was now liable for Child Support:

Cheryl We can just manage but if I don't work under the table then we don't have a dollar spare. If we didn't have Accommodation Supplement and Family Assistance we'd be shot. As it is we only have enough to cover the mortgage, the food, tight on petrol, cigarettes are a luxury. We're lucky because [Partner] keeps our veggie garden and our fruit trees, we've got apples, bananas, peaches, plums, beans, tomatoes. We don't have to buy veges much. [Partner's] on ACC. We're down to 80% of his wage and he's not allowed to go back to that job. ACC are not overly friendly. People like us already feel stink just having to ask. It's not the sort of thing we do. And then they sort of look at you sideways. Mum and Dad are on Sickness Benefits so they can't help. Mum helps by coming down so I work and earn fifty bucks. That fifty bucks means if I want to buy [Baby] a treat I can. If I want to buy something I can pay it off by earning that. Under the table makes the difference between sanity and insanity – makes you feel like you're doing something to try and help your situation. The fact is if it was taxed there's no point doing it.

Some had problems getting their complete entitlement:

Kent I've got a job, I'm just waiting for the right hours, that suit the boss, that suit me. I'm on Sickness Benefit, it just covers our expenses. [Ex-partner's] on DPB but I'm going to have to go and change it around. Because I've got most care of [Baby] now. So I'll get [Baby's] support added on to my Benefit.

Dee We split up more or less because I had trouble with WINZ. They were harassing me sort of thing, saying they weren't going to force me to put a father's name on the birth certificate but they'd deduct money from me each week. Basically the problem between me and [Boyfriend] was I had to try and get the father's name on the birth certificate. It was a bit hard on him because he had spent so long raising her as his. He loves her and that, he didn't really want to share her with another guy. But he sort of got over it. Mum looked after [Baby] once or twice while I went

out [to Boyfriend's] so we could work it out. [Baby's] father is really not much of a nice person so we just worked it out that, you know, we weren't going to let him get between us, that [Boyfriend] was still the better dad. So we're waiting to hear back from the lawyer because we've got to do a paternity test and everything. He's already done one for one of his other kids, but to get his name on the birth certificate we've got to do it. WINZ still gives me the Benefit but they take the deduction off. WINZ are actually nice, the case manager was really nice to me. I wasn't OK about getting him on the birth certificate at first but I know that if he does anything to hurt her I'll go against him. He actually called around here one night late. And Mum sat up, Mum talked to him and that and then he's been in contact with Mum asking me to contact him. But I just don't want to, I just want to go through the lawyers at the moment. I can manage on DPB. I know if I need extra it's there, either Mum or Dad will lend it to me, or [Boyfriend] will.

Fay and Jack were in dire financial circumstances: Fay said 'With finances we're actually really stuck. This place is \$350 a week, I don't know how we'll pay the rent this week'.

Tania and Gary were much better off but still struggled:

Tania It's so different. We've gone from two incomes and not much expenses to one income and extra everything. I shop every two weeks. We get home kills done, sausages and things. We've done little things like change the phone to a fixed contract and taken off Sky channels we never watch. We used to have luxuries, broadband internet. We've got a huge vege garden now. We're picking some chickens up tomorrow, trying a bit of self-sufficiency.

Gary I think 99% of our fights have been about money.

Tania We get by, but some months it starts getting stressful. I mean it kind of leads to other little arguments because you're stressed about money. It's like a vicious circle.

Gary All of a sudden it's like I don't look after [Baby] enough. And a lot of the stuff that comes out, I think it's just that you're retaliating, you don't even mean half of it. It's just to have another dig sort of thing.

Tania The problem too is I'd like to get my hair done and I still want to be able to go once in a while and get a massage or something to feel normal. And I can't, I have to ask: 'Can we afford it this week?'

Gary And I'm the bad guy. Because I say 'Nuh, can't afford it'.

Tania So I go 'Well, I do all this, I deserve something'.

Gary Tania says that she feels like I'm her dad. Which I don't like. Just because I'm controlling things. Well, not so much controlling, just because I know where things are at. I know we can or can't afford it. I'm the money person, always have been, I've always taken charge of the mortgage, the main bills. When Tania was working she paid all the day to day living expenses and that always worked really well. Now I have to make sure there's enough money for the mortgage, everything else kind of rolls around that. It's pretty much day to day, fortnight to fortnight, pay to pay.

'Not a dollar spare'

For many participants financial well-being was precarious. Tania and Gary were relatively well off but the dialogue reproduced above suggests how easily escalation may occur in situations where other problems fray nerves and reduce tolerance. Participants appreciated WINZ assistance and generally found staff helpful but policies may have unintended consequences, as Dee found. Participants suggested that 'someone who could come and talk' (see, for example, Kent and others, Table 3, Appendix 2) would address difficulties created by financial strain before they became problems and would also help resolve relationship problems, not uncommon, as indicated below.

'The next level'

Participants were well aware of effects of transition to parenthood on couple relationships:

Roz I know a lot of people who have had a baby and then split up. And what I think it is, is after a woman gives birth she just changes. When you're with somebody and you don't have a baby you always put that person first. Whereas after, it's the baby first. I think the men find it quite hard. And the financial stress as well.

John: It is hard for a male. Women feel different when they become a mum. Maybe there should be something to prepare them, and men, for changes in their relationship.

Though most issues that couples dealt with were described as 'pretty minor' and were worked through quite easily by 'just talking', they still required attention. The following dialogue is representative:

Matt It's not just the two of us anymore. It's just so much more work, in total. I think we both kind of think that we're doing more work than the other one.

Clare Yes, we're both convinced that the other one never does the dishes – so we've had to negotiate that quite a lot.

Matt It's pretty minor.

Clare A normal level of issues around housework and things which we'd not had to really deal with before.

Matt We had time before - it's just lack of time. I think we really don't see enough of each other, just literally don't spend time together.

Clare We're quite tired - up at six, sleeping at nine. And I've actually noticed that with going back to work I've just got nothing left at the end of the day. And what suffers is actually me and Matt, it's not so much me and [Baby]. I come home, I have an hour and a half with [Baby], I barely talk to Matt except for the time with [Baby], play with him, feed him, then it's the end of the day. I think nurturing is what suffers when you're really busy.

Matt I feel a lot more responsible. I'll take precautions that I wouldn't have taken before. More pressure. I feel much more pressure with my work, financially, than before. I don't particularly mind.

Clare The flip side of that is that I feel a lot more looked after. We've gone from being ruthlessly fifty-fifty equals to me being much happier with him taking more of the protective role. Actually that's worked quite well but it wasn't something we were looking for.

Quotations about status were interesting in that there was a noticeable difference here between older and younger participants: for some older women with established careers it was as though their status was diminished, while younger women were proud of their new role: 'I love being a mum'. Older women were dealing with shifts and dents in their sense of self. Bird and Schnurman-Crook (2005: 146) state that:

Self-identity as a professional is based on engaging in career activities that require interaction with others in the work environment... A common problem for dual-career couples is finding a satisfactory balance between equally prized family and professional identities.

This problem appeared to be affecting Jess and her partner in that she had relinquished her professional identity in favour of motherhood:

Jess I do have days when I just think 'Oh my goodness', because I did have quite a responsible job before. [Partner] I think stresses about it more than me. I think because I've got total – you know, when you do lose your brain. And he says, you used to be so clever, and now you're just a bit dim. I'm so forgetful.

Ange You don't get included in lots of things any more. It's like you're almost pitied, in a way. Just the way people approach you, like you don't have any views, you know? It's weird. When I go out in my work role people ask me technical questions, what my opinion might be on things. When I go out with him, no-one asks my opinion - well, unless it's 'Which nappies do you use?' It's like you're the carer for this little child but not really a person any more.

Ange's comment critiques a widespread attitude that parenting is a low level occupation, evident in Clare's employer's attitude and noted by other participants too. This societal value diminishes the role of parent and minimises the skills needed to parent well. This is

likely to compromise the sense of self-efficacy concomitant with developing competence in the parenting role. During the first interview Jess said that she had always been good at what she did and was worried she would not be a good mother. By the time of the third interview women interviewed knew that being a mother is a '24/7' job, for which they had received nothing much in the way of orientation or in-service training, and, if they did it well, this was seldom acknowledged or even noticed. Yet skills developed are likely to be transferable and competence generalisable to new challenges. Participants who expressed a sense of competence at the end of the first year spoke of having reached a 'new stage' or 'the next level', indicative of the magnitude of the transition to which they had adapted:

Dean It's interesting having a baby because you change teams. You go from the team that doesn't have children to the team that does so it opens up conversation with a whole lot of new people, which is kind of cool. This has been phenomenal for me, in the sense of letting go, changing to an emotional connection from a commercial reality. I think we're in a new stage in our life.

Most very young parents had done a lot of growing up in a very short time. They were proud of their achievement in adapting to parenthood but found that the huge adjustment they made was not understood by friends their own age:

Abby Before we had her we were like young and having fun and everything. Now she's come along we don't really care about that other life, we're more parentalistic now. But we do go out now and then, we give her to [Partner's] sisters for the night. We went out two weekends ago because it's two years since we got together. And we went out Friday night for a work do and got completely trolleyed, which I won't do again. I had a hangover. I thought 'Oh my gosh, you can't do that when you've got a kid'. Before you have a baby it's about you, you know, like 'I'd like to get that top', sort of thing. But now I don't care what I wear. I'm happy to dedicate things to her, give her the best childhood she can have. You know, be a mum.

Kim I think young mums do well, they've got more patience. They don't get frustrated. When you're old it's like you don't have as much energy as you do when you're young. If I ever need a break or I'm tired from getting up at night, I'll say to Jon 'It's

the weekend, you slept in yesterday, now can you look after him for an hour or two while I have a little bit of a sleep in?' And he does, he'll get up and watch him for a couple of hours. Because we're teenagers me and him can relate a lot to each other because we met at a young age and ever since we've just made a close bond, he's been there for me when I've been down and depressed and I've been there for him. I know him inside out and he knows me. He's such a good dad. And he tells me every day how much he appreciates me. He's like 'Babe you're doing it right, look how happy our son is. I've never seen a baby so happy like him before'. He comes home and always compliments me on something. He appreciates me. And my thing for him is 'How has your day gone at work?' Sit there and listen. He gets up really early for work, he doesn't get back until late, so in the weekend I try and let him have freedom, I don't expect him to look after [Baby], that's still my job. Young guys I know, my friends and everything, say 'Oh my God you've got it really hard. He doesn't let you do this, he doesn't let you come out' and I'm like 'I'm a bloody mum, how can I be doing all that, that you're doing? I can't'. We've done the whole couple thing, we've been to parties and everything so that's no big thing. Been there, done that that, we're on to being parents, we've gone to the next level, just at a young age.

Avoiding the 'tipping point'

Participants' narratives suggest that a series of stressful incidents and circumstances could 'tip' a couple so far that 'debriefing' would no longer put things right. They were well aware of how one thing leads to another:

Karen You get a combination of sleeplessness, I get really achy shoulders so I'm in pain, and then a few other things tip you, and you end up having a ghastly conversation, a dreadful couple of hours. We always debrief after those.

As when talking about financial strain participants spoke of the potential value of having an opportunity to talk things over with someone who would 'pop in and take an interest', as Karen put it, someone equipped with counselling skills and relevant knowledge, or in Lisa's words, 'people that train in that field of work, that sort of become like therapists in a way, for the mum'. They felt that easily accessed support of this kind could help reverse escalating problems.

‘Pressures’

Some participants faced very hard times. Abby and John had to deal their baby's birth injury, which restricted movement of a limb. They were told that this might improve spontaneously over a few months but it did not, so an operation was necessary. Maya had to evade her baby's father, who had become threatening. I was unable to interview her a third time as she was in Refuge. After a succession of difficulties Fay and Jack split up, as did Dee and her partner. Two couples had serious problems linked to the care of a child from a previous relationship. Two participants had PND, which was probably a factor in Dawn leaving Kent and the baby.

When their baby was in hospital Abby and John coped by keeping a journal so that they could later tell the baby about her time in hospital; looking after one another ('talking and talking'); and also through kind, professional support from hospital staff:

Abby The nurses were absolutely wonderful, I can tell you. They were just so stress-free, they would joke around, [Baby] absolutely loved them. If we needed them they were there. They knew what they were doing. One of them went with John when he went to the operating room and was very supportive, helping him, like patting his back. And the girl I walked back with, I was in tears, she was very, very nice.

John took time off work, resulting in lost income, which in turn led to financial difficulties.

Although trying hard to make a life together when I interviewed them when their baby was a year old, Fay and Jack had become enmeshed in a chain of adversity which eventually culminated in separation (as Fay let me know a few weeks later). Chronic financial strain was a key factor in this. Jack describes a cascade of risk:

Jack Any bad circumstances you're under are exaggerated, aren't they, because you're just unable to deal with them. You're physically and emotionally drained. And suddenly you've got all these new responsibilities and pressures I guess. So anything that's already there existing is just worse - and you're sleep deprived. Pressures just become bigger and bigger and bigger and you become less able to deal with them so they kind of compound, that's what I found. I didn't realise what

was happening until after it had happened really. Parents were asking. So, 'Do you need help?' 'No, not really, I'm OK'. Really they could have come and done something, something simple like make dinner or whatever, anything would have helped. I should have said 'Yeah, come and help'. But I kind of felt that it was all under control.

Although indirectly, Dee's relationship problems stemmed from her financial situation in that Work and Income's request that she name her baby's father had emotional consequences for the young man who saw himself as her baby's stepfather. This type of scenario warrants further study because the role of WINZ is crucial to the resilience of some families; it is most unfortunate if a system that is essential to reducing risk inadvertently undermines family resilience because of policies which inevitably place restrictions on entitlements. Families in situations of this kind may need support to deal with relationship fallout and manage red tape. For example, in a comprehensive multi-agency programme considered successful, social workers found themselves providing teenage parents with counselling and 'brokering' (Brindis et al., 1987).

Several participants had to deal with difficulties arising from previous relationships, especially when a man's older children were involved. Cheryl and Tom had ongoing problems with Child Support and travel costs for his son, who was living with his mother hundreds of kilometres away and Amy had problems with her partner's ex-partner, the mother of his older child, especially around access visits:

Tom I'm not saying that I don't want to give him any money, it's just that the whole system's rude. We could survive if we only had to pay \$57 a month, like she did when we had him, but we have to pay much more than that, it's based on income. We just cannot afford to fly him up, or for any of us to get sick because we can't afford the doctor's bill. We can't afford extras, we can't afford any house maintenance, we can't afford car maintenance. It's taken away all our options. We live day by day.

