INSTITUTE OF EDUCATION, UNIVERSITY OF LONDON

GENDER, PARENTHOOD AND HEALTH:

A STUDY OF MOTHERS' AND FATHERS' EXPERIENCES OF HEALTH AND ILLNESS

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ABSTRACT

This study makes an original contribution to the literature on gender differences in health and illness which attempts to explain why 'women get sick and men die'. It focuses on how women and men *as parents* experience health and illness. It also contributes to studies of motherhood, specifically women's experiences, and extends this by making visible men's experiences of fatherhood.

A qualitative study of fifteen working class families, involving both parents, was undertaken. Using a feminist theoretical framework based on parents' 'lived experiences' of health, I explored gender differences in health status, attitudes and behaviour; and the additional role of material and social resources. Each parent was interviewed three times over the course of a year. Data were also collected using health diaries.

The mothers reported more health problems than the fathers. The data lend support to the 'nurturant role hypothesis' ie. that mothers' social role as carer leads them to have different experiences of health and illness from fathers. The mothers experience their role as more stressful than the fathers, particularly with regard to the lack of opportunity to rest. The finding that the 'mothering' role has a significant negative impact on health is supported by data that show that fathers who are more involved in childcare report more health problems than fathers less involved.

Three typologies of parenthood have been developed which extend the hypothesis in important ways: (a) the congruence between mothers' ideologies of parenthood and their actual situation; (b) fathers' degree of involvement in childcare; and (c) the congruence between mothers' and fathers' ideologies. An analysis of gender differences in concepts of health adds to the explanation of parents' different health experiences. Finally, the structural context within which women and men carry out their roles as parents helps to account for the health differences found.

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As ever, the ultimate responsibility for the final version of this thesis rests with the author alone.

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CHAPTER ONE
INTRODUCTION: GENDER DIFFERENCES IN HEALTH AND ILLNESS

> I had my children several years apart. I must say that I was much better in pregnancy, and up to the time of the birth of the child was able to do most of my work...But it was after confinement that I had to be very careful...Much depends on what kind of a husband the woman has. Worry must be a great drawback to a woman in that state...A woman cannot possibly get on if she has a bad, worrying husband. I think that makes a lot of difference (Margaret Llewelyn Davies (ed). *Maternity: Letters from Working Women* 1984:170-1. Originally published in 1915 by GB Bell and Sons).

Introduction

The purpose of this thesis is to shed further light on the much-researched conundrum that 'women get sick and men die', that is, while men have higher death rates and a shorter life expectancy rate than women, women tend to report more illness than men. I am interested in the second part of the conundrum: why women report more illness than men. I hypothesise that this can partly be explained by women's and men's different gender and social roles, namely as mothers and fathers. Specifically, the study is concerned with the differential effects on men's and women's health of caring for a child, and how this relates to other roles such as marital responsibilities, unpaid and paid work. I have selected a working class group of parents in order to highlight gender rather than class differences. Working class families were chosen because most children live in households headed by a parent whose present or last occupation is a manual one. However, I hypothesised that gender differences in health and illness could also be accounted for by differences between mothers and fathers in terms of their differential access to material and social resources.

This study attempts to fill a gap between several different areas of literature. The sociomedical approach to sex differences in health has focused on broad gender differences. Only a few studies have considered gender differences in health within the context of the relationship between women and men and the family (see eg.

Aneshensel et al 1981, Clark et al 1987, Thoits 1983, Ross and Mirowsky 1988, Popay and Jones 1989). The study therefore involves considering men as fathers and husbands as well as 'breadwinners', and considering women as 'breadwinners' as well as mothers and wives. Although there are studies of the effect of combining employment, marriage and motherhood on women, few studies have looked at how the role of 'father' affects men's health (the notable exception is Popay and Jones 1989). In extending the boundaries of work on multiple roles, gender and health this study considers in detail the *quality* of these roles and their effect on the health of both women and men. It also makes an original contribution to the sociology of gender and health by focusing on how men and women *as parents* experience health and illness.

A second area of literature contains the sociological studies of motherhood and its effects on women (eg. Bernard 1975, Ginsberg 1976, Oakley 1979, Boulton 1983). Many of these studies have shown how feelings of tiredness, loneliness and depression are common among mothers of young children (eg. Richman 1976, Brown and Harris 1978, Graham and McKee 1980). These important studies made visible women's experiences of motherhood but did not consider the experiences of fathers. While subsequently some researchers began to look at men as fathers (eg. McKee and O'Brien 1982, Beaile and McGuire 1982, Russell 1983), my study brings together the public and private worlds of women and men.

This is a qualitative study of gender, parenthood and health which analyses a group of *working class* mothers' and fathers' experiences of health and illness. The fieldwork for the study took place in North London between May 1986 and December 1987. The purpose of these first two chapters is to outline the theoretical and empirical background to my own study within the context of the general debate on gender differences in health. This chapter is divided into three main parts. The first outlines the aims and theoretical position of my own study. Part two reviews the literature, mainly UK and North American, on gender differences in health and illness, before going on to review the literature on gender *roles* and health. In part three, the issues of gender and class inequalities in health are discussed.

I A STUDY OF GENDER, PARENTHOOD AND HEALTH: AIMS AND THEORETICAL POSITION

Aims of the Study

(1) To document the health experiences of the working class mothers of young children.

(2) To document the health experiences of the working class fathers of young children.

