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**EXPERIENCE AS A MOTHER OF A "CRYING BABY" :
A SINGLE COLLABORATIVE CASE STUDY**

A thesis submitted to
the Education Department
Massey University
in partial fulfillment of the
requirements for the degree of
Master of Arts

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1991

For my family,
Clyde, Daniel, Jeremy and Jessica

ABSTRACT

A single collaborative case study was conducted to document a woman's experience as a mother of a "crying baby". Social constructionism provided a guiding framework for answering the foreshadowed problem and question of "why does this mother define her infant as a crying baby?". This problem provided the initial focus for the study, which commenced when the infant was thirteen weeks old and concluded shortly after his first birthday. The problem developed into four major questions regarding the mother's definitions and expectations of motherhood, her desire for a close relationship with her infant, her definition of the infant's crying as "colic", and finally a question of how a developing relationship between a mother and a "crying baby" can be supported. The study draws the conclusion that the prevailing western construction of motherhood is a difficult role to fulfill. Women in western societies carry responsibility for the welfare of their children, essentially in isolation, and this leads to unrealistic demands on their ability to cope when difficulty is experienced. Alternatives to the present construction are proposed, along with suggestions for helping mothers in difficulty to re-evaluate their roles as mothers, and to come to a personally meaningful definition of their commitment to motherhood.

ACKNOWLEDGEMENTS

I wish to thank Dr. James Chapman for his supportive assistance throughout the completion of this thesis. His helpful comments have been invaluable. I am also extremely grateful to Judith Loveridge and Bill Anderson, for the hours they have contributed to reading, commenting on and discussing this research with me.

Thanks are also due to Ruth Anderson, Eric Archer and John Kirkland for their assistance with earlier parts of this research. I am also indebted to Jan McPherson, Nancy Bell and Ivan Snook for their tremendous support when I needed it most.

I would like to thank "Caroline", "Robert", "Sarah" and "James", for welcoming me into their home and for their generous assistance and contribution to this case study. Without their co-operation and collaboration this research would not have been possible.

Finally, I wish to express my gratitude to Clyde Smith for his assistance at all stages of this research and for his continuing support and encouragement.

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CHAPTER ONE

INTRODUCTION

An opportunity was presented in March, 1989, to conduct a single case study of a mother with a "crying baby". My initial question at the outset of the study was "why does this mother define her infant as a crying baby?". The study used this question as a foreshadowed problem (McMillan and Schumacher, 1984) to guide the later research. Becker (1961) suggested that case studies use a developmental perspective, as certain issues assume a primary focus as the study progresses. This study was also collaborative, because the mother was an active participant in the research process and helped to select the primary issues for further examination, and because she commented on the draft of this thesis to ensure its accuracy and reliability. Lather (1989) has suggested that collaborative case study research is empowering for all participants involved, as both researcher and participants have the opportunity to reassess and evaluate their own decision making and theoretical orientation.

The single case study would serve as a vehicle to explore a unique and revelatory experience (Yin, 1984). Several sources of information regarding mother and infant were made available, in the form of "infant motion forms" (Kirkland and Bisman, 1990), "cry diaries", and the opportunity to collect audio recordings of the infant's crying and interview and observation data.

The foreshadowed problem developed into several questions as the study progressed, which encompassed four major areas for examination : motherhood, relationships, colic and social support. These areas were examined in light of social constructionist theory (Sampson, 1989), in order to provide an insight into how a western definition of personal responsibility may play a role in a mother's experience of difficulty with an infant. The four questions are as follows :

- 1) How does this mother define her role as a mother and why?
- 2) What sort of relationship does this mother want with her infant?

- 3) What is colic and how did this mother respond to it?
- 4) What social support is needed to support a developing relationship between a mother and her infant, when the infant is a "crying baby"?

Chapter Two provides a review of literature to establish a background to answering these questions. Initially, this chapter will present the argument that motherhood is socially constructed, in order to perpetuate the prevailing social conditions (Riley, 1983). The current western view of motherhood, in which the mother is primary caregiver and essentially responsible for her infant's welfare, is discussed as a socially constructed role. Sampson (1989) suggested that prevailing constructions or norms, are socially negotiated understandings, which are sustained across time by social processes and expectations.

Integrally related to the western construction of motherhood is the construction of "secure attachment" (Bowlby, 1988) as the appropriate relationship between a mother and her infant. Attachment is discussed as one of the possible relationships that a mother could have with her infant. A critique of the history and major principles of attachment theory follows.

In the present study, the mother experienced difficulty with her infant's frequent crying episodes, which she attributed to "colic". Colic and a medical model of attribution (Brickman et al., 1982) are discussed, and the review concludes with an examination of how social support, if available in an appropriate manner, can facilitate the development of an emerging relationship.

Brief mention of the methodology used has been given at the beginning of this chapter, and is more closely examined in Chapter Three. In Chapter Four, a summary of the case study data is presented. An historical background is provided, along with a discussion of the mother's social context, medical definitions concerning her infant and her expectations regarding relationships. The mother's comments on the first draft of the thesis are also included, as a means of ensuring reliability and sustaining the collaborative nature of the research.

The final chapters of this thesis will examine the four questions outlined previously, and the data relating to these, in light of social constructionism. The discussion will also examine the strengths and weaknesses of the study, highlight some suggestions for future

research and provide some concluding remarks regarding possible alternatives to the problems facing mothers today.

CHAPTER TWO

REVIEW OF LITERATURE

"Man is an animal suspended in webs of significance he himself has spun" (Geertz, 1973, p.5).

The social construction of motherhood

For many women, the transition to motherhood entails formulating expectations about the sort of relationship they wish to have with their infant. These expectations will be influenced by their own experience of pregnancy, their own childhood, present domestic situation, medical care and available support. However, they will undoubtedly be affected by their access to literature, ante-natal classes and other parents. Riley (1983) proposed that mothers are exposed to a normative view of a mother's responsibilities, that stresses the importance of a mother's constant contact with her infant. Riley states that this normative view is directly attributable to popularized versions of post-Kleinian psychoanalysis, in particular to Bowlby and Winnicott. Similarly, Gorham and Kellner-Andrews (1990) state that many "mother's groups" (in particular La Leche League) have emphasised the need for close mother-child relationships and for constant physical contact. Such groups have exclusively and unashamedly used Freudian and Kleinian research to support the notion that "maternal deprivation" will have dire consequences on the infant's development. This practice continues today, even in the face of evidence which contradicts the notion of "maternal deprivation" for children in day care (e.g., Rutter, 1980; Belsky, 1984).

It is important to remember that women are not passive participants in the myth-making of motherhood. Urwin (1985) emphasises that motherhood is socially constructed in two major ways, with numerous consequences. First, through the medium of books, films and the popular press. Such material appeals to the fantasies or feelings which women have experienced or is congruent with ideas already held. A socially reinforced desire for children,

plus an "expectation that childrearing will enhance their own sense of completeness and productivity"(p.190) characterises the social reproduction of motherhood. Motherhood is actively promoted in western cultures as the "most important and fulfilling role offered to any human being" (Urwin, 1985, p.190).

The second process by which motherhood is socially constructed is through ante-natal classes, mother's groups, routine ante-natal and post-natal medical checks and checks on the baby's development by health workers. Mothers come to see their infant in terms of relative adherence to or deviation from a universal norm. A universal norm is problematic, because it implicitly invokes comparisons between infants. Infants are assessed in relation to a population, rather than within individual contexts. Such comparisons may induce a sense of pride in the mother, but also of anxiety if the infant's development deviates from the norm. The Health Department in New Zealand issues each new mother with a book, which contains sensible advice, but which includes standard deviation charts of "normal development". A universal norm assumes that development will be the same in all contexts, and does not recognise that different growth patterns may be appropriate in different cultures and contexts.

Urwin (1985) states that the acceptance of these notions is a good illustration of how theories based on clinical cases or forms of pathology may contribute to defining the role of the "normal" mother. The child centred nature of the "normal" mother-child relationship permeates many theories; from Winnicott's notion of the "good enough mother", providing availability plus attention to assist development of the child's creativity, to Piaget's notion of the child as an "active learner", combined with Bowlby's early accounts of the effects of maternal deprivation on the child. Riley (1983) points out that it is insufficient to assert that this is simply the popularisation of theory, because acceptance of theory does not explain why a particular theory lends itself to dilution or is broadcast to a wider audience. Psychoanalysts in the 1930s, 40s and 50s promoted their own theories, using the clinical practices of psychoanalytic treatment, giving advice to parents, broadcasting on national radio and writing articles on childrearing in the newspapers and women's magazines (Riley, 1983). Winnicott's notions of the 'good enough mother' were widely broadcast on wartime radio in Britain, and were republished in 1945 as issues of The New Era. Winnicott depicted the male parent as a

remote bearer of authority of the outside world and the mother as all important in the childrearing of children. "She is a specialist in this matter of her own children and if she is not overawed by the voice of authority she can be found to know well what is good and bad in the matter of management" (Riley, 1983, p.89). However, as Dally (1982) points out, being a 'good enough mother' was fine if you had confidence in your own intuitive instincts. It was quite unhelpful, however, to anyone who doubted their intuitive ability to know a child's needs.

After World War Two strong political pressures were exerted to save money by closing child care centres, to push women back into the home and thereby create jobs (Dally, 1982). Bowlby's work was readily adopted and provided the moral justification for doing so. The government supported Bowlby's ideas about maternal deprivation, because they were catchy, convenient, cheap and solved emerging unemployment problems (Dally, 1982). Bowlby's 1951 World Health Organization (WHO) report concluded that the prolonged deprivation of maternal care may have grave and far reaching effects on the character of the young child and so on the whole of his future life. Bowlby drew an analogy between maternal deprivation and the shortage of Vitamin D in infancy -- the latter resulted in rickets, the former in delinquency and affectionless behaviour (Riley, 1983).

Vellacott (1989) looked at attempts to regulate mothers through the imposition of authoritarian psychology norms; "do this, and you'll be a good mother" (p.179). Vellacott examined the history of the role of mothers throughout this century. Early in the century, mothers were advised to mold children into patterns of regularity, discipline, self restraint, through regulation of bowel movements, sleeping, bathing and play. Watson advised against the overflow of maternal tenderness and this was supported by the disciplinarian, Truby King, in the forties. At this time, however, a movement was made toward seeing mother-love as a mother's job. This view of the mother-infant relationship was that it is an instinctual, libidinal, close fulfilling bond. Mothers were given advice through the media, that women who worked, no matter what the reason, were depriving their children and denying their deepest instincts. Children were encouraged to engage in spontaneous free play. Mothers could be blamed for almost anything, and doubts began to creep in about allowing children to express these

instinctual urges. In the fifties and sixties an anti-child, anti-youth mood arose, expressing the need for limits. In the seventies, self-actualization was popular, giving rise to conflicting feelings about how to put self first with a baby. The solution from the women's movement was simple -- do not have children. In the 80s and into this decade, women have looked for ways of integrating motherhood and a career, against the same pressure to stay home with their children. Throughout all of these movements in motherhood, Vellacott concludes that a mother is made responsible,

both in the sense that she must carry out certain functions in order to meet certain needs in the child, and in the sense that in order to fulfill these functions, she must herself be, unconsciously as well as consciously, a certain kind of person (p.185).

Furthermore, Vellacott states that the ever changing needs of motherhood are set up by society as ways of regulating mothers, and through them, family life.

Although women are expected to be certain kinds of people, the development of role appropriate characteristics has not been closely examined. Hartup (1986) states that maternal development as a factor in the mother-child relationship has not been well studied. Hartup asserts that motherhood is described as a developmentally "flat" period, with few reorganizations. Hartup concludes that this is a mistaken assumption, because the childrearing years can extend from twelve to forty-five. A child-centred approach typically discounts the needs of the mother, by proposing that the needs of the mother are identical to the infant's (e.g., Penelope Leach's Baby and Child, 1977). Such an approach poses obvious difficulties for any mother whose feelings and experience are contrary to the prescribed norm, and who experiences or desires a sense of separateness from her infant. As Urwin (1985) states, both of these processes of social constructionism structure and define "normal" motherhood.

Furthermore,

by providing reassurance, knowledge and practical suggestions and by constantly stressing the rewards, they present the view that not only is mothering a desirable and worthwhile job of work, but one in which it should be possible to be thoroughly satisfied and fulfilled. By implication a woman who does not find this has failed to grasp how it should be done (p.195).

Riley (1983) and Urwin (1985) propose that notions of motherhood are socially constructed, in order to perpetuate the prevailing social conditions. Furthermore, an infant's "secure attachment" to the mother is promoted in western societies as the appropriate goal achieved by undertaking the multiples roles of feeding, playing, educating, cleaning, cooking and organizing a household. It is possible to deconstruct the prevailing western view of motherhood as inequitable and sexist, but it is also important to help women who are trying desperately to cope with the pressures of motherhood to make sense of their world. One way in which women can explore and formulate a personally appropriate meaning to their own parenting situation is through collaborative case study research. For a mother who has made the commitment to full time motherhood, the experience of motherhood may provide a first opportunity to form a close relationship, involving more factors than simply attachment.

Social constructionism provides a useful way of explaining how the western construction of motherhood is created and perpetuated. The following section will examine how and why motherhood is a socially constructed concept, and will discuss notions of individuality and personal responsibility and how these relate to a women's experience of motherhood.

The social construction of personhood in western societies

Sampson (1989) considered the North American version of psychology's subject, the self-contained individual, as a firmly bounded, highly individuated conception of personhood. He refers to Geertz's (1979) comments regarding this concept as a precise summary :

The western conception of the person as a bounded, unique, more or less integrated motivational and cognitive universe, a dynamic center of awareness, emotion, judgement and action, organized into a distinctive whole and set contrastively against other such wholes and against a social and natural background is, however incorrigible it may seem to us, a rather peculiar idea within the context of the world's cultures (Geertz, 1979, p.229).

Geertz, a cultural anthropologist, conducted his field work in Bali, Java and Morocco. He used these cultures' conceptions of the "person" for comparison with the western view,

concluding that the peculiar feature of the western view is its search for an autonomous fully integrated entity in itself, defined by its separateness and distinctiveness from other people and the rest of nature (Sampson, 1985). Allport (1960) also noted the western predilection for defining persons on the basis of their separations from their life contexts. Gilligan (1977) suggested that notions of separateness may be more male-oriented than universal ideas even in the west.

Sampson (1985) proposed that control and a sense of order and coherence in western culture is maintained as follows : order and coherence are achieved by means of seeking control and mastery over the world, through a person system designed to achieve control, which is thereby characterized as a centralized, equilibrium-preserving structure.

Sampson (1989, p.2) lists six challenges to this concept of the separate self :

- 1) Cross-cultural investigation have examined the peculiarity of the current North American view and have uncovered several, less individuated, alternatives (e.g., Geertz, 1973, 1979; Heelas & Lock, 1981; Schweder & Bourne, 1982; Miller, 1984).
- 2) Feminist re-conceptualizations of the patriarchal version of social, historical and psychological life have introduced some strikingly different views of personhood (e.g., Chodorow, 1978; Gilligan, 1982; Lykes, 1985).
- 3) Social constructionism has amplified the earlier ideas of Mead (1934), arguing that selves, persons, psychological traits and so forth, including the very idea of individual psychological traits, are social and historical constructions, not naturally occurring objects. Constructionism casts doubts about the inevitability of the currently dominant Western version (e.g., Gergen, 1985; Harre, 1984; Sampson, 1983).
- 4) Systems theory has presented an epistemological position in which ontological primacy is granted to relations rather than individual entities, once again raising questions about the inevitability and reasonableness of the entity-based North American ideal (e.g., Bateson, 1972; Dewey & Bentley, 1949; Maruyama, 1979, 1980).

5) Critical theory, originating in the Frankfurt School tradition, has located the current North American conception in the heartland of advanced capitalist ideology. Critical theorists question not only the ideal, but also force us to consider that psychology's subject may be a character designed to serve ideological purposes; that psychology, in studying that character and presenting so-called facts about its qualities, helps to contribute primarily to societal reproduction rather than truly to human betterment (e.g., Adorno, 1967, 1973, 1974; Habermas, 1971, 1973, 1975; Horkheimer, 1941, 1972; Horkheimer & Adorno, 1972; Marcuse, 1964, 1966, 1968).

6) Deconstructionism, a relatively recent perspective developed within post structuralist literary criticism and linguistic analysis, has challenged all notions that involve the primacy of the subject (or author). This unsettling picture of our familiar western world undoes the security of the current North American ideal (e.g., Coward & Ellis, 1977; Derrida, 1974, 1978, 1981).

Sampson (1989) suggested that societies create both the types of character essential to societal reproduction and the ideologies necessary for the reproduction of these characteristics. In western societies, concepts such as individuality, autonomy and freedom play an essential role in this reproduction. Society tends to assume that a person's characteristics are a reflection of their individuality, rather than a reflection of a person in context. Because of this, people tend to attribute their problems to something about themselves, rather than to their circumstances. As Sampson (1989) says :

This tendency to interpret social ills as psychologically derived creates a psychological subject who is given the full burden of responsibility for correcting his or her troubles. In this manner, underlying structures that systematically thwart a group's opportunities (such as economic structures that breed racism and sexism) are reproduced in so far as we view the troubles of people to be a problem of their will power, motivation, intellect or personality dynamics (p.5).

Creating a psychological subject has the effect of giving the full burden of responsibility for any difficulty to the person and by implication the burden of control over that

difficulty. Western societies are unique, in that we expect mothers to be primary caregivers (Boulton, 1983). Mothers fulfill multiple roles, essentially in isolation, and they are expected to cope (Boulton, 1983). For this reason, an isolated mother in the suburbs with an irritable infant is deemed to be responsible not only for the full care of that infant, but also for the control of the situation.

Sampson (1985) suggests that the contrasting sociocentric ideal, identified in cross-cultural studies (Azuma, 1984; Geertz, 1979; Kojima, 1984; Miller, 1984; Schweder & Bourne, 1982; Weisz, Rothbaum & Blackburn, 1984) maintains that order and coherence are achieved by means of seeking to fit into the ongoing scheme of things, through a person system designed to minimise self-other distinctions, which is thereby characterized as a decentralized, non-equilibrium structure. Basically, Sampson proposes that people cannot function in isolation, they are always part of a group or of a context, social or historical. The fundamental essence of being human is to interact.

Social constructionism is one way of examining how the world may be understood in social terms. As Gergen (1985) says :

The mind (Coulter, 1979) becomes a form of social myth; the self concept (Gergen, 1985) is removed from the head and placed within the sphere of social discourse. In each case, then, what have been taken by one segment of the profession or another as "facts about the nature of the psychological realm" are suspended; each concept (emotion, motive, etc...) is cut away from an ontological base within the head and is made a constituent social process (p.271).

Gergen (1985) further suggests that what was previously considered to be an individual psychological process becomes a derivative of social interchange. The explanatory locus of human action is then with consideration of persons in relationship.

However, the dual and complementary notions of personal responsibility and control are pervasive in western culture and a major re-organization would be required for society as a whole to reconceptualise in contextual terms. As Gergen (1985) points out, accepted understandings are sustained across time by the vicissitudes of social processes (e.g., communication, negotiation, conflict, rhetoric) rather than by the empirical validity of the perspective in question. Accordingly, a mother's definition of her role as a mother is a form of

negotiated understanding. Such understandings are of critical significance in social life, as they are integrally connected with the activities in which people engage. Descriptions and explanations are forms of social action. Rules for "what counts as what" are inherently ambiguous, continuously evolving and free to vary with the predilections of those who use them. On these grounds, Gergen (1984, 1985) proposes that the major deployment of the term "truth" is primarily as a means of warranting one's own position and discrediting contenders for intelligibility.