Amy His ex is not an easy person to get along with at all. It's her way or no way. I'm not allowed to be here when she's here. She comes up and she just screams me out, in front of his daughter. [Daughter] used to come every weekend, every Friday, all

last year. There were constant problems – if he drops her off five minutes early she says ‘Oh you don’t love your daughter’ but if he’s late - and the watches are different, like hers says six o’clock and his says five to - he gets an earful for being late. He just can’t win. She was supposed to pick up [Daughter] and I was coming back from my dad’s house and she was 15 minutes early - of course she just went absolutely bonkers. We were parked in the road, and the neighbours came out and it was just so embarrassing. I could hear her past trucks and that, she just went off her nana. Not a stable person. Her mum’s just the same. I’ve got a protection order against her.

Beth’s relationship problems were probably linked with PND. She also suffered chronic pain. The effort to get out of the house became too much for her. She was seeing no-one but immediate family and her GP. PND was integral to problems experienced by Dawn and Kent. Kent and his mother Lisa explain:

Kent We broke up maybe five months back. I’ve had most care of [Baby] since. Dawn’s sort of staying around everywhere, in motels and stuff. Now and again she pops in. It was stress from having the baby I guess, I’m not sure. She couldn’t quite cope with being a mother so young. We had our own place, then she left and the rent was a bit expensive being on the Benefit so I moved back home. She was going to stay at her friend’s house down the road there. She’s a bit of a spinner. She’s taken [Baby] in people’s cars that I don’t want her in, I mean I don’t trust their driving. I’m not giving her another chance, I don’t trust her. Me and Mum look after [Baby].

Lisa He’s a very good dad, I’m really proud of him.

Kent I sort of stick to myself, but I pop out and see my mates now and again. I never really was much of a partyer. I feel I’ve come out more responsible, for sure.

Lisa Dawn was really great for quite a few months. Then she decided she wanted to be on her own, be away from Kent, they had their differences. So she went to her friend’s. She was good there for a while, her friend is a really good person. But then she started hanging round with the wrong type of people, new friends she met, and that’s when she just sort of went off the rails. You could tell she wasn’t

herself. She was depressed but it went undiagnosed for quite a while. She wanted to go to counselling but it was going to cost her \$80 each time. So she never went. My other son's girlfriend, they're in Oz now, took her to the doctor and he said she had PND, gave her some tablets. She started taking them and she was doing really well for a couple of weeks and then she stopped. Every time she stopped taking her tablets she was bad again. You could see, it slipped back. And she would admit that, she'd say 'Oh I've got to make sure I take these tablets'. So, it's just something that's happened. No matter who you are you can get PND. She needed someone that could come round. If they had someone checking up on them after they have a baby that would be good. She found it very upsetting when she stopped seeing her midwife, after the six weeks. You get so attached to your midwife and then you stop seeing her all of a sudden. It's like, 'You're in Plunket's care now' - for the baby it's good, but Plunket care seems to be more about Baby than Mum. Mum gets left out. That's what I find needs to be changed. They need to have someone that's trained up to come and check on Mum, see how Mum's feeling, right through until Baby's a certain age, still keep that contact with them. It's like a feeling of abandonment, I think, for some new mums. I reckon they need to have people that train in that field of work, that sort of become like therapists in a way, for the mum. Like a home psychologist that comes in to see the mum to see if you've got any worries or anything like that - if no worries that's brilliant, but just to know that they're like a friend that's going to come in and have a chat but like a therapist. And if something's wrong they might be able to help and guide them.

Someone to talk to

I bring the reporting of participants' narratives to a close and move on to reflection on the fieldwork in the next chapter with a comment that not only brings together the frequently voiced ideas of 'someone to talk to' and 'support for fathers', but also touches on other topics often raised and, importantly for me as researcher, suggests that methods used were appropriate:

Karen [Partner] gets a lot of information about parenting from talking to his friend, hearing how he's doing, how his partner's doing. They talk about their kids a lot. And I think that's really valuable. If he wasn't working with [Friend] it wouldn't be happening at all. There wouldn't be that conversation. There's a level of conversation that men

don't always get to around their children. Sometimes you don't review and reflect because you go on to the next thing and the next thing. But I do look at the year, and think 'Wow'. Anyway, it's been really good for me to talk to you because it makes me stop and think about how things have been and that's been a good process. You want to talk when you've just given birth, you really wanna talk about it, but nobody else really wants to talk about it, so to talk about parenting and support and non-support, and your first year and how it's going and who you are and what sort of things you employ to make it easier and what things make it harder is really a good thing to do. Maybe that's part of the support thing, to have someone just pop in and take an interest.

CHAPTER 10 FROM SHORE TO SHORE

Transition from one stage of life to another has been described as ‘a voyage between stable states’ during which ‘the traveller will experience some conflict on leaving one shore for the other’ (Cowan & Cowan, 2003: 425). A journey like this takes time because ‘the passage from one stage to another requires a transitional period in which there is change, disequilibrium, and some psychological stress or confusion’ (Cowan & Cowan, 2003: 425). Applying this metaphor to my study, it seems that when participants embarked they were not well enough provisioned with knowledge about how to cope or where to seek help on arrival at the other shore. By the end of their first year of life with a baby, however, most had adapted to their new roles and rated themselves as doing well across a range of family functions that can be seen as providing a general picture of competence and as indicative of resilience, a notion commonly applied to the process of overcoming the difficulties and stress often associated with transitions.

This study set out to explore the experience of first time parents in a range of circumstances in New Zealand as they adapted to life with a baby and developed competence, demonstrating resilience. It explored factors that participants experienced as helpful or unhelpful in dealing with challenges encountered during transition to parenthood, with a particular focus on the detail of informal, semi-formal and formal support and participants’ views of the helpfulness of such support. Gathering detail about support was undertaken with a view to being in an informed position to consider implications for policy and service delivery.

This chapter begins with a reflection on the study. This is followed by an overview of the narratives in relation to participants’ experience of adaptation to life with a baby, considered in relation to the frame of reference derived from the literature and presented at the end of Chapter 3 and referring to participants’ views on what helped them gain competence and adapt successfully. Then, with reference to how support may have influenced participants’ process of developing competence and resilience, I reflect on what the narratives indicate to be the uneven and partial system of support for families adapting to life with a baby. This is preparation for addressing the final research question, ‘What are the implications for policy and service provision?’. This is the focus of Chapter 11.

Looking back

When I began my own voyage of discovery I set out to map the experience of families having a first baby in New Zealand today and discover what helps overcome the challenges of the crucial first year with a first baby and get off to a good start in the parenting role. I saw this venture in simple terms; however, my trip from shore to shore turned out to be more challenging than anticipated. My reading of the resilience literature, undertaken to explore how people overcome challenges, soon showed that this topic is anything but simple. The literature indicates that resilience is the result of complex interaction with the environment. This is borne out by empirical work on children's resilience. Yet in investigating the family resilience literature I found that it either described family characteristics thought to be associated with resilience or, if concerned with promoting resilience, focussed on therapeutic intervention to bolster intrafamily processes deemed to strengthen families to face the slings and arrows of family life, if not outrageous fortune. This therapeutic strand of the literature is rooted in the US and is dubiously transferable to other contexts. Further, its recommendations for working with families, typically time intensive, seem unlikely to appeal to those in transition to parenthood, a time when daily life is normally busy and unpredictable. While the literature on children's resilience indicates that supportive resources in the environment promote resilience by helping children develop competence and self-efficacy, I was intrigued to find that the role of such support did not seem to figure in the family resilience literature. I became interested in exploring the role of formal and semi-formal support in enhancing the resilience of families adapting to life with a baby. Since in New Zealand these forms of support are largely provided under the auspices of the state, I thought it possible that understanding how support is experienced by these families might help us understand how policy and service provision might be adjusted to enhance families' capacity to overcome difficulties, develop competence in new roles and get off to a good start.

Consulting the general resilience literature indicated that understanding resilience in families adapting to life with a baby might be progressed by viewing their experience with reference to key aspects of this literature, as discussed in Chapter 3. Two strands of the family resilience literature are especially relevant. The first describes the influence of structural factors on ability to cope, indicating that policy will have an important influence on families' ability to get through the changes inherent in transition to parenthood. The

second indicates that when families find themselves caring for a family member who is in some way vulnerable, as when a chronic illness is diagnosed, access to reliable information is critical. The literature on support for parenting was also a source of sensitising concepts in that it suggested that providing support in ways perceived by users as respectful and reliable is key to success; and indeed to engaging potential users.

My study followed the progress of 25 women in diverse circumstances in New Zealand as they made the transition to parenthood. It also explored the experience of their partners, both through the women's narratives and through interviews with a number of these men. Depth interviews, producing narratives seen as 'conversations with a purpose' (Jarrett, 1992: 177), facilitated a research relationship consistent with a human rights approach (Ife, 2008). The use of narrative inquiry produced stories and quotations illustrating participants' experience and rich in detail about the participants' experiences and the practical realities of the lives of families with a first baby.

According to Flyvbjerg (2001), it is detail that enables researchers to understand situations well enough to make recommendations for beneficial change, grounded in practical reality. In my study detail was provided in abundance. Participants spoke freely, illustrating their narratives with stories about their own and peers' experiences and describing how they used support, how they felt about doing so and whether or how it helped. Some remarked that this process helped them review their progress. Participants' use of figurative language vividly represented the essence of common experiences. Hence some of the metaphors and slang phrases through which they expressed themselves are used as chapter and section headings.

As discussed in Chapter 4, reflexivity helps researchers consider their work through the lens of personal interests and biography. I began this study with an interest in how families might get off to a good start in the parenting role. This interest springs from my knowledge of what can happen when the life trajectories of families raising children go awry. As a social worker and as a person, I deplore the lost opportunities for learning and joy, the loss of potential and the waste of resources that is the inevitable result when this happens. Further, since a child's development may be permanently affected by inadequate care in the first year of life, protective care at that time is a basic human right. In a country with an avowed state commitment to the well-being of children, the state has an obligation to

ensure that families are in the best possible position to care for infants adequately so that they remain safe, secure and able to realise their full potential. Hence, it seems to me, it is important to devote thought and care to strategies for promoting good outcomes for infants via support for their families. This was the impetus for the practical orientation of the study and was a factor in participants' decision to participate and their willingness to give their time on successive occasions.⁶¹ I see the study as a shared endeavour. That participants felt involved in the study is indicated by the level of detail they provided; their entrusting me with deeply personal information; and the complexity of their ideas about change. Several said that they found talking about their experiences helpful but mostly they were sharing information in order to throw light on what life was like for them and others. The way in which they confidently produced ideas for beneficial change implies that they accepted that I was consulting them as experts on adaptation to life with a baby in New Zealand.

Throughout the study I have felt an obligation and responsibility to report participants' stories, quotations and views transparently and sensitively. In this chapter I step further towards the role of narrator rather than reporter, drawing the narratives together and presenting an overview of participants' experiences of parenthood and their perspective on support for transition to parenthood.

Something that resonates through the narratives, and is perhaps obscured because so variously expressed by different participants, is a sense of surprise, even sometimes dissonance, about what adaptation to parenthood was actually like as opposed to what they had imagined it beforehand. As noted in Chapter 5, Riessman (1993: 3) suggests that 'Narratives specialize in the forging of links between the ideal and real, self and society'. Many of the stories told during my study are coloured by the sense of 'deviation' that Reissman believes that stories may incorporate and convey.

An overview of a year of parenthood

The overview that follows addresses the research question restated below:

What was the experience of first time parents in a range of circumstances in New Zealand today as they adapted to life with a baby?

⁶¹ See Participant Information Sheet, Appendix 5.

The set of narratives from first interviews is infused with a sense of anticipation mixed with trepidation. Participants were looking forward to at last 'meeting the baby' but wondered whether they would 'be a good mum'. This is particularly evident in the narratives of older women, who were used to succeeding in work roles and fretted a little about whether they would be equally successfully in the totally new role of mother. Younger women expressed determination to do the best they could for their babies. While prospective fathers were reported to be keen to 'be a hands-on dad', some were said to be worried that they would replicate 'bad' parenting behaviour exhibited by their own fathers.

Participants commonly showed interest in learning about parenthood and were apparently picking up information wherever they could. Finding that antenatal education focussed on preparation for childbirth, most participants sought information about infant care elsewhere, many reading extensively. Those who sought information from relatives or friends with young children found that conversations usually turned to childbirth rather than infant care or any other aspect of life with a baby. Formal opportunities to learn about infant care or general coping after the birth were sketchy to say the least. Though basic information was provided at some antenatal classes and one woman had the opportunity to attend a talk on breastfeeding, information thus provided was not absorbed in a way that was useful when participants found themselves responsible for a real live baby, when they were often taken aback and flummoxed by difficulties encountered. This general theme was expressed in different ways, setting the tone of some interviews and prompting rhetorical questions, from men as well as women, along the lines of 'Why did no-one tell me?' Most notably, participants were astonished by the intensity of the early weeks and months of life with the baby; by the 'constantness' of the demands on them and the '24/7' nature of their new role.

Several younger participants stopped attending antenatal education, or never started, because they perceived mainstream classes as 'not for me'. The presence at an antenatal class of fellow participants of similar 'age and stage' appeared to determine whether it fulfilled the function of instigating an informal network of support. Two examples illustrate: a coffee group started at Rae's class, diverse in background and ethnicity but not so much age, was still meeting, though depleted in numbers, after a year; and the youngest participant (Lucy, aged 16) attended a 'young people's class', found it useful and thought

she 'might keep in touch with some of the girls'. In general, prospective fathers seemed to perceive the purpose of antenatal classes as preparation for the physical demands of childbirth, seeing their own participation as supporting their partner. The one participant who reported that the class addressed preparation for fatherhood felt that this was unsuccessful, partly because 'you need a bloke for the blokes'.

Affiliation with a midwife in the way discussed by Brown (1998) was an important factor in developing a sense of capability at this early stage. Making the important choice of 'the right midwife' appeared to be the start of a sense of having some control over a daunting situation. While it is not possible to measure how far this generalises into dealing with problems encountered later, a close, collegial relationship with a midwife seemed to establish a matter-of-fact approach to difficulties.

Participants received many gifts and loans of baby clothes and clothing. This helped financially and prepared the way for imminent role change. Support of this kind enabled family and friends, even acquaintances, to demonstrate that they cared about the baby and its parents. It was a tangible sign of the existence of a support network. In a way it was recognition of participants' introduction into a kind of club, a 'sorority of mothers' (Lewis, 2008), or, in a phrase I recall reading years ago in an account by Susan Sontag of her experience of having her son, a 'mafia of mothers'. During first interviews, family and friends were repeatedly cited as sources of information and assistance in the future.

The second set of interviews, undertaken when babies were around three months old, produced stories and quotations about participants' experiences of childbirth, the early weeks of parenting and support received. Participants commonly and freely expressed views on what they liked and disliked about support received and what they would have liked to be different. They were generally appreciative of medical care for childbirth. Local birthing centres were praised for support received afterwards but this was not true of hospital care; participants felt that they had to leave hospital before they were ready. Some women were in a position to compare these types of facility, having been transferred to hospital for the birth, then back to a birthing centre for a recovery period. Birthing centre staff were apparently adept at coaching new mothers in infant care skills, including breastfeeding, and were perceived as 'making a fuss of' them and their babies. Food provided was plentiful and appetising. New fathers were welcomed at birthing centres,

able to spend peaceful time with their partner and baby and sometimes coached in infant care, including bathing. In hospitals, on the other hand, men reported that they felt disregarded.