(3) To compare and contrast the findings of (1) and (2) with reference to:

- Parents' concepts of health and illness
- Parents' ideologies of parenthood
- The division of responsibility of domestic work, especially childcare
- The relationship between domestic work and other roles such as paid employment
- The type and quality of these roles (not just the number) and perceived satisfaction with these roles
- Differential access to material and social resources.

Theoretical Position

The general issue in my study is gender differences in perceived health status and behaviour within the context of the family, at the intersection between the so-called private world of domestic work and the public world of paid work. This study explores areas which previous studies have ignored; namely, gender differences in concepts of health, and the role of material and social resources in these gender differences. Although the study group consisted of working class families, there were considerable differences among them in access to material and social resources.

Popay and Bartley (1987) have noted how research on class inequalities in health has focused on the link between people's health and their public lives in paid work and the material conditions in which they live and work, ignoring the health implications of conditions in the private work of the family. Similarly, the research on gender differences in health has focused on the different social roles performed by women

and men. The material conditions in which these roles are performed have largely been ignored (see also Arber 1991).

The theoretical framework for the present study is a feminist one based on McBride and McBride's notion of 'taking women's *lived* experiences as the starting point for all health efforts' (1981:41, their emphasis); and 'trusting in the world views of women themselves as recorded by female sociologists' (Clarke 1983:76). This has been extended to include taking men's as well as women's lived experiences, and the effect of these experiences on their subjective beliefs and actions concerning their health have also been explored. As most health surveys base their findings of gender differences on women's reports of their own and their partner's health, it was important to ask mothers and fathers separately about their perceptions of health, and health and illness behaviour. Further, in her guide to non-sexist research, Eichler argues that while it is 'androcentric' (viewing the world from a male perspective) to exclude women from stratification studies, it is 'gynocentric' (the female version of androcentric, but not comparable in terms of scale) to exclude from studies of the family consideration of men's role as parents (1988:148).

In addition, the study makes a significant contribution to the sociology of health and illness by looking at the existence and effects of lay concepts of health and illness between gender, as distinct from social class, groups. There is a large body of literature on social class differences in concepts of health and whether these differences can explain class differences in health and illness behaviour and therefore outcome (eg. Calnan 1987, Blaxter and Patterson 1982, Pill and Stott 1982, Cornwell 1984, Herzlich 1973, Williams 1983). However, there is no literature on gender differences in concepts of health which, given the differences in mortality and morbidity, is a significant omission. The present study analyses how far these working class parents' concepts of health and illness coincide with other working class groups' concepts discussed in the literature.

Most of the literature on gender differences in health and illness is based on the secondary analysis of large scale data sets. These analyses set out the differences, but

cannot look in detail at the processes behind the differences found. The present study has taken a small sample of women and men and explored in depth these processes using interviews and health diaries. In particular, the use of health diaries and the detailed data which they are able to collect has thrown new light on gender differences in health and illness.

The methods used in most of the literature are based on the assumption that:

> Sex differences in health can be explained with confidence only when there are adequate controls (statistical or sampling), so hypotheses can be tested independently of each other (Verbrugge 1979a:70).

Useful as these surveys are in testing various hypotheses, some of these studies have pointed to the need to examine aspects of men's and women's everyday lives which might contribute to these differences (eg. Gove and Hughes 1979, Arber et al 1985). Indeed Verbrugge herself states:

> Existing health statistics offer direct evidence that health experiences differ substantially for men and women, and they give clues about facets of health which are not measured. The full picture of health is not known, especially about symptoms of daily life and self-care actions for illness (1979a:163).

Many of the studies do not seem to be concerned with the lives people lead but whether there is a statistical significant difference between, for example, morbidity rates in women with one role and women with three roles, in other words:

> Outside attempts at an objective analysis have been stressed at the expense of the subjective meaning to the social actors (Clarke 1983:76).

What I aimed to do in the present study was to *map* the social processes which lie behind these large-scale statistics by exploring men's and women's perceptions of health and illness within the context of their daily lives. This has wider theoretical implications than just for the debate on gender differences in health and illness. There has been a tendency in the sociology of health and illness to take for granted the socio-economic structural framework of society, with the result that the private world has been neglected in favour of the public world, and that formal arrangements and structures have been described with the loss of the informal (Clarke 1983, Graham 1985). Rose, with reference to social policy, has called for the reassertion of the

Titmuss paradigm:

> ...with its insistence on the intimate and concrete (which) refuses to dissolve the specificity of women's oppression into the sex blind categories of the "new" political economy (1981:501).

II GENDER DIFFERENCES IN HEALTH AND ILLNESS

The large-scale studies mentioned above have uncovered a paradox between sex differences in mortality rates and those in morbidity and utilisation of health services (Nathanson 1975, 1977, Verbrugge 1976, Marcus and Siegel 1982). While in all contemporary industrial societies men have higher death rates and a shorter life expectancy than women, health surveys consistently show that women tend to report more illnesses than men. In addition to this, women utilise health services at substantially higher rates than men. These trends hold even when illness, disability and utilisation of services associated with pregnancy and childbirth are excluded (Nathanson 1975).