The present section has examined how the western construction of individual responsibility sets the scene for the role and responsibility that a mother has for her new born infant. Definition of that responsibility is proposed to be socially constructed within society. The construction of personal responsibility is so pervasive, however, that it becomes a norm by which people are measured. A mother who experiences difficulty with her infant or who feels unable to cope with the multiple roles and responsibilities, may start to feel that she is not a "good mother" and may succumb to feelings of helplessness. Feeling an inability to cope with the infant's irritability or with the responsibilities of motherhood may even make a mother question if she is able to provide a "secure base" for her child or to form the close relationship, which society reinforces is necessary for the infant's healthy development. Much of the literature aimed at new parents makes claims about the quality of the relationship, which can and should be achieved for healthy development to occur. The next section will address what a relationship is, and follow on to discuss what is the expected relationship between a mother and her infant.

Relationships

Weiss (1986) identifies six types of relational bonds in western society and describes the emotional bases upon which relationships are formed. The six types of relationships are as follows:

- 1) Attachment - this bond is based on feelings of enhanced security linked to the person to whom there is attachment. It is believed to be based on the development of the emotional

system which Bowlby identified as linking children to parents. The system, in adults, has changed from its childhood configuration as it is directed to a new figure. The presence or absence of the figure still fosters feelings of security or of separation distress (especially under conditions of threat).

- 2) Affiliation - this bond is based on recognition of shared interests and outlooks or aims. The sharedness leads to a sense of mutuality, affection, respect and loyalty.
- 3) Nurturance - this bond is based on a sense of commitment, investment and responsibility for someone perceived as weak and needful.
- 4) Collaboration - a shared commitment toward achievement of a goal with a colleague, teammate or partner. Mutual respect lends support for feelings of self worth.
- 5) Persisting alliance - feelings of identification or overlapping identities. A sense of obligation to provide help as needed, the right to help, of lives permanently associated. This bond is common in kinship ties, in some bonds of marriage and communal groups.
- 6) Help obtaining - a bond to someone perceived as knowledgeable, wiser, trustworthy, supportive and a legitimate source of guidance. Such a bond is especially likely to be formed by adults doubting their own ability to deal with challenges.

Davis and Roberts (1985) provide descriptions of relationships in which people create or re-create their version of the world, which they call "I-thou", "I-them" and "I-it" relationships. People assign, or are assigned, a status to others within a relationship thereby reflecting their selection and experience of the range of possibilities. Davis and Roberts (1985) propose that relationships are a form of social practice. Insiders ("I-thou") are involved in the practice and are able to appreciate the intrinsic rewards, whereas outsiders ("I-them" and "I-it") have different reasons for maintaining personal relationships. For the imperialist ("I-them") it is to uphold truth, for the rote status assigner ("I-it") to fit into the prevailing social order.

Development of the "attachment" relationship, as described by Weiss (1986), is the focus of much of the literature on motherhood and child development which has proliferated in recent years. I will discuss how the whole relationship between a parent and an infant must essentially be more than simply "attachment" for a close relationship to form. Relationship in this thesis will be taken to mean a synthesis of many of the elements involved in all of the

relationship types outlined by Weiss (1986) and the "I-Thou" relationship proposed by Davis and Roberts (1985). It seems probable that different elements of these relationships would be called upon in different situations as the infant develops from child to adult. A relationship is a form of negotiated understanding, in that the elements of the relationship which have prominence at any one time will be in response to a particular situation or given need, and will have a certain social appropriateness. In this way, attachment may be primarily important in infancy, but affiliation or collaboration may be important factors in the relationship at other points in the life span. The nature of the relationship between a parent and child is not static, but essentially dynamic, similar to Sampson's (1985) view of personhood.

The term relationship is used in a special sense to mean precious moments of mutuality between people, with an ever changing focus. It seems all too possible for members of a family to occupy the same house and engage in regular interaction without ever experiencing a mutual relationship. This is evident in the mother's comments that her closest "relationships" are with her children, raising questions about the nature of the interaction with her husband. Such interactions need not be unhappy, they may simply not fulfill a human need for closeness, love and security. As Brown and Harris (1978) found, an intimate relationship with a husband or partner protected women from depression following stressful life events. Similarly, Lieberman (1982) concludes that when women experience prenatal distress, there is no viable replacement for the husband's support. When the husband is not perceived as available, other confiding relations are not seen as a substitute. Perception of a husband or partner as not supportive may therefore increase a mother's sense of vulnerability.

Just as an infant needs to know that a mother will be available and responsive to form a secure attachment, a mother needs to feel that she can depend on her infant to respond to attempts to communicate, settle to repeated soothing procedures and sleep and wake to some sort of predictable and regular routine. A need for consistency, predictability and emotional availability (Emde, 1980) is required by both mother and infant for a harmonious and secure attachment to form. When both mother and infant's security needs are met, the attachment relationship provides the basis for a mutually rewarding relationship to form.

Emde (1987) presents the notion of a shared reality, or a personal memory that contains knowledge structures of "we" in addition to knowledge structures of self and other. Views of a parent and infant participating in a shared development of a "we" reality are quite distinct from accepted forms of "I-thou" (dialectical thinking) or "I-it" (seen in some experimental approaches). Emde (1987) suggests that such a "we" approach has its historical roots with Cooley (1912), Mead (1934) and Vygotsky (1962), rather than with the developmental traditions of Freud and Piaget. Such a tradition is reflected in the general idea that an infant is born pre-adapted for social interaction and participates actively in a social system with caregivers. Spitz (1963) and Bruner (1982) noted the development of a pre-verbal dialogue, with a set of shared expectancies and rules of operation. By seven to nine months this dialogue has become "intersubjectivity" (Bretherton, Mcknew and Beeghley-Smith, 1981; Stern, 1985; Trevarthen and Hubley, 1979) wherein the infant develops a sense that its own intentions will correspond to the intentions of the other (Emde, 1987). Infants will persist with varying alterations of intentional behaviour until the communicative act is met with a response. Communication is then more than just shared intentions; it is joint referencing of events (Scaife and Bruner, 1975), shared feelings (Stern, 1985) and "a mutual faith in a shared world" (Bretherton, 1987, in Emde, 1987, p.1310).

This section has outlined that the "attachment" relationship is only one of the possible relationships that a parent could develop with an infant. I will argue that a close relationship with a developing infant is a synthesis of changing elements of all the relationship types outlined by Weiss (1986), the "I-Thou" relationship proposed by Davis and Roberts (1985) and the shared reality described by Emde (1987). Because the social construction of motherhood only emphasises the importance of the "attachment" relationship, it seems vital to explore what attachment is and how it came to be given such a central role in the development of mothers in western societies. The following section will examine the history and major principles of attachment theory.

Foundations of Attachment theory

Attachment theory was first described in 1927, when John Bowlby was working in a home for emotionally disturbed boys. Bowlby's experiences in this institution led to a decision to become a child psychiatrist and psychoanalyst. Motivation for Bowlby's formulation of attachment theory came from findings demonstrating pervasive ill effects of institutional and hospital care on infants and young children (e.g., Bender, 1947; Bender and Yarnell, 1941; Bowlby, 1940, 1944, 1988 b; Bretherton and Waters, 1985; Burlingham and A. Freud, 1942, 1944; Goldfarb, 1943; Levy, 1937; Skodak and Skeels, 1949; Spitz, 1946). Findings from these researchers could not be easily explained by the prevailing secondary drive theories, such as social learning and psychoanalytic theories. Such theories proposed that the primary drive was for food, the secondary drive for dependency. Bowlby's theory had its underpinnings in ethology, control systems and cognitive science, with a pervasive influence from psychoanalytic principles. In 1949, Ronald Hargreaves (then chief of mental health with the World Health Organization) asked Bowlby to be a short term consultant for a United Nations study on the needs of homeless children. Bowlby wrote and published in 1951 the WHO monograph Maternal care and mental health.

Another significant figure in the development of attachment theory was Mary Ainsworth. Ainsworth originally worked with William Blatz in Toronto, where she wrote her dissertation entitled An evaluation of adjustment, based on the concept of security. Ainsworth met Bowlby at the Tavistock Clinic in London, a special research unit established by Bowlby to examine young children's responses to separation from their mothers. Ainsworth was associated with the clinic from 1950 to 1954, and applied some of Bowlby's ideas to her study of infancy in Uganda in 1955. Bowlby was strongly influenced by Konrad Lorenz, Robert Hinde and Julian Huxley, and their ethological notions of how strong bonds between parents and offspring may influence development. In 1963, the WHO published a collection of articles on "deprivation of maternal care". Of these, Ainsworth's (1962) article comprehensively covered issues and research problems arising in the field of attachment theory. At the same time, Harlow and Harlow (1965) were studying the effects of maternal deprivation on rhesus

monkeys and Hinde and Spencer-Booth (1971) were publishing similar work generated from the Tavistock Clinic (Bowlby, 1988 b). Riley (1983) criticizes Bowlby's use of ethology, because of

its flattening of specificities into generalization, its appeals to animal analogies, its depiction of the child as the repository of intense, innate, unexplained emotional impulses. Bowlby's earliest uses of psychoanalysis were shot through with ideas of the instinctual; from the start of his career, animal references and human-animal analogies abound (p.93).

Riley further points out that Bowlby's analogies to animals are in many instances cross gender and cross species, for which he makes no apology.

Drawing on evidence from these studies, Bowlby presents the following principal propositions concerning attachment :

- 1) Emotionally significant bonds between individuals have basic survival functions and therefore primary status.
- 2) They can be understood by postulating cybernetic systems situated within the Central Nervous System of each partner that have the effect of maintaining proximity or ready accessibility of each partner to the other.
- 3) In order for the systems to operate efficiently, each partner builds in his or her mind working models of self and of other and of the patterns of interaction that have developed between them.
- 4) Present knowledge requires that a theory of developmental pathways should replace theories that invoke specific phases of development in which it is postulated a person may become fixated and/or to which he/she may regress (Bowlby, 1988 a).

A secure base

Bowlby (1973, 1979, 1980, 1982) postulated that children build representational models of their attachment figure and that these representational models are complementary to the representational model that they build of themselves. A child whose parents are available and supportive will construct a representational model of self as able to cope but also worthy of

help. Conversely, a child whose parents are consistently lacking in responsiveness, who threaten abandonment or who actually abandon the child will tend to build a representational model of self as unworthy and unlovable.

Rather than being in a constant state of flux, Bowlby sees the internal working model of the attachment figure as being fairly stable. As Bowlby (1980,) says "Ways of acting and thinking that are at first under deliberate control tend to become less accessible to awareness as they become habitual and automatic" (in Bretherton, 1987, p.1067). This relative stability can lead to over simplification and distortion of the model, yet it is only when the gap between the model and reality makes the model unhelpful that a person will accommodate the model to reality. In some instances, accommodation will not occur as a child uses defensive exclusion of material in response to intolerable mental pain or conflict (Bretherton, 1987). Bowlby (1980) suggests that such exclusion occurs when a parent habitually rejects or ridicules a child's security seeking or anxious behaviour, so the child excludes conscious access to the working model of "bad" unloving parent and only retains the "good" loving parent model.

One of the major difficulties with Bowlby's hypothesis of an internal working model is that all of his writing is notably vague about how this internal model is created, accessed or modified. Bowlby uses Piagetian terminology, suggesting the creation of cognitive schema, but the role of memory, affect and time on this model are not fully explored. Also, it is debatable whether infants are capable of creating or modifying such complex schema.

Ainsworth, Blehar, Waters and Wall (1978) have identified three principle patterns of attachment. These patterns or classifications are derived from Ainsworth's (et al., 1978) "Strange Situation Procedure", that involves an infant in a series of three minute separations and reunions with the caregiver and a stranger in an unfamiliar room. Ainsworth's classification derives from Bowlby's (1969) notion of a biological purpose of attachment, to provide emotional security and social autonomy (Wolkind and Rutter, 1985), and she accepts Bowlby's notion of a "secure base" in the attachment relationship as the pathway for healthy development. The "strange situation" was part of Ainsworth's Baltimore study, which involved monthly four-hour naturalistic observations of 26 mother-infant dyads in their homes. The "strange situation" was undertaken at 12 months.

Pattern A : Anxious/Avoidant Attachment

1) Exploration independent of caregiver

- a) readily separate to explore during preseparation
- b) little affective sharing
- c) affiliative to stranger, even when caregiver absent (little preference)

2) Active avoidance upon reunion

- a) turning away, looking away, moving away, ignoring
- b) may mix avoidance with proximity
- c) avoidance more extreme on second reunion
- d) no avoidance of stranger

Pattern B : Infants secure in their attachment

1) Caregiver as secure base for exploration

- a) readily separate to explore toys
- b) affective sharing of play
- c) affiliative to stranger in mother's presence
- d) readily comforted when distressed (promoting a return to play)

2) Active in seeking contact or interaction upon reunion

- a) If distressed
 - a) immediately seek and maintain contact
 - b) contact is effective in terminating distress
- b) If not distressed
 - i) active greeting behaviour (happy to see caregiver)
 - ii) strong initiation of interaction

Pattern C : Anxious/Resistant Attachment

1) Poverty of Exploration

- a) difficulty separating to explore; may need contact even prior to separation

- b) wary of novel situations and people

2) Difficulty of settling upon reunion

- a) may mix contact seeking with contact resistance (hitting, kicking, squirming, rejecting toys)
- b) may simply continue to cry and fuss
- c) may show striking passivity

In addition to coding the behaviour that was observed during the "strange situation", Ainsworth and her colleagues (Ainsworth, Bell and Stayton, 1974) also devised general rating scales to characterize the mother's interactive style with her infant during fourth quarter home visits, that is in the infant's last three months of its first year. These scales were assessed along four dimensions :

- 1) sensitivity - insensitivity : mother's ability to see things from baby's point of view, notice and interpret infant's cues accurately and with consideration. It also implies that mother does not distort baby's communications in light of her own preoccupations, needs or defenses.
- 2) acceptance - rejection : mother can temporarily accept the limitations that the maternal role imposes on her other activities, so that she does not cast the baby into the role of opponent.
- 3) cooperation - interference : refers to mother's respect for baby as a separate person, her skilful intervention when the baby is interrupted in an activity, and her willingness to use gentle persuasion instead of direct control.
- 4) accessibility - ignoring : denotes the degree to which the mother makes herself psychologically available to the infant when she is in the room, the degree to which she attends to her infant's signals even when there are distractions or other demands on her attention.

In Ainsworth's Baltimore study, ratings of sensitivity, acceptance, cooperation and accessibility were considerably higher for mothers of Pattern B babies during the "strange situation" than for mothers of A or C babies (Ainsworth et al., 1978).

Bowlby (1988 a) suggests that "the pattern of attachment consistent with healthy development is that of secure attachment, in which individuals are confident that their parent (or parent figure) will be available, responsive, and helpful should they encounter adverse or frightening situations"(p.4). Securely attached children (pattern B) are aware that their parent is readily available, sensitive to their signals and lovingly responsive when they seek protection, comfort or assistance. Such attachment denotes possession of a secure base. Anxious-resistant children (Pattern C) are uncertain if the parent will be available, responsive or helpful when called upon. Such children are prone to separation anxiety, clinging and are anxious about exploring the world. Parents may be available and helpful on some occasions but not on others. This uncertainty is compounded by separations and especially by threats of abandonment used as a means of control. Anxious-avoidant (Pattern A) children have no confidence that when they seek care they will be responded to helpfully; they expect to be rebuffed. These children may attempt to live life without the love and support of others, resulting from circumstances such as constant rebuffal, repeated rejection, ill treatment and prolonged institutionalisation. Such withdrawal can lead children to become compulsively self sufficient or persistently delinquent (Bowlby, 1988 a).

Sroufe and Fleeson (1986) suggest that infants will behave according to established dyadic patterns during the "strange situation procedure", thus revealing qualities of the relationship history. As they say, "It is the infant's expectations concerning caregiver responsiveness that promote exploration in the novel setting" (p.55). Sroufe (1985) proposes that stability of pattern, when it occurs, cannot be simply attributed to the child's temperament. On the contrary, Sroufe highlights evidence that many personal characteristics traditionally described as temperamental and ascribed to heredity are related to the context in which development occurs. Bowlby's early work had leaned toward an inherent element to attachment, but his later work reflects a shift toward environmental factors. As Bowlby (1988 a) states, "infants described as difficult during their early days are enabled by sensitive

mothering to become happy, easy toddlers. Contrariwise, placid newborns can be turned into anxious, moody, demanding, or awkward toddlers by insensitive or rejecting mothering" (p.5).

At about six to eight months of age, infants develop selective attachments to a particular individual. As Wolkind and Rutter (1985) state "an infant is likely to seek his mother even if she attempts to ignore him and will not go to even a friendly, smiling, responsive stranger. Infants may develop selective attachments to more than one person, but there is a definite, persistent hierarchy among them" (p.36). Attachment patterns, once established, tend to persist. Bowlby (1988 a) indicates that this is because the way parents treat children continue unchanged and tend to be self perpetuating. A secure child is happier, more rewarding, less demanding. An anxious child is whiny and clinging. An avoidant child keeps its distance, is bad tempered and prone to bullying. Bowlby proposes that the anxious child's behaviour elicits an unfavourable response in others, perpetuating the cyclic nature of the interaction.

However, although an assessment of the "strange situation" tends to be stable, as an assessment of the quality of the relationship history, it does not apply to the relationship with both parents. Sroufe and Fleeson (1986) suggest that the Ainsworth procedures assess relationships, not individuals. In this way, an infant may show secure attachment with one parent and an anxious attachment with the other. Wolkind and Rutter (1985) state that people have mistakenly equated attachment with dependency, although Bowlby originally differentiated the two. Attachment refers to dyadic relationships, not to any individual characteristic (Ainsworth, 1982, Sroufe and Waters, 1977). Wolkind and Rutter (1985) highlight two sets of findings that demonstrate this :

- 1) The quality of the child's attachment to one parent does not predict quality of attachment to the other (Lamb, 1978; Main and Weston, 1981)
- 2) Infants with secure attachments at 12-18 months are less likely to show high dependency at 4-5 years of age (Sroufe, Fox and Pancake, 1983). Secure attachment fosters autonomy rather than dependency.

Attachment is not a simple synonym for 'social bond'. Bowlby did not intend it to apply to all aspects of an infant-parent relationship, and further suggests that the attachment

figure and the playmate are conceptually distinct (Bowlby, 1982). A child is said to seek the attachment figure when under stress but to seek a playmate when in good spirits. These roles are not incompatible, so the same person could fulfill both roles. Attachment theory does not cover playful interactions between parent and child (e.g., Brazelton, Koslowski and Main, 1974, Stern, 1977), even though such interactions may contribute to the nature and quality of the relationship.

Attachment is not equivalent to the whole adult-infant relationship, rather it is a particular feature. Wolkind and Rutter (1985) suggest four main characteristics of an attachment relationship, that make it distinct from other relationships (Rutter, 1980) :

- 1) Anxiety inhibits social play, it intensifies attachment (Lamb, 1977 a,b). Also, clinging/hugging are infrequent in play, but frequent in attachment.
- 2) Presence of the attachment figure promotes exploration of environment (Rajecki, Lamb and Obmascher, 1978). If the person to whom the child is attached is close, the child is more likely to move away (e.g., a secure base)
- 3) Presence of the attachment figure reduces the child's anxiety in stressful/unfamiliar situations.
- 4) Separation protest will occur if the child is separated from the individual to whom he or she is attached.

One of the difficulties with attachment theory lies in cross-cultural findings, which show marked variations in the frequency of distribution of secure attachment or of different types of insecurity. Attachment theory carries the implicit assumption that the secure pattern is the "normal" one, leading to healthy adaptation. This assumption stems from North American studies and the finding that secure attachment tended to be associated with sensitive, responsive parenting. In North Germany, however, the avoidant pattern predominated in Grossman's (1985) study. In Japan, resistant patterns were far more numerous than in the United States. In Israel, Sagi et al. (1985) found that many Kibbutzim infants were unable to complete the separation procedure because of inordinate distress. The findings raise important questions about whether infant's responses to the strange situation mean the same thing in all circumstances. Ainsworth's (1974) scoring system was designed for essentially "normal" one

year old infants. It may be misleading when applied to abnormal groups or older children. Thus Main, Kaplan and Cassidy (1985) talk of the need for an insecure-disorganized-disoriented group, for those children who show both avoidance and proximity seeking in response to separation.