It was in the first days at home that participants realised how much they did not know. Several spoke of being at a loss, unsure what to do when the baby cried or feeding was difficult. Some had not been shown how to bath a baby. Many frequently called telephone phone advice lines. Although some learned from family members, many spoke of 'floundering in the deep end'; whether they sank or swam was up to them. For a few, family was a source of additional problems. In these early days midwives were relied upon for guidance as new mothers recovered from childbirth and learned to care for the baby. Midwives were spoken of as protective figures, knowing and caring enough about a woman to understand her needs and intervene on her behalf to ensure her needs were attended to. However, midwives were not available on call. Many participants sought guidance and reassurance from family and friends. Beth, for example, expressed deep appreciation of on-call support from her mother, father, sister and teenage niece. However, she had virtually no contact with any-one else apart from her partner, her GP and a pregnant checkout operator at a local store. When this woman left work to have her own baby Beth was totally reliant on family members for social interaction. She said that she found it too hard to get to the local coffee group and, since the Plunket nurse was only available in her rural township occasionally, she preferred to visit her GP, who eventually diagnosed her with PND, understood to be associated with isolation (Rankin, 1988). Beth's was an extreme instance of social isolation but other participants experienced isolation, speaking of being left alone on the first day home with the baby; being alone with an inconsolable baby for hours on end; missing out on early Plunket visits and invitations to join coffee groups because of slipping through a crack in the system; and having no contact whatsoever with other new parents. When opportunities for social contact were available participants often did not at first know about them.

For many participants, responsive, consistent support, personified in the collegial, professional support provided by nearly all LMC midwives, came to an abrupt end with the midwife's departure after six weeks. This came as a bit of a shock for most. As Julie said, 'We were just another family - it's on to the next one now'. Participants found that Plunket nurses were often too busy for a trusting relationship to develop. After home visits ceased

they were perceived as 'for weighing and measuring'. However, Plunket Family Centres were different: staff were seen as having the time to be responsive. Apparently there is no mechanism for checking that new mothers are linked to a Well Child provider. Two participants slipped through a crack at this point and it took each some time to work out what to do. While both eventually made the effort to find out how to access Plunket they missed out on early visits and the chance to join in at the start of a coffee group. If this in any way reflects a common scenario, then many new parents must fall through this crack.

At this early stage participants had broadly similar basic needs (high quality maternal and infant health; adequate income and accommodation) and support needs (advice; information, coaching; positive feedback). In using services participants wanted to maintain their autonomy; they wanted access to information and guidance from an authoritative source as opposed to instruction from a 'bossy' or 'directive' source. When services were delivered in the latter way participants felt demeaned, uncomfortable and simply stopped using the service or ignored advice received. As noted in previous studies (e.g. Quinton, 2004) the style of delivery of a service, its ambience as well as its accessibility, featured in many narratives and participants expressed definite views about what they disliked or preferred. Sometimes a preference was so marked (for example for antenatal education designed to suit young parents) that it almost could be categorised as a need. Participants wanted to be treated with respect. It is here that the detail of participants' narratives is especially illuminating; often it was the detail of what others did and said in the early days that either encouraged women or demoralised them.

Narratives from later interviews typically suggest that work/life balance caused worry. The idea of returning to paid work was one that many participants pondered and fretted over. Several expressed a sense of being torn between somewhat unsatisfactory options. A category of support that could be classed as informal is support from employers. Even in first interviews some participants mentioned feeling valued when employers were accommodating about the timing of a woman returning to work and willing to adjust hours of work to suit her. This was experienced as a welcome boost to confidence, occasionally later eroded by what felt like diminished status, from valued employee to 'mum', when managers who had promised flexibility had moved on or when 'flexibility' turned out to mean doing lower status work. As Clare (lawyer) and Dee (waitress) both found despite their different types of employment, the attitude of a manager when a woman returns to

work may subvert an overtly supportive arrangement, perhaps reflecting a macrolevel attitude that positions parenting as low status. Some participants could not find a childcare solution with which they felt comfortable and decided not to return to work. Others were firmly committed to being a 'full-time mum' but only too aware of the financial consequences of this choice. While some women who made this choice made friends through antenatal classes or coffee groups and spoke of reciprocal babysitting, emotional support and invitations to go on outings, many found it hard to find interesting things to do. As the first year progressed, women felt more pressure to return to work, causing some to agonise over the relative advantages of working, earning money and regaining lost status, versus being with the baby and 'being there' to observe the baby achieving milestones. This was a tough problem for several women; some oscillated between working and not working, or increased then reduced their hours of work; others did not return to work but expressed some sense of diminishment in status, even intellectually.⁶² Of note in the third set of interviews is how much effort women not in paid work put into counteracting loneliness and boredom. If motivation to do so were compromised by depression, or by being repeatedly knocked back by not fitting into a group or course, women were literally on their own. The coffee group scheme worked for only a few; others were more or less adrift. While the kind of young mums group that Zoe wished for is provided by Auckland Women's Centre, who transport young women to the group from all over Auckland, Zoe lived elsewhere. In Ungar's terms (2008) participants were willing to navigate to sources of support. However, these were thin on the ground, and, when available, did not suit everyone.

The issue of the status accorded parenting was raised by several participants, either in relation to parenting actually being work, or to how participants perceived themselves to be regarded by others. Some participants, Cheryl most forcefully, argued for a 'full-time parent allowance' equivalent to Childcare Subsidy to recognise that parenting is valuable work. Cheryl thought it absurd that if someone else looked after her child while she worked this would be regarded as work requiring payment, while if she chose to look after her child herself she would not be regarded as working. Perception of status was to some extent linked to a participant's age. Some, particularly older women with established careers, were surprised by what felt like loss of status, the consequence of stepping out of the role of respected professional and into the role of 'just a mum'. Younger women, however,

⁶² As Jess did. (see previous chapter).

apparently saw motherhood as enhancing their status; they noted, with some surprise, that professionals they came into contact with, including midwives, some Plunket nurses and WINZ staff, took them seriously and treated them with understanding and respect. Less positively, men spoke of feeling like 'the invisible man'; 'at a loss' or 'spare'. Those who had envisaged being a 'hands-on dad' were disappointed that at first 'you can't add any value', although as babies got more interactive they found that their role developed into more active fathering. Some couples found that a new father's ability to be 'hands-on' was limited by work commitments. State schemes to compensate for reduced income when a new mother gives up paid work often did not entirely mitigate financial strain; men felt pressure to work longer hours, thus limiting time with the baby.

The situation for fathers warrants special comment. The findings suggest that the needs of new fathers are currently not well met. Fathers interviewed, or whose views were reported, apparently internalised the notion that they would be a 'hands-on dad' but found that this role was delayed. Participants suggested that disappointment could be avoided by telling prospective fathers that their active role with the baby begins when a baby starts to interact and that a useful strategy would be to provide new fathers with information on infant development (a 'manual', see Appendix 2); opportunities to learn what they can do in the meantime (bathing, soothing, altering the home in preparation for the baby becoming mobile); and access to some type of relaxed, reliable support to help process change inherent in becoming a father. This would lay a foundation for a 'team approach' to parenting, something several participants mentioned as helpful.

Throughout transition to parenthood young parents tended to face more 'daily hassles' (Patterson, 2002a) than older ones, especially around transport, accommodation and finances. However, financial well-being was problematic across the age range. Many participants were 'living on a shoestring', some a very frayed shoestring, in danger of breaking, others on a much more substantial one, but still a shoestring from their point of view. To find a cheaper house, or a better house for similar rent, several younger participants moved house during pregnancy or in the baby's first year, some more than once.⁶³ For instance, Sara shifted to an outlying area where rent was comparatively cheap but subsequently felt isolated and soon shifted again. Since few first time parents are likely to be in a position to haul themselves out of financial difficulty, the state system of income

⁶³ Two older couples also moved house during the baby's first year. Both couples were renting. One couple were financially secure but wanted more space; the other, Fay and Jack, were in financial difficulty.

support and tax credit is critical. The current system provides a basic income for most, but, according to participants' narratives, it really is basic. The precariousness of living on such an income was remarked upon not only by participants in this situation but also by others, including the affluent, whose situation was merely not as good as previously. Financial strain was evidently a risk factor for family resilience; it was cited as a cause of the relationship problems of the three participants who placed themselves lower than 4 for nurturance and belonging on a 1-5 scale. Relationship instability was also more of an issue for younger than for older participants. However, this may be as much due to short relationship duration and unplanned pregnancy as to age. Of the three couples who separated after the baby's birth, one couple were both in their mid thirties. In each case the pregnancy was unplanned and the couple had been together only a short time beforehand.

An interesting aspect of the study was participants' understanding of family. This was broad and flexible, indicating that strategies for assisting families with a first baby may be constrained by clinging to the idea of nuclear family, which, though spoken of as the norm by some participants, was not the family form depicted in all the narratives. These present a range of notions of family, occasionally including close friends as well as kin and involving complex understandings of reciprocity. In terms of support from family, types of assistance anticipated and sometimes pledged before the baby's arrival did not always eventuate. For instance, some grandmothers seemed to enjoy the prospect of looking after the baby more than the reality. Table 3⁶⁴ shows that participants received information and practical, material and emotional support from family. This is a similar picture to that presented in a review of studies of support provided to families with young children (Miller & Darlington, 2002). Some participants, especially younger ones living with or close to their own parents or other relatives, had such support available almost on call. This could be very helpful indeed, as shown by Tania's description of her aunt's unobtrusive, practical help. Older participants generally had less support from family, as found in a study of social support for new mothers across a wide age range (Bornstein et al., 2006). Broadening the notion of family might encourage the dissemination of information and support to family members likely to support new parents, thereby strengthening the network of informal support available.

⁶⁴ Appendix 2.

This chapter next addresses the research question:

What factors did a diverse set of first time parents experience as helpful or unhelpful in dealing with challenges encountered during transition to parenthood?

Here I return to the frame of reference derived from the general resilience literature and presented at the end of Chapter 3:

- Resilience is a process of developing competence in response to challenges, thus demonstrating ability to get through a difficult time.
- Resilience is compromised by accumulation of difficulties, which may become a downward spiral from which it is hard to escape.
- A life event or transition may be experienced as a turning point, altering a trajectory of risk to one of resilience.
- Resilience is the result of resources that operate at all levels of a person's environment, from the personal and interpersonal to the structural and attitudinal.
- A key mechanism underpinning resilience is the development of self-efficacy and agency, envisaged as ability to find a way to overcome difficulties. This enables people to acquire skills useful not only for current problem solving but also in the future.
- Resilience is influenced by contextually specific factors.

Considering transition to parenthood through a resilience lens brought two aspects of this experience into focus. First, it clarified that people in this situation are going through a process of developing competence while coping with new challenges. Second, it indicated that resilience could be promoted by paying attention to protective factors at various levels of the ecological model, including those encompassed in, or that could potentially be strengthened by, the system of support provided by the state. This frame of reference is applied below to help comprehend and explain participants' experience of adaptation to parenthood and then, in the section headed 'A perspective on support', to indicate how the support system could be enhanced. The discussion notes aspects of the family resilience literature that might have been expected to be important but that did not feature strongly in participants' narratives.

An application of the concept of resilience

This section looks at each of the points extracted from the resilience literature in turn.

Developing competence

Resilience is understood to be a process of developing competence when challenged by a difficult situation. Participants' narratives show that many experienced either a sustained period of adversity, or intermittent occurrences of problems, when they were anxious or bewildered, expressed as 'at a loss' or 'floundering', as they took on new roles and responsibilities. Mostly the difficulties they faced were unanticipated; while they might have been cognisant that their lives would change, that they would have less income, that the baby was likely to wake at night or cry a lot, that they might miss work or be alone with the baby for long periods of time, they were taken aback by what this actually meant to them when it eventuated. The resilience literature indicates that regaining equilibrium when challenged by a life transition takes time; this was certainly the case for participants. Yet the development of competence in a range of domains associated with key family functions is a thread that can be followed through most of the narratives, and, when their babies were a year old, most participants considered themselves to be doing well in all these functions: material well-being; protection of vulnerable members; nurturing and self-development; and sense of belonging. This sense of accomplishment indicates that they had successfully developed competence while dealing with challenges inherent in transition to parenthood.

In danger of sliding towards a cascade of problems

Looking at the risk end of the risk/resilience continuum, the narratives show how draining adaptation to parenthood may be, making it hard to persist in seeking solutions to problems. Some participants experienced serious problems, including depression, couple conflict or financial problems, to the point where family functions were disrupted. As suggested by the notion of a cascade of problems, participants in this situation tended to find that one difficulty led to another and problems escalated. For example, the difficulties of two couples who separated were linked to financial issues, which caused a series of further problems, including unsettled accommodation problems. Depression was a factor in one of these situations, as it was in another situation where a participant considered herself to be struggling with the family functions of sense of belonging and financial well-being. Isolation was also a factor in her situation.

Turning points

The narratives of some younger participants indicate that for them transition to parenthood was a turning point. They mused about how their attitudes and behaviour changed when they became parents; in Abby's words, they felt 'more parentalistic' and found themselves 'giving up a freedom lifestyle' to focus on parenthood because 'you've got to be a role model for your little one'. In this typical comment Abby echoed, almost word for word, participants in a study of adolescent Latino parents (Dornig et al., 2009). Kim's narratives provide an exemplar of a lifestyle transformation. Her midwife's willingness to listen, understand and advise enabled Kim to resolve an issue which was threatening her relationship with her partner. Looking back after a year of parenthood Kim noted how much she had changed and expressed satisfaction with how well she had coped. Her story provides a classic example of resilience developing over time.

Drawing on resources at all ecological levels

Looking first at microsystem level and regarding new parents as protagonists, participants' narratives suggest that it might be helpful to present transition to parenthood as requiring a team approach where at first the father's role is to support the mother, meanwhile developing expertise in bathing or soothing the baby. Men whose experiences informed the study felt disappointed that their role of 'hands-on dad' was in effect postponed and said they would have preferred to be forewarned about this. Roles shift so much at this time that people may feel uncertain or even supplanted. This appeared to be the case for a number of fathers, who were not only unclear about how to 'be a dad' but found themselves no longer, as Tom put it, 'the be all and end all' to their partners. It is possible that this could cause feelings of displacement, upsetting sense of belonging.