Table 1.1: *Gender differences in reported health in the UK*

All age groups % who reported:	All (n=25031)	Women (n=13030)	Men (n=12001)
Long-standing illness	32	33	31
Limiting long-standing illness	18	19	17
Restricted activity	13	15	11
Consulting GP in 14 days before interview	15	17	12
Age 16-44 years **% who reported:**	**All** **(n=25031)**	**Women** **(n=5258)**	**Men** **(n=5038)**
Long-standing illness	24	24	24
Limiting long-standing illness	11	12	10
Restricted activity	11	13	9
Consulting GP in 14 days before interview	13	18	8

Source: *GHS* 1989 (OPCS 1991)

In England and Wales, for example, 60 percent of women aged 65 will survive to 80 compared with only 40 percent of men. Death rates for men are almost twice those of women between the ages of 55 and 74 (Silman 1987). The life expectation for a boy born in 1985 was 73.2 years compared with 78.8 years for a girl (*Social Trends 22*). In contrast, Table 1.1 shows data from the General Household Survey (GHS) illustrating women's higher reporting rates of long-standing and limiting long-standing illness, restricted activity, and use of health services for all age groups; and women's higher reporting of limiting long-standing illness, restricted activity, and use of health services for the ages 16-44 years.

There is some question as to whether these data reflect 'real' differences in illness or are merely artefacts of differential illness behaviour. One hypothesis is that these data are a product of women's greater willingness to report symptoms and to act on them (see eg. Mechanic 1978, Verbrugge 1979a). Alternatively, the findings are considered a 'real' phenomenon and are attributed to female biological susceptibility or to social causes. Of the social causes, the two most-repeated explanatory models are:

> (1) the sick role is more compatible with women's other role responsibilities; and (2) women have more illness than men because their assigned social roles are more stressful (Nathanson 1975: 57).

The aim of this thesis is to explore these three models in the context of women's and men's experiences as parents by employing alternative methods to those used in large-scale studies. First, I will review the evidence for these explanations.

(i) Biological Explanations

For certain symptoms, it may be that biological differences between women and men provide the explanation. The crucial biological differences between males and females are genetic in origin. The female possesses two large X chromosomes, the male one X and a much smaller Y. The Y chromosome has been described as an incomplete X as it only carries the genetic instructions for maleness, while the X chromosome carries many genes in addition to those responsible for sex determination. This genetic difference has been held responsible for sex differences in infant mortality

(Nathanson 1977), as well as for greater male susceptibility to disease generally (see Oakley 1972). Nathanson argues that although the genetic hypothesis seems to be consistent with the data on sex differences in mortality and morbidity among the very young, the divergent paths assumed by these differences in older age groups suggest that other factors quickly come into play (1977:21).

Another biological difference between men and women is their hormonal balance, which in women changes markedly with age. These differences have been used to explain both low rates of coronary heart disease among women prior to menopause, and low susceptibility to certain cancers following the menopause (Nathanson 1977). Neither of these specific hypotheses have been confirmed; and more generally, few accept that biological differences can explain the sharp increase in mortality differences in recent decades or the female excess in morbidity (Nathanson 1977, Gove 1984, Marcus et al 1983). However, in the past in developed countries and in many less developed countries today, the biological process of reproduction played a major role in mortality among women of child-bearing age. Women in this age group in industrialised countries are high users of health services, and much of this excess use appears to be accounted for by disorders of the reproductive system. For example, data from the US show that in the age range 17-44, women have twice as many physician visits and hospital stays as men do. When reproductive and other sex-specific conditions are excluded, there is still a gap of about 30 percent for ambulatory care, but the gap for hospitalisation virtually disappears (Verbrugge 1985:162). Most of the literature reviewed here pays remarkably little attention to reproductive orders and disorders when:

> ...there is a way in which women's reproductive experiences contaminate the rest of the health experiences of women (Clarke 1983:76).

(ii) 'The ethic of health is masculine' Hypothesis

This hypothesis supports the 'artefact explanation' that women report more illness than men because it is more socially acceptable for them to adopt the sick role, and therefore the role is easier for them to assume - 'the ethic of health is masculine'

(Nathanson 1975). This hypothesis has been tested more frequently in relation to mental illnesses, which differ from most physical illness in that they are generally thought to be more stigmatizing. Verbrugge (1979a) and Mechanic (1978) argue, in a variation of this hypothesis, that the differences are not 'real' but artefacts of women's greater willingness to report illness because it is more socially acceptable for them to do so. This has been disputed by Gove and Hughes (1979), who claim that neither Verbrugge (1979a) nor Mechanic (1978) cite evidence which proves their hypothesis. Gove (1984) cites a study which found no significant differences between males and females regarding either expectation or actual receipt of sick role legitimization (Wolinsky and Wolinsky 1981 cited in Gove 1984). Cleary et al (1982), in their investigation into sex differences in medical care utilisation, found that the analyses of the data they obtained and data from other studies, indicate that part of the sex differences in utilisation can be attributed to 'real' differences in health. However, the problem with these studies is that they all use different measures of illness behaviour and so comparability is limited (Clarke 1983). Waldron (1983) found that sex differences in reporting vary depending on the particular type of morbidity measure considered. For example, for self-ratings of general health women may be more predisposed than men to rate their health poor, but no significant sex differences were observed in reporting of physician visits or hospital admissions.