The "attachment relationship" is one indicator of the whole adult-infant relationship. It can not be applied to all of a relationship. It is, rather, a particular feature of a relationship. The attachment categories identified by Ainsworth, and extensively used as an indicator of infants' development, do not appear to be a universal phenomenon, nor do they apply to all situations within western societies. It seems important, therefore, to explore how theorists propose that the attachment relationship is created and transmitted within families.

Transmission of Attachment

Freud described the child's relationship to the mother as "unique, without parallel, established unalterably for a whole lifetime as the first and strongest love-object and as the prototype of all later love relations - for both sexes" (Freud, 1940, p. 188). Ideas that childhood relationships affect later close relationships (including adult love and parent-child) are central to Freudian theory, although Freud's statement does not address the respective contributions of mother or infant. It merely claims that a pattern, once established during early years, will remain stable and be perpetuated in other relationships. This notion has remained central in psychoanalytic theory and psychoanalytically oriented work (e.g., Benedek, 1949; Berger and Kennedy, 1975; Bettelheim, 1967; Fraiberg, Adelson and Shapiro, 1980; Giovacchini, 1970; LaBarre, Jessner and Ussery, 1980; Winnicott, 1965).

Traditional psychoanalytic theory placed emphasis on the flow of libidinal energies deriving from sexual and aggressive drives, on the laying down of a basic personality structure during the preschool years and on the shaping of adult personality through partial fixation at particular psychosexual stages (Dare, 1985). Psychoanalytic theory implies that early psychic traumata would result in lasting major sequelae, which would be difficult to modify after the first five years. Such assumptions are reflected in Bowlby's (1951) review of the effects of

maternal deprivation, in which he argued that the consequences of a lack of mother love in the first two years were likely to be permanently damaging (Rutter, 1987). Bowlby's view concurred with Freud's, that neurosis could only be acquired in the first six years. Bowlby further proposed that if a selective attachment was not formed in the first two years of life, it would lead to later difficulty in forming relationships.

Rutter (1987) states that the notion of libidinal energies is out of keeping with the evidence, and that the postulates of psychosexual stages are wrong in several key aspects. Furthermore, he reports that there are good reasons for rejecting the concept that mother-child relations are built on oral-satisfaction and sexual drives (e.g. Bowlby, 1969; Kline, 1972; Rutter, 1980). Also, there is evidence to suggest that the ill effects of early traumata are not inevitable and irreversible (Clarke and Clarke, 1976; Rutter, 1981a) and that adult mental disorders differ markedly in their links with childhood (Rutter, 1984a). Rutter concludes that there are difficulties associated with the notion of a critical period for development of attachment, with lasting major sequelae.

However, many theorists have supported Bowlby's notions of intergenerational continuity to attachment relationships. Most theorists jump from discussing an "attachment relationship", which is a particular feature of the whole adult-infant relationship, to simply referring to "the relationship". Many fail to distinguish what the extra features are, how they affect the "relationship" or the transmission. Sroufe and Fleeson (1986) make the following propositions regarding relationships (p.58) :

- 1) relationships are wholes, that is more than simple combinations of individual characteristics
- 2) there is a continuity and coherence in close relationships over time
- 3) the whole relationship "resides" in each individual
- 4) previous relationship patterns are carried forward to later close relationships.

Relationship histories are in this way brought forward into future relationships (called transference in psychoanalysis). The child learns how to love and be loved or if the child has experienced traumatic early relationships, of being exploited and how to exploit. The child knows "all the parts" of the relationship and is motivated to recreate the whole in other circumstances (Sroufe and Fleeson, 1986). The difficulty is readily apparent, in talking about

transmission. Sroufe and Fleeson state that whole relationships are transmitted, yet they do not indicate how the individual features (such as attachment) are transmitted. Their work also tends to assume that relationships are either the same with both parents, and does not provide discussion of how a person will carry forward a history of very different relationships with parents or caregivers.

Similarly, Cottrell (1969) presented the following points to describe how early relationships are carried forward to future relationships. Attachment patterns may be transferred from one generation to the next in these ways:

- 1) Established relationships are difficult to modify.
- 2) Relational patterns are learned and "reproduced in appropriate context" in the absence of obvious rewards. That is, patterns are learned merely by being in relationships.
- 3) Relationships in one situation will be evoked in similar situations (either participant part may be played).
- 4) Self-other patterns are perpetuated because :
 - a) persons select relationships in which a pattern is readily enacted.
 - b) ambiguous situations are "structured to let a pattern be expressed".
- 5) Patterns carried forward evoke responses in others "called for by the pattern" which "support and validate it".

Both of Sroufe and Fleeson (1986) and Cottrell (1969) fail to make the distinction between the attachment pattern and the relationship, they are assumed to be fundamentally the same.

However, attachment is a feature of a relationship and there is doubt whether this feature is the same for all cultures or contexts. These reservations cast doubt on the inevitability of "relationships" being transmitted as faithfully as both Sroufe and Fleeson (1986) and Cottrell (1969) suggest.

Morris (1980, in Sroufe and Fleeson, 1986) found that maternal histories were associated with independent assessments of infant-caregiver attachment. "In particular, lack of a stable family relationship structure and the subject's perception of her own mother as not nurturant and not competent in the maternal role predicted anxious patterns of attachment in the offspring" (p. 64). Mothers recreate the relational pattern, however different the expressed

behaviour might be. Sroufe and Fleeson (1986) state that "it is meanings, not behaviours, that are carried forward from relationships"(p.66). Although the link between maternal history and infant attachment has been assessed, the contribution of the father's history on the child's attachment has not been fully addressed. The impact of alternative care situations, where the father or someone else is the primary caregiver or the infant is in day-care is not examined either. The mother is assumed to be the primary and full time caregiver.

Bowlby (1973) suggested that internal working models of self and parents developed in childhood play a major role in the intergenerational transmission of attachment patterns. Parents who are supportive when called upon, and who encourage autonomy and communication, have children who are stable, self-reliant and able to question and revise their working models. As Bowlby (1969) concluded :

Because in all these respects children tend unwittingly to identify with parents and therefore to adopt, when they become parents, the same patterns of behaviour towards children that they themselves have experienced during their own childhood, patterns of interaction are transmitted, more or less faithfully, from one generation to another. Thus the inheritance of mental health and of mental ill health through the medium of family microculture is certainly no less important, and may well be far more important, than is their inheritance through the medium of genes (p.323).

Evidence of continuity of this sort has been found in studies of women as they become mothers. Psychological difficulties in pregnant women and new mothers have been linked to disrupted childhoods and stressful separations (Wolkind et al, 1976, Fromner and O'Shea, 1973). Fromner and O'Shea (1973) found that women who report, during pregnancy, a history of separation before their eleventh birthday are particularly likely to have marital and psychological difficulties after their own baby's birth, and also trouble with infant's feeding and sleeping management. Wolkind, Hall and Pawlby (1977) report that women with this sort of family history interact significantly less with their five month old infant than women with settled childhoods. Mothers with disrupted childhoods spent twice as long out of sight of their babies, and less time holding, looking and talking to them. Mothers were asked the question

"It takes a bit of time to begin to see baby as a person - do you feel this yet?". Mothers from disrupted families were less likely to say they did see their five month old infant as a person.

Bowlby (1988 b) reported that women whose childhoods have been disturbed tend to engage less in interaction with their infants than do mothers with happier childhoods. Although Bowlby suggests a certain inevitability about the transmission of attachment, Vaughn, Egeland, Sroufe and Waters (1979) report that changes in maternal circumstances can alter the infant's attachment to the mother. Available social support as well as a mother's own early care are both related to her infant's "strange situation" assessment. These researchers note that mothers of infants who changed from anxious to secure patterns of attachment reported significantly greater reductions in life stress than mothers of infants changing in the other direction. Crockenberg (1981) found that social supports, which served to facilitate secure attachments, mitigated the ill effects of unresponsive mothering. Very poor parent-child relationships without separation may pre-dispose mothers to depression (Crook, Raskin & Eliot, 1981; Parkes, 1983). An insecure attachment in childhood may not lead directly to adult depression, but it may render a mother vulnerable to later hazards and stresses; perhaps through impairments to self esteem, self efficacy and feelings of control over one's environment (Brown and Harris, 1978; Brown, Harris & Bifulco, 1985; Cicchetti & Schneider-Rosen, 1984). It seems particularly important to investigate the moderating effects of new relationships and a supportive environment. A single case study is a useful way to intensively explore the formation of a relationship and the part that supportive environment can play. It may also be particularly useful for collecting first hand information about the development of a close relationship between a mother and infant, when the infant is a "crying baby". Issues arising in the single case study may then form the basis of a larger study, involving a more representative sample of mothers.

In western societies, since the second world war, the secure attachment relationship between mother and child has been promoted as being appropriate, leading to healthy development (Dally, 1982). The nature of the mother-infant relationship has a changing history even within this century (Vellacott, 1989). Boulton (1983) points out that the idea of a mother as a fulltime caregiver is peculiar to western societies. Other societies undoubtedly

have their own particular construction of the appropriate mother-infant relationship should be, but in western societies the influence of the mother as "secure base" has been pervasive. Sampson (1989) stated that acceptance of norms, such as a "normal" role of motherhood and a "normal" mother-infant relationship, are socially negotiated understandings, which are sustained as social expectations across time. A person may feel a sense of inadequacy if the role is not experienced or not fulfilled according to the prevailing social understanding. The lengths to which people are prepared to go in order to be parents are testimony to the social desirability of the role. However, expectations of motherhood are more than simply having preconceived ideas about what being a mother is like. Expectations will also be influenced by a mother's recollections of how her own parents fulfilled the socially negotiated role of parents.

Ricks (1985) presented evidence (Main, Kaplan and Cassidy, 1985; Morris, 1980; Ricks, 1982; 1983; Ricks and Noyes, 1984) that there is a significant relationship between a mother's retrospective recollections of childhood attachments and a mother's ability to serve as a secure base for her child, assessed in the Strange Situation. However, Ricks (1985) states that it is also possible for a mother to provide a secure base for her child, despite an insecure attachment history in childhood. Significant emotional experience is the means by which this can occur, according to Ricks, in the following ways :

- 1) A parent may not wish to treat her child as she was treated, but it is difficult to act on this wish unless experience alters the underlying representational models of self and other. Emotional experience may not provoke conceptual change, but change is unlikely to occur in the absence of emotion.
- 2) If postulates regarding attachment bonds are acquired through internal representation of experience in early relationships, then change may occur through three types of emotionally corrective experiences in relationships:
 - a) change within the same early relationships across time;
 - b) repeated experiences in other relationships that disconfirm earlier acquired models and through;
 - c) an especially a strong emotional experience within a single relationship.

Ricks (1985) further suggests that re-organization of attachment postulates is especially likely to occur at specific points in the life span. Adolescence offers an opportunity for re-organization (Main and Goldwyn, in press; Main, Kaplan and Cassidy, 1985; Morris, 1980, 1981; Sroufe and Fleeson, 1986) with the advent of formal operations, adolescents suffering from an anxious attachment may profit from the ability to consider hypothetical situations, alternative relationships, family contexts or parenting situations. Also, establishment of relationships outside of the family may alter existing attachment-related postulates. Another significant time for change is with the birth of a child. In the Amherst study (Ricks and Noyes, 1984; also Belsky, 1984; Osofsky and Osofsky, 1984) mothers often spontaneously discussed their own childhood relationships in relation to what they hoped for their infants.

Bowlby (1969, 1973, 1980) proposes that close personal relationships serve a protective function throughout life, such that bereavements lead to grief and the presence of the loved one enhances resilience in the face of stress and adversity. This does not mean that relationships throughout life will be with the same person, nor that the form will remain the same, but that the function of the relationship will remain the same. Rutter (1987) states that there is an implicit continuity in the underlying structure, behavioural organization or biological propensity, not in the surface representations.

Considerable difficulties have arisen from using the term "attachment" to describe the behaviour, such as proximity seeking and separation anxiety, and the postulated explanatory concept (Hinde, 1982). It is not sufficient to simply assert that the function of relationships remain the same throughout the life span, although efforts to gather evidence to prove or disprove Bowlby's claims have been difficult (Hay, 1985). Evidence that different forms of relationships do indeed represent similar processes has been fragmentary (Hay, 1985).

Many critiques of the evidence of supposed lasting sequelae from infancy experiences (e.g., Clarke and Clarke, 1976; Rutter, 1981a) have drawn attention to the probability that many of the supposed sequelae stem from current adversity rather than past experiences. That is, that infants exposed to abuse or neglect in the early years may turn out badly not because of what happened in infancy, but rather because in middle childhood and adolescence they are still suffering from serious family adversities. As Rutter (1987) states, the main impact on current

psychological functioning stems from the women's family circumstances in adult life, but may reflect previously experienced adversity. There is undoubtedly continuing adversity in some families, but whether it can be attributed to poor family relationships, as Bowlby does, or to a reflection of sustained economic and social support difficulties in the family context, is an issue worthy of further exploration.

Attachment theorists have shown considerable flexibility in their use of the term attachment, as a behaviour, a concept, a feature of relationships and as a whole relationship. The contribution of a supportive partner and environment is not fully addressed. A multi-pronged approach, which incorporates the moderating effects of family and social structures, personal life style and circumstances would be much more fruitful.

Within the following section an attempt will be made to explore some of the avenues which a mother could follow, when difficulty is experienced in achieving the socially constructed "secure attachment" or "normal" relationship, which she expects. Sometimes this difficulty is experienced as a "crying baby", and a mother may seek medical advice as to what the cause of the infant's crying is. In the present study, colic was given as the cause of the infant's crying and the reason why the desired relationship was not being achieved. For this reason, a brief exploration of the colic literature will follow, with implications of appropriate social support thereafter.

A medical model

A mother experiencing difficulty in her relationship with her infant is likely to look for reasons as to why the infant is unhappy or to justify why the relationship is not fulfilling the socially constructed expectations which she may hold. In some cases the reason identified is a social belief, which alters as the culture alters its belief base. As Wright (1987, p.104) states "social constructivist analysis starts from the basis that all human knowledge, including medicine, is the product of human social activity and is used by human beings to bring into existence their own lives and experience". Wright (1987) discusses the social construction of infancy, and documents its transition from being a moral, ethical obligation of women to

support the infant to being a domain of expert, medical, instrumental control. Control over relationships, childrearing and the environment can all be justified in the name of historical "truth", but in reality may be expressions of social practice (Wright, 1987).

There are other ways of explaining why people give particular reasons as the cause of an event. Attribution theory is one such way. Attribution theory is essentially concerned with perception of the causes of behaviour and, in extensions of the basic theory, with the consequences of these perceptions (Rogers, 1982). Weiner (1974) and Bar-Tal (1978) originally applied attribution theory to the study of achievement motivation, with the finding that people's perception of the causes of their own successes and failures were important determinants of achievement behaviour and expectancies about future performances. Four major causes of success or failure were identified : ability, effort, task difficulty and luck. These causes were then assessed along two dimensions, internal/external and stable/unstable. People who could attribute their own success to stable, internal causes, such as ability and effort, were more likely to be motivated to future successes.

Attribution theory has been extremely useful in fields other than school achievement, and has been applied very effectively in fields of social psychology. In the area of social support, the attribution of personal responsibility has been discussed by Brickman, Rabinowitz, Karuza, Coates, Cohn, and Kidder (1982). Brickman et al. propose four models of helping and coping, which relate to conceptualisation and responsibility in problem solving (see Table 1). These four models are useful in explaining why people choose the avenue of help that they do, and are particularly useful in the present study for investigating why the mother chose a medical way of defining her infant's difficulty. The four models which these researchers propose are as follows :

- 1) moral model: people are responsible for problems and solutions.
- 2) compensatory model: people are not responsible for problems or solutions.
- 3) medical model: people are not responsible for problems but are responsible for solutions.
- 4) enlightenment model: people are not responsible for solutions
but are responsible for problems.

Brickman et al. (1982) suggest that real world settings often contain a mixture of assumptions that characterize the various models, but they cite evidence from a study of college graduates by Rabinowitz (1978), which suggested that the models do exist in a relatively coherent form in real-world settings.

A mother with an unsettled infant may accept that there are certain types of babies, who are unsettled and that this situation is beyond her control. Belief in a medical model means that she is not responsible for the problem of her upset baby, but she is responsible for seeking help with the solution.

Within a medical model, people see themselves or their children as ill or incapacitated. This view exempts them from their ordinary social obligations and imposes on them the responsibility for seeking expert help (e.g., Arluke, Kennedy and Kessler, 1979; Parsons, 1951; Segall, 1976). People are also expected to try to get well, by making use of the help offered. Experts are trained to recognize the problem and to provide a solution or treatment, the success of which is also determined by the expert not the patient. Accepting help is not seen as a weakness under this model, as the person cannot be expected to cope without help. Brickman et al. (1982) suggest that the major deficiency of a medical model is that it fosters dependency, and that people may lose control over situations and behaviours that they once managed well. However, one of the positive strengths for a mother of a "crying baby" of accepting a medical model is that of personal empowerment. Seeking medical intervention and finding a "cure", may relieve the stress of the situation, give respite from the infant's crying and provide greater opportunities for the desired close relationship to form.

TABLE 1

(From Brickman et al, 1982, p.370)

**CONSEQUENCES OF ATTRIBUTION OF RESPONSIBILITY IN FOUR
MODELS OF HELPING AND COPING**

Attribution to self of responsibility for problem	Attribution to self of responsibility for solution	
	HIGH	LOW
	moral model	enlightenment model
HIGH		
perception of self	lazy	guilty
actions expected of self	striving	submission
others beside self who must act	peers	authorities
actions expected of others	exhortation	discipline
implicit view of human nature	strong	bad
potential pathology	loneliness	fanaticism
LOW	Compensatory model	Medical model
Perception of self	deprived	ill
Actions expected of self	assertion	acceptance
Others besides self who must act	subordinates	experts
Actions expected of others	mobilization	treatment
Implicit view of human nature	good	weak
Potential pathology	alienation	dependency

Defining an infant's crying as "colic" fits comfortably with a medical model, as described by Brickman et al.(1982). A parent sees the infant as being ill or has difficulty coping with the crying, and seeks medical advice. The following section will outline what is meant by the term "colic" and the advice given to parents of children presumed to be suffering from this affliction.

Colic

Definitions of irritability in infants, such as colic, are prevalent in the medical literature. Such definitions have been relied upon by medical practitioners and parents alike to explain the incidence of continued irritability in newborn infants. Illingworth (1985) provides a "classic" definition of a colicky infant, of :

a well, thriving baby who early in the evening, for no apparent reason, develops paroxysms, beginning with a flushing of the face, a frown, drawing up of the legs, followed in a few seconds by high pitched screaming, suddenly ending in a few minutes, and followed in a few minutes by another paroxysm. The attacks recur for up to two or three hours. In the attack the baby is inconsolable, there are loud borborygmi, and the pain is relieved by the passage of flatus from the rectum (not from the stomach) by the passage of a stool, or it is said, by an enema (p.981).

Although the behaviour of infants with colic is fairly traditionally defined (Brennemann,1943; Spock,1944; Brazelton,1962) the causes of the behaviour are variously attributed. Such attributions range from wind in intestinal loops (Illingworth, 1955), allergy (Lothe, Lindberg and Jakobsson, 1982), the variety of foodstuffs in the mother's diet (Evans,1981), through to ineffective maternal responses (Taubman, 1984), family tension (Wessel, 1954), poor parent-child relationships and conflict over role acceptance (Lakin, 1957, in Illingworth, 1985). Illingworth (1985) suggests that maternal anxiety has been defined as a cause, but he stresses that anxiety is a result, not a cause of infantile colic.