The importance of self-development is as pertinent at this time as at others. As the months went by women began to find themselves isolated and bored. Some of the professional women in the study feeling as if they were in a backwater, or becoming 'a bit dim' as Jess said. There was little indication of pathways in the system that would lead new parents through such issues; they had to just deal with them themselves. At this stage a buoyant attitude helped them do 'something actual or practical' (Heiman, 2002: 169) to seek out interesting activities. This form of agency appeared to be conducive to a chain of beneficial consequences. By persisting in their efforts to get out and about, a few got to know other

women with babies and developed friendships characterised by reciprocal practical and emotional support. Karen's description of joining a playgroup⁶⁵ is an example of this. Conversely, Beth appeared to become increasingly isolated and depressed. A buoyant attitude also helped those who found returning to work less straightforward than expected, enabling them to manage childcare arrangements and cope with perceived differences in how they were regarded in their work role.

Support at microsystem level included support from family members as well as personal strengths and forms of behaviour, notably 'teamwork' by which participants meant a couple taking different but mutually supportive roles and changing how they allocated tasks, such as shopping, preparing meals, infant care and looking after partners who were working long hours to earn income. Although in interviews participants were invited to talk freely and lead the conversation in whatever direction they wished, few indicated that they attached importance to the role of elements Walsh's Framework for Family Resilience (e.g. 1998), such as cohesion or, rather surprisingly in my view, communication. Two who did were Dee, who spoke of attempting to resolve a particular problem by 'talking and talking' and Abby and John, who used a diary to record their feelings during the time that their baby was in hospital for an operation that could prevent permanent disability, and then read each other's entries. Fay and Jack stopped attending couple counselling, which they had begun before their baby's birth, because they had used the six free sessions funded by the Family Court and did not have any money spare to pay for further sessions. It is possible that if they had received professional support more quickly after the traumatic experience of their baby's birth, and also if the medical procedure Fay needed had been attended to promptly, then the chain of adversity they experienced may have been averted.

Within the therapeutic perspective (e.g. Walsh, 1998) outlined in Chapter 4, family rituals are seen as one of the 'keys to family resilience'. While family rituals did not feature strongly in participants' narratives, many spoke of the baby's first birthday party in a way that indicated it was perceived as a ritual. These parties were held by many families associated with the study and were experienced as emotional affairs; some were large scale events with many guests. The first birthday party seemed to be seen as a milestone, marking achievement, rather than as a key to family resilience. Something else that could

⁶⁵ Chapter 7.

fit under the category of ritual was purchasing a set of formal photos of the baby and the family. This was mentioned by several younger participants, especially those living in the country.

An area where support in the community was much valued was in providing authoritative guidance when difficulties were encountered. An example is Rae's experience of the Plunket Family Centre, where the staff knew her well enough to realise that she was not an over-anxious mother needlessly concerned about a temporary problem, but that her anxiety indicated a problem. Her GP, on the other hand, had not picked this up. A less dramatic example is the help Julie and her partner received from the local Plunket nurse, who kindly but firmly guided them through a process of managing their baby's sleeping pattern⁶⁶. The effectiveness of support from family members depended on their attitudes to the new parent as well as the nature and extent of their knowledge. While some provided stalwart, down to earth, on-call support, such as Leah and her partner received from various family members, others found that family members could not always be relied upon to provide assistance even when they had previously promised help of one kind or another. Sometimes, while willing to help, family members seemed to be even more at a loss about what to do than the new parents themselves, or were relying on dimly remembered advice received when their own children were infants. Availability of resources was a key factor in participants' ability to either return to work or find adult company and something interesting to do. Women regarded childcare that they felt comfortable with as a precondition for returning to work but in some areas options were limited.

The narratives indicate that there is scope at exosystem level for government agencies and service providers to develop policy, resources and services that will help meet the needs of a wider range of people in transition to parenthood. Significantly, the importance of parenting is not reflected in income support strategies. Many participants struggled financially and their struggles sometimes had consequences for their capacity to establish themselves in a community or affected stress levels and couple relationships. There may also be scope for strategies operationalised at mesosystem level, such as meetings attended by agencies operating in a particular area with the aim of rationalising services

⁶⁶ Chapter 8.

provided, thus promoting congruence and potentially attending to any gaps in service provision.

The macrosystem affects the status of children, parents and parenting, exerting a pervasive influence over the priority given to the well-being of children and families and whether parenthood is perceived as a private matter, the responsibility of each individual family, or a shared responsibility warranting support resourced by the state. Participants' narratives suggest that the macrosystem currently transmits contradictory messages: infant well-being is a state responsibility but parenting is a private matter; optimal infant care is critically important but parenting is a low status occupation. Older participants spoke of feelings of diminished status. Paradoxically, younger participants found that their responsibility for a baby seemed to elevate their status.

Participants used forms of support, such as paid parental leave, Working For Families Tax credit or DPB, that helped them make progress in fulfilling another family function, that of economic well-being. However, they were not always aware of what they might be able to get. Many participants experienced financial strain. Even with regard to the fourth family function of protecting vulnerable members, here the baby, resources available were patchy across the areas where participants lived.

Overall, sources of support in the environment for adapting to the parenting role were thin on the ground. Participants willing to seek support sometimes found that the support available to them was delivered in ways that did not suit their situation or circumstances and made them feel uncomfortable or disregarded. While maternity and infant health care was generally praised, participants had little opportunity to learn baby care skills and perceived themselves as being left to 'flounder'. When they turned to family and friends as consultants this type of support was helpful when these people were knowledgeable and a source of strength, as Clare pictured her mother. However, new parents may simply have no-one to consult, or those consulted may suggest practices that are counterproductive, no longer recommended or simply wrong. Informal support of this type can be risky if advice supplied is inadequate or if those that new parents turn to are themselves stressed. Some participants suggested extending the provision of information to people likely to be a significant part of a child's life, including grandparents, aunts and uncles and close family friends. There was a sense that providing these key people with information that would

help them understand how they could best help and inform them about current infant care practice would acknowledge the potential value of their assistance and lay a foundation for an enduring beneficial influence on the continued development of family resilience. Table 3, Appendix 2 provides a comprehensive list of the types of support that participants found helpful or that they thought would be helpful for new parents like themselves.

Self-efficacy

Some participants with incipient problems managed to resolve them at an early stage. This appeared to give them confidence about ability to resolve future problems, implying, as the literature indicates (e.g. Fraser et al., 1999; Fredriksson et al., 2003b) that successfully resolving problems reinforces agency and builds self-efficacy. Some who faced challenging issues reported that they emerged stronger, with an enhanced sense of self-efficacy, as Abby and John did after coping with their baby undergoing significant medical intervention. For participants whose difficulties were of a routine type, for example the broken nights and occasional episodes of bewilderment to be expected with a new baby, coping with these difficulties was a source of pride.

The children's resilience literature suggests that self-efficacy is the driving force that enables people to extricate themselves from entanglement in risk and embark on an upward spiral of achievement, thus demonstrating resilience. In turn, achievement reinforces self-efficacy, promoting the development of competence generally. A key function of support available within a young person's ecological context is to provide opportunities to develop talents and a sense of self-worth and link children with mentors who may help them develop self-efficacy. When I began the study I thought that a similar function might be performed by sources of support for transition to parenthood. However, this did not turn out to be how participants experienced support or conceptualised what they needed. While supportive resources in the environment were used by participants as part of their process of developing competence and resilience, there were differences between how this appeared to work for them and how it is believed to work for children and young people. What participants in my study appeared to want was to be able to access information, advice and guidance as and when they needed it and provided in ways that offered options and thus recognised their existing capacity for making choices based on existing self-efficacy. They preferred support that was collegial in style rather than directive. Indeed, when support was provided in a directive way it was often rejected.

It appears that although self-efficacy was important for resilience at this stage, the salient point is not so much that support is important for development of self-efficacy as that support is more acceptable and powerful when it recognises self-efficacy.

Recognising context

The narratives strongly indicate that context was barely recognised in the provision of resources and services for transition to parenthood. While the age range of women having a first baby is now very broad, there was little evidence of services and resources being adapted to suit the preferences and needs of different age groups and even less evidence of consideration of background and culture. Moreover, participants' narratives suggest that speakers of English as a second language may not be well catered for by maternity health care services. In alluding to negative consequences of these issues the narratives suggest that much good could be achieved by attending to them.

A blurred and incomplete big picture

Participants' narratives show that far from being comprehensive, support for transition to parenthood is fragmented, partial and designed to suit a limited range of people. There is no indication of a planned approach to providing families with an overview of potentially useful formal and semi-formal services or schemes for protecting financial well-being. Participants were vague about what life with a baby would be like and nothing prepared them for the extent of the changes they would soon be dealing with. There was little evidence of variation in the style of antenatal education to suit diverse needs. Apparently families are expected to fit themselves into a class rather than being able to attend a class tailored to meet their needs. Even when participants enthusiastically engaged with this type of support it was of minimal use in preparing them for transition to parenthood, being evidently focussed on childbirth. In subsequent interviews, when aware of the magnitude of the change inherent in transition to parenthood, participants reflected on the best time to educate people about life with a baby, but reached no clear conclusion. On the one hand they wished that they had had the chance to learn more, on the other they thought that maybe information about life with a baby is absorbed only when it is directly relevant to what is going on at the time.

Antenatal education worked for some participants, but not all, in developing a sense of self-efficacy in relation to childbirth. The LMC role appeared central at this time. Some

participants spoke of actively seeking the 'right' midwife, by which they meant one who would understand them on a fairly personal level. Through the trusting, respectful relationship that they seemed adept in establishing, midwives evidently conveyed belief that women were 'more than capable of doing it', as Fay said, thus helping them to build belief in themselves. While typical of women who had their 'own' midwife, this sense of self-efficacy was not expressed so clearly by those with different arrangements. Also, a midwife who knew a woman well was able to attend to the detail of her care, acting as a kind of guardian and ensuring that her needs were met. Midwives were evidently skilled in engaging and including fathers. In a study of new migrant mothers, DeSouza (2006) found that Korean, Indian and Chinese women used their networks to find midwives who could speak their language and understand their needs. However, the cultural background of midwives is not an issue brought to light by my study.

The sparseness of support available to participants does not bode well for the promotion of the resilience of families adapting to life with a baby. While the number of women interviewed for this study is small, their narratives indicate that currently support for preparation for parenthood is patchy and provided in a style that does not suit large groups of first-time mothers (young mothers for example). Maternal health care, deemed excellent by most participants, focusses on the physical well-being of mother and child. Antenatal education, the only other obvious source of formal support, focusses on childbirth; information provided about adapting to life with a baby is superficial and ineffective, being recalled by participants only hazily or dismissed as inadequate. Participants basically prepared *themselves* for parenthood, either by reading or by consulting their network of friends and family. With the exception of some of the support provided by some midwives, neither sense of belonging, nor nurturance and self-development, appeared to be a concern of formal or semi-formal support available to new parents involved in this study. Yet it is possible that if Dawn had been able to access such support, her PND may have been attended to early enough to prevent the problems that ensued for Dawn, her partner, their baby and her partner's family.

Taking account of Rutter's argument (1987) that resilience is the result of averting the ill effects of risk while making use of opportunities to develop competence, it would seem that resilience promotion in a particular context should address both risk reduction and competence enhancement. Since neither strategy is much in evidence with regard to

enhancing resilience in families in transition to parenthood, an opportunity is being missed to make the birth of a first child a turning point for many more families by ensuring the availability of various types of support to boost their capacity to address difficulties they may face in various areas of their lives.

The following discussion of support presents further indications of participants' experiences of support that enhanced their resilience and their views on what might work better. The discussion is informed by ideas about respect and reliability, identified in the literature (e.g. Quinton, 2004) as influencing the uptake and effectiveness of support.

A view of support

Previous chapters document participants' experience of adapting to life with a baby, coping with changes and difficulties entailed and learning to operate comfortably in their new roles. In talking about their experiences they provided an abundance of suggestions about how the system of support for transition to parenthood might be enhanced. Table 3⁶⁷ presents, verbatim, participants' suggestions for improvements in this system. Types of formal, semi-formal and informal support that participants found helpful are also noted in this table. This is an important result of the study as these ideas were produced by people currently experiencing adaptation to parenthood, and who had taken the time to reflect at some length on how support could be improved for people like themselves.

The ecological perspective recommended in the literature (e.g. Waller, 2001) indicates that the current system of support for adaptation to parenthood in New Zealand is far from comprehensive. Rather than looking at personal factors that might help families adapt to parenthood and develop competence and resilience, I wanted to explore the role of supportive resources in the environment. While this was a focus of interviews, participants commonly spoke of drawing on personal resources. I saw their insights in this regard as potentially informing beneficial change in the support system. A caveat applies to Table 3: when I began the study I framed support much as Cobb (1976: 300) did, as information and action that 'makes the recipient of support feel cared for, esteemed and valued and creates a sense of belonging to a network of mutual obligation'. However, it became evident that participants in fact perceived themselves more as consumers, believing that they should be able to exercise choice and select a preferred service from among a range

⁶⁷ Appendix 2.

varying in style. For expedience, and for lack of a more appropriate term, I continue to use the term 'support' in this discussion.

Looking first at support available during the very early phase of transition to parenthood, antenatal education seems to be provided in ways that best suit people in their late twenties or older. Younger participants found mainstream antenatal classes off-putting; their response ranged from putting up with feelings of discomfort to dropping out. Antenatal education was firmly focused on childbirth and most participants had no access to education about caring for an infant other than self-directed learning, commonly books. The question of when to provide education about life with a baby is tricky. Participants lamented the lack of such education but recognised difficulties in timing; before the birth of their child they were 'not ready' for information but afterwards found that, as Cara said, 'suddenly you've got this baby and you think 'well, I haven't actually read anything about what to do now''. Many participants described panic when a baby was unwell or even simply displaying new but perfectly normal behaviour. Several were unaware of how to access support when struggling to cope with common difficulties.

An optimistic attitude (characteristic of resilience) appears to be enhanced by a sense of being valued; the narratives suggest ways in which this might be done. Possible strategies include consciously creating a welcoming, congratulatory atmosphere in maternity units; providing information about common problems that may be encountered and how to deal with them; and spending more time coaching new parents in infant care, including breastfeeding. For families with a first baby to quickly become established on the best possible trajectory it is important that providers of formal support through the health care system are aware of their potential role in promoting competence. Women in maternity care are essentially a captive audience but currently this is not utilised to their benefit. Enabling women to stay longer in maternity care might turn out to be an investment in the long run, helping convert transition to parenthood into a turning point. The narratives suggest that the health sector is in a strong position to enhance the resilience of families adapting to life with a baby; midwives, maternity facility staff and Well Child service providers are well placed to promote parents' competence and thus resilience. This now seems obvious to me, but was not so at the start of the study when I thought there might be an important role for social workers in assisting families to learn parenting skills, deal with relationship change and generally stay on track.