A variation of this hypothesis is that women may perceive more symptoms than men because they have more interest in health and are generally better informed about disease than men (Mechanic 1978, Nathanson 1977). Hart (1982) argues that there is a gender difference in orientation to one's biological self; women are socialized into being much more concerned about their looks and their bodies; and once married or co-habiting with a man, women are usually responsible for hygiene and cleanliness in the home. This 'all adds up to a more caring approach to the body and its hygiene' (Hart 1982:31), and as a result women are more likely to turn to the body expert, the doctor, for advice on how to look after themselves, while men are more likely to adopt a disinterested stance. This was confirmed in a study by Hibbard and Pope (1983) who found that it is a greater attention to and evaluation of body clues that partially accounts for greater morbidity reports and higher utilisation rates among

women (see also Briscoe 1987). In connection with this, women's reproductive role may also 'sensitize' them to symptoms they might not otherwise be aware of (Clarke 1983:76). In addition, women report more psychological symptoms because they translate non-specific feelings of distress into conscious recognition that they have an emotional problem more readily than men (Mechanic 1978:208).

There is a large variability in responses of men and women depending on the illness condition or symptom involved (Mechanic 1978:213). The hypothesis that help-seeking is more concordant with the female than with the masculine role may be stronger for mental than for physical illnesses. In his review of existing data, Mechanic (1978) found that although women express illness differently, or report symptoms more readily, they do not do this uniformly in response to all types of symptoms. For example, in the area of psychological distress, sex differences in illness reporting is greater for symptoms such as headaches, lack of energy, dizziness, and anxiety than it is for chronic indigestion, 'nervous stomach', perspiring hands, heart beating fast and paranoia (Mechanic 1978:209). Secondly, although women are more inclined to seek help:

> Such patterns are to some extent selective and do not generalize to all sources of assistance (Mechanic 1978:213).

(iii) Fixed Role Obligations Hypothesis

The first of the two hypotheses which considers the gender differences in health and illness to be 'real', focuses on the sociological implications of sex differences in 'fixed role obligations'. People having many fixed role obligation (ie. ones that are difficult to reschedule) are expected to experience more role competition with the sick role and therefore be less likely to define themselves as ill or take on the sick role (eg. 'I'm too busy to be ill'). Those that propose this hypothesis use it to explain the apparent higher rates of morbidity among women because they believe that, on aggregate, women have fewer fixed role obligations than men. As Marcus and Seeman state:

> Women can more easily adopt the sick role because they are less frequently employed full-time outside the home, and experience fewer work and time constraints on behaviour - thus leaving them freer to reduce their usual

activities when feeling ill (1981:175).

Other investigators have articulated the hypothesis similarly (Mechanic 1978, Nathanson 1975, Verbrugge 1979a, Marcus and Siegel 1982, Cleary et al 1982).

One such hypothesis is that women use health services more frequently than men because, in the aggregate, they have fewer work and time constraints on their behaviour, thus making it easier for them to suspend or reschedule their activities to visit the doctor (Mechanic 1978, Marcus and Siegel 1982, Nathanson 1975, 1977, Verbrugge 1979a, Cleary et al 1982). This is then used to explain the higher female morbidity rates. However, there is very little evidence to support this hypothesis (Gove 1984:79).

First, although it is assumed that women who are not employed outside the home have a more flexible schedule than those men and women who are employed outside the home (Gove 1984:79), time budget studies have shown the long hours worked by these women (Oakley 1974, Szalai 1972). The evidence is very strong that married women who are employed outside the home, even part-time, are under much greater time constraints than their husbands (Gove and Peterson 1980, Kowarzic and Popay 1989). Further, a number of studies have found no gender differences in illness behaviour after controlling for actual differences in physical disorder (Cleary et al 1982, Marshall et al 1982). However, Marcus and Siegel (1982) found that although men's and women's fixed roles did not affect the extent to which they sought help for acute illness, they believe that the fixed role hypothesis may explain sex differences in behavioural responses to chronic symptoms (p.186). Gove argues that the evidence overall indicates that the various factors affecting access to medical care, including the degree of fixed roles, have little effect on whether men or women receive care (1984:80). A major implication of the view that the sick role is seen to be more consistent with women's role obligations is that women with a larger number of role responsibilities will be unlikely to adopt the sick role (Nathanson 1975:61). This hypothesis will be explored later in the section on gender roles and health.

In their analysis of the US National Medical Expenditure Survey, Wilensky and

Cafferata (1983) attempted to establish specific factors which explain some of the higher use of health services - in this case, physician services - by women. Using a health economics framework they asked 'is their use higher because their time and time price, their preferences or their need for medical services differ, or is it that they are more sensitive at the margin to one or more of these factors?'(p.132). What they found was that for most of these factors the differences between men and women were not large, and they were not always in the direction which would suggest greater use by women. For example, women were found to be more responsive to time costs than men. However, women did show a greater responsiveness at the margin to chronic conditions, although not for disability days.

In a British study of gender differences in GP consultation, Briscoe (1987) also attempted to establish which factors might explain these differences. She found that not only do women consult more often than men, but that the factors which affect women's and men's consultation rates are different. Health status (need) and social factors (including parenthood and marital status) are more important for men, while psychological predisposition is of greater significance for women. For men, while fatherhood was associated with increased consultations, married men had fewer consultations than their currently non-married counterparts when health status and parental role were controlled for. Women are more predisposed to consult especially for vague symptoms or for reassurance Briscoe suggests because 'perhaps they are more interested in health matters and more aware of day-to-day fluctuations about which they seek reassurance from their doctor' (1987:511).