Budin (1907) documented a condition which he called "overfeeding" (implicit in the term is the assumption that the condition was due to excessive milk intake) to describe infants who initially grew "too fast" but whose growth then faltered, babies who vomited, babies who were colicky, and finally babies who produced frequent stools which were liquid, and sometimes frothy and/or green (in Woolridge and Fisher, 1988). Concern for this condition spread, resulting in restrictions of the duration and frequency of feeds being recommended by medical practitioners and rigorously reinforced by maternity homes and midwives. Woolridge and Fisher (1988), by contrast, suggest that these symptoms are an artifact of feed management. Babies fed on a schedule take in large amounts of low-fat foremilk and small amounts of high-calorie hindmilk. Babies may come off the breast seeming hungry as they have not satiated their calorie intake, but they are unable to go back on the breast because they have reached their maximum capacity for volume intake. The low fat content may cause rapid gastric emptying and symptoms of fretfulness and "overfeeding". Woolridge and Fisher (1988) noted a 79% improvement in babies in their Bristol study, whose mothers changed to a pattern of letting the infant feed on one breast until satiety was reached.

La Leche League (1987) prescribe a somewhat similar approach to Woolridge and Fisher (1988), although they would not like to align themselves too closely with the medical profession. La Leche League was formed to give the power of parenting decisions back to the parents, and would fit more closely to Brickman's(1982) compensatory model. They define colic as a catchall term meaning "loud, persistent screaming for undetermined reasons" (p.102). Calm, gentle handling, and short, frequent feedings from only one breast per every two to three hour period is recommended. The extra closeness and cuddles are advocated for soothing the "colicky" infant. The mother is also advised to exclusively breast-feed the infant; to avoid juice, formula or vitamin preparations. Elements of the mother's diet, such as Brewer's yeast, caffeine, artificial sweeteners and dairy products are also suggested culprits of allergy and colic in infants. Elimination of substances to which there is a family history of allergy is advised. A "colic hold" wherein the infant is held along the parent's arm, with feet lower than head, and gently rocked during the "colic" attack is reported to be useful, as is a deep, warm bath for parent and infant during "colicky" sessions.

Minchin (1983) suggests taking the following steps for the relief of an infant's "colic". Firstly, decrease the amount of lactose that goes into the infant's small intestine all at once, by (a) expressing milk before the morning feed to reduce the flow; (b) to give boiled water before a feed; (c) to posture feed so that gravity does not assist the flow or (d) feed from only one breast at a time. If none of these help, Minchin suggests examining the mother's diet and keeping a diet diary, and to carefully eliminate foods, one at a time. If all else fails, Minchin suggests a complete check-up by a physician.

A study by Jakobsson and Lindberg (1983) suggests that 35% of breast fed infants, in their double-blind crossover study of (66) breast feeding mothers, ceased to have symptoms of "colic" once cow's milk was eliminated from the mother's diet. Colic disappeared in 35 of these infants and reappeared on at least two challenges (cow's milk to mother) in 23 infants (35%). Evans et al. (1981) suggest that it is the variety of the mother's diet which is the significant factor, rather than simply an allergy to cow's milk. In their study of 20 breast fed infants, these researchers found that increasing numbers of foods in the mother's diet were associated with increased numbers of colic attacks. However, Jakobsson and Lindberg reject Evans results, on the grounds that they chose soy milk as a placebo. Lothe, Jakobsson and Lindberg (1982) found that 53% of 66 infants studied reacted to soy formula as well as to cow's milk formula. Jakobsson and Lindberg (1983) conclude that infantile colic can be a symptom of food intolerance in both the breast fed and formula fed infant.

Illingworth (1985) dismisses much of the literature on the relative influence of allergy on "colic", because of a lack of satisfactory criteria. Illingworth cites evidence (Illingworth, 1954; Wessel et al, 1954; Paradise, 1966; Weissbluth, 1984; Stahlberg, 1984; Liebman, 1981; Jorup, 1952; and Hemmings, 1981) that colic is not preceded by a significant history of allergy and manifestations of allergy in the infant, nor that colic will cease when the mother avoids cow's milk. Illingworth (1985) documents the success of treatment, in the form of the anticholinergic drug, dicyclomine hydrochloride (Merbentyl). Illingworth berates the withdrawal of the drug, which occurred after links were made between its use and sudden infant death syndrome (Edwards, 1984; Williams and Watkin-Jones, 1984; Spoudes and

Shribman, 1984). Illingworth (1985) also notes that many doctors routinely recommend gripe water, and suggests it may achieve some result because of its alcohol content.

Hunziker and Barr (1986) state that about 20% of normal newborns in western society are affected by "paroxysmal fussing" or "3-month-colic". They further state that early infant crying is an adaptive behaviour that acts to promote mother-infant proximity and to provide opportunities for social interaction. Anecdotal reports from cross-cultural studies show little to no fussiness in societies in which infant care practices differ significantly from western practices (e.g. Brazelton, Robey and Collier, 1969; Goldberg, 1972; Konner, 1972; Mead, 1935). The most common difference noted in the above studies is that infant caregiving is characterised by constant close mother-infant proximity and extended carrying. Dietary differences are also a factor, as Jakobsson and Lindberg (1983) have pointed out. Hunziker and Barr (1986) noted the elimination of the 6-week "peak" to fussing behaviour in their study of supplemented infant carrying in the newborn period. Hunziker and Barr conclude that these mothers were systematically predisposed to detecting their infant's demands and to shortening their response time to distress, thereby facilitating a more synchronous mother-infant interaction.

Within a medical domain, any of the avenues followed by the participant mother would be acceptable causes of colic : allergy, mother's diet, bowel pain, a tight anal sphincter or simply hunger. However, the "colic" literature also suggests that maternal anxiety or tension and conflicts within the home environment may be a possibility. Within such a definition is the implicit assumption that somehow the infant's difficulty is the mother's fault. Taubman's (1984) notion of training mothers to make appropriate responses implies this. It may be that definitions within the medical domain, such as "colic", are necessary for the parents well being and sense of efficacy. For a new mother to be accused, even by implication, of insensitive mothering when her infant cries may mean a risk to the mother's mental health and the infant's safety. Helping a mother to cope may mean accepting a definition which puts them into a passive position, such as accepting a medical definition of the perceived problem. A sense of personal success may then be achieved if these parents are instrumental in negotiating a "cure".

Achieving a sense of personal success or self efficacy for a mother with a crying baby is an important issue. Donovan and Leavitt (1985) suggested that learned helplessness theory (Seligman, 1975) can be used a model to account for observed differences in responsiveness to infant's signals and especially to the distress signal of crying. Learned helplessness theory claims that people exposed to uncontrollable events learn that responding is futile (Donovan and Leavitt, 1985), and that experience with uncontrollable events generalizes to situations beyond the immediate one (Seligman, 1975). From a developmental perspective, this could mean that a mother's current effectiveness in responding to her infant's signals and coping with crying episodes will be related to her future responsiveness and coping ability. Donovan and Leavitt (1985) state that "maternal competence is dependent upon the mother learning that efforts during interaction with her child are effective" (p.253). If a mother has previously been unsuccessful in coping with or managing infant crying, then a sense of helplessness may ensue.

Defining an infant as "difficult" is consistent with a "moral" model (Brickman et al., 1982) and of high responsibility for the problem, and for finding solutions, by changing behaviours. A definition of "colic" is consistent with a medical model (Brickman et al., 1982) and of low personal responsibility for the problem. Seeking medical advice may also suggest a certain reliance on the advice of "experts" Similarly, seeking help from the university cry clinic, reinforces the need for other opinions. These may be perceived as viable avenues of support. The following section will examine how a mother, who has made the commitment to full-time motherhood, and experiences difficulty in the form of a crying baby, can best be supported.

Social support

Brickman et al. (1982) suggest that social support is not necessarily of positive benefit for the recipient. Close personal relationships are reported to help people cope better with stressful situations (Cobb, 1976), although Brickman et al. (1982) state that most studies on helping and coping tend to assume that support agencies fulfill the same role as close personal

relationships. As Brickman et al. (1982) state, seeking help for marital or parental problems may be associated with more, rather than less, distress. Much of the difficulty with social support arises from application of the wrong model, or lack of recognition that people may seek sympathy from one group and solutions to problems from another. Accepting social support from an inappropriate model may make belief in one's own ability to formulate solutions all the more difficult. Learned helplessness (Seligman, 1975) has been discussed in relation to infant crying, but it is also useful in discussing responses to inappropriate support situations. If the support offered creates more stress, rather than lessening it, then a mother's sense of helplessness may be increased. As Brickman et al. (1982) concluded, people who believe that they can control their own outcomes are more likely to persist in the face of difficulties and are less likely to show signs of stress (e.g., Seligman, 1975).

Brickman et al. (1982) consider that the compensatory model provides the avenue of optimum potential for growth and development. Within this model, support (e.g., resources) does not need to be solicited, it is routinely available, not a gift or a privilege. Brickman et al. propose that recipients can refuse aid, if they deem it unnecessary, and also determine what time, place and quantities will be used. This element of the compensatory model is questionable, as it seems unlikely that a person in a highly stressed state is capable of rational decisions about what sort of aid they need or in what quantities. However, the notion of having readily available aid for mothers in distress is an appealing one. Under a compensatory model, some participants may come to see themselves as deprived or suffering, not from their own deficiencies, but from failure of the social environment to provide them with the goods and services to which they are entitled. Support in these terms is to mobilize on behalf of the person until the resources have been supplied and the person can take responsibility for his or her own fate. Support is focussed on empowering, with the help of peers, in order to deal more effectively with the environment.

Within this model, medical practitioners and professional support agencies would approach a mother experiencing difficulty with a new born infant with a question: "how can I help you?". Typically, within a medical model, support is dispensed with the statement "this is how I can help you". To gain the continued interest and support of the medical practitioner, the

mother is obligated to accept the help offered. Within a compensatory model, no sense of obligation would apply as the mother simply uses support as needed. Schumaker and Brownell (1984, p.13) provide a definition of social support which is useful in clarifying this concept, which says that social support is "an exchange of resources between at least two individuals perceived by the provider or the recipient to be intended to enhance the well being of the recipient". Such a definition carries with it the notion of exchange and also of at least two participants in the interaction.

Schumaker and Brownell (1984) state that the inherent notion of exchange or reciprocity within social support poses certain threats to those in need of the support. Cobb (1976) suggests that a social support network may be characterised by a sense of mutual obligation. Gottlieb (1981) reports that a threat is posed to stability of supportive relationships by perceived inequity. Similarly, Shinn, Lehmann and Wong (1984) propose that the obligation to reciprocate may stress existing relationships. Within western society, a norm of reciprocity exists (Gouldner, 1960); that people usually return the benefits they receive from others. Support, therefore will be influenced by the recipients perception of the providers real costs, intentions and benefit from providing the support. In New Zealand, however, where the state provides social support in the form of benefits for the sick, unemployed, solo parents and the elderly, is unlikely that recipients feel any obligation to repay the support they receive. It is more probable that a person will feel indebted if the social support comes from a private source or from a person in a similar situation. Accepting support may place the recipient into a state of tension or indebtedness (Greenberg, 1980). As a result, the recipient may find alternatives to accepting support from some avenues or will not seek assistance, because of an inability to reciprocate. Schumaker and Brownell (1984) conclude that the following methods may be useful in minimizing effects :

- 1) to sensitize provider and recipient;
- 2) for recipient to assist someone other than the provider;
- 3) mutual self-help groups;
- 4) a formal support system; for example professionals or experts, where the needs of the recipient may be shared among many sources.

Taylor (1983) proposes that people under stress undergo three processes, which need to be recognised in any support programme. These processes are a search for the meaning of an event, an attempt to regain mastery over their lives and finally a need to enhance their self esteem. In the present study, the participant mother's need to define her infant as having "colic" or a medically defined "problem" is an example of the need to search for meaning, in order to regain some sense of control over her life. The mother's self esteem was undoubtedly affected by her perception of herself as unable to cope like "normal" mothers. Inappropriate support may threaten a recipient's self esteem, if it implies a superiority-inferiority relationship, conflicts with values of self reliance or requires a person to admit impairment (Chesler and Barbarin, 1984; Dimmatteo and Hays, 1981; Fisher, Nadler and Whitcher-Alagna, 1982; Schumaker and Brownell, 1984). Appropriate support, therefore, needs to be empowering for the recipient, providing opportunity for a sense of self efficacy to develop.

Brownell and Schumaker (1985) stress that the results of interventions are not always positive. Recipients of support may feel that their privacy has been violated, or providers may feel their role to be a burden. Results may also be context specific, influenced by personal and demographic characteristics, the history of the support relationship, the size, structure or availability of social networks and the life domain (e.g. home, school, work) in which the person is experiencing difficulty. Most interventions and support programmes are aimed at heterogeneous groups, not at specific people, and may therefore be contextually inappropriate. Support, therefore, needs to be altered to suit the person in need. Providers can provide opportunities to help increase social networks and can teach skills to help the recipient access support resources, but the recipient must be able to decide whether to use the opportunities. It may in fact be quite unethical for support providers to re-shape a person's values to fit a social scientist's current intervention (Brownell and Schumaker, 1985).

Finding social support and help seeking behaviour are complex issues. One of the ways that collaborative case study research can support a mother is to provide a forum, in which a mother can de-construct her role as a mother and decide for herself if she wants to accept the socially constructed norms of motherhood with which she is presented. De-construction of these norms is one thing, however, but making sense of an on-going situation

is another. The following section will discuss the reasons for choosing a single collaborative case study and how this sort of study is a useful way of exploring the factors influencing a developing relationship between a parent and a newborn infant.

Purpose and rationale for a single case study

In most general terms, the purpose of this study has been to document the developing interaction between a mother and her infant. At the beginning of the study, one very broad question guided the interview process and the types of data collected. The question was "Why does this mother define her infant as a crying baby?".

Several different forms of data were available in this endeavour, although not all are presented in this document, for the reasons outlined in chapter three. As the study developed, it became important to establish the answers to the following questions :

- 1) What is colic and how does it affect the relationship between a mother and her infant?
- 2) How can a mother of a crying baby be given support?
- 3) How does this mother define her role as a mother?
- 4) What sort of relationship does his mother want with her baby?
- 5) What is the context of the mother's difficulty with the infant?
- 6) What is it like to be the mother of a crying baby?

The last two questions are answered within the case study data in chapter four, as the mother's historical and social context are discussed and her views about life with a crying baby are presented. The first four questions were further refined as the study progressed and form the basis of the discussion in chapter five. The questions will be examined within a social constructionist framework. The four questions are as follows :

- 1) How does this mother define her role as a mother, and why?
- 2) What sort of relationship does the mother want with her infant?
- 3) What is colic and how did the participant mother respond to it?
- 4) What social support is needed to support a developing relationship between a mother and her infant, when the infant is a "crying baby"?

Yin (1984) proposes three rationales for choosing a single case study design. They are as follows:

- (1) the critical case : to test a well formulated theory, wherein the case meets all the pre-requisite conditions.
- (2) the extreme or unique case : a rare or unusual case which is worth documenting or analyzing.
- (3) the revelatory case : when an opportunity to observe and analyze a phenomenon previously inaccessible to scientific investigation.

The present case study seems to meet the criteria for both a unique case and a revelatory case. It was unique, in that this mother came to the university with her second "colicky" infant, recounting a personal history of allergy, and a history of unresponsive parenting due to her parents substance abuse. This mother was also a practising Jehovah's Witness, committed vegetarian, and a mother dedicated to being a "good mother". It was revelatory in that it provided the opportunity to follow up on the previous issues and to explore how these factors would affect or contribute to life with a "crying baby".

McMillan and Schumacher (1984) suggest that ethnographic case studies start out with a sense of a "foreshadowed problem" rather than a research hypothesis. Such a foreshadowed problem may be broadly based questions about the what, why, or how something happens. In this case study, no fixed hypothesis was formulated; but a foreshadowed problem was seen in working out why the mother defined her children, in particular the infant James, as a crying baby.

King (1979) proposes that a case study should be vaguely anthropological and essentially non-structured. King suggested the notion of "verstehen"; or the study of meanings, because he reports that "theory should follow from research, not precede it" (in Cohen and Manion, 1985, p.137). Similarly, MacMillan and Schumacher (1984) state that the research problem in ethnography comes from the field rather than the literature review. Researchers start with general knowledge of the setting (time, place, participants) and a general idea of the event, and recognise the various possibilities. A research question is formulated from an intuitive feel for a problem. Similarly, Becker (1961, in Stake, 1988, p.257) calls this

definition of focus a "developmental perspective", as certain themes assume a primary focus for the study.

Stake (1988) suggested that case studies have boundaries which are continually re-negotiated by researcher and participants. Stake proposed that a case study does not seek to tell the whole story, but it may present a unity of experience which other research methods may not be able to do.

The case study which will follow has in many senses evolved, as the mother and I discussed what she considered to be the important issues in her particular situation. A single case study provides an interesting contrast to many studies of mothers, such as Ainsworth's (1972) Baltimore study, which made determined assessments of the relationship between a mother and her child, after only four visits within the infant's first year. A single case study can document the changes and the challenges to a developing relationship and present a picture of a unique experience.

CHAPTER THREE

METHOD

Approach and purpose of the study

MacMillan and Schumacher (1984) present the notion of entering a case study with a broad conceptual framework, in order to recognise events that occur, which change or sharpen the initial focus. "As events unfold, the various conceptual frameworks are cast aside, combined, or reworked until explanations are generated that most closely fit reality" (p.311). During the course of this study, an examination of the social and historical construction of relationships and of decision making presented itself as a relevant focus for a conceptual framework. This focus had been communicated to the mother throughout the year by the nature of the questions asked, and has possibly affected the account of her life and decisions, and perhaps even her avenues of definitions. Certainly at the beginning of the study, the mother appeared to primarily give credence to a medical definition of why her infant could be irritable.

Primarily my research role was defined as a non-participant observer and interviewer, although this implies a more static nature to the research than was actually experienced. Research in studies such as this may be collaborative in that it seeks to involve the participant in the research process, although the researcher provides the theoretical orientation and possible interpretations in light of the study. In this study, a commitment was made to using theory which also seemed appropriate to the mother, by explaining how I proposed to interpret the case study data and discussing how the literature would be used in the written thesis. Involvement may provide alternative avenues of definition or opportunities for personal change. Lather (1989) proposes that emancipatory social science must be premised upon the development of research approaches which empower those involved to change as well as to understand the world. Empowerment, in Lather's terms, opposes the reduction of the term as

it is currently used to mean individual self assertion, upward mobility and a psychological experience of being powerful. Lather draws on Gramsci's (1971) notions of counter-hegemony; to define empowerment as meaning "analyzing ideas about the causes of powerlessness, recognizing systemic oppressive forces, and acting both individually and collectively to change the conditions of our lives" (1989, p.4). Lather stresses that such empowerment is a process undertaken for oneself; it is not done "to" or "for" someone.

In this case study, all interviews were discussions rather than monologues, so that the themes addressed of motherhood, forming relationships, social support and of medical definitions were collaboratively brought forward as important issues for further discussion. Although I did not consciously attempt to "empower" Caroline, I have concluded that a collaborative forum is an effective and useful way of re-evaluating issues, definitions and decisions, in a non-threatening manner. Such re-evaluation could be a means of arriving at personally appropriate meanings of life choices, rather than an unquestioning acceptance of social norms.

A commitment was made to involving the mother in the research process. For this reason, the mother was asked to proof-read the case study material. Caroline's comments on the first written draft of the case study are included in the next chapter. Caroline also agreed to read, comment on and give approval of the finished thesis before it was submitted. Caroline's collaboration in the research extended to an expressed interest in reading the completed thesis for validity purposes. Yin (1984) suggests that such a review by participants is not only a professional courtesy, but is also a way of corroborating the essential facts and evidence presented. Yin further states that participants may disagree with the conclusions reached by the researcher, but they should agree with the "facts" of the case. Such corroboration will enhance reliability of the case.