Despite participants' apparently envisaging themselves as consumers of services, what they preferred and required was consistent with the support literature (e.g. Quinton, 2004). What they wanted from formal support was reliable information, advice and guidance provided in a respectful, collegial way, presenting options rather than prescribing action, so that it was they who made the ultimate decision about what to do rather than a professional. The quality of the relationship that providers were able to establish was a key factor in whether participants remained engaged with a service. They sometimes rejected support perceived as 'bossy' or directive. This echoes Quinton's (2004: 189) finding that parents wanted services that 'took their views and needs seriously, listened to them and were emotionally supportive as well as practically helpful'. The support of LMC midwives was experienced in this way by participants in my study and was missed when it came to an end. Trusting relationships with midwives apparently enhanced women's self-efficacy throughout pregnancy, childbirth and the early postpartum period.

Practical, material and emotional informal support from family and friends was deeply appreciated when matter-of-fact and closely matching needs, as opposed to being well-meaning but inept, not needed or intrusive. Feedback that participants received from family and friends was occasionally frank, as when Clare's sister said: 'Get over it Clare, your career's not everything' or when Tania's mother pointed out that she could hardly expect to fit her usual dress size three weeks after giving birth, but this kind of response was appreciated as down to earth and in the recipient's best interests.

Appraisal support (Warren, 2005) for parenting was mentioned more frequently during later interviews, perhaps because it is easier to see that a parent is doing well when a baby begins to respond and reach milestones. Amy's story of her careful parenting being ridiculed illustrates a less positive side of appraisal. While Amy resisted her peer group norm of casual, irresponsible parenting, parental self-efficacy may be undermined if a parent's efforts to 'do it right' are mocked by members of their network. Amy was convinced that no amount of information would change her friends' attitude because it was ingrained. This raises the issue of how prospective parents acquire knowledge and values about parenting and its responsibilities. Competence, an integral aspect of resilience, may be compromised by conflicting advice and derailed by prevailing attitudes contrary to good parenting. It is possible that, lacking formal support that suits them, some new parents

may follow role models whose parenting is misguided or even dangerous, or rely on people who give out of date advice. Since infant care practices recommended a generation ago have been superseded, the most well-meaning supporter may cause confusion or create the impression that a new mother is not coping well and cause irritation and annoyance. This underlay Lucy's wish⁶⁸ that her mother would wait to be asked for help. Lack of alternatives meant that participants often turned to family and friends, who could indeed be helpful when they were calm and knowledgeable or got on with what needed to be done without requiring direction or being intrusive. Yet sometimes those to whom participants would naturally have turned were unavailable, living some distance away or even overseas. A few participants were estranged from family. Such disconnection was more common for men than for women.

Semi-formal support was of limited value, and indeed limited availability. Sometimes this form of support was experienced as alienating and so was not used. Coffee groups were perceived as a forced situation where participants were lucky if they found someone compatible. It appears that coffee groups do not attract young, less affluent or non-Pakeha participants. Abby, who said 'I love my coffee group', was an exception among young participants, most of whom did not attend coffee groups. In fact the only other participant who appeared to actually enjoy her coffee group was Ria, who attended a long-established mixed age rural group that included a cousin and family friends and functioned as a gateway into local community life. However, Mainly Music, a church-based drop-in activity open to anyone caring for young children, appeared to be easy to attend, widely available and used by participants in diverse circumstances.

Paid parental leave was considered a boon by those eligible but ineligibility caused indignation, especially if a woman had worked in a job for a very short time less than required for eligibility. Some fathers had little time off work around the birth; one in effect had none. Yet no-one suggested paid parental leave for fathers, perhaps because they thought this might mean less for mothers and they wanted more maternity leave, not less. The narratives suggest that if fathers are able to take unpaid leave, a good option might be to split the leave, taking some immediately after the birth to support the new mother, then more after four or five months (the time when fathers noticed babies beginning to interact with them more) thus perhaps providing an interlude for enjoying bonding.

⁶⁸ See Chapter 7.

Overall, participants' access to support was variable; not only were available resources restricted in type, tending to suit some (namely older, middle class women) far more than others (younger, less affluent), but some participants had very limited access to any services at all. The findings suggest that the landscape of support for families having a first baby in New Zealand is complex but incomplete. A picture of support available would show detailed, vivid areas (LMC midwife care; medical care for infants); areas clearly depicted but with details yet to be completed (financial assistance; paid parental leave); areas that have faded (Well Child home visiting service; support from peers, mentoring); and areas only sketched (training in infant care; support for new fathers). Further, it is as though this picture is superimposed on another showing an idyllic but mythical place where all families with a first baby cheerfully cope by drawing on personal strengths and the knowledgeable support of a willing personal network. In this place the adage 'It takes a village to raise a child' is put into action. During the second interview I asked participants what they thought about this adage. Most thought it unrealistic. Ange's response was blunt: 'Wake up to the real world, it's not happening'. Ria's was: 'I think that's a wonderful romantic idea and I wish it could be more like that - but it's not'. While a 'village' approach may have been true to life in the days when cohorts of women embarked on motherhood together and had access to informal support from peers as well as relatives and others, times have changed. Few novice parents in my study could learn by osmosis or develop parenting self-efficacy by observing more experienced parents. Formal and semi-formal support does not appear to have compensated for the loss of this function of informal support.

Participants could clearly identify room for improvement in the support system and offered many suggestions about how gaps could usefully be filled (Table 3).⁶⁹ Table 3 also notes types of support that participants experienced and found particularly helpful. Ideas in Table 3 were all volunteered in the context of participants' discussion of their own situation and that of others in a similar situation. Ideas were often prefaced by recognition of resource constraints; participants were well aware that increased availability of one type of support might mean less of another. That being said, participants definitely wanted more information about basic infant care skills and easier access to sources of support if problems arose, especially the opportunity to talk things over with someone both trained and friendly. Participants mentioned two types of formal support in connection with this:

⁶⁹ Appendix 2.

'drop-in' centres (like Plunket Family Centres); and a 'check-up' home visit providing an opportunity to raise issues which could then be resolved in subsequent visits or addressed by referral to a resource or service. Like Kent's mother Lisa, participants thought that by giving new parents the chance to reflect, someone 'like a friend that's going to come in and have a chat but like a therapist' might see behind a veneer of coping and pick up problems like incipient PND, serious financial strain, relationship problems or violence that might otherwise be noticed by no-one until it was virtually too late to prevent enmeshment in a chain of risk. Visits of this kind might accomplish what Rutter (1987) sees as the dual foundation of support for resilience: avert problems and create opportunities. In final interviews there were further suggestions about 'more home visits' by someone knowledgeable and trained to listen, who would, in Karen's words, 'pop in and take an interest'. This was seen as a way to process and resolve relationship issues.

There were many ideas about practical assistance in the early days at home with a first baby. There were also suggestions about making it easier to access information, including ongoing information about infant development, perhaps in the form of a class, 'a bit of a top up', available when babies were around six months old, and easier access to Well Child services. This kind of service is in fact available at Plunket Family Centres but these are few and far between. Jan suggested that some parents would benefit from 'someone to stay with you for a day or two, down the track, if you're having issues' in order to fully understand a problem and reach a position of being able to plan for its resolution. Some felt that new parents should be overtly encouraged to 'reach out for help if needed'. Participants thought that people may feel too embarrassed or shy to seek support: 'It's probably their upbringing that stops them asking'. On a more structural level, Zac suggested that something that might be useful was for 'breadwinners' to be able to work part-time for a while. A few participants suggested what Cheryl dubbed a 'stay-at-home-parents allowance'.

Participants suggested strategies that would come into play before as well as after the birth of a first child. Their ideas include bringing young parents into classrooms to talk about the realities of parenthood; and also education in the form of 'people sharing their stories' to help prospective parents understand that 'there will be quite a bit of adjusting to do but most of it just happens if you let it', a strategy that Abby thought would capitalize on prospective parents being 'excited' about learning. Targeting antenatal classes at various

age groups was also suggested. Some mentioned the potential value of specific forms of information, including 'information you could draw on later if the baby's an unsettled one'; information for prospective fathers that would help them understand what they can do to 'make the job easier'; and information for extended family or others who might wish to help out, to equip them with knowledge required to usefully do so.

The narratives suggest that formal and semi-formal support services for transition to parenthood in New Zealand have not caught up with the diversity of parents' needs and preferences. People who do not match the standard user profile implicit in formal support are expected to fit themselves into it as best they can. Participants' stories and quotations suggest that their ideal scenario of formal and semi-formal support would entail being able to make choices among a range of options varying in style and ambience to suit preferences, aimed at a market niche almost, and offering what amounts to good customer service. For example, rather than express relief that they and their babies were expertly and safely cared for during childbirth and the perinatal period, participants spoke of the attitude and demeanour of hospital staff, the general atmosphere in the hospital or birthing unit and details like food served⁷⁰ - areas where the quality of their experience, especially in hospitals, often did not live up to expectations. Even when complications occurred during childbirth or afterwards the focus of narratives was not on health professionals' knowledge and expertise but on communication and relationships with them. The impression given by participants' collected stories and comments is that what would meet their requirements is a menu of resources, offering both practical and emotional support that could be called upon when needed. For a fortunate few this kind of support was available informally. Others found it in formal or semi-formal support, such as Plunket Family Centres, which appeared to operate in ways that appealed to parents, with staff approachable enough to mitigate any diffidence or shame about asking for help. However, a significant proportion of participants had no-one available to them who could provide anything like this: some struggled for extended periods of time before they found anything that could help them with a problem or issue; others were never able to access support of the kind they needed.

⁷⁰ Presumably they received the standard hospital fare, more suitable to people who are ill than to voraciously hungry new mothers.

Ungar's (2008) twin concept of navigation and negotiation is helpful in considering how strategies for promoting resilience in families with a first baby might be adjusted or augmented to more closely mesh with what people in this situation actually need and want. Navigation refers to motivation to access available support, negotiation to designing resources to meet needs and preferences determined by background and culture. It follows that negotiation can only be successful if the groundwork has been established by meticulous consideration of the context of the lives of the people for whose benefit resources are intended. Otherwise they may miss the mark and be perceived as irrelevant and may even be counterproductive, undermining rather than reinforcing competence. This countermands the transplantation of programmes that have worked in one context or setting to another. People's needs are diverse, as is how they demonstrate competence and resilience: 'Resilience is a multidimensional construct, the definition of which is negotiated between individuals and their communities' (Ungar, 2008: 219). In drawing the study to a conclusion the following chapter addresses what the findings imply for the structure and delivery of the support system for families in transition to parenthood in New Zealand.

CHAPTER 11 CONCLUSION

In this concluding chapter I reflect on improvement in the support system in order to improve the odds of families with a first baby developing competence and resilience rather than becoming enmeshed in difficulties and problems. This addresses the study's final research question: What are the implications for policy and service provision?

Implications for policy and service delivery

The narratives suggest that a standardised delivery system does not provide support in an equitable way. Perhaps thinking about families with a first baby as consumers would help in considering unmet needs. A more flexible, responsive set of services might be created by customising standard services to more closely match the needs and preferences of specific groups of new parents, as already occasionally happens with antenatal classes for teenagers. Given that funds are finite, properly informed decision-making about the support system requires comprehensive understanding so that relative benefits may be weighed up. Reflecting what the narratives infer and views directly expressed, this section draws implications from the study about policy and service delivery and resilience promotion:

- Since 'pregnancy and the immediate period following a birth are periods of heightened sensitivity to the need to adopt healthier lifestyles' (Tuohy, 2007: 4) the health sector has a key role to play in promoting competence. Significant benefit could accrue from designing new strategies for helping parents acquire knowledge about infant development, parenting skills and role and relationship change. Such strategies could frame parenting as important and the seeking of support as a sensible, strong course of action, making it more likely that new parents will reach out for help if they find themselves struggling, thus perhaps reversing a downward spiral. Social workers based in hospitals could support families directly or link them to other services and sources of support. Plunket home visits represent a singularly important but currently underutilised opportunity to see the reality behind what may be a facade of coping. The nurse's ability to build relationships is central.
- A fundamental aspect of promoting resilience is ensuring that families, whatever their circumstances, have enough income to get by from day to day and that

people know what is available to them. Since 'the opportunities and chances available to the poor, their families, and their communities are limited in a very real sense' (O'Brien, 2001: 47) boosting income can create opportunities and overcome feelings of powerlessness and hopelessness. Since poverty is a common precursor or component of risk chains, reducing poverty may well be a more constructive and ultimately cost effective strategy for promoting resilience than supporting people to overcome the effects of poverty, by which time they may be enmeshed in difficulty.

- Education about how to cope with common difficulties and where to access support would prevent a compendium of problems further down the track and so be cost-effective as well as reducing adversity and distress and promoting confidence and resilience. Antenatal education could possibly fill this gap. However, participants expressed uncertainty about whether they were actually ready to absorb information about life with a baby before being challenged by the reality. After the baby is born it may be hard to make the time to attend education about this.
- There is considerable scope for antenatal education and other formal and semi-formal services to be provided in more relevant, context-specific ways incorporating specific world views or designed for certain age groups. For example, since young parents are considered to be at increased risk, but yet have been shown to be keen to make a good job of parenting, it seems likely that there would be value in devoting resources to supporting them in ways that take account of their particular needs and make it easier for them to access and use support.
- Most sources of formal support do not seem to offer the time required for people to get to the point of revealing problems like PND or the effects of a baby's disturbed sleeping pattern; opportunities are missed to ensure that action to reduce risk is undertaken early enough for the path a family takes to be diverted from risk to resilience. An idea raised repeatedly was a home visit by a trained professional at least once after the departure of the LMC. It was felt that this would provide new parents with an opportunity to talk in depth about aspects of role change. Problems stemming from relationships, financial strain, PND or anything else could thus be picked up and dealt with at an early stage, either by further visits by the same person or by referral to the appropriate source of further help. Some participants

wished that the LMC could undertake this 'check-up' visit but recognised, as Roz said, that 'midwives are 'pushed to do what they're doing anyway'. In speaking of her idea of someone 'trained in that field of work' to spend time with a family showing signs of struggling, Lisa described a role that could be filled by a health worker or family support social worker.

- Prospective fathers might benefit from more information about what life with the baby may be like for them. For example, it might reduce frustration if men know that they may 'take longer to get used to the crying'. It may be that prospective fathers should be informed that in the early days of their child's life they will have an important role in supporting the mother, and that their importance to the baby will become apparent a little later. Involving new fathers in learning infant care skills, such as bathing, soothing and perhaps baby massage, might equip them to more quickly take up the role of 'Dad'.
- Enabling first time mothers to spend time in a birthing centre might promote breastfeeding expertise and avert breastfeeding problems later on. It might also, by allowing both new parents to learn infant care skills, facilitate attachment.
- The narratives indicate the importance of a strengths perspective (Saleebey, 1996; 2002b) which requires that professionals convey respect and a sense of partnership when interacting with service users. Further, 'appraisal support', based on noticing developing competence, reinforces self-efficacy, whereas confidence is compromised by feeling out of place or belittled.