A proposition that can be derived from the fixed role hypothesis is that women will be more likely than men to adopt the sick role in the home. This hypothesis has been supported by several epidemiological surveys which show that women are more likely than men to have days of restricted activity (Nathanson 1975, 1977, Verbrugge 1976, Verbrugge 1985). Data from two studies support the idea that the fixed role hypothesis at least partially explains why women have more days of restricted activity than men and why women, once they decide to stay in bed, have more bed-days than men. However, it is possible that a bed-day for a man actually means the whole day

in bed, while a bed-day for a women may mean spending only part of the day in bed - the rest being spent doing childcare and domestic chores as usual (Gove 1984:80-81).

(iv) Nurturant Role Hypothesis

The nurturant role hypothesis is the second of the two hypotheses which accepts as its premise that women do in fact experience more illness than men. This hypothesis accounts for the difference in terms of women's social roles. Most of the literature has been directed at explaining the apparently higher female rates of mental illness.

One socially-oriented hypothesis which has been applied to physical illness is the nurturant role hypothesis developed by Gove and Hughes (1979). According to this hypothesis, women in our society are generally expected to occupy a nurturant role, both performing daily the essential household tasks and taking on the major responsibility for the care of children, spouses and aged relatives. As a consequence most women will (1) find it more difficult than men to adopt the sick role completely, and (2) tend to experience the demands of others as excessive and as impairing their ability to rest and relax. Women are therefore apt to become both physically run down and to be unable to adopt the sick role successfully (Gove 1984:80).

Gove and Hughes tested this hypothesis and found that:

> The sex differences in physical health largely reflect real differences in physical health, and that this difference can be primarily attributed to women confronting more nurturant role demands and generally being in poorer mental health (1979:143).

Gove (1984) does not see the nurturant role hypothesis as conflicting with the fixed role hypothesis because women who work outside the home are fulfilling both the nurturant role and lead a structured, difficult-to-reschedule life; and housewives are in a situation where it is easier to partially adopt the sick role, but difficult to adopt it fully.

GENDER ROLES AND HEALTH

Up until now, the literature I have reviewed has dealt mostly with overall sex differences in health and illness. To say that women experience higher rates of morbidity than men does not really mean anything unless we look further to see *which* women are less healthy than *which* men. If we accept the hypothesis that the higher rates of morbidity in women are at least partially due to their social role in society, then clearly there will be differences *among* women who have different social roles and life experiences. This more detailed study allows us to test some of the hypotheses which have been developed to explain gender differences in health. For example, if women have higher rates of illness because their nurturant role is stressful and causes them to become ill, then men who have a nurturant role (eg. lone fathers) will report higher levels of illness than single men or men in couples.

While the literature has drawn attention to other factors which affect the health experiences of women and men such as age, employment, marital status and, occasionally, parenthood (but for this read motherhood), there are two vitally important factors which have been neglected by much of the literature; social class and cultural/ethnic background. These factors have an enormous influence on the way women and men perceive symptoms, act on these symptoms, receive treatment, and on their life experiences which affect their health. While the literature on gender differences in health has neglected this area, more recently the literature on class inequalities in mortality and morbidity which had previously focused on men has begun to consider class inequalities among women (see eg. Arber 1986, Moser et al 1988). Popay and Bartley have noted how the division in research on social class and gender inequalities has:

> ...serious consequences for our understanding and aetiology in relation to women's experience of health and illness for it has led to a neglect of the health implications of the material conditions of women's lives and their unpaid labour in the home (1987:16).

These issues are taken up in part three of this chapter.

In this section, however, I will review the literature that has looked more closely at the different roles women and men have and the effect they have on their health. This

literature is directly relevant to the study of parenthood and health, but usually parenthood is subsumed under discussions on employment and marital status. If parenthood is considered separately, it is in the context of its effect on women which, although reflecting the fact that the vast majority of women still have primary responsibility for child care, reinforces the assumption that this should be so (see also New and David 1985).

In the case of marital status, it is well known that mortality rates are significantly higher for the unmarried than for the married, and that this differential is much greater for men than it is for women (Nathanson 1975, 1977). In terms of morbidity, the relationship is not so clear. Most studies show that the married of both sexes have lower morbidity rates than the unmarried (eg. Nathanson 1977, Morgan 1980, Gove, Hughes and Style 1983). It has been suggested that with regard to health status, the married state is less advantageous to women than it is to men, thus concurring with Jessie Bernard's (1972) view that within each marriage there are two marriages - his and hers, his being more healthy than hers (see Appendix A for a more detailed account of this literature).

The issue of employment and women's health is a complicated one. Employment has been found to have a positive effect on the health status of married women, particularly as a protection against depression (eg. Nathanson 1980, Waldron 1980, Verbrugge 1983a, Hibbard and Pope 1985). In contrast, housework has been found to be a devalued and socially isolating occupation (Oakley 1974). However, other studies have found that women's entry into the labour force may increase their exposure to stress with negative consequences for their health (eg. Haynes and Feinleib 1980).

An alternative view is that rather than employment 'causing' variations to health status and behaviour, it is health status that causes variations in labour force participation ie. women in poorer health are 'selected out' of the labour market (Waldron et al 1982). (A similar argument has been posed to explain the differences in morbidity between marrieds and unmarrieds.)

Employment for women, therefore, may provide opportunities for social support, self-esteem, and social identity - a possible health enhancing situation (Hibbard and Pope 1985, Ginsberg 1976, Nathanson 1980, Gove and Geerken 1977). At the same time, intrinsic job characteristics and the work environment may be sources of stress - a possible health risk (eg. Haynes and Feinleib 1980). Finally, employment will have different effects on a woman's health depending on her social class and family situation (Nathanson 1980, Parry 1986, Kandel et al 1985, Walker and Best 1991). (For a more detailed account of this literature, see Appendix B.)