This case study has focussed on the mother's experience, because it was her definition of a "crying baby" which was originally presented. The results, however, must also reflect the collaborative involvement of both the mother and myself in the research process. Another factor in the decision to focus on Caroline's experience, was her role as primary caregiver of both children. An insight into her decisions about the children and her definitions of

motherhood, relationships, medical issues and social support were sought. It was also important to discover how she perceived the effects of husband, family and community upon her life with this infant, because of the social constructionist approach which was adopted. For these reasons, this case study does not suppose to give a balanced view of the opinions of all members of the family, but it does try to establish why this mother defines her infant as a "crying baby" in the family context.

A single collaborative case study provides a forum for exploring how a socially constructed view of motherhood, in this case in a nuclear family unit, has implications for the definitions and practices undertaken within the family. Material collected from interview and observation with this case have provided a useful and fruitful avenue for exploring transgenerational effects on relationships which mothers form with their new born infants. It was not the intention of the present study to assess any external validity (Cohen and Manion, 1985), but to highlight possible avenues worthy of pursuing with a larger, more representative sample, as well as integrating any findings with contemporary theory.

Ethical concerns

An outline of the case study being conducted was referred to the Massey University Ethics Committee on 13 April 1989, explaining the family situation and my involvement in the family home at that time. My ethical concerns conveyed to the Ethics Committee were as follows:

- 1) that there has been full disclosure to the mother about procedures
- 2) that these procedures are not intrusive of her family life
- 3) that there has been informed consent voluntarily given
- 4) that she may discontinue at any time without prejudice.

In addition to these concerns, I have supplied the family with copies of any notes taken, copies of written drafts and I have sought their comments and criticisms. I have also asked for approval before submission of the thesis, in case it is offensive or inaccurate in any way. I have avoided offering advice or giving solutions to any difficulty experienced, although part of

the discussion process has involved explaining my own methods in given situations and offering knowledge of different techniques or approaches which I have encountered in my reading for this thesis.

Finally, I have sought to protect the family's identity by changing names and details, and I have avoided discussion of the family with anyone outside of the research. At various times, conversations were held between the mother, her doctor, my supervisor and myself.

Data Collection

During the first interview, the mother and I established that several sources of information, to document the study, were available to me. Four major procedures were initially adopted for the data collection. These were as follows :

- 1) Audio recordings of the "colic attacks".
- 2) Examining "cry diaries" (Kirkland, 1985) being kept by the mother. These were rating forms of the infant's behaviour throughout the day, at fifteen minute intervals.
- 3) "Infant motion forms" being completed for the "Infant Motion Study"(Kirkland and Bisman, 1990).
- 4) Ethnographic data collected from observation and interview.

The participant mother had agreed, at the initial interview, to participate in an ongoing study of infant motions (conducted by Dr. John Kirkland). The rational behind the study was to document possible links between infant motions, parental feelings and eating habits. This study paid particular attention to infant's stools, urine, eating and behaviour, as well as to mother's feelings and actions.

Data from the "infant motion study" were used to provide some "hard data" to compare and contrast with the more subjective case study data. The "infant motion study" (Kirkland and Bisman, 1990) was used as a vehicle for exploring the basis for the mother's medical definition of the cause of the infant's crying. Results of this study gave some support for the mother's assumption that James was intolerant to dairy products, received through the mother's breast milk, as the infant's symptoms of colic, green stools and mucus in the stools

and respiratory system subsided after Caroline ceased to consume any dairy products (McLachlan-Smith and Kirkland, 1989).

Audio recordings of the infant's crying were collected during colic attacks and during crying bouts following the cessation of colic. The "cry diaries" were useful for the mother and I, as they helped us to establish when the best time to record the infant's "colic attacks" would be. Initially, I had contemplated using this data as a listening exercise, to see what other people considered to be a "colic" cry. This exercise did not eventuate, as the recordings were not of particularly good quality and were frequently characterised by lawn-mowers and adult and pre-schooler conversation. The most important point, however, was that finding out how other people would react to James' cry was irrelevant for the developing focus of the thesis. Establishing how and why Caroline reacted to James' cry, and exploring how she was supported through the difficulty experienced was far more important.

No initial timeline was set for completing the study. A commitment was simply made to follow the infant and mother until the infant ceased to be a "crying baby" or for as long as it took to document the case. Visits were arranged to take place in the mother's home at her discretion, to get as natural an environment for mother and baby as possible.

Case study data were collected during visits to the participant mother's home, initially while the infant slept or between bursts of recording the infant's crying. The mother was asked to communicate anything which seemed relevant to her present situation. The mother was given a copy of any notes when taken and was given the option to withdraw at any stage. A telephone call was always made to arrange a suitable and convenient time to visit, and the mother was given my home and university phone numbers so that she might establish contact at any time. The family's anonymity has been protected by using pseudo-names; Caroline and Robert for the parents and Sarah and James for the children.

Timing and setting

This case study was undertaken in the mother's home at daytime, primarily in the kitchen/dining room, frequently over a cup of tea when an interview was being conducted.

When the baby was awake, observation was undertaken in the kitchen/dining room or in the lounge. After the parents moved house in early October (1989), the format was sustained. The parents first home was a two bedroomed, "Housing Corporation", semi-detached flat. The kitchen/dining room housed a stove and kitchen sink, a refrigerator, table and chairs and a small coffee table. The kitchen overlooked the clothes-line in the backyard. The lounge was of similar proportions, with two small sofas, a television, a bookcase and numerous photos of the children. The second home was also a "Housing Corporation" house, but considerably larger. It had three double bedrooms, a larger lounge, and a long, narrow kitchen/dining room. It was in the same area as the first home, in a quiet street with a large, fenced back section. Caroline and Robert paid a slightly higher rent to the Housing Corporation for the second house.

Most of the early interviews or observations were conducted twice daily, from 10.30 to 12 noon and from 4.15 to 6.00 p.m. These times were chosen as the best times to collect audio recordings of the "colic attacks", to observe the infant's most irritable behaviour and the mother's coping methods, and the nature of the family interaction. Times were primarily chosen, however, because they suited the mother. Mother and children were usually present at morning visits, father was also present during evening visits.

This pattern of visiting was maintained until the "colic attacks" stopped, or the identifiable "peak" to crying behaviour disappeared and Merbentyl (dicyclomine hydrochloride) ceased to be administered -- a period of five weeks. (Merbentyl is only available on a Doctor's prescription now in New Zealand, because of the role it may play in cot death. Merbentyl used to be commonly used for "colic" and was readily available over the counter at a Chemist.) Visits were then reduced to every couple of days, to weekly and eventually to every three weeks, and then monthly. Visits were then timed between 1.15 and 2.45 p.m, to meet with Sarah's Montessori school hours. Reasons for gradually withdrawing my presence were twofold. Firstly, to avoid disrupting the family as they adjusted to a different life with their infant (without "colic"), and secondly to avoid compounding a possible "support effect", wherein the mother was reporting "dreadful" times with the infant on the days I was unable to attend. A possible transference effect may have been real or imagined, but it seemed unfair to let the mother form a reliance on me, when I was unqualified and unprepared to fill an active

support role. Undertaking any counselling or therapy of any sort was not part of my role for ethical reasons; my only purpose for being in the mother's home was to observe and to interview. As the months passed, the visits became more social in nature, and both mother and I enjoyed the opportunity to discuss the family's development and any changes which had taken place. I also found it easier to consider and think objectively about my observations, with the slower pace of data collection.

Guba (1978, in MacMillan and Schumacher, 1984) introduced the notion of "naturalistic inquiry" to describe field research which uses non-interfering data collection techniques. As much as possible, an attempt was made to be unobtrusive and non-intrusive. Within the household, I avoided offering physical help with the children or the housework, although my own inclination as a mother made me want to offer assistance. Where possible, I avoided direct interaction with the children, in order to observe the interaction between parent and children more readily. Of course, this is virtually impossible when dealing with a curious pre-schooler and an engaging infant. Taking a large supply of paper for Sarah to draw on while Caroline recounted current events proved to be a happy compromise.

Personal background

My own background as a mother of three children and of experience with a "colicky" baby and a child who is intolerant to dairy products made this case a relevant and interesting study. I am also of a similar age to the mother and her husband, so feel grounded in the same generation. These parallels have made for advantages and disadvantages. The advantages are having had experience with similar childrearing issues. The difficulties involve separating out my own decisions and definitions and from making any sort of judgement of the mother. The challenge, therefore, has been to seek out the mother's definitions and to explain them in light of a theoretical orientation, rather than an intuitive sense of right and wrong. MacMillan and Schumacher (1984) state that the challenge of a case study is in resolving the question of "who am I?" in relation to the case study; this ability evolves with time and experience. This point will be addressed in the discussion.

Summary

This chapter has looked at five aspects of the research methodology; the approach and purpose of the study, ethical concerns, data collection, timing and setting and my own personal background. The following chapter will present the case study data, gathered from interview. Results of the "Infant motion study" are presented elsewhere (McLachlan-Smith and Kirkland, 1989). The following chapter will be divided into sections to recount the mother's historical background, social context, relationships, medical definitions and also Caroline's responses to the first draft of the case study.

CHAPTER FOUR

CASE STUDY

This chapter will present case study data gathered from interviews over the research period. This chapter concludes with Caroline's responses to the first draft of the case study, where I had asked her to read for accuracy and validity. As the quotations were derived from hand recorded interviews, I also asked Caroline to check that I had recorded her intention correctly.

An historical perspective

Caroline was born in England in 1963. Her mother is a New Zealander, who went to England to gain her 'overseas experience': there she met and married Caroline's father. The mother has two daughters; Caroline is the youngest child.

Caroline discussed the impact of her own family life on her own decisions as a mother on many occasions. She suggested that experience of her own childhood made her determined to provide a different environment for her own children. Caroline's parents' marriage was troubled from an early stage. Her father drank a lot, and her mother attempted to leave a couple of times. She tried to return to New Zealand when Caroline was a small baby, and reached as far as the ship with the two girls. She developed a severe migraine, however, and had to leave the ship, because there was no-one to care for the children. The mother's migraines were evidently completely incapacitating.

When Caroline was two and half years old, both parents came to New Zealand and settled in a small village in northern Wairarapa, where her father found employment with the local brewery. The family stayed in the village and the father continued to drink. He became violent when he drank whiskey, although he didn't actually physically harm the family. Caroline records "a few close shaves", and that she used to run to her bedroom to avoid him

and his fierce temper when she knew he had been drinking. She admits to feeling scared of her father and of having no sense of a relationship with him. Caroline described how a constant psychological pressure was maintained on the family by the father's drinking. Evidently, Caroline's father is still drinking, despite attempts at Hamner Springs to cure the addiction, but is less violent now as he drinks wine instead of whiskey.

As a baby, Caroline was cared for by a friend of the family in her home, while her mother was working as a nurse.

I was very shy, insecure. I wouldn't let my mother out of my sight. My father is an alcoholic and my mother was constantly saying she was going to leave. She did leave occasionally, only overnight, but took us too. I felt uptight, with migraines in the tummy. I felt the same at Massey. I felt panicky if she was late, if she had gone somewhere and I wasn't sure where.

As a child, Caroline was told she was a "plodder" compared to her elder sister, and that she always had to study and strive hard to achieve at school. She experienced difficulties as a teenager with both parents and tended to "snap" at them. Her mother's lack of responsiveness to her needs was hard for Caroline to understand, and it has only been in the past decade that Caroline has discovered that her mother has been using valium for twenty-eight years. During childhood, however, she could not make sense of her mother's confused state. Caroline described what her relationship with her parents is like now :

I tolerate them now - I used to snap at them as a teenager. Now I treat her like I'd treat someone else's mother. I've stopped expecting her to behave like a normal mother.

Caroline reported that she needed help with Sarah in the early stages of James' pregnancy, but her mother refused to come and help her. Caroline had expected her mother to be available and supportive to her when she had children, but her mother did not fulfill these expectations. Caroline had thought that she may be sympathetic, as she had suffered terribly from morning sickness herself.

Caroline attended the local primary school until Form Two, then she went by bus (a three mile trip) to the district high school in the nearest town. She completed five years of

secondary education. During adolescence, Caroline regularly acted as a "baby-sitter" for the neighbouring children. Caroline's love of children, and her own sense of being "good with children", lead her to Teacher's Training College in Palmerston North, upon finishing school. Caroline chose this career by herself, but was encouraged by the Vocational Guidance officer at the school. She was selected for teacher training within the first round of selected applicants.

Caroline found studying and doing teacher training "sections" in schools very stressful and demanding. She spent two years at Teacher's College, during which time she experienced a return of her childhood sensations of panic, feeling up-tight and "getting migraines in the tummy". Caroline indicated that these symptoms were her typical reactions to stress. After a year in the hostels and another year flatting with students, Caroline went flatting with an older woman (aged 26). She reports craving "routine and security". A decision was made at this point that there was more to life than striving and studying, and she left Teachers' College. She joined the Jehovah's Witnesses and began a course of religious study. She got to know the congregation and enjoyed the routine.

Robert followed a somewhat parallel path. He originally came from Hastings, the youngest of a family of four boys. He completed five years of secondary education in Hastings and came to Massey University to undertake a Bachelor of Business Studies. Caroline met her future husband during her first year. In their second year, they went flatting, with two other Teachers' College students and two other Massey students. Caroline and Robert became friends and started dating at the end of that year. They left the flat; Caroline to flat with the previously mentioned older woman, Robert went into private boarding. Robert could not decide on what subject to major in for his degree. He enjoyed a holiday job painting and decorating, so he left the University. His parents were terribly disappointed in this decision. Caroline and Robert joined the Jehovah's Witnesses together, pursuing individual paths of study. They dated throughout that year, and were married in September, 1984.

Robert continued to work as a painter and a decorator, in a small business, until the birth of James. He then went into business on his own, as a painter. After she left Teacher's College, Caroline had a series of temporary part-time jobs, working in a coffee shop and doing

food preparation. She then had a position for some months before Sarah's birth, answering telephones for a couple running a business at home, and helping out with the children.

When asked what had attracted her to Robert, Caroline said that there was no initial appeal. They got to know each other while flatting and became good friends. The reasons given for choosing him as a husband were "just got on well, there wasn't anyone else and it was about time to get married". She also reported that it was the first time that she had had a good friendship with a male, and felt this was a good basis for a marriage. The first year of marriage was quite peaceful. The second year's peace was reportedly shattered by the birth of their daughter in September, 1986.

Caroline described her picture of having children before the children were born, saying that she hadn't visualised any problems and felt fairly confident. She had previously looked after other people's difficult babies. Before Sarah was born, she had just finished a job (as a "home help") working for a woman with four preschoolers and she had virtually looked after the second-to-youngest until he was seventeen months old.

I felt quite realistic, I knew it wasn't a bed of roses and I knew about waking in the night.

Caroline collected a lot of baby clothes before Sarah was conceived, and read Kitzinger's Pregnancy and Childbirth. She kept notes of Sarah's growth and development (movements, size and so on) on a photocopy of Kitzinger's week-by-week foetal growth chart, which she later completed and compared with James' growth and development during the pregnancy. Caroline and Robert attended ante-natal classes at the maternity hospital during Sarah's pregnancy, and Caroline went to "stretching for pregnancy" classes. However, Caroline had a particularly difficult pregnancy and did not enjoy her post-partum stay in the hospital. She left the hospital feeling anxious about her ability to cope. She recollects that the nursing staff were insensitive to her difficulties with a "crying baby" and were patronising of her attempts to sooth the infant. She also reports feeling confused by the conflicting advice offered by different members of the nursing staff.

I had terrible morning sickness, twenty four hours a day, with both children. From five weeks to three months with James. From five weeks to four months with

Sarah. Despite this, I would like more children - two doesn't feel like a complete family.

Sarah is reported to have had "colic" for six months. During colic attacks, she was constantly carried or rocked in a pram. Caroline gave her Merbentyl (dicyclomine hydrochloride) every two to three days, when she couldn't stand the crying anymore. Sarah was breastfed until three months before the birth of James.

I was totally thrown by colic...I wasn't experienced...I didn't have a label. Sarah screamed constantly - I had no confidence left by the end of the first week.

During James' pregnancy, Caroline again attended "stretching" classes, but did not repeat the ante-natal classes. Robert looked after Sarah while Caroline went to "Home Birth Association" meetings, which she enjoyed. Caroline elected to deliver her baby at home, as she was unwilling to repeat her earlier unsettling experience in the public hospital. She hoped that the more tranquil home environment would be a pleasant and less stressful place in which to give birth. She also hoped that the home delivery would help Sarah adjust to having a new sibling. The labour and delivery were rapid and normal, fulfilling Caroline's expectations of a peaceful, non-stressful birth. James was born on the 13 December, 1988, weighing 3600 grams (7lb 13oz). James was calm and tranquil for the first two weeks, and then he began to cry. Caroline refused to do all the things that she had done with Sarah; walking, carrying or rocking in the pram.

I felt detached from James, when it started at about three weeks. I didn't put him into the pram, I didn't want to admit that he was like Sarah. He changed after the first two weeks and I resented the change. He got an hormonal rash and wasn't very attractive then.

In desperation, she tried Merbentyl (dicyclomine hydrochloride) and noted the improvement in his behaviour. Caroline then decided that this infant also had "colic". She decided to present her unique experience of two "colicky" babies to the university cry clinic, to seek advice and as an interesting case to research. Caroline described her ideal for a baby as follows.

I would love to be on soyabean milk throughout pregnancy and after birth with no allergies. I wouldn't have to use Merbentyl. I don't necessarily want a baby to

sleep four hourly, but not to rock 24 hours in a pram. I've had two, I need a break now.

The social context

At the commencement of the study, Caroline and her family were living in a two bedroomed semi-detached council flat, in a highly populated urban sub-division. Council housing is usually available to families on low incomes in Palmerston North. When the second child was born, Robert applied for a three bedroomed house, which they qualified for with two children. Despite frequent calls to the Housing Corporation to check on their position on the waiting list, a three bedroomed house did not become available until late September. Shortly prior to this, Caroline had talked about getting a recommendation from the family doctor about the difficulties of living in a small flat with an irritable infant. The Housing Corporation would then place the family at the top of the housing waiting list, because of an established need and urgency. Caroline indicated that the space limitations were causing difficulties in the family :

I'm not a 'stressed' person usually, only when I'm under a lot of pressure. I tend to get short tempered, and lash out at Sarah because of the baby screaming.

In the flat, James had to sleep in the same bedroom as the parents, so that Sarah would not be disturbed by James' crying in the night. The new house is by contrast roomy and modern. There is also a large fenced section for Sarah to play in. The Housing Corporation in New Zealand owns over 60,000 rental properties in towns and cities throughout the country. These houses are rented out using an income related rent formula and are initially allocated according to a points system. Points are awarded to those on a waiting list regarding established need, urgency, length of time on the list, number of children and income.

The family doctor arranged for "home help" when James displayed signs of "colic", and Caroline was having difficulty coping with house work, a pre-schooler (aged 2 years) and a "crying" baby. The Department of Social Welfare will pay for "home help", for a short period of time, in situations where a need has been established.

The demands of a toddler make a difficult situation worse. The baby by himself would be more easy than Sarah was. The situation sometimes feels impossible, sometimes not too bad. I felt like I needed somewhere to phone or to go, or to have someone to visit.

The "home helper" visited for four months, although Caroline gradually reduced her hours over that period, so that she could ease herself back into fully running her household. Initially she was coming for two hours, on five days of the week.

At the beginning of the study, when James was 13 weeks old, Caroline recounted that a public health nurse had visited twice since the infant's birth. She most frequently went to the family doctor, and she had an appointment with the paediatrician at the hospital. These people were her only sought out sources of professional advice.