Participants' narratives indicate that implementing the strategies listed above would go a long way in preventing new parents sliding towards the problematic end of the risk/resilience continuum and, at the same time, help new parents develop competence self-efficacy and guide them in the direction of resilience.

Further research

Much more work is needed to work out how the system of formal and semi-formal support might better promote the competence and resilience of families in transition to parenthood in New Zealand. Exploration of the following topics may be especially useful:

- Needs and preferences of specific demographic and ethnic groups with regard to delivery of services (e.g. antenatal education; Well Child services) in ways that suit them.
- Optimal timing and content of education about life with a baby, taking prospective fathers into account as well as mothers.
- Composition of coffee groups and their value in engendering a network of support.
- Possibility of providing some form of education for family members or other providers of informal support for first time parents.
- Consequences of regulations pertaining to Income Support, Tax Credits and Child Support.
- Issue of providing 'full-time parents' with the equivalent of Childcare Subsidy, thus recognising the importance of attachment, taking account of evidence that fulltime work by mothers of babies under a year may have adverse implications for child health and development as well as maternal wellbeing (Smith et al., 2009); and generally valuing parenting as an important contribution to society.
- Role of attachment in promoting adaptation to parenthood. Participants' narratives imply that promoting attachment was not a focus of formal support received in the days and weeks following the birth. While this topic was not directly raised by participants, and was beyond the scope of the study, it is an intriguing topic.

Who benefits, who misses out?

Ife (2008) recommends an approach to research that promotes debate and action to create beneficial change. Flyvbjerg (2001) argues that research grounded in detail provides a basis for making judgements and decisions about improving people's lives. An underlying concern of research from this perspective is the issue of how power influences 'who gains and who loses'. In the context of support for families with a first baby, this question might be better framed as: 'Who benefits, who misses out?'

Analysis of the findings of my study indicates that the question of who benefits and who misses out is aligned with availability of services and the style in which they are provided. Some participants had much easier access to relevant support than did others. A wider range of delivery mechanisms is required to ensure that services cater for the diversity of families now experiencing transition to parenthood in New Zealand. Participants' narratives suggest that cultural diversity is not at all well attended to in service provision. Services

were described as being delivered in a homogeneous manner and style. This is of concern given the results of de Joux's (n.d.) exploration of this issue, which indicated that Maori women would be much more likely to attend antenatal classes designed to meet their particular needs.⁷¹ Also, while none of the participants in my study had trouble speaking English, two reported having observed Asian women having difficulty communicating with hospital maternity ward staff. As noted above, this area warrants further study, most appropriately undertaken by researchers of relevant background. Finding that young women viewed antenatal classes as 'not for them', Cliff and Deery (1997: 144), wonder 'whether older married mothers are actually the preferred clientele' of professionals responsible for designing and delivering these services'. If support is designed and delivered according to assumptions about what will meet potential users' needs and about the style in which support should be provided, it will suit only a relatively narrow band of potential users, who are probably, in terms of background and circumstances, not unlike the designers of the support: mature, educated, affluent, culturally 'mainstream'. One teenage father who participated in my study had been unaware of the existence of antenatal classes. Families today are used to exercising choice and likely to see themselves as consumers. To engage them it may be necessary to put considerable thought into delivery mechanisms for basic services, as well as their content. If services are to effectively enhance resilience, it may be wise to undertake some form of market research and involve potential participants in service design.

Parenthood today appears to be regarded as largely a private matter. Participants felt the 'loss' of their LMC when 'handed over' to a Well Child provider. Thereafter they were more or less on their own and sometimes found themselves 'floundering'. For lack of easy alternatives, many turned to family and friends for support and advice. A danger with reliance on this source of support is that advice or role modelling provided may encourage parenting practices that are inadequate or even unsafe; the worst case scenario is that an infant's right to safe, nurturing care that promotes optimal development may be compromised. It is apparently assumed that people will somehow just pick up parenting skills required. This seriously underestimates the complexity and difficulty of the parenting role. A rhetorical question springs to mind: What does it say about our valuing of children and families if, effectively, no education is available to help families with the significant and often stressful process of transition to parenthood?

⁷¹ As noted in Chapter 6.

Resilience in its various, context-specific manifestations is the positive pole of a continuum spanning a range of possible responses to a challenging transition. The negative pole can take the form of a wide range of disturbing, damaging and traumatic circumstances and events, including child maltreatment. The human costs of a family sliding towards the negative pole are huge; the financial cost to society is likely to be onerous (Juby & Rycroft, 2004). It could be argued that everyone misses out when families are not adequately supported during transition to parenthood. Hence the critical importance of either preventing problems or tackling them before they begin a chain of adversity, and the concomitant importance of helping new parents establish themselves on a 'pathway to resilience'. The tantalising converse of the demoralising prospect of a cascade of problems and the trouble it is likely to cause is that proactive, preventive intervention may initiate a positive chain (MacLeod & Nelson, 2000) or positive ripple effect (Middlemiss, 2005).

It has been argued (Smokowski, 1998; Cicchetti, 2003) that the construct of resilience can inform preventive interventions and social policy and thus 'decrease the vast erosion of human potential that mental disorder, maladaptive functioning and economic misery engender' (Cicchetti, 2003: xx). Smokowski (1998: 341) says that 'prevention programs offer a natural opportunity to wed resilience theory to practice'. Putting adequate resources into promoting resilience in families transitioning to parenthood would enable New Zealand to authentically demonstrate commitment to Article 25 of the Universal Declaration of Human Rights: 'Motherhood and childhood are entitled to special care and assistance'. Given that child abuse statistics in this country remain distressingly high (Connolly & Doolan, 2007), if New Zealand is to live up to its obligations under international conventions we need to become much better at ensuring that families are in the best possible position to care for infants. Too many families get swept up in a cascade of risk so that tertiary intervention is required to haul them back, by which time much damage has already been done to children and families and it may be too late to prevent further damage. Promoting self-efficacy while paying attention to context and implementing a comprehensive approach could underpin a system of 'strong connected support that is easy to access and provides the right help at the right time' (MSD, 2004a: 25) thus 'enabling families to be strong and resilient and supporting them to function well' (MSD, 2004a: 75). Patterson (2002a: 244) says that 'the cumulative costs of a family's inability to fulfil their core functions are significant'. These costs are pervasive and of different kinds,

expressed in unfulfilled potential as well as money and permeating every level of the ecological context, just as resilience does. A comprehensive approach to promoting resilience would change the balance of service provision, shifting resources from intervention to prevention and enabling specialist services to concentrate on families that desperately need them.

Research from the perspective of phronesis is expected to reach a position on the subject of study based on a 'sense of the ethically practical'. This approach equips the researcher to at least partially answer the question: What should be done? Seeking to answer the research questions for this study has raised further questions, which can only be rhetorical at this point. For example: Why are lactation consultants not routinely available when it is known that breastfeeding is important but initially difficult for many? Why is it assumed that families with a first baby will simply adapt when it is known to be a difficult transition, or that family members will help out when it is known that families are often dispersed? Who would know if a family with a first baby were struggling, for example as a result of PND or debt? What happens when new parents turn for support to family members or friends who do not have the skills to assist them and may themselves be stressed? While I consider every one of these questions to be important, the last is critical because it is possible that this is the scenario underlying some cases of child maltreatment. The position that I have reached is that there is considerable scope for support for transition to parenthood to be improved to enhance resilience. Doing so would avert avoidable problems and thus benefit families, their children and society. What I now believe 'should be done' is that a comprehensive review of formal support should be undertaken to ensure that the optimal set of services is available to all families adapting to life with a baby. This would be an important step in ensuring that all have a good chance of getting off to a good start.

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APPENDIX 1

Table 2 PARTICIPANT LIST

PARTICIPANT	MOST RECENT OCCUPATION	AGE	PARTNER'S AGE
<i>New Mothers (Anna and Maya interviewed twice, all others three times)</i>			
Lucy	School student	16	15
Anna	Shop assistant	16	32
Dawn	Rest home assistant	17	18
Zoe	Cleaner	17	20
Kim	Horticultural worker	18	19
Amy	Shop assistant	19	26
Maya	Sandwich bar assistant	19	25
Abby	Childcare worker	19	24
Dee	Waitress	20	20
Tania	Receptionist	20	26
Julie	University student	22	22
Roz	Childcare worker	23	26
Cheryl	Petrol station forecourt manager	26	31
Leah	Bank teller	28	28
Beth	Childcare worker	28	30
Jess	Industrial biologist	29	31
Rae	Forestry manager	29	32
Clare	Lawyer	31	38
Cara	Sales manager	33	33
Jan	Physiotherapist	33	34
Ange	Photographer	33	37
Fay	Residential care assistant	34	34
Ria	Business development consultant	34	33
Celia	Business owner	37	37
Karen	Editor	40	44
<i>Significant others (each interviewed once)</i>			
Kent (Dawn's partner)	Unemployed	18	
John (Abby's partner)	Factory worker	24	
Gary (Tania's partner)	Surveyor	26	
Tom (Cheryl's partner)	Builder, later on ACC	31	
Tau (Anna's partner)	Farm worker	32	
Brad (Ria's partner)	Architect	33	
Col (Cara's partner)	Journalist	33	
Jack (Fay's partner)	Photographer	34	
Dean (Celia's partner)	Business owner	37	
Matt (Claire's partner)	Manager	38	
Zac (Karen's partner)	Specialist builder	44	
Lisa (Kent's mother)	Care worker	45	
<i>Women who withdrew from the study after only one interview (no data reported)</i>			
Ruth	Hospitality worker	28	27
Sue	Immigration consultant	34	35

Table 3 HELPFUL AND POTENTIALLY HELPFUL TYPES OF SUPPORT

(Note: Abbreviations in brackets in the 'found useful' column refer to source of support or to self-directed action:
F = formal support, SF = semi-formal support, I = informal support, A = self-directed action; P = purchased)

Type of support	Found useful by participants	Participants' ideas / comments
Preparation for childbirth	<p>Antenatal education classes found helpful by most (but not all) participants (F)</p> <p>One-off home visits by childbirth educator (when no class available) found helpful but a bit rushed (F)</p> <p>LMC care (F)</p> <p>Own reading (A)</p> <p>Hearing about other women's experiences of childbirth (I)</p>	
Opportunities to learn about life with a baby.	<p>Hands-on learning (Lucy was sent by her parents to help look after a cousin's child, Dawn went to stay with her mother who had herself just had a baby) (I)</p> <p>Well-established mixed age rural Plunket coffee group (SF)</p>	<p><i>'Bring young ones into antenatal classes, to talk about it, actually being in that situation themselves - I reckon if they had young mums come in and talk, you know, when they do their antenatal course. Tell them it's not always the way you plan it to be or the way you want it to be'. (Dee)</i></p> <p><i>'I think one of the things that would help people is to know beforehand that there will be quite a bit of adjusting to do but most of it happens if you let it happen. Education in the form of people sharing their stories could make a difference for new parents'. (Zac)</i></p> <p><i>'You're pregnant for 9 months, it's a long time, and me and my partner were actually excited to go to the antenatal classes, I mean once a week for that set amount of weeks, you know, it's countdown. So why not have a class about after the birth, that's free. I mean books are good, but I find that a lot of them are written in America and lifestyles are different'. (Roz)</i></p> <p><i>'It would be better to learn how to look after a baby before rather than after. Home visits would probably be better because it's more personal. Better than a class because if you're sitting there with everyone and you don't know what's wrong or what's right, you don't really want to ask question'. (Lucy)</i></p>

Type of support	Found useful by participants	Participants' ideas / comments
Information and support for prospective fathers	Mentoring (F)	<p><i>'Maybe antenatal classes could talk about how different babies do go through that unsettled period, if they gave you information you could draw on later, what to expect if the baby's an unsettled one I think they do touch on how husbands can help, I don't really know. You just think that babies sleep and eat, and sleep and eat'. (Jan)</i></p> <p><i>'Definitely before Baby's born there should be ways for guys to find out as much as possible to make the job easier'. (Kent)</i></p> <p><i>'The men go with women to antenatal classes 90% of the time, so actually have a man there and split it up and then come together. I think that would be a good idea, if there was a man and a woman. Get a man to run the antenatal classes as well. Or maybe it could be a thing like instead of the men having to speak out, which can be quite hard, making it so that at the end of each class the person who's running it hands round a pen and paper and everybody has to write down something they would like to know about it, and put it in the box, and at the next class all those questions could get answered. It's just a thought but I think there should be like man midwives for men, someone who can explain this is what's happening, this is what your partner's going through. So they have a meeting once a week. I mean I know it takes up time. I mean every time I go to Plunket it's always the mothers there, it's never the fathers. I think too because Plunket is run by women It would be good to have a man in there somewhere for the men. You know how the woman's always seeing her midwife, but the male doesn't always go. You could build on that, have the option of a visit together. I mean they run little programmes at the hospital for men, but it's quite impersonal, and it's not very often, and it costs you, these are extra classes that you've got to pay for. I mean [Partner] wouldn't go to that because he wouldn't know anyone. (Roz)</i></p>
Antenatal education targeting different age groups	A class specifically for teenage mothers found useful by the one participant who attended a class of this kind. (F)	<i>'In the antenatal class him and me were the youngest. I think that does put up a whole lot of boundaries. Classes for younger parents would be good'. (Roz)</i>
Material support	<p>Baby clothes, maternity clothes, equipment e.g. baths, cots (gifts or loans) (I)</p> <p>Paid Parental Leave (F)</p> <p>Sickness Benefit (F)</p>	

Type of support	Found useful by participants	Participants' ideas / comments
Employers being flexible	Employers being flexible about a woman returning to work (took the pressure off and indicated that she was valued as an employee) (SF)	
Helping partners to help	Men who were encouraged by health professionals to help out at the birth felt included and valued. (F)	
'Look after ' new mothers for longer	Women who felt looked after (i.e. given the opportunity to rest in a birthing centre where they were coached in breastfeeding and other infant care skills) deeply appreciated this, as did partners, some of whom also received coaching in bathing etc. (F)	
Making it OK to ask for support	Availability helps in this respect. 'Like the Plunket line is actually really good. They say they'll call you back, and they call you back within 15 minutes'. (Ria) (F)	<i>'The thing is for new mums to be aware of the warning signs, what's going on around them - as soon as they feel tired, seek for help. It's probably their upbringing that stops them asking, I think if there was, perhaps, a lecture or something that they could attend. Some of them are in the birthing unit and gone the next day. Midwives might be able to tell mums to reach out for help if needed. Maybe from friends, friends with kids. I find you want to draw on someone with experience. Who've already done it themselves'. (Dee)</i>
Practical assistance	<p>Provision of meals (I)</p> <p>Someone doing practical household tasks (I)</p> <p>Non-intrusive on-call practical support from family members was deeply appreciated by several participants. Babysitting was also appreciated, whether by family members or someone paid to do this. (I & P)</p>	<p><i>There were times when I just felt that it would have been really neat if someone could have just whipped out and got my groceries for me. There were little errands. In the first 3 or 4 months I wasn't up to doing errands, I didn't really want to leave the house. (Karen)</i></p> <p><i>That practical support we get from our parents, an hour or two makes a huge difference. I don't know how you replicate that, for people that don't have it. (Ria)</i></p> <p><i>'When we had [Baby] we stayed with [Partner's] parents, we had full on support for 2 weeks, financial , everything, they just let us get accustomed to having [Baby]. When we were talking about this I drew a comparison with the tribal situation, in tribes it's the whole tribe that helps bring up a child. We found then though, after two weeks, when we went back home, we cut our lines of support, we had no support from anywhere. A substitute would have been good, just for a while'. (Fay)</i></p>