Parenthood

Surprisingly little research has been undertaken in this area, and such that there is, has been limited to women (Verbrugge 1983a), or rather mothers. In 1968, Alice Rossi remarked that given the number of unwanted pregnancies and the evidence of parental abuse of children:

> ...it is all the more surprising that there has not been consistent research attention to the problem of *parental satisfaction*, as there has long been on *marital satisfaction* or *work satisfaction*...cultural and psychological resistance to the image of a non-nurturant women may afflict social scientists as well as the American public (1968:31, her emphases).

Rossi's paper, which argued that the transition to parenthood is more difficult than marital and occupational adjustment in American society, was an attempt to rectify this neglect.

Despite the social scientists' neglect of the private world of women's work (for this is what the gender blind term 'parenthood' actually refers to), the experience of mothering has not gone unrecorded (see eg. Llewellyn Davies 1984, Spring Rice 1981). In 1939, Margery Spring Rice described the world of the working class wife and mother as follows:

> The working mother is almost entirely cut off from contact with the world outside her house. She eats, sleeps, 'rests' on the scene of her labour, and her labour is entirely solitary...whatever the emotional compensations, whatever her devotion, her family creates labour, and tightens the bonds that tie her to the lonely and narrow sphere of 'home'. The happiness that she often finds in her relationship of wife and mother is as miraculous as it is compensatory (Spring Rice 1981: 105-6).

Returning to the present day, there is evidence to suggest that caring for children is both beneficial and detrimental to a woman's health and well-being. Obviously it is affected by other factors such as her marital status, social class, number and age of children, and whether she is employed outside the home (Brown and Harris 1978, Ginsberg 1976, Rivkin 1972, Umberson 1989). As Oakley (1982) points out:

> The effect of children on women (*another unstudied subject*) is not uniform; here, as elsewhere, the habit of generalising about women as a category can be deeply misleading (1982:227-28, my emphasis).

It is important to distinguish, at this point, between illness and illness behaviour. It has been found that the presence of pre-school children disinclines women to adopt the sick role (Rivkin 1972). These women, especially if they are employed, are more likely to use the medical care system rather than to prescribe for themselves (Rivkin 1972). Mothers are usually responsible for taking their children to the doctor, and this behaviour on behalf of their children may affect their own illness behaviour (Balbo 1987).

Given that research into parenthood and health has concentrated on women, there is little evidence on the sex differences in this area, and what there is, is conflicting. While Verbrugge (1983a) found that in terms of physical health, parenthood has similar (beneficial) effects on women and men, Aneschensel et al (1981) found that women were significantly more depressed than men when there were children in the household (see also Gove and Geerken 1977). Similarly in a more recent study on 'child care and emotional adjustment to wives' employment', Ross and Mirowsky (1988) found that the presence of children increased depression levels for non-employed wives, and employed mothers who have difficulty in arranging childcare and have sole responsibility for childcare have extremely high depression levels. In contrast, they found that children and their care have no such effect on husbands.

Studies on the relationship between parenthood and health on a very general level reveal conflicting findings. In an unusual paper, Veevers (1973) hypothesises that parenthood is a protective factor against suicide, since a large part of the variation in suicide rates which has been attributed to different marital statuses may more

accurately be attributed to different parental statuses. Two other studies found that women with no children at home experience more symptoms than women with children (Marcus and Seeman 1981, Rivkin 1972). This may be explained in part by social selection; women in poor health not having children in the first place. On the other hand, other studies have revealed that the presence of children in the parents' home has a negative impact on the psychological well being of parents (Gove and Geerken 1977, see a review by McLanahan and Adams 1987). When other factors such as marital status and employment are included, however, the picture becomes more complicated (see section on 'Multiple Roles, Gender and Health' below).

It might seem obvious that being a lone parent is more detrimental to health and well-being than being one of a two-parent family. Both Marsden (1973) and Evason (1980) found that the experience of living alone with children is a contributory factor in depression for women. Evason (1980) found, however, that this depression is closely related to income; mothers above the poverty line (40 percent above Supplementary Benefit level) are less likely to report symptoms of depression than single parents living in poverty (1980:57). She also found that employment protected lone mothers from depression. Graham (1986), in a study of 102 one and two-parent families, found that lone mothers may be at no more risk of isolation and stress than other mothers in low income thresholds. Parry (1986) found very little evidence associating single parenthood with psychiatric symptoms or psychological distress. She did not find single parenthood to be a source of strain due to financial hardship and lack of social support (cf. McLanahan 1983). On the other hand she did find that many of the married women in her working class sample suffered financial difficulties and a lack of social support despite their marital status. She argues that these results confirm Thoits' (1983) view that it is unwise for researchers to use marital status as a proxy variable for social support.

Comparing the health and illness of lone mothers and lone fathers might shed light on the competing hypotheses for gender differences in health. However, as only one in nine of single-parent families is headed by a man, there is less research in this area. Evason (1980) found that lone fathers are significantly less depressed than lone

mothers. While they are just as likely to be socially isolated, lone fathers are more likely to be employed, earning incomes which lift them and their children out of poverty. O'Brien (1982b) found that lone fathers did better if they felt they had *chosen* to be their children's main carers. As New and David (1985) wryly pointed out, 'no doubt mothers would too, if such a choice were offered' (p.229).