The family doctor is very supportive. We've visited him sometimes once a week.

He tells me that I'm not being paranoid, that I'm providing 'good mothering'.

Caroline resented advice offered by well-meaning friends and relatives, as she reports that they had never experienced life with a "crying baby" and implied that somehow the baby's crying was her fault. Offers to look after the infant were rejected, because James was even worse when Caroline was away and because Caroline found the thought of James being allowed to "cry it out" very difficult to accept. Caroline reports that this rejection of help was seen by friends as over-protectiveness. Caroline explained how a mother should be helped in this situation :

Assuming it's a first baby, you'd need some support on a daily basis, not necessarily to do work or taking the baby. Just having another adult to spend part of the day with her. Perhaps taking the baby for a walk in the pram - if you want them to.....

A support group - with mothers of crying babies. Mothers who are going through it or have been through it and can give practical suggestions and sympathy. Just sharing the feeling of desperation.

An understanding doctor, when you think there's something seriously wrong with the baby. Many trips to the doctor are made to be convinced there's nothing wrong

- you can be made to feel that you're neurotic. There is something wrong -

something is making the baby cry, they can't make out it isn't happening.

Caroline reported feeling responsible for any decision making regarding the children, as Robert had little knowledge of or previous contact with children. She indicated that he showed little initiative in response to the children, and would have to be asked to take Sarah to the toilet or to pick up James when he was crying. Caroline recounted an occasion when she had been to a Home Birth Association meeting in the middle of winter, and returned to find that Robert had been rocking a screaming James in his pram for an hour, without any covering blankets on. Caroline suggested that it would not have occurred to him to cover the infant up or to carry him. Upon questioning, Caroline admitted that she wished for more practical support from Robert, although she knew he meant well. She recounted how good her sister's husband was with their children and stated a desire for a similar situation for herself.

Robert was self-employed during 1989, mainly doing contract painting and decorating for the Housing Corporation. He usually worked three to four days every week as a decorator, and spent the other day "witnessing". This involved knocking on doors in the neighbourhood, to inform people of the teachings of their religious denomination. Caroline also took part in "witnessing" when James was having a settled day. Sarah often went with her father. Caroline explained that she intended to stay home with the children at least until they started school, thereafter she would only work part-time.

Caroline indicated that there was little outside activity during 1989, due to an unsettled baby. Occasionally she would visit her sister, who lived nearby or go to a friend's house, while Robert looked after the children. Being a "Jehovah's Witness" meant living a "routined life"; with three meetings per week -- two evenings and a Sunday afternoon. "Witnessing" was an additional commitment.

The implications of the religion for the family were being organized to attend meetings, around the needs of the infant. Sometimes only one parent was able to attend the meeting, because James was having a particularly "bad" day. There were also biblical implications for childrearing; high standards of discipline, respect for parents and authority and training according to biblical principles. Caroline called the "Jehovah's Witness" code for child rearing

a "spare the rod and spoil the child" approach. Caroline reported that the congregation seemed united in these ideals and were supportive of families and their commitment to living according to these guidelines. Caroline stated that the religion did affect childrearing, because :

There are higher standards of discipline, but I would have been much like that anyway, I don't like undisciplined children. Spare the rod and spoil the child. The bible speaks of disciplining children.

When asked how soon she starts disciplining children, Caroline replied "I don't know -- once they're mobile, to teach them not to touch"

On the refrigerator was a coloured picture of a tree, entitled "Fruitages of the spirit" and labels attached read "self control" and underneath was "peace". Upon questioning, Caroline explained that they had failed on "self control" or patience, so they were now working towards "peace" in their home life. The picture was a project that Robert had undertaken with Sarah, illustrating the influence of their bible principles on their everyday life.

Relationships

On many occasions, Caroline talked about what she wanted out of the relationships with her children :

I expect the groundwork to be built now. I want a close relationship, to treat the children as friends. I want respect for the parent-child relationship, without losing discipline. I've seen it work in other families. A lot of people say they're closer to sons than daughters. Girls are more independent. It's nice to have a baby longer.

But you can't compare relationships

When asked if she had a different relationship with Sarah, Caroline replied "Yes, I would predict a closer relationship with James. Sarah is very serious natured. James is happy, bubbly, just like me. Robert is the serious one, Sarah is like Robert". I asked if it was a contradiction being married to Robert and Caroline replied "Yes, it pulls me down to be with Robert, it's not my nature to be like that". I then asked if she saw their differences as a

problem, to which she answered "No, it's just different senses of humour, different T.V., different books. I just accept that we're different".

When James stopped having "colic attacks", Caroline described how she saw her relationship with James at that point.

I think we're still getting to know one another. I knew him better when he had the colic. People say it's all over, but a lot of the miserable patterns are established. I still have home help - cutting out one day at a time - a weaning off. I'm coping with the extra load, but still feel not up to normal mothers.

Caroline expressed a desire to "bring the baby up according to my own wishes, without anybody interfering". She told me that some people would not accept the way that she felt about the baby, and her decision to stay with him as much as possible.

When James was six months old, we had a long discussion about the nature of relationships and how Caroline saw her relationship with James developing.

I feel we've found common ground. I find he's a placid baby, which is different. Sarah would scream about everything. James will tolerate a lot more. He will be really tired and go to sleep the moment the car starts. Sarah kept screaming till she got into her own bed.

We discussed whether Caroline thought that she had achieved a sense of harmony with the baby and the close relationship, which she had previously desired.

Yes, I think so - it's hard to tell with a little baby. It gets better as they get older and they're able to respond to more things. We've got a better relationship than when he had the colic. When he had colic, I felt like a machine, there to control the colic, to pacify, rock, keep as quiet as possible. Now when he's up I can interact and play with him. It's not a constant battle to stop the crying. When he cries now, he doesn't cry a lot, it's usually for reason now, when he's tired or not wanting to sleep.

Caroline also outlined what she thought the long term effects would be on the relationship between a mother and crying baby.

If the baby continues to be a crying baby, the relationship would be quite distant.

The baby may go from being a difficult baby to being a difficult toddler. If the mother had switched off when the baby was little, then she may find it difficult to switch back on. Babies with a stressful start continue on to be stressful toddler.

For example, Sarah couldn't have any stimulation as a baby and still now will burst into tears when she's supposed to be enjoying herself - at the esplanade.

When James was seven months old, Caroline said :

I feel more tired than when he was tiny, continuing exhaustion, my resources are beginning to dwindle. Emotionally, I'm not much different to other mothers.

Everything is a bit of a struggle - I'd like more time to myself, a bit more freedom.

It's a bit easier to leave...but I don't regret the months passing. I don't want to get pregnant again yet...pregnant and breastfeeding...no break from a child being completely dependent.

Colic and other medical issues

In March, 1989, Caroline presented at the university cry clinic seeking to share her experience of her second child, then a three month old infant. During the initial interview, Caroline agreed to participate in an on-going study of infant motions, to complete a "cry diary" and to share her experience of this infant and her elder child, both of whom she indicated suffered from "colic". Sarah had had "colic" for six months, and the infant was still having "colic attacks". At this stage, Caroline expressed her major concern as the infant's lack of sleep and the mucus she noted in the infant's respiratory system and motions.

At the second interview, Caroline agreed to allow a case study of mother and infant to be conducted in the family home. She also agreed to make the motion study results and the cry diary available as resource material, and to allow audio recordings of the infant's "colic attacks" to be obtained.

During 1989, contact was maintained to monitor the progress of the infant and to provide continuing interest and support for the mother. Various aspects of the infant's

development, family history and Caroline's emotions and thoughts have been communicated during my visits. Data generated from these communications provided the base for answering the question "why does this mother define this baby as a crying baby?"

At the beginning of this study, Caroline explained why she thought the baby had "colic". The label or definition was originally introduced to her by the family physician before she left the hospital with her first child. Sarah is reported as having marked periods of intense crying from five days old. When James was two weeks old, the mother noted similar signs of distress. She decided that she could safely call it "colic" when he responded favourably to a dose of Merbentyl (dicyclomine hydrochloride) at three weeks of age. She continued to give the infant Merbentyl, on doctor's prescription, whenever there was a "peak" to crying, usually twice a day.

Within this study, Caroline has been documented pursuing several medical definitions of why the infant was crying. The first of these was "colic". A possible explanation of this infant's "colic" was the presence of an allergy to dairy products in the mother's milk. She indicated that the colour and the presence of mucus in the stools, and the mucus in his respiratory system was the basis for her suspicions. Caroline is essentially a vegan; when she initially presented at the university clinic she was eating no red meat, fish or chicken, few eggs and no cheese, yoghurt or cow's milk. The only dairy product which she was using was a whey based substitute. At the beginning of this study the mother was exclusively breast feeding James. This diet is apparently one of personal choice, not medically or religiously prescribed. However, Caroline would like to raise the children as vegetarians. The children occasionally ate fish and chicken, but otherwise followed the vegan diet. Robert eats red and white meat and some dairy products. At the present time, the children occasionally eat red meat, usually on social occasions.

On advice of the paediatrician, Caroline eliminated the whey based substitute from her diet, as the paediatrician reported that this whey-based substitute was the most often reacted to of all the dairy product substitutes. He gave her a tin of a soya-bean based milk, and suggested she use this for a couple of weeks. The result was spectacular: initially the infant was recorded as vomiting for a couple of days, which the family physician proposed was a "toxic burn-out"

effect. Following this, his stools changed from green to gold, the mucus subsided in his respiratory system and stools and the "peak" to crying behaviour where "Merbentyl" had been administered previously ceased to eventuate. Caroline found the change in diet affected her initially, although she wasn't sure why.

He is worse today than usual. I feel very tired and feel like I'm dragging myself around. I've got swollen glands, sore ears and a sore throat. Perhaps the "whey" milk was supplying more protein than the "Prosobee".

I'm still feeling very tired. I'm not sure if it's the "Prosobee" or just four months of accumulated tiredness. I'd like some 'time out', to be completely by myself and to recoup my energy.

Despite reported dramatic improvements, Caroline still reported the infant to be "difficult" and irritable. She recorded that James was seldom sleeping more than an hour at a time, and waking frequently and in distress during the night. Caroline was unsure how to cope with the new pattern of crying, as she said :

He's been crying for long periods of time but not working into a colic attack. He won't feed, he won't settle at all. I don't know what to do with this pattern of crying. I have been giving Merbentyl anyway, in an attempt to make him settle.

A few days later we talked about Caroline's feelings about 'life after colic' and she shared the following emotions :

A sense of acceptance, as it is a second baby, feeling optimistic about the future with him. Yet no sense of elation. The baby doesn't scream, but still cries, doesn't sleep and has all the former behaviours minus the colic.

After the colic attacks stopped, however, Caroline noticed dramatic differences in his behaviour. She resisted the doctor's suggestion to reintroduce the "whey" milk, saying :

I'd like to continue with soyabean to see if the behaviour continues. I'm not keen on reintroduction, it's so nice to have a happy baby.

James' improvement was noticed by family and friends, and the lack of colic attacks made a difference to Caroline's energy levels.

It's quiet now - I have the inclination to dash off and work, but also to stop and play. Playing doesn't really occur when the baby is crying.

James became interested in everything within days of the colic stopping. He's now holding things and playing. He's more peaceful with all of the family now. He's grumpy when he's tired and can't seem to catch up. Other people have noticed how much more peaceful James is now, compared to before.

The infant's motions slowed down; from having five to seven motions every day, to passing only one every three to four days. Caroline noted that James was distressed by the third day, and not drinking or sleeping. However, Caroline did not report him as having constipation. She consulted a Naturopath at this time, who recommended a herbal tea for James. Caroline reported that that it made no difference, and he hated the taste of the tea.

Caroline returned to the hospital at this time and consulted the paediatrician about her concerns. The paediatrician diagnosed a tight anal sphincter and recommended daily stretching of the infant's anus, using a finger stall. A similar difficulty was experienced with Sarah when she was an infant. In Sarah's case, the family physician prescribed the use of enemas, which were utilized from six weeks to eighteen months. Caroline did not recollect Sarah as having constipation either, but mainly suffering from irritability and discomfort if she did not pass a motion regularly. James' difficulty with a tight anal sphincter only manifested itself shortly before any solid food was introduced. The paediatrician expressed concern about the infant's iron in-take at this time and wanted to carry out a blood test to check for anaemia. The mother refused, wanting to delay until after she had managed to get him eating "solids". Part of the Jehovah's Witness belief involves abstaining from blood transfusions, and Caroline explained that she personally wasn't keen on the idea of blood tests either. She has had misgivings about immunisations, although the children have been immunised.

At 32 weeks, James weighed 10.6 kg (22 pounds) and was crawling rapidly. Then, by 38 weeks, he was walking quite steadily if held by one hand and confidently taking steps between items of furniture. Meals were taken at the table, sitting with the family; eating stewed fruit at lunch-time and vegetables at dinner-time; with a little olive oil "to make his bowel move". James occasionally says "dad" and frequently says "mum". At this stage, he was very

adventurous when Caroline was in sight, but became "clingy and distressed" when she went out of sight. Caroline's major concern was still James' lack of sleep. If he slept less than an hour at a time, he awoke grumpy and crying. The problem she reported facing was how to get James to sleep by himself and for longer than an hour.

Caroline's comments on the draft case study

The following section was tape recorded and later transcribed, as accurately as possible. Comments which follow are the mother's responses as she read the first draft of the case study material. My questions and comments have been briefly included, in italics, to give a sense of the collaborative nature of the interview process.

- I resent having a year added onto my age. I was born in 1963.

- This bit here about "...couldn't understand her mother's lack of responsiveness to her needs and only recently discovered about the valium..." I'm not sure about "...that in her childhood however she couldn't make sense of her befuddled state..." I really thought she was pretty normal. At the time. I thought we were having a normal upbringing. But it wasn't till in retrospect I can look back and see things and remember things. But at the time I thought it was pretty normal.

When did you find out that she'd been taking valium?

-I knew she was taking it (the valium). But I didn't realise it had any effect on people's behaviour. I just knew because it was there all the time, it was not until I realised that it altered personality and alters this and alters that ... that a lot of her behaviour was due to the fact that she was addicted to that (the valium). But until then no, I knew she was on it but I just thought she just needed it for nerves basically.

And had she taken it the whole time you were a child?

Took it all the long, not sure if during pregnancy.

-the paragraph here about "being Jehovah's witness had implications for their lifestyle" and that I'd indicated that there was little outside activity, occasionally a visit to my sister. That was simply because of circumstances rather than ... it sounds as if it's because of the religion just the way its written, but that was simply circumstances because I couldn't go far because of James.

Is it different now?

Yes, it's far easier to go out now.

-just a little technicality- we've got two evening meetings, not just one. One Tuesday and Thursday evening and Sunday afternoon.

-I was actually only joking when I said that!...that we'd failed on self control (in response to description of "fruitages of the spirit" on the refrigerator). Oh dear. James ate it (the poster).

- essentially a vegan - it makes me sound like Mr Spock, like a vulcan.

Is that how you describe yourself?

I usually say vegetarian. Do vegans eat eggs?. I never sit down and have a boiled egg. They don't have any dairy products, so probably now I am. I eat a few eggs in things.

-I'd say that's extremely accurate (after reading the draft of the case study).

There's one bit I've realised I've left out, about your social support. . What do you consider to have been the main sources of social support?

About social support...basically the doctor... the public health nurse and a paediatrician.

I remember we talked for quite a while one day about how you felt about Robert not helping you with the baby - have your feelings about support changed?

Well if James was still tiny I don't think anything would have changed...but because he's older and he just adores Robert now and Robert can take him out for the whole morning and James will be happy for the whole morning, take him out witnessing and he'll just have a sleep in his buggy, and bring him home. He just absolutely adores Robert now.

Does Robert have problems with small babies?

Small crying babies - they're enough to undermine anybody's self confidence and because sometimes the only way I could cope with him was to feed him. Robert didn't even have that. That was the main thing he found difficult - that he had no way of soothing him, if I wasn't here.

He wouldn't take a bottle or a teaspoon?

No.

Are you quite happy about that going into my thesis? My main concern is that it isn't offensive or appallingly inaccurate.

- It's not offensive to me, but I just don't think I would be able to let my parents see it, my mother would take exception to parts of it.

I have only written what you've said - I've ignored all other points of view, in order to document your experience of motherhood.

I wouldn't change anything, it's accurate ... it's the truth, that's what happened. They still take valium and alcohol, I think you could ask me again in ten years and I'd still say yes. I think you've done very well at condensing all the notes.

I'm not sure about the social context section. Can you make a living on what Robert earns?

Will he continue on his own?

-Robert is going to stay out on his own (he runs his own contract painting and papering business). We get enough to get by but we certainly have to be very careful, we've never got a surplus. You budget according to what you earn. It's a bit easier now he's out on his own, than when he was just getting a wage. That was difficult, but then we only had Sarah.

I don't think I've ever asked you if you'll go back to work?

James turning five seems an eternity away, and I'd never work full time. I've never given it (work) a lot of thought. I may in the future get some part time work.

Who do you think your closest relationship is with?

- closest relationship - apart from children? I say I feel closest to my children but before I had them it was to Robert. No-one before that, well ... if I had to pick someone I would have said my mother, but it wasn't really a close relationship.

What about your sister?

Sister - I think we are closer now, but as a teenager we weren't, we went separate ways but just kept in touch.

Do you think you could depend on her?

We see a lot of one another now, and the children get on really well and if anything happened to Robert or I, Debbie gets the children.

The way I've been reading the literature is to look at relationships and how perception of support can effect the formation of relationships with your own children. How do you think your background has affected your ability to form relationships?

- I'd say that the result of my upbringing is that I find it more difficult to form attachments with adults, but not with my own children, that was just instant bonding.

Most people feel completely at a loss with a screaming baby, but it's more difficult without a network of support. I used to ring my mother, howling down the phone, and she'd put me back together. How did you cope when Sarah was a baby?

- with Sarah I used to phone my mother quite a lot just as a sounding board really, but with James I didn't, because she just wasn't interested. With him I just decided that the rest of the world isn't really interested in what's going on in these four walls. That's why I found it really good once I started keeping the notes, seeing John, and seeing you. Because it's just telling someone what has happened... this baby has screamed all day, I feel a lot better just having said that. I can't remember saying a lot of what is in here actually.

Sometimes it's really important to simply say something - the way society constructs motherhood it's simply not acceptable to say I've had a dreadful day....

-Available social support (in response to description of available family units in Finland) - that Karitane unit comes close, doesn't it, in that mothers who've got problem babies or who are at

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the end of their tether can go there and there's often other mothers there, so I guess that comes fairly close to it.

- what an ideal set-up...a unit for families in distress - that's what you need, You don't want the baby taken away from you. You don't want someone to say I'll take the baby while you rest, you're not going to rest, you're going to worry about your baby.

It makes so much sense, doesn't it, to keep the family together and affect changes within the family...

(Talking about problems with the children now) -We just can't get her to bed (Sarah - the older child), if she sleeps in the afternoon, nine or ten at night and she's wide awake. I enjoy my evenings, I look after them all day in the evening I like to read or knit or whatever I like to do, and I can't do those things with her up, because she just cuts into my concentration.,so I like them both in bed I would get up tight because I was trying to knit with all that happening. If she doesn't have a sleep she's in bed by six., and that's her down for the night.

You've talked at various times about the need for routines, about being organised, about being in control, to get things settled....

-Yes, control, in that you know that you're going to get tea cooked that night, as opposed to you're still going to be rocking the pram and the baby is still going to be screaming. That's one of the hard things to cope with - you don't have any control, you don't know whether you're going to make it to town that day, to get your shopping done you can't plan anything. That's something I found really hard, you can't say yes you'll definitely do something, as you don't know what the baby is going to be like or don't know if you're going to have been up all night or if he's going to have screamed all day. So you don't have any control basically over what you're doing. Now that he's getting older, I have got some form of routine, I have got some control. I know he will have an afternoon sleep and I will get something done.