Type of support	Found useful by participants	Participants' ideas/comments
Support for breastfeeding	Lactation consultant (P)	
Information for wider family about how they can help		<i>'It's probably not parents who need to be prepared and involved, I think it could easily extend to information for the broader family, you know, like grandparents-to-be, uncles and aunties, like little sheets of information or even websites about what does an auntie do. Things like that, that would make them feel it's not just about the parents and everything's about the parent and child, but there's other relationships that are important'. (Ange)</i>
Reminders		<i>You can't really plan ahead, also I forget things. Just a bit more information, or just somebody coming at the appropriate time to remind you. When you've just had baby, and you're dealing with so much stuff, and you've actually been given so much information, sometimes it's hard to remember the bit that you need at that time. So I think somebody just needs to kind of remind you and tell you what's available'. (Jess)</i>
Information about services available	SKIP information, fridge magnets etc. (F)	<p><i>I would want access to information and for it to be relatively easy – I wouldn't want to go and approach someone, I'd like it to be relatively easy. It can be hard to ask for help. But if you don't get help the problems can snowball. It would be good to have brochures with numbers of information about centres and what they deal with and what they specialise in, as opposed to books. Something you look at on a regular basis I imagine. I even thought maybe ads on TV. I haven't noticed any ads. Stuff that people look at on a regular basis, so that they can't miss it'. (Leah)</i></p> <p><i>'A pamphlet for families wouldn't be a bad thing – like what sort of support you could get. Like for me, honestly, for me to get some of my jobs done, like I went from being an absolutely busy, busy, busy person to suddenly being unable to be busy for the reason of having a small child. When he's up and doing I can't really do anything. You think well where did that day go, I've changed his nappy and I've fed him and I've put him to sleep and it's taken up the whole day'. (Ange)</i></p> <p><i>It's information and resources but at when? It's kind of having them available, because some women, that first twelve weeks is hell. That first twelve weeks for me was glorious and then about twelve weeks it started to get a bit harder. So it's more having it like so you know, so everyone's got that, it's almost like your fridge magnet, so you had Poisonline for this, Plunketline for that'. (Ria)</i></p>

Type of support	Found useful by participants	Participants' ideas/comments
Appraisal support	<p>Praise from family members, midwives and Well Child providers for doing well in the role of parent (I & F)</p> <p>Participants noticed that more people praised them for their childcare skill as the baby got older. Plunket Family Centres were evidently particularly good at this. Some Plunket nurses also managed to boost participants' confidence by genuine praise. (I & F)</p>	<p><i>'I think that praise is really important, but I don't quite know how it could be given more. Even telling fathers, I think, to remember to say the woman's doing well, that's really important'. (Karen)</i></p>
Home visits to provide guidance and give new parents a chance to reflect and process and resolve issues	<p>The close relationship normally established with the LMC provided a channel to talk about problematic issues. (F)</p>	<p><i>'Sometimes you don't review and reflect because you go on to the next thing and the next thing. But I do look at the year and think ...anyway, it's been really good for me to talk to you because it makes me stop and think about how things have been and that's been a good process. You want talk when you've just given birth you really wanna talk about it, but nobody else really wants to talk about it, so to talk about parenting and support and non-support, and your first year and how it's going and who you are and what sort of things you employ to make it easier and what things make it harder is really a good thing to do. Maybe that's part of the support thing, to have someone just pop in and take an interest'. (Karen)</i></p> <p><i>'It would be good to have more home visits. Midwives take on a big role really and I don't think they get the recognition that they deserve. They're helping someone through a good and a bad part of their life and it's making that transition. Helping make the transition as smooth as possible. They're pushed to do what they're doing anyway, I don't think they could take on any more'. (Roz)</i></p> <p><i>'You totally don't know what to expect. You're not ready for information. Men are not ready before the baby is born, they're not ready at that point. Even when you're pregnant, that's all you focus on. Then suddenly you have this baby, and you've read all these books on birthing, and you think well I haven't actually read anything about what to do now. We were just like 'Woa, far out', that's when we needed support ' (Cara)</i></p> <p><i>'I definitely think in an ideal world every single new mum would have a counselling service every month from 6 months pregnant till the baby was one year. You know, they'd have some sort of, they'd have someone that they could talk to. And someone would look after the baby so the new mum could just talk, and reflect'. (Ria)</i></p>

Type of support	Found useful by participants	Participants' ideas/comments
		<p><i>'If you didn't have good parents you'd want someone to talk to, wouldn't you? Someone that could come and talk. Sometimes you don't want to talk to your friends about your personal stuff' (Kent)</i></p> <p><i>"If somebody like a mother, who's had a baby already, someone would have been around just to say this ok this is fine, sit down, I'll put the kettle on. Because there's that feeling of 'shit am I doing it right? And that kind of overwhelming thing. We didn't get that from anyone'. (Fay)</i></p> <p><i>'There are things that you can go to, but I think that they cost, and it's the time to do it. I guess you could start up a little service where you went round to people's houses but that's, again, it would not be free. I know that the nurses from the Plunket Centre will go round to homes as well. But I don't think that's a regular thing. It's if people can't get to there'. (Rae)</i></p> <p><i>'Someone to just come and just talk to you, to be able to check... between the mother and whoever the third party is. You could say 'We're coping fine, we don't need anything, carry on to the next person', or 'Hey look, we're not coping, what's the next step?' and then that person maybe try and get the necessary help or have the contacts, a counsellor, a doctor or whatever. Introduce someone. Almost like, not a counsellor, but someone just to talk to for the mum and give you some reassurance, what you're going through is normal. Even if you only saw someone like that a couple of times, it would be enough for them to see whether there was a problem there or whether there wasn't I got given a form to fill in when [Baby] had her. But filling out a form and actually talking to someone is two different things.' (Tania)</i></p> <p><i>'If people came in sort of checking up, sort of thing, to see if he's OK and all that, if you're OK, actually coming to you.' (Amy)</i></p> <p><i>'A Plunket person could come to you, be here and actually see what he's like in his own environment and potentially talk you through, OK, he's doing this, and just give you some suggestions.' (Jan)</i></p> <p><i>'Mum gets left out. That's what I find needs to be changed. They need to have someone that's trained up to come and check on Mum, see how Mum's feeling, right through until Baby's a certain age, still keep that contact with them. It's like a feeling of abandonment, I think, for some new mums. I reckon they need to have people that train in that field of work, that sort of become like therapists in a way, for the mum. Like a home psychologist that comes in to see the mum to see if you've got any worries or anything like that - if no worries that's brilliant, but just to know that they're like a friend that's going to come in and have a chat but like a therapist. And if something's wrong they might be able to help and guide them.'(Lisa)</i></p>

Type of support Information about infant development and coping generally	Found useful by participants	Participants' ideas/comments <i>'Something that would be good is what basic stages are, like at one month they're doing this, at two months they're doing this, and it was actually all laid out, and it was something a bit simple. It's not like you had to flip through one of these tomes. You know, smiling at 6 weeks. Not a tome. These are the main things that happen in the first month, second month, 6 through 8, 8 through 10. This is when they crawl. The first month, they start liking colour. So you kind of know what to look for. Between 4 and 6 months it just gets better.'</i> (Matt) <i>'It would be good if they said 'Babies will quite possibly do this and this and this, it's quite normal for them'. That would be reassuring. I guess if you were given a little list or something that would probably be quite helpful, like these are things that you could do. So it's there. Being guys you tend to think of the solution. What probably wouldn't be silly is to have a class before the birth, then a bit of a top up, at six or seven weeks, just one session, you could have a whole lot of questions.</i> (Col) <i>It would be good to hear someone else who's gone through the stuff you're going through. Antenatal classes are just for first time parents, about the birth.</i> (John)
Opportunities to learn parenting skills	Playcentre, Plunket Family Centres, Parents Centre and community groups were all mentioned as avenues for learning parenting skills. (F & SF)	
Tips and tricks of the trade		<i>'I got a good fridge magnet from that SKIP thing. They should give that kind of stuff out in hospitals when they give those packs out. I got this bag of stuff from [Partner's] auntie. Lots of stuff, tips on stress. I think it should be given to all young mothers, any mother, in the hospital.'</i> (Zoe) <i>'If you could just be told the tricks of the trade, like how to get round a supermarket without your kid losing it'.</i> (Jan)
On-call advice	Relative or friend experienced in infant care to call upon when uncertain or anxious. (I) Health phonelines (F)	

Type of support	Found useful by participants	Participants' ideas/comments
Companionship and social support	<p>A few coffee groups provided a range of people to spend time with. A rural group was a rich source of companionship and a way into the local community. (I)</p> <p>A 'beer group' for new fathers, established at an antenatal class, was well attended and diverged into family barbecues. (I)</p> <p>Some coffee groups provided women (and in one instance, men) with a supportive group that allowed friendships to develop. All groups spoken of as helpful in this way began at antenatal education classes. Mainly Music was a non-threatening activity for a wide range of people, where apparently they could choose to interact with others or not. (SF)</p>	
In-home problem-solving service		<p><i>'It would be handy to have someone potentially stay with you for a day or two, down the track, if you were having issues, like we were, to see if they could suggest any other ways of doing things. I mean I know you've got the Plunket line and all the rest of it, but it's different to having someone who's actually seeing'. (Jan)</i></p>
Increased availability of Well Child services		<p><i>'It would be good to be able to take him down to the Plunket more often, to get him weighed and measured'. (Amy)</i></p>
Stay at home parents' allowance		<p><i>A stay at home parents allowance, like the childcare allowance. That would be brilliant. I think they put too much value on people going back to work, when the most important job you can have is raising your children, and parent seem to get punished for wanting to stay at home and raise their children, They get all the benefits to get them back out to work when the most important job they could be doing and should be doing is raising their kids'. (Cheryl)</i></p>

Type of support	Found useful by participants	Participants' ideas/comments
Flexible work		<p><i>'I think something on a societal basis that could work for people is part-time work after a few weeks, if one is the main breadwinner, kind of like merge the two things. So often when you go to work you get up and the baby's still asleep and you come home and then there's just an evening routine kind of thing. Then the kid gets put to bed early in order for the parents to have time for themselves, or with each other. It's a personal preference thing, but the working day fits right in between there so you know, the needs of family seem to have to fit around the work. Whereas how would it be to be able to kind of overlay the two? Someone for instance could go to work at 10 o'clock and come back at 3 o'clock and have more time either side. And I think especially with people who are office-based workers, to be able to partly combine it with what's called teleworking so if for instance a mother would like to earn income again, she could be teleworking for a few hours a day, or performance based to create a certain result within the week, but I can fit it in however it fits in for me.. Step back and see what your income needs are. Kind of glide time. Lots of people could work on Saturdays part-time if they wanted to. There is a social aspect for those who don't want to lose touch with their workmates'.</i></p> <p><i>(Zac)</i></p>



Massey University
AUCKLAND

9 March 2005

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Irene de Haan
C/- Associate-Professors M O'Brien & M Belgrave
College of Humanities and Social Sciences
Massey University
Albany

Dear Irene

HUMAN ETHICS APPROVAL APPLICATION – MUAHEC 04/081
"A Good Start: Family Resilience in Families with Infants."

Thank you for your application. It has been fully considered, and approved by the Massey University, Albany Campus, Human Ethics Committee to proceed to the Health and Disability Ethics Committee, Auckland.

Could you please forward to us a copy of the letter of response from HDEC, once that committee has considered your application?

If you make any significant departure from the Application as approved then you should return this project to the Human Ethics Committee, Albany Campus, for further consideration and approval.

Yours sincerely

Associate-Professor Kerry Chamberlain
Chairperson,
Human Ethics Committee
Albany Campus

cc Associate-Professors M O'Brien & M Belgrave
College of Humanities and Social Sciences

e-mail: pat_chainey@moh.govt.nz

14 June 2005.

Ms Irene de Haan
616 Matakana Valley Rd
RD 5
Warkworth.

Dear Irene,

NTX/05/05/043 A good start: resilience in families with infants: PIS/Cons V#2, 5/6/05

Thank you for your amendments, received 8 June 2005 – the amendments were nicely highlighted.

The above study has been given ethical approval by Northern X Ethics Committee for the Northern Region. Please change your Information Sheet/Consent Form Version No. to V#2, 05/06/05 as the study number presently used as a footer is not a version no. The approval has been given under this version.

It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider, within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.

Certification

It is certified as not being conducted principally for the benefit of the manufacturer or distributor and may be considered for coverage under ACC.

Accreditation

This Committee is accredited by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, March 2002.

Documents Approved:

- Information Sheet/Consent Form V#2, 5 June 2005.

Progress Reports

The study is approved until 30 October 2006 but is subject to annual review. An annual progress report is required by 14 June 2006.

..../2

A form should come off our database requesting this information two months prior to the review date but if a form is not received, it is still your responsibility to provide a progress report and this may be obtained from the website below. Please note that failure to complete and return this form may result in the withdrawal of ethical approval.

Please advise the Committee when the study is completed and under the ethical approval process, final report is also required at the conclusion of the study.

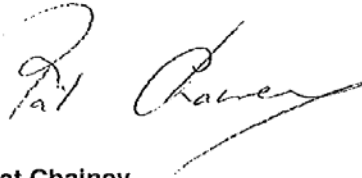
Requirements for SAE Reporting

Please advise the Committee as soon as possible if there are any serious adverse events that may relate to this study.

General:

All amendments to the study must be advised to the Committee prior to their implementation, except in the case where immediate implementation is required for reasons of safety. In such cases the Committee must be notified as soon as possible of the change.

Yours sincerely,

A handwritten signature in cursive script, appearing to read 'Pat Chainey', written in dark ink.

Pat Chainey
Administrator, Northern X Committee

Cc: Massey University, Albany.



ARE YOU HAVING YOUR FIRST BABY?

I am a Massey University PhD student who wants to find out:

- WHAT MAKES LIFE WITH A NEW BABY EASIER OR HARDER?
- WHAT HELPS FAMILIES GET THEIR BABY OFF TO A GOOD START?

I am looking for 30 women having a first baby to help me find answers to these questions, and would like to invite you to be one of these women, and to talk with me three times over the next year or so.