Clark et al (1987) examined the influence of domestic position (ie. age, gender, marital status, and childcare responsibilities) on health status. Both married and single men who are 41 or older report better health if there are children in the household. Women under 40 who are single and women over 41 who are single have much poorer health if there are children in the household. They describe this as the protective effect of children for men, or the health burden of children on women. Popay and Jones (1989), however, found that lone fathers reported worse general health and higher rates of recent illness than fathers in couples, and similar rates of recent illness as mothers in couples but higher rates of poor general health. In a study of gender differences in GP consultation rates, Briscoe (1987) found that although, overall, women had higher consultation rates than men, fatherhood was associated with increased consultations. Meininger (1986) also found the presence of children in the home to have a significant effect on the illness behaviour of men.

The relationship between parenthood, employment and health is also a complicated one and findings are inconsistent. In a study of married women with children, Welch and Booth (1977) found that mothers who had worked outside the home for more than a year were healthier than mothers not employed outside the home and mothers who had been employed for less than one year. Baruch et al (1985) found that women who scored highest on all indices of psychological well-being were women who were married, had children, and whose occupational status was high. Gove and Geerken (1977) found that, compared to employed mothers, non-employed mothers perceived more incessant demands on them, had more desire to be alone, were lonelier, and had more psychiatric symptoms. Aneschensel et al (1981) found that family and work roles tend to be associated with reduced depression among men and women. However, Cleary and Mechanic (1983) found that the strain associated with the

parental role is an important determinant of psychological distress for women employed outside the home.

Although employed married women experience slightly less distress than housewives, having young children in the household is especially stressful for the employed mothers and counteracted the advantage of employment. For housewives, Cleary and Mechanic (1983) found that being a parent and the number of children in the household is negatively related to depression (cf. Ross and Mirowsky 1988). Barnett (1982) also found no difference in well-being (role satisfaction and self-esteem) between employed and non-employed mothers with preschool children. These findings are in contrast to Ginsberg's (1976) findings that work outside the home becomes a source of self-esteem for many women in a society where status accrues to economic gain. The relatively low status attributed to the work of childcare can sometimes be internalised by women in terms of low self-esteem, which may be counter-acted by paid employment.

Brown and Harris's work on depression in women has made an important contribution to this debate (Brown and Harris 1978). They found that one-third of all women in their sample were suffering from a psychiatric disorder or were borderline in terms of accepted clinical criteria. Depression was concentrated among working class (23 percent) rather than middle class (6 percent) women; but working class women were only at higher risk of developing depression when they had children at home.

In explaining these findings, Brown and Harris view clinical depression largely as a social phenomenon and have developed a model which, in terms of the presence and absence of three factors, goes some way to explaining the aetiology of depression. The provoking agents influence when the depression occurs, the vulnerability factors whether these agents will have an effect and symptom-formation factors the severity and form of the depressive disorder itself. The provoking agents are described as loss, or threat of loss, and long term difficulty. These were not enough on their own to explain the social class differences in depression, since when working class and middle class women had a provoking agent, working class women with children were

still four times more likely to develop a depressive disorder (Brown and Harris 1978:278). Thus Brown and Harris developed the idea of vulnerability factors to explain this. These are: lacking an 'intimate tie' - someone to trust in, especially husband or boyfriend; having three or more children under the age of 14; loss of mother before the age of 11; and not having employment outside the home. They conclude that some of the social class difference in risk of depression is due to the fact that working class women experience more severe life-events and major difficulties, especially when they have children - particularly important are problems concerning housing, finance, husband, and child (excluding those involving health). But most of the class difference in depression is due to the greater likelihood of a working class woman having one or more of the four vulnerability factors, rather than due to their risk of experiencing a provoking agent (1978:279). In particular, employment outside the home halves the risk of depression among those with a provoking agent.

The Brown and Harris study also raises the issue of the number and age of children affecting the mother's health (although this also interacts with employment). More children means more health problems (Brown and Harris 1978, Verbrugge 1983a:28). Similarly, mothers with pre-school and school-age children have higher morbidity than mothers with teenage children (Rivkin 1972, Umberson 1989). In their study, Brown and Harris (1978) divided women into three groups according to the age of their youngest child at home; where the child is less than six, between six and 14, and 15 and over. They found that when a mother has a child under six *and* three or more under 14 living at home, she is particularly vulnerable; twice as likely to be disturbed as other women with three or more children under 14 and four times as likely than the rest of the women with a child at home (1978:152). This is consistent with other surveys of motherhood that have shown how the feelings of tiredness, loneliness and depression are very common among those who care for young children (Richman 1976, Graham and McKee 1980).

Parry (1986), however, did not find that the presence or absence of a pre-school child had any effect on the mental health measures she used. She suggests that this is

because her study excluded all mothers with a child under 18 months, and so the most demanding period of childcare is ending by this time (although this is highly questionable). In addition, Parry argues that the effect of postnatal depression is therefore excluded and she thinks that this might explain other research findings which report the presence of pre-school children as having a negative effect.

It is clear that the problems associated with the parental role are not uniform for all women, and neither do they perceive these problems uniformly. In answer to the question 'do you like looking after the child/children?', three-quarters of the working class women in Oakley's (1974) sample expressed ambivalence, while the same proportion of middle class mothers were definitely positive. Childcare and housework are inextricably linked but fundamentally opposed roles (Oakley 1974), so it is important to mention in this context the evidence of high degree of dissatisfaction that women have with these roles (Oakley 1974, Ginsberg 1976). Many women 'adjust' to this dissatisfaction by taking tranquilizers which:

> ...'permit' them to maintain themselves in a role or roles which they found difficult or intolerable without the drug (Cooperstock and Lennard 1979:335).