The need for routine came through when you were talking about being a Jehovah's Witness...

-"Got to know the congregation and enjoyed the routine". I don't know that I consciously enjoyed the routine or maybe the connection of me wanting some form of routine. I don't

know if that was a conscious thing or something you thought fitted in with what I'd been saying.

No, that was a comment that you'd made in relation to your flatmate, feeling comfortable with her and with the church routine.

Did I say that? Is that right? Oh yeah, but I suppose that's right, from floundering around at Teachers College and not really knowing what I was doing it was quite refreshing to have something like that.

I've avoided going into the religious issues too much, as everyone has different beliefs. But I wondered about the reasons for choosing Jehovah's Witnesses, then and now?

I wouldn't say that the wanting of routines and things had anything to do with with becoming a part of the beliefs of the religion. It was simply the beliefs- the religion offers routine in that the Bible talks about family life.

When were the Jehovah's Witnesses started?

-1943, the Jehovah's witnesses adopted the name (before that they were International Bible Students, founded in 1863). Use the "New world translation" as a bible, although any bible can be used to support belief, this version is simply in modern language.

Are there any pressures imposed by being Jehovah's Witness?

-pressures- from the Jehovah's witnesses - scriptures talk about using the "rod of reproof", disciplining children, teaching about spiritual things. Bible training is very important - part of the learning process, to teach about spiritual things in everything around.

Does the religion prescribe how to raise children?

-Religion allows for individuality - some parents don't discipline as much as others. We're not extremely strict, but we do discipline. I would expect to be pretty much the same about discipline and childrearing even if not a Jehovah's Witness. Expect Sarah to sit for two hours at meetings; she will and has done since she was 17 months old. James is still ghastly. The training is good for them. A creche is available and I don't expect James to manage yet.

Summary

This chapter has explored the many issues arising from this mother's life, and her difficulty experienced in looking after her family with a crying baby. There are many issues which could be explored further, but it is not possible to do justice to all of them. For this reason, the discussion will focus on the social construction of motherhood, relationships and the need for a secure attachment, a medical model of difficulty with an infant and finally how social support can be a factor in empowering a mother experiencing difficulty in achieving the western construction of motherhood.

CHAPTER FIVE

DISCUSSION

A single collaborative case study has been a complex and interesting task to undertake. So many themes could have been addressed at great length, but it is beyond the scope of this work to do justice to them all. This chapter will attempt to answer the four questions outlined in chapters one and two, which stemmed from the foreshadowed problem, of "why does this mother define her infant as a "crying baby"?".

The first question involves examining how the theory of attachment has permeated the western construction of motherhood, making constant care and involvement a developmental norm for healthy development. The second, addresses the sort of relationship which Caroline hoped to form with her infant, and why. The third question will be answered with a discussion of why a mother experiencing difficulty with an infant, and the prevailing construction of motherhood, may seek medical explanations of any difficulty experienced. The final question is answered with an examination of how a mother, who has made a commitment to full time motherhood, can best be supported.

Attachment and the social construction of motherhood

One of the issues which was touched upon in Chapter two, was the popularisation of theory and how theory permeates the practice of motherhood. The media, ante-natal classes, the medical profession and other people all play a role in reinforcing the role adopted. This section will address the question of "How does this mother define her role as a mother?".

When I decided to look at the role of motherhood that Caroline had adopted, I was faced with a list that fitted neatly in with Bowlby's idealization of motherhood. Caroline wanted a close relationship with her children and to treat them like friends. She provided 24 hour, 365 day care. She reported feeling totally responsible for the care and decision making

for the children. She expressed a belief in continuity, that a stressful infant would become a stressful toddler, and possibly adult thereafter. She believed that her own parents had not fulfilled their obligations as parents adequately, and she was doing everything deliberately to live a different life with her own children. Finally, she saw colic and the various other medical problems as impediments to the development of the "normal" baby, to which she could be a "good" mother and have a "close relationship".

Caroline treated her own mother as if she were someone else's, because she wasn't a "normal" mother. Caroline's mother had worked during her infancy, compared to her own full-time commitment. She had read Kitzinger, attended ante-natal classes and belonged to the Home Birth Association. A further dimension of Caroline's commitment to full time motherhood was provided in the teachings of the Jehovahs Witness belief, in its support of the traditional family structure, respect for parents and elders, the 'rod of reproof', and biblical teachings on the role of women and children.

One of the interesting aspects of the study was that Caroline was very conscious of not being a "normal" mother. She did not appear to see any conflict between the two statements of wanting to be friends (an essentially equal status position) and for her children to have respect for the "parent-child relationship". Closeness was therefore possible, as long as it did not step outside of the bounds of what was socially acceptable and "normal". She indicated that she didn't feel she had a "normal" relationship with James, because of the home help. Being normal, was, then, total responsibility, a self maintained tidy house, a close relationship and a happy, healthy nuclear family unit, self contained and self supporting. Her worries were of continuity, if she didn't make things normal in infancy, then she would continue to have difficulties in the future with the children. Her comments about Sarah not enjoying herself when she is supposed to (e.g., a trip to the esplanade) reflect this. In her own life, she reflected on the sense of anxiety in her childhood, which resurfaced as "migraines in the tummy" at Teachers' College.

Controlling factors which the mother perceived to have disrupted her own childhood, such as drug addiction and alcohol abuse, may give a sense of control over her children's experience of childhood. Adopting a rigorous code of childrearing practice, governed by

religious teaching and accepting a 'traditional role' may structure or influence what relationships with children can or should be. Similarly, an emphasis on performing the tasks of motherhood may preclude many opportunities for forming a relationship with an infant. By providing constant attention and cleaning, feeding, and changing, a mother may gain a sense of having fulfilled her obligations to the infant and provided the ground work for a close relationship to form. Irritability in the face of such careful attention becomes a direct challenge to the mother's ability as a mother. Indeed, the mother may fear that certain standards have not been met (such as being a good mother), that the uncontrollable infant may become an uncontrollable and unprincipled adult, or that the lack of order and routine in the household may lead to physical or emotional breakdown by the family members, such as succumbing to alcohol or substance abuse.

The influence of Bowlby's work on motherhood has been profound and pervasive. Dally (1982) points out that Bowlby's claim in 1951, that mother-love in infancy is as important for mental health as are vitamins and protein for physical health, was probably correct, but was taken out of the context of war-orphaned children. Dally proposes that it mistakenly lead some people to place an almost mystical importance on the mother and to regard love as the only important element in childrearing. Dally (1982) concludes that this is nonsense, but has been very influential in child care. This thesis has proposed that a relationship is a synthesis of the differing types of relationships outlined by Weiss (1986), the "I-Thou" (dialectical) (Davis and Roberts, 1985) and a shared reality (Emde, 1987). A child will need to experience many different sorts of relationships at different times, during which mother-love may not only be inappropriate but suffocating.

Bowlby stressed that continuity of care was all important and that women should provide "constant attention, day and night, seven days a week, 365 days in the year" (Dally, 1982, p.101). Bowlby also stated that women derive profound satisfaction from seeing the child grow to independence, knowing her care made it possible. Caroline's fulltime commitment to the care and well being of her children is testimony to her desire to do her very best for her children, and perhaps to experience such satisfaction. But as Dally counters : "there is nothing here about the woman who does not derive profound satisfaction from her

children, or who finds her joy and satisfaction in them considerably diminished by the constant attention that Bowlby insists is essential" (p.98). Constant attention may have seemed ideal to a member of the upper classes, such as Bowlby, who idealized their mothers, but who were brought up by nannies. The western construction of personal responsibility and Bowlby's demand that children have constant attention places women in a difficult and vulnerable position. Caroline's isolated position in the suburbs and her desire to be a "normal" mother, placed her in a very vulnerable position. Her need for support, when she experienced difficulty with her infant, put her outside of the experience of a "normal" mother. Not being a "normal" mother presented a considerable challenge to Caroline's sense of self esteem

Riley (1983) states that Bowlby cannot be disassociated from a charge of instilling guilt and suffocation into a generation of mothers. In a similar vein, Boulton (1983) explains that Bowlby's use of psychoanalysis and ethology together have contributed to a view that the mother-child relationship is unproblematic for normal women. Motherhood is "neither 'naturally rewarding' nor 'inherently frustrating' but, rather, a woman's experience as a mother is the product of a complex set of social and psychological factors" (Boulton, 1983, p. 62).

In her study of fifty mothers, Boulton identified four experiences of motherhood which could be divided into two major groups; the enjoyed and the irritated. Within the "enjoyed" group, 38% (of the 50 mothers) were "fulfilled", while 10% were "satisfied". In the "irritated" group, 20% were "in conflict" and 32% were "alienated". This demonstrates, that in Boulton's study at least, only a little over a third of mothers providing full time child care are actually experiencing the profound satisfaction which Bowlby predicted. Not all women feel a strong sense of meaning and significance in motherhood, even if they have made the commitment to stay home. Boulton concludes :

Children may bring a sense of meaning and purpose but they do not necessarily do so.

Though they may have potential to give a sense of meaningfulness and intrinsic worth to a woman's life, children may bring no more than an 'appropriate' or socially desirable role. This, too, is an important point, for it belies the expectation and general assumption held about motherhood. A sense of meaning and purpose does not come automatically or inevitably in motherhood. It is not wholly instinctual and there is

nothing as straight forward as fulfillment of a need. Rather a positive commitment to the children and a sense of meaning and purpose in looking after them must be created and sustained in the values, meanings and interpretations given to children and childcare, as well as by the society in which they live (p.119).

Indeed, for a mother living with a screaming infant, there seems little likelihood that the child will bring much pleasure. If a mother has done all of the things prescribed by the childcare experts and the infant continues to cry, then a mother may reach one of two conclusions, either something is wrong with her (she's not a "good mother"), or something is wrong with the baby (he's not a "normal" baby).

Relationships

For many women, the opportunity to have a child is an opportunity to look forward into a future of love and care. Indeed, many women are going to extraordinary lengths and expense in the hope of having a child. Unfortunately, all the love in the world will not guarantee an easy experience of motherhood. Part of the expectations concerning motherhood will be associated with the sort of relationship that a mother may form with her infant. This section will examine what sort of relationship Caroline wanted with her infant and why, and explore some of the ways that early relationships are formed.

Caroline perceived her own parents as emotionally unavailable (Emde, 1980) to her during her childhood and also during her difficulties with Sarah and James. Caroline reported feeling insecure and anxious, in her childhood, whenever her mother was out of sight. She later experienced anxiety at Teacher's College, as "migraines in the tummy", which she also attributed to feelings of insecurity. Because of her own emotions in childhood, Caroline hoped to provide a different experience for her children. To do this, she had made a commitment to fulltime motherhood and to achieving a close relationship with Sarah and James.

Caroline's experience of difficulty with both Sarah and James, as infants, created obstacles to the formation of the "secure" attachment which she hoped to establish. Caroline suggested that Sarah had turned into a more depressed little girl, than she might have been,

because "colic" prevented formation of a close relationship during her first weeks of life. Because of this, and a belief that James was temperamentally a more placid baby than Sarah, Caroline was determined to form a close relationship with James. Caroline had also suggested, at one time, that mothers and sons form closer relationships, than mothers and daughters.

However, there were constraints placed upon the nature of Caroline's desired relationship. The children were to be friends, but to have respect for the parent-child relationship, for authority and for the discipline and teachings of the church. However, Caroline made herself physically and emotionally available to her children. James slept in his parent's bed frequently in his first year, to stop him crying, and Caroline continued to breast feed him until well into his second year. Caroline stated that her closest relationships were with her children.

Within the literature on relationship difficulties, an increasing focus has been brought to bear on the influence of early relationships and how these effect a mother with a new born infant. Cramer and Stern (1988) suggest that mothers bring a set of representational themes to their relationship with their infant. These themes are made up of specific and generalized memories beginning in the mother's own childhood. After childbirth, these themes become activated if latent, or interacted if already activated; that is acted out and re-experienced as part of the mother-infant interaction. Cramer and Stern (1988, p.24) propose a psycho-therapy, which involves identifying representational themes using the following criteria :

- 1) The theme existed in the mother's past life history in the form of core conflictual memories and expectations.
- 2) The theme concerns parent-child content, that is intergenerational issues.
- 3) The theme is "enacted" by the mother in the interaction with her infant (enacted in the sense that her actions and responses to her infant are readily comprehensible in terms of attributed meanings that come from representational themes).
- 4) The infant's role in this interacted theme results in the formation of a sign or symptom in the infant, as designated by the mother.

Cramer and Stern (1988) report that when a mother has been able to liberate her mental representation of the infant from these interfering representations from her own history that do

not properly belong to the infant, then new paths for growth and development become available for both mother and infant. Cramer and Stern further indicate that the mother's psychic functioning in the post-partum period and for months afterward undergoes a dynamic turmoil. This turmoil allows for both greater openness for change and a more intense need for therapeutic relationships.

Attuning to an infant may dispel any sense of separateness which a mother may have felt after the infant's birth. The need to be in constant physical contact denies any sense that the infant becomes a separate individual after birth (although bottle-feeding and separate sleeping arrangements may reinforce a sense of separateness). Furthermore, a mother may become aware that her infant resonates to her moods and emotions, which strengthens a sense of mutuality. Stern (1985) calls this intuitive understanding, or mutual psychic area, "attunement". Stern (1985) describes attunement as "the performance of behaviours that express the quality of feeling of a shared affect state without imitating the exact behavioural expression of the inner state" (p.142). A mother becomes aware that her infant is able to communicate with her from a very early age, although the behavioural expression may differ. Stern suggests that attunement is expressed as cross-modal matching; for example, the baby may respond to the rising tones of his mother singing with a rhythmic waving up and down of his or her arms. For a mother of a "crying baby", with little support, however, the opportunities to "attune" may be limited. A tired and stressed mother is unlikely to be as receptive to subtle changes in the infant, as a well rested and well supported mother.

Despite the difficulties involved for some mothers, infancy offers a unique opportunity: for both mother and baby to form a first relationship. This relationship may be doubly significant in that a mother knows that the infant will not desert her and is dependent on her for his or her survival. The relationship formed has long-term potential and may embody the mother's hopes and dreams for a care-giving future. Establishing a relationship with an infant may be a first experience of closeness and of the multiple factors involved in a relationship over time, and may provide a platform for the formation of other relationships.

Emde's (1980) notion of "emotional availability" is useful in determining what a parent's perception of their availability can be and how that perception will determine their

interaction with their infants. A mother's emotional availability may be determined by her representation of her own life history, although a close adult relationship or active social support may mitigate this experience (Ricks, 1985). Similarly, a first close relationship with an infant may change the representational themes which a mother may bring to future relationships.

One of the difficulties associated with the whole notion of a close relationship, is the idea that somehow a "secure" attachment and a close relationship are the natural and normal thing for a mother. A mother who experiences any difficulty with her infant may look for reasons as to why the infant is irritable. In the present study, Caroline attributed James' irritability to "colic" and other medical conditions, and defined the medical cause as an obstacle to the formation of her desired close relationship. The following section will address why and how a mother may look for answers within a medical domain.

Colic and other medical issues

One of the difficulties associated with any medical definition of irritability in an infant, is that medicine, like conceptions of motherhood and relationships, is a form of social practice (Wright, 1987). If, as Hunziker and Barr (1986) point out, colic is virtually unknown in non-western cultures, then can we say that colic is a medical condition or again a result of social practice with our infants? Why do children in other cultures display so little fussiness? Does it have anything to do with what we feed our children? What are we doing wrong?

It may be that western women have been conditioned to rely on medical definitions of difficulty. As Wright (1987) explains, the history of medical involvement in infant care has been characterized not as a set of social norms that women should follow because they derived from desirable values (what Habermas (1971) calls 'communicative action'), but as instrumental instructions deriving from technical rules. Concern for the infant mortality rate, the notion of germ pathogeny and the obedience to medical rules has influenced infant care in this century (Wright, 1987). As Wright (1987) states "the consequences of disregarding such

advice were presented as material failure - the working out of scientific laws leading to the death of the child - not as social non-conformity that ought to be stigmatized" (p.117).

In light of the pressure that all women have faced regarding the normal care of infants in western society in this century, it is not surprising that a mother experiencing difficulty would look to symptoms and medically based causes, and seek medical advice. One of the interesting paradoxes of the present study has been that this mother has been active in her pursuit of 'personal medicine'. She had become a vegetarian for the believed health benefits, and had put her children onto to this diet as well. The whole family drank a whey based milk substitute because she believed it to be healthier than drinking cow's milk. She joined the Home Birth Association, and delivered James at home, in an attempt to avoid the stress of large hospitals and the conflicting advice offered. She sought the advice of a naturopath, when she was unsure of the advice offered by the medical profession. I suspect that all these measures are closely related to Bowlby's notions of the profound satisfaction experienced from motherhood. If a mother has taken control of the care of her children, and all the accompanying responsibility, then she alone can take the credit for that child's health, well being and development. However, when difficulty occurs, the sense of responsibility may become overwhelming and the medical profession are relied upon to come up with a cure.

Within the duration of this study, the mother has been documented pursuing several avenues with the medical domain. The first of these was "colic". A possible and quite plausible explanation of this infant's colic was the presence of an allergy to dairy products in the mother's milk. This suspicion, agreed upon by mother, physician and paediatrician, was supported by the nature and colour of the infant's stools and the presence of mucus in the infant's respiratory system and stools.

On the paediatrician's advice, Caroline stopped drinking the whey based substitute and changed to a soyabean formula. James' colic stopped, rashes disappeared and mucus subsided, according to the mother's account. These changes were supported by the infant's results on the infant motion study (McLachlan-Smith and Kirkland, 1989).

Caroline used the method of feed management outlined by Woolridge and Fisher (1988). She did not time feeds or regulate breast feeding to a timetable. Her style of feeding

continued unchanged throughout the dietary changes and is therefore unlikely to be a factor in the changes documented. Caroline opted to exclusively breast feed. James received nothing except breastmilk in the first six months, so any food allergy was unlikely to come from outside influences. Caroline avoided caffeine and usually drank herbal teas. Jakobsson and Lindberg (1983) found that 35% of infants ceased to have colic after dairy products were eliminated. However, Evans et al. (1981) suggest that it is the variety of food stuffs in the diet. In this case, colic stopped, but the symptoms of allergy have continued despite the removal of dairy products from the family's diet. At the time of writing, James has persistent eczema and Sarah has recurrent ear infections, possibly attributable to an unidentified allergy.

James' "colic attacks" occurred, according to Caroline, at midday, late afternoon and early evening, and sometimes in the early hours of the morning. When James had a "colic attack", Caroline would hold him and attempt to feed him, but the infant would continue to cry. Quiet holding would continue, until the crying reached what the mother perceived to be a peak to the crying or the height of the attack, then she would administer Merbentyl. I found it interesting that after Merbentyl was given, Caroline would rock, sing to, cuddle or rock James in the pram, until he began to settle. It was as if Merbentyl was the cue for soothing and settling behaviours to begin. Caroline's response suggested a certain "learned helplessness" (Seligman, 1975). A twofold reaction seemed to be taking place. On one hand, she did not want to medicate James, she wanted him to be a "normal" baby. This is probably why she delayed administering the Merbentyl, in the hope that he would not need it, or perhaps because of the associated risks (e.g., the link with "cot death"). On the other hand, she had repeatedly experienced an inability to soothe the infant without Merbentyl. Giving James Merbentyl then became the cue for soothing to begin and for helplessness to end. The use of medicine was therefore empowering in this context.