If you think you might be willing to help:

- Read the 'RESEARCH PROJECT INFORMATION FOR NEW FAMILIES' sheet

or

- Talk to your midwife or GP about the project



A Good Start: Resilience In Families With a First Baby
PARTICIPANT INFORMATION SHEET FOR NEW MOTHERS

You are invited to take part in a research project that aims to find out about life with a first baby. My name is Irene de Haan and this research is part of my work for a PhD in Social Policy and Social Work. I hope to interview up to 30 women - around half in Auckland and half between Auckland and Whangarei. I have asked midwives and GPs to make information about the project available to women who might be interested. To get a more complete picture I also want to interview 'significant others' (such as partners, relatives or friends) so if you take part I will ask you to please consider whether you can put me in touch with someone close to you who would be willing to be interviewed. If you have any questions or comments, or would like to take part, I can be reached through the midwife or GP who has given you this information, or at 0299854105 or at dehaan@paradise.net.nz. My supervisors for the research, Associate Professor Mike O'Brien and Associate Professor Michael Belgrave, can be reached at 094140800.

What helps new mothers enjoy life with a baby?

Having a first baby is a big change in a woman's life. I would like to hear about what this is like for you - including any stresses or strains and what you find helpful or unhelpful. And I want to find out what you think might help other new mothers adjust easily to life with a baby. I will interview you 3 times – once about 6 weeks before the baby is due, then twice more when the baby is around 3 months and a year old. Interviews will be at your home or somewhere else convenient. Each interview will take about an hour and will be taped to ensure that no important information is missed. You might like someone important to you to be with you when I interview you – that's fine by me.

A possible benefit of the research is that better understanding of what helps or hinders adjustment to parenthood could lead to better planning of policy and services. On a personal level, you might find it useful to talk about your own views and experience - the interview will give you time to reflect, celebrate achievements and identify any stress so that it can be dealt with. There is a risk that an interview may bring an upsetting problem to light. If this should happen, I can put you in touch with professional assistance if you request it.

Your choice

Taking part in the project is entirely voluntary. If you do take part, you can choose not to answer any particular question, and ask for the tape recorder to be turned off, and decide not to take part in any further interviews. You are always welcome to ask questions.

What will happen to the information?

At the end of the project I will write a report based on information provided by the people interviewed. Some of your thoughts or ideas may be included, but nothing will identify you personally. Information given during interviews will be kept totally confidential unless someone is at serious risk, in which case I will make sure that the person is safe by talking their situation over with them and if necessary referring them to someone who can help, such as a health or social service. Recorded and written information collected during the project will be archived at Massey University Albany. If you prefer, the information you provide will be returned to you once the thesis has been placed in the university library.

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact a Health and Disability Advocate, telephone no. 0800 555 050 Northland to Franklin.

In the unlikely event of physical injury while participating in the project you may be eligible for ACC and may wish to contact your nearest ACC office.

This project has been reviewed and approved by the Massey University Human Ethics Committee, no. MUAHEC 04/081. If you have any concerns about the conduct of this research, please contact Associate Professor Kerry Chamberlain, Chair, Massey University Campus Human Ethics Committee: Albany, telephone 09 414 0800 x9078, email humanethicsalb@massey.ac.nz.

This study has received ethical approval from the Northern X Ethics Committee. Version no. NTX05/05/043

A Good Start: Resilience In Families With a First Baby
PARTICIPANT INFORMATION SHEET FOR SIGNIFICANT OTHERS

You are invited to take part in a research project that aims to find out about life with a first baby. My name is Irene de Haan and this research is part of my work for a PhD in Social Policy and Social Work.

I plan to interview up to 30 women - around half in Auckland and half in the area between Auckland and Whangarei). To get a more complete picture I also want to interview 'significant others', such as partners, relatives or friends. If you are prepared to be interviewed as a significant other, the following is what you need to know.

I can be reached at 0294887788 or at dehaan@paradise.net.nz. If you have any questions or comments, or would like to take part, please feel free to contact me or my supervisors for the research, Associate Professor Mike O'Brien and Associate Professor Michael Belgrave. They can be reached at 094140800.

What helps families adapt to life with a baby?

The birth of a first baby creates change, not just for the baby's mother, but for 'significant others' as well. I would like to hear about what this is like for you - including any stresses or strains and what you find helpful or unhelpful. And I want to find out what you think might help people adjust easily to life with a baby.

The interview will take about an hour and will be at your home or somewhere else convenient to you. It will be taped to ensure that no important information is missed. The woman who has given you this information may wish to be present at the interview – that's fine by me.

A possible benefit of the research is that better understanding of what helps or hinders adjustment to parenthood could lead to better planning of policy and services. On a personal level, you might find it useful to talk about your own views and experience - the interview will give you time to reflect, celebrate achievements and identify any stress so that it can be dealt with. There is a risk that an interview may bring an upsetting problem to light. If this should happen, I can put you in touch with professional assistance if you request it.

Your choice

Taking part in the project is entirely voluntary, and, if you do take part, you can choose not to answer any particular question, and ask for the tape recorder to be turned off, and decide not to take part in any further interviews. You are always welcome to ask questions.

What will happen to the information?

At the end of the project I will write a report based on the information provided by the people interviewed. Some of your thoughts or ideas may be included, but nothing will identify you personally. Information given during interviews will be kept totally confidential unless someone is at serious risk, in which case I will make sure that the person is safe by talking their situation over with them and if necessary referring them to someone who can help, such as a health or social service agency. Recorded and written information collected during the project will be archived at Massey University Albany. If you prefer, the information you provide will be returned to you once the thesis has been placed in the university library.

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This study has received ethical approval from the Northern X Ethics Committee. Version no. NTX05/05/043

A Good Start: Resilience In Families With a First Baby

CONSENT FORM
for 'new mothers' and 'significant others'

I have been told about the research project *A Good Start* and have read the PARTICIPANT INFORMATION SHEET. The details of the project have been explained to me to my satisfaction.

I understand that I may ask questions about the project at any time.

I understand that a summary of the results will be sent to anyone interviewed who requests a copy, and that the Ministry of Social Development will receive a copy of the report because they have partly funded the research, and that the results may be used in journal articles or books, or possibly in training people working with families with babies (e.g. Plunket or Public Health Nurses).

PLEASE READ THE STATEMENTS BELOW AND CROSS OUT YES OR NO FOR EACH PAIR OF STATEMENTS.

- I agree to participate in this project under the conditions set out in the PARTICIPANT INFORMATION SHEET. YES/NO
- I agree to my GP or other current provider being informed of my participation in this study YES/NO
- I agree to my GP or other current provider being informed of the results of my participation in this study YES/NO
- I understand that participation may lead to referral to a specialist service YES/NO
- I am aware that the exception to confidentiality will be if the interviewer has serious doubts about the safety of myself or others. YES/NO
- I understand that I have the right to withdraw at any time. YES/NO

PLEASE READ THE STATEMENTS BELOW AND CROSS OUT THE ONE THAT DOES NOT APPLY TO YOU.

- I agree to the interview being audio taped / I do not agree to the interview being audio taped.
- I agree to information that I provide being archived at Massey University Albany / I do not agree to information provided by me being archived at Massey University Albany and want this information to be returned to me as soon as the project is complete.

Signature: _____ **Date:** _____

Full Name - printed _____

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact a Health and Disability Advocate, telephone no. 0800 555 050 Northland to Franklin.

In the unlikely event of physical injury while participating in the project you may be eligible for ACC and may wish to contact your nearest ACC office.

This project has been reviewed and approved by the Massey University Human Ethics Committee, no. MUAHEC 04/081. If you have any concerns about the conduct of this research, please contact Associate Professor Kerry Chamberlain, Chair, Massey University Campus Human Ethics Committee: Albany, telephone 09 414 0800 x9078, email humanethicsalb@massey.ac.nz. This study has received ethical approval from the Northern X Ethics Committee

A Good Start: Resilience In Families With a First Baby

CONSENT FORM for midwives and GPs

I have been provided with information about the research project *A Good Start*.

I have been provided with copies of the PARTICPANT INFORMATION SHEETS and the details of the project have been explained to me to my satisfaction.

I understand that I may ask questions about the project at any time.

I agree to provide information about the project to my patients. I will make the voluntary nature of participation in the project clear to any women who are interested in taking part.

If a patient is interested in the project I will, with her agreement, give her contact details to Irene de Haan so that she may contact the patient to talk with her about the project. I understand that information provided by participants during the project will be kept confidential by Irene de Haan unless a participant or some other person is at serious risk.

Signature: _____ **Date:** _____

Full Name - printed _____

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact a Health and Disability Advocate, telephone no. 0800 555 050 Northland to Franklin.

In the unlikely event of physical injury while participating in the project you may be eligible for ACC and may wish to contact your nearest ACC office.

This project has been reviewed and approved by the Massey University Human Ethics Committee, no. MUAHEC 04/081. If you have any concerns about the conduct of this research, please contact Associate Professor Kerry Chamberlain, Chair, Massey University Campus Human Ethics Committee: Albany, telephone 09 414 0800 x9078, email humanethicsalb@massey.ac.nz.

This study has received ethical approval from the Northern X Ethics Committee . Version no. NTX05/05/043.

A Good Start: Resilience In Families With A First Baby

CONSENT FORM

for midwives and GPs to give to women who might wish to participate in the study

I would like to find out more about Irene de Haan's research on families with a first baby.

I consent to my midwife or GP making my contact details available to Irene de Haan.

Signature:

Date:

Full Name - printed

Contact details

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact a Health and Disability Advocate, telephone no. 0800 555 050 Northland to Franklin.

In the unlikely event of physical injury while participating in the project you may be eligible for ACC and may wish to contact your nearest ACC office.

This project has been reviewed and approved by the Massey University Human Ethics Committee, no. MUAHEC 04/081. If you have any concerns about the conduct of this research, please contact Associate Professor Kerry Chamberlain, Chair, Massey University Campus Human Ethics Committee: Albany, telephone 09 414 0800 x9078, email humanethicsalb@massey.ac.nz.

This study has received ethical approval from the Northern X Ethics Committee . Version no. NTX05/05/043

A Good Start: Resilience In Families With A First Baby

**CONSENT FORM
for 'new mothers' to give to 'significant others'**

I would like to find out more about Irene de Haan's research on families with a first baby.

I consent to Irene de Haan contacting me.

Signature:

Date:

Full Name - printed

If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact a Health and Disability Advocate, telephone no. 0800 555 050 Northland to Franklin.

In the unlikely event of physical injury while participating in the project you may be eligible for ACC and may wish to contact your nearest ACC office.

This project has been reviewed and approved by the Massey University Human Ethics Committee, no. MUAHEC 04/081. If you have any concerns about the conduct of this research, please contact Associate Professor Kerry Chamberlain, Chair, Massey University Campus Human Ethics Committee: Albany, telephone 09 414 0800 x9078, email humanethicsalb@massey.ac.nz.

This study has received ethical approval from the Northern X Ethics Committee . Version no. NTX05/05/043

Interview 1 *Before the birth of a first baby*

- Introduction. Background, purpose of the research.
- Consent form
- Tell me a bit about yourself and what you've been doing in the past year or so (work, education etc).

AGE, PARTNER'S AGE, JOB, INTERESTS

- What are you especially looking forward to?
- What do you think might be a bit hard?
- How have you been getting ready?

CHILDBIRTH / AFTERWARDS

- *For preparation mentioned* - How have you found that?
- Support afterwards?
- *Miracle question*. 'If you could have exactly what you need to be ready...'

Interview 2 3 months after the birth of a first baby

- The birth – how did it go?
- Partner?
- How did you get on in the first few days?
- First few weeks?
- Looking back to before you had [Baby], what do you think would have been helpful? (FOR THEN, FOR AFTERWARDS)

> Ecomap exercise

- How have you found life with a baby compared to what you imagined it?
- What did you find helpful? / Unhelpful? / What would you have liked to be available?
- How have you found that? Helpful - how? Unhelpful – how?
- Looking back to before you had [Baby], what do you think would have been helpful? (FOR THEN, FOR AFTERWARDS)
- How about now? What would make life with a baby easier for families like yourself?

Based on what has been said:

- If you could have exactly what you need [for...], what would that look like?
- What could be done to make the support system more effective?

How have things been different for you since XXX was born?

‘It takes a village to raise a child’ – Views on this

Interview 3 **First year with a baby**

- Intro - How is Baby doing? / You? / Partner?
- Looking back to before you had [Baby], what do you think would have been helpful? (FOR THEN, FOR AFTERWARDS)
- Looking back over your year with Baby, tell me about how you've found it.
- What is different about how you imagined life with a baby to how you actually found it?

Prompt for Easy / Difficult

- Types of support, experience of each received

Explain family functions

- Functions 5/1

Discuss functions – e.g. why a 5?/1?

- What do you think would be helpful change in the system of support for families with a first baby?

Interview guide: Significant others

Introduction/Information Sheet/ Consent Form

- So Baby's now [Age] – How are things going?
- How have you found life with a baby compared to how you imagined it?
- How prepared were you for [Birth/ days & weeks after?]
- What did you find helpful?
- What have you found difficult?
- What do you think could be done to help families having a first baby?
 - What changes in the support system?

APPENDIX 8

List of support services

A Good Start: Resilience in Families With Infants
(Irene de Haan: doctoral research project)

AGENCIES PROVIDING SERVICES TO WHICH PARTICIPANTS MIGHT BE REFERRED

CYF	0508616616
Cot death	0800 164 455
Gambling Crisis Hotline	0800 654 655
<u>Auckland area</u>	
Family Support Services (Grey Lynn)	09 360 0229
Family Start Waiparera/Pasifika	09 835 0150
Te Whanau O Waiparera Trust	09 836 6683
Barnardos	09 625 0560
James Family:	
Waitakere	09 835 1288
Leslie Centre	09 620 4750
Shakti Asian Women's Centre	09 636 8512
Auckland City Mission:	
Foodlink	09 377 4322
Crisis Care	09 377 2395
Community Alcohol and Drug Service	09 845 1818
Maternal Mental Health:	
Waitakere	09 488 4634
Central	09 307 4949 ext. 4454
Women's Refuge crisis line	09 378 1893
Shakti Asian Women's Safe House	0800742584
Living Without Violence North Harbour	09 489 3770
Saftinet crisis line	09 303 3939
<u>Rural area</u>	
Helensville Women's Centre	09 420 7992
Homebuilders Family Support Maungatoroto	09 431 7418
Kaiwaka Family Support	09 431 2661
Women's Refuge:	
Te Puna O Te Aroha	09 437 2127
Tryphena	09 437 6576
Bream Bay Trust stopping violence services	09 432 7197
Maternal mental health:	
West	09 488 4634
North	09 430 4100 ext. 3501
Norfolk House alcohol and drug service	09 438 3868

Cartoon from *Dominion Post* September, 2005