This may also explain the increasing rates of smoking amongst young women (Graham 1987).

Childcare, particularly of young children, is often very isolating (Hughes et al 1980:17) and in this isolation 'experiences become personalised, with problems seen as self-inflicted and failures seen as a cause for self-recrimination and blame' (Graham 1985:35). Women see themselves as continually and ultimately responsible for the health, development and happiness of their children:

> However much help a mother may get in bringing up her children, she is still likely to feel that she is the person beyond whom there is no recourse or appeal, and who is answerable for whatever happens (Hughes et al 1980:18).

The feeling of responsibility may have an effect (beneficial or detrimental) on a mother's health.

While it is important to show that mothering is a demanding, sometimes frustrating

and infuriating, occupation to counter the prevailing ideology that women do and *should* experience 'a sense of joy, pride and achievement in creating a nurturing and happy environment for their families' (Pringle 1980), it is important to remember that for many women, children provide a source of satisfaction which they are unable to achieve in any other part of their lives:

> They symbolise achievement in a world where under-achievement is the rule...they are the inalienable property of women, who otherwise are placed by society in a propertyless condition...and they make a women feel genuinely wanted (Oakley 1982:228).

It is these paradoxes that must somehow be assessed in any work on the relationship between mothering and health, and indeed, between fathering and health. For example, a recent study by Umberson (1989) stresses the importance of looking at the quality of the parent-child relationship as a factor influencing parents' psychological well-being.

Multiple Roles, Gender and Health

As I have already noted, the growing participation of women in the work force has raised concern about the effect of employment on women's health (Hibbard and Pope 1985). The early studies looked just at the effect of the occupational role on women's health, but later investigations explored the effect of the 'dual role' (paid employment and unpaid domestic work) on women's health. As we have seen, while some argue that employment has a protective effect, others have found that the strain of paid employment coupled with doing most of the work associated with raising children results in greater physical and mental health problems for women (Haynes and Feinleib 1980, Cleary and Mechanic 1983). These findings led investigators to look more closely at the effect of multiple roles and multiple identities on health. Unfortunately, most of this research is 'gender blind' because it either focuses only on the effect of multiple roles on women, thus ignoring men's roles as fathers; or it is concerned with the effect on multiple roles on people's health without distinguishing between women and men.

The roles encompassed by the phrase 'multiple roles' are marriage, employment, and parenthood. In their study of multiple roles, researchers have developed two

theoretical perspectives, both based on the human energy concept, which lead to opposite conclusions about the effect of multiple roles on women's (and sometimes men's) health. The scarcity hypothesis emphasises energy limitation and role strain, while the expansion hypothesis focuses on the gratification derived from accumulating diverse roles (Froberg et al 1986). Both of these frameworks are concerned primarily with *number* of roles rather than with specific role *types* and *characteristics*.

The scarcity hypothesis has been the dominant framework for investigating stress associated with multiple roles. It contends that because human energy is limited and people are faced with a wide array of role obligations, role strain - difficulty in meeting role demands - is normal. Role strain may be due to role overload (constraints imposed by time) or role conflict (discrepant expectations) or both. According to this theory as the number of roles increases, so does the potential for role strain, ultimately leading to a deterioration of physical and mental health (Froberg et al 1986).

The scarcity hypothesis has found only limited empirical support in the literature on women's multiple roles. Haynes and Feinleib (1980) found that women who had worked outside the home and had also raised three or more children were more likely to develop coronary heart disease (CHD) than housewives with the same domestic responsibilities. Waldron (1980) also found higher rates of CHD among full-time employed women than part-time workers or housewives.

The proponents of the expansion hypothesis challenged the scarcity hypothesis by suggesting that men's mental health advantage over women could be explained by their involvement in both family and work roles (Gove and Tudor 1973). By providing linkages to other persons and resources, multiple roles bring rewards such as privileges, status, security, self-esteem, and social relationships. Human energy resources expand to meet the challenges of multiple roles provided the roles are rewarding.

Empirical evidence is more supportive of the expansion than the scarcity hypothesis.

Verbrugge (1983a), for example, looks at the effect of multiple roles on physical health, including gender differences. She found that employed married parents tend to have the best health profile, while people with none of these roles tend to have the worst health profile. Of the three roles, employment has the strongest positive effect and parenthood the weakest. The combination of job and family roles has no special effect, positive or negative, on either women's or men's health. Although people with multiple roles tend to have the best health, this is due to the straightforward effects (1983a:25). Verbrugge suggests three possible reasons for these findings. First, social involvement may reduce risks of illness and injury. Job and family ties offer large emotional benefits and resources, which in turn may enhance physical well-being. Secondly, socially involved people may perceive symptoms less readily. Thirdly, the factor of social selection may be operating ie. those with poor health are less likely to be married, employed and/or parents. This was supported by the finding that people with 'no' roles have a poor health profile and as Verbrugge says:

> It is hard to believe that the absence of job and family ties changes health risks, attitudes and behaviours so drastically as to account fully for these people's poor health (1983a:26).

In contrast to the commonly held view, Verbrugge (1983a) found no evidence that combining