Whether James had "colic" is probably not the most important issue to be discussed here. What is important is exploring the mother's response to colic within a social constructionist framework. Hunziker and Barr (1986) propose that increased carrying, as is the case in other cultures, will reduce crying. However, Hunziker and Barr but do not fully address the fact that in non- western cultures the carrying is not done by an unsupported

mother in an isolated suburban unit. Many hands undoubtedly make light work of an irritable infant. I suspect that reducing the separateness between mother and infant in western society, by increased carrying, is likely to place a greater strain on a mother. Mothers of these sorts of infants are already stretched beyond their limits. Colic may be more prevalent in western cultures as a symptom of how unsuitable our present childraising methods are for both mother and infant.

The so called 'traditional role' of motherhood, which the mother in this study has adopted, is in fact only traditional in western societies. As Boulton (1983) points out, in almost all non-industrial societies women combine child care with important economic responsibilities and share responsibility for children with other women. While women and children are linked in these societies, as they are in our own, both are a more important part of the wider social group. Boulton (1983) states that the variety of responsibilities, including vital productive work and the sharing of work activities, including child care, are important to the quality of the relationship of women with their children, and by implication to their experience as a mother.

Minturn and Lambert (1964) conducted a cross cultural study of six childrearing communities in Mexico, the Philippines, Okinawa, India, Kenya and New England (USA). Two sets of findings are of interest here. The first is that "mothers who are primarily responsible for the care of their children are variable in their expressions of warmth and do not gear their hostility to the behaviour of their children" (Minturn and Lambert, 1964, p.116). Minturn and Lambert found that women were more stable when they had responsibility for other work and got a respite from childcare. The second finding of interest is that it is unusual for a mother to spend the majority of her time caring for the children and to have no responsibilities besides child care. In all societies, except the African and American, the majority of women spend less than half their time looking after children and have a high proportion of child care done by another. African women take responsibility for child care and economic work, but many of these children are old enough to help with the work and oversee younger children.

In Minturn and Lambert's (1964) study, only the New England mothers were solely responsible for child care. Their exclusive and often trying responsibility for children acted to counter the warmth the researchers expected under such conditions, and as a result "their behaviour vacillates between self-conscious warmth and sympathy and the impatience born of the fatigue of being constantly "on duty" and the frustration of personal desire" (p.89). These findings parallel Caroline's comments, about needing a break from being pregnant or breastfeeding, feeling drained after the months of crying and lack of sleep, and feeling short tempered with Sarah, because of feeling stressed.

Another important point is that mothers who have another adult (especially a grandmother) living with the family are warmer to children and more stable. Another adult both reduces the isolation of a mother in a nuclear family, giving companionship and emotional support and relieves her of child care chores. These in turn allow the mother to express more warmth to children, than she could if she were their sole caretaker (Minturn and Lambert, 1964). Caroline expressed the need to talk to another adult on many occasions, and said that the case study research fulfilled a need for her, in that she felt that someone was genuinely interested in how she was feeling and coping.

The important issue which therefore needs to be addressed is not how can we control "colic", but how can we reorganize society, so that women are not given the sole responsibility for child care management. The next section will examine the issue of social support within a traditional motherhood role structure and will suggest some implications for alternative social structures.

Social support

The previous section has highlighted evidence which suggests that the difficulty faced by women in western society is an artifact of their isolated and unsupported position in society. Western notions of personal responsibility (Sampson, 1985) create the sense of isolation and the need to seek medical explanations of why difficulty is being experienced.

In the present study, the mother's tangible support situation was relatively good. She was living with her husband, in a Housing Corporation house, on an income assessed rental, provided by the state. Her husband was supportive of her role as primary caregiver of the children and he agreed with her decision making about them. She was receiving "Home Help", paid for by the Social Welfare Department, for two hours a day on five days of the week. She was also receiving a "Family Support" benefit of \$36.00 per week. A Public Health Nurse visited occasionally, she had the backing of her faith and the congregation for her roles of parenthood, a sister living nearby, on whom she could depend, and a very supportive doctor. Despite all of these things, Caroline felt in need of support, and noted how she wished for more support in decision making and more initiative from Robert, and she stressed how unsupportive her mother had been. The question is, if providing services does not really alleviate difficulty experienced with irritable infants, then how can a mother best be supported? Is it possible to support a mother and her developing relationship with her infant?

Such support may function in various ways. One possibility is a centre, to which families in distress could go and make use of available facilities. A centre would get around the reluctance which many parents experience at the thought of being separated from infants, older children or partners. Such a centre exists as "A Mother and Child Home and Shelter" in Oulu, Finland and is described by Kantojarvi-Laami (1989). This centre is designed to offer help to parents of infants under two years who have colic, cry a lot or are otherwise troublesome to their parents. A major goal of the centre is to prevent violence in the family, which Kantojarvi-Laami suggests can occur as a result of fatigue. Typically mother and child (or children) visit the centre for a three day stay; where they receive accommodation, meals, care of children at night and also help in the form of discussions, training and information. Parents may return for subsequent stays if necessary, join a regular discussion group and ring the centre for advice regarding their concerns about their infant.

In a similar vein, an intervention with teenage mothers is documented by Unger and Wandersman (1985). This intervention is called the "Resource Mother Home Visit Program" and was designed to build upon a new mother's strengths. The programme sought to provide different types of resources, in different amounts, at different times during a mother and child's

development. A match between the needs of mother and child and the provider of support was aimed for, in order to perceive and deliver desirable resources. A personal and social focus was emphasised, to enhance personal competence through education and information and to improve the quality of emotional and instrumental support in networks.

Resource mothers were experienced mothers and para-professionals, matched in race and socio-economic status to the teenage mother. Visits were conducted monthly throughout pregnancy and the infant's first year, with a structured curriculum. Three types of resources were offered to participant mothers; emotional help, informational assistance (problem solving, education, referral) and instrumental support (transport to doctor, baby toys, diapers and so on). Aims of the programme were to increase the appropriate use of medical and social services, to reduce perinatal complications, improve maternal child rearing attitudes, to promote maternal confidence, to promote infant competence and to reduce social isolation. The programme involved the mother's family, encouraged use of a social network and promoted the importance of the mother's influence in the infant's development. Results of the programme suggest that mothers involved in such programmes have a stronger perception of available support and make smoother transitions to motherhood. As Unger and Wandersman (1985, p.43) state "social networks and perceived support have important potential for facilitating and sometimes impeding adjustment during stressful transition periods". It is for this reason that any intervention must suit the needs of the mother and her infant, not simply the requirements of a large welfare department or hospital programme.

Another possibility may be to form a support group of mothers, who mobilize into action to clean houses, cook meals and take care of the many details which get new mothers down. A group may be formed from ante-natal classes; organized by hospitals, doctors, church groups, social workers and so forth, basically anywhere a group of expectant mothers gather. The group could meet on a formal basis with an educational focus and also socially, in order to consolidate friendships formed. Such a group may also help to break the notion of the nuclear family and of the reality of isolated mothers in the suburbs struggling to cope with too many responsibilities; the interaction may provide opportunities for forming close relationships within the group. Many extended families operate on such a system. In her turn, the mother

responds to similar needs in other mothers when she feels able to help. Returning the care which she has experienced from others may mitigate any sense of indebtedness or obligation, and enhance self efficacy and self esteem (Schumaker and Brownell, 1984).

Finally, the notion of a "doula", or someone who mothers-the-mother seems like a useful avenue of support. Raphael (1973, in Neville and Neifert, 1987) found that over 300 cultures and several animal species contain some form of institutionalized emotional and physical support for new mothers. "Doulas", in these cultures, are those people who surround, interact with, and aid the new mother in the perinatal period. The primary task of the doula is to shield the mother from pressures and stress which could interfere with the establishment of lactation, through information, physical help, example, encouragement, praise and concern. Neville and Neifert (1983) suggest that in western society, where too many new mothers are isolated in the perinatal period, that mothers fall victim to fatigue, feelings of incompetence and disorganization, and lack of competence in their ability to nourish their baby.

A change of focus could make the "doula" supportive to the developing relationship; without losing the essence of support and encouragement. The other roles of the doula may also be vital for the mother's peace of mind in her relationship with her baby. Neville and Neifert (1983) suggest a sister, mother or mother-in-law or close friend as a suitable "doula"; but it is essential that the person is readily available at short notice.

For a mother with little environmental support, finding a "doula" could be a difficult task and may reinforce their sense of loneliness or isolation. A sensitive medical practitioner could introduce a mother to a willing volunteer; a sort of "rent-a-doula" instead of "rent-a-granny". Such an arrangement need not be one-sided; many middle aged women feel a sense of loss and emptiness when their own families leave the nest, and helping a new mother may fulfill a need to "mother". Trusting such a person may set the stage for forming a close relationship with the new infant.

Schumaker and Brownell (1984) confirm that providers do receive benefits from providing support for others and cite the following evidence from research. One benefit is simply knowing that because of them, others' lives may be better (Batson, Fultz, and Schoenrade, 1984). Similarly, the "ability to be nurturant is a fulfilling and self validating

experience" (Kessler et al, 1984, p.16). The provider may have an increased sense of efficacy and vicariously experience a broad range of life events and develop a repertoire of coping strategies. Self disclosure from the recipient is an act of trust, which is a compliment to the provider (Archer and Cook, 1984), as is the willingness to develop a relationship or to strengthen an existing relationship. Providing support within a network also means that one's own needs may later be met.

Ricks (1985) reported that the perinatal period is a good time for assessing the impact of earlier relationships and to make meaningful choices about the relationship which the mother wants with her own infant. In this sense, the mother and infant may form a "first relationship", in which both mother and infant are mutually responsive and fulfilled. Experience in this "first relationship" paves the way for secure attachment for the infant and for the possibility of further close relationships for the mother. An infant's need for proximity and unquestioning love may disconfirm a mother's sense that she is unloved or undeserving of love. A "doula" may encourage the "first relationship" by drawing attention to how favourably the infant responds to the mother. Such a technique is outlined in greater detail by Fraiberg, Adelson and Shapiro (1980). A similar approach has been adopted by the Tavistock Clinic in London, under the "Homestart" scheme, in which an experienced mother/volunteer undertakes to regularly spend time in a mother's home, encouraging mothering "skills" and also supporting the mother's emerging relationship and effectiveness with her infant (Bowlby, 1988 a).

Many of the studies, which have just been cited, reinforce the need to support the developing relationship between mother and infant, and they also reinforce the appropriateness of supporting a mother who has dedicated her life (at least in the short term) to full time motherhood.

Different groups have widely differing views of what social support should be and this is largely determined by a view of what motherhood should be. Pringle (1974), Leach (1979) and Kitzinger (1978) see fulltime motherhood as best for both children and mothers and therefore propose measures to make it easier for women to stay at home. Leach (1979), for example, believes that "women need only social approval and support to enable them to settle

happily to fulltime caring for their children" (p.104). Boulton (1983) cites several measures proposed by theorists such as these :

- 1) earning related allowances for women caring for children at home
- 2) self help groups
- 3) community and housing facilities catering to the needs of women
- 4) drop-in centres for expert advice
- 5) part-time jobs which do not interfere with the needs of children
- 6) education to improve society's attitudes to children.

However, as Boulton points out, these measures may reinforce a woman's secondary position in society and the division between men's and women's worlds, leaving a woman more vulnerable within the family, increasing the number of women who feel monopolized by motherhood.

Boulton (1983) cites the work of Gavron (1966), Bernard (1975), Safilos-Rothschild (1971) and the Rapoport (1971) as offering an alternative view of motherhood as imposing restrictions on the development and self realization of women as individuals and sustaining their 'second class status' in society. These theorists propose the following measures to support women, as mothers, in society :

- 1) changes in education of girls to prepare them for family and employee roles
- 2) a recognition of fathers as parents and parenting and domestic care shared on an equity basis
- 3) provision of supervised play areas in public areas to enable women to lead "public" lives
- 4) good quality child care and a societal change in attitude toward non-parental care
- 5) restructuring of the workplace - job sharing, part-time jobs, flexible working arrangements and pressure on the Government to give greater priority to the needs of families.

Although these ideas have been around for quite a while now, I have included them to demonstrate simply how powerful and pervasive the social acceptance of the role of fulltime motherhood is. Twenty years on, we are still fighting for the right to good quality child care and juggling the responsibility for the home, children and a full time job if you choose to work. With the recent change of government in New Zealand, fulltime mothers have been made more

dependent on their husbands and have had their secondary status reinforced. The recent removal of the family benefit, the unavailability of child care subsidies to a woman whose husband earns even a modest income, and the government policy of only paying bulk funding for six of the hours that a child is in childcare, are all testimony to the prevailing agenda of keeping women in the home. Making childcare only available to the wealthy and keeping women financially dependent on their husbands or partners, all point to a hidden agenda of keeping women out of the workforce and preserving entrenched inequalities.

However, not all women want to work, and a woman who chooses to stay home is entitled to support as surely as a woman who works full time. For support to be effective, it needs to be personally appropriate. A third of the mothers in Boulton's (1983) study were fulfilled as mothers. It is possible that a mother may feel fulfilled, but also exhausted by the difficulties experienced and the responsibilities which she is shouldering. It is for these women that support within in the home is essential.

Strengths and weaknesses of the present study

The weaknesses of the study have perhaps involved a personal involvement in the same developmental tasks of early adulthood as the mother. This involvement made for a strong awareness of the issues of new motherhood, and also has provided opportunity for self-disclosure more readily available to the mother. Such self-disclosure may have presented alternatives to the mother which may not have been otherwise available. In this way, a study is also a study of interaction between researcher and participants over time. Gitlin (et al, 1988, in Lather, 1989) suggests that all methods have a political moment which at a fundamental level express a relationship between people; social relations mediate the construction of knowledge and who speaks for whom becomes a central question. Lather (1989) concludes that decentring notions of the "great interpretator" (Dreyfuss and Rabinow, 1983) and "the master of truth and justice", whose role it is to reveal truth and reason to those unable to see or speak it, provides a base for a reciprocally educative focus. Such a focus "breaks down the distinctions between emancipatory research and pedagogy by producing a collaborative

analysis that doesn't impose the researcher's understandings of reality, that doesn't say what things mean via a privileged position and theoretical assumptions" (p.18).

For this reason, a major regret is that audio recordings were made of the infant crying, rather than recording the mother's initial feelings, definitions and decisions. Although time consuming and intrusive, sequential and chronological tape recordings would be a useful addition to case notes. In an attempt to overcome some of this difficulty, a decision was made to take in the draft of the case study material and to record the mother's responses to it. A draft of the responses was taken back and the mother's responses to the draft and to the original draft (after she had had time to read it at her leisure) were sought, to check for consistency and coherency.

One of the major strengths which a single case study presents is the unique opportunity to intensively discover themes arising from a person's experience of life with a newborn infant. Commitment to the study on the part of the researcher gives a good base for forming a working relationship with the participant, providing opportunity for greater self disclosure than more distanced or quantitative research strategies. Finally, the single case study does not provide universals or generalizable theoretical findings, but it can highlight some of the issues which need exploration with a larger, more representative sample of population. MacMillan and Schumacher (1984) report that findings from single case studies are not generalizable or predictable to other settings or populations, but they are no less valid or important than the findings from experimental design. As they say "Case study design merely reflects the immediate purpose of the ethnographic research: to discover and to understand the complexities of a single phenomenon" (p.322).

CHAPTER SIX

CONCLUSIONS

A single collaborative case study provides a unique opportunity, to explore themes arising from a mother's experience of a "crying baby", influencing the development of her desired relationship with her infant. The present study investigated a foreshadowed problem, of "why does this mother define her infant as a crying baby?". This foreshadowed problem developed, as the study progressed, into four major questions. All of the questions contributed information about the mother's reasons for defining her infant as a "crying baby".

The first question addressed how the mother defined her role as a mother. Caroline had attended ante-natal classes, read Kitzinger, joined the Home Birth Association and had adopted a rigorous code of childrearing practice advocated by the Jehovah's Witness belief. She had chosen, as a result of these influences, to be a fulltime mother, at least until her children started school. Furthermore, she believed that she was essentially responsible for any decision making concerning her children, and for their care and well being. Caroline expected that if she was available, provided the appropriate care and established a close relationship with her children, then she would be a "normal" mother. Her experience of difficulty was, then, a challenge to her sense of self esteem and self efficacy as a mother.

A socially constructed view of motherhood which makes an infant's "secure attachment" to the mother a primary goal, consolidates a mother's vulnerability if difficulty is experienced. Caroline wanted to form a close relationship with James, and she perceived his irritability to be an obstacle to the formation of this relationship. She perceived her own parents to have been emotionally unavailable to her, throughout her childhood and during her difficulty with Sarah and James, and she hoped for a different experience for her own children.

Caroline initially attributed James' irritability to "colic". She displayed a certain "learned helplessness" to James' crying, but a medical intervention (Merbentyl) proved

empowering, as a means of controlling James crying and as a cue for soothing behaviours to begin. A medical attribution, of James as a "crying", colicky baby, was probably a safe and empowering avenue of attribution. Having found a "cure" for the crying, Caroline could not charge herself with not being a "good mother".

The final question drew on elements from the previous questions, to establish how the developing relationship between a mother and her "crying baby" could be supported. It was established, that readily available social support is imperative, if a mother is to cope with the multiple roles of fulltime motherhood. A collaborative forum was also discussed as a useful way for a mother to establish a personally appropriate meaning of her commitment to motherhood.

Collaborative case study method provides a forum for deconstructing the myths of motherhood for women, formulating personally appropriate meanings and identifying helpful support. It is also useful for intensively discovering the complexities of a single phenomenon, with a wealth of knowledge which more formal testing would overlook. Finally it is an important avenue for identifying relevant avenues for larger scale research.

Implications for future research

Intensively exploring the historical, social and contextual themes in a mother's life provides the impetus for a larger scale investigation. It is vitally important to deconstruct how motherhood is socially constructed in western societies, and to examine critically the frameworks upon which the prevailing notions are based. The impact of developmental theory upon definitions of "normal" mothers and babies has been highlighted in this thesis as an important organizer of how parents define their role and practice with their children. Similarly, medicine has been described as an example of social and historical practice (Wright, 1987), thereby defining and prescribing treatment for an infant's irritability. Examining the inter-relationship between developmental theory and medicine, and the resulting effects upon the social construction of motherhood, provides a fascinating focus for further research.

Hartup (1986) stated that maternal development as a factor in the mother-infant relationships has not been fully addressed. Future research could, therefore, examine maternal development during the child-bearing years (12-45). This research could also address the effects that a child-centred approach to motherhood has on maternal development. Such research may involve exploring the effects on self esteem for women who do not enjoy the "rewards" of motherhood.

Another notion, which would be interesting to examine with a larger sample, is the nature of the mother-child relationship over the life-span. Weiss (1986) has described several different types of relationships, and I have asserted in this thesis that different types of relationships will be appropriate at different times during the child's development. However, it may be interesting to examine more closely whether society has expectations of what type of relationship is appropriate at the various stages of the child's development. This research would also need to examine the construction of the mother-child relationship in other cultures.

It has been shown that a perceived social network of family or close friends can prevent or mitigate experience of difficulty with a newborn infant. It is worthwhile exploring how social support networks could prevent expectations of "perfect babies" from arising. It would be revelatory to establish if women do sustain a different experience of motherhood, if they have support readily available to them. A multi-pronged approach would be necessary, to examine women's relationships with their infants, incorporating the influential effects of family and social structures, personal life style and circumstances.

In this case study, lack of any close relationships created difficulty in forming a mutually rewarding relationship with her infant. Research suggests that this mother's difficulty is not a unique phenomenon, the resulting sense of separateness and vulnerability is a factor in the difficulties which many mothers experience in the transition to motherhood. Further research would involve untangling the processes whereby women adopt a socially constructed 'traditional role' and also to examine how theory permeates a women's experience of motherhood. Identifying a group of vulnerable mothers, through a medical practitioner, social worker or similar, and investigating the effectiveness of increasing their educational, instrumental and emotional support seems to be an interesting issue for further investigation.

Finally, it seems imperative to explore to what extent a collaborative forum may be empowering for women, as they attempt to make personally meaningful decisions about the course of their own lives.

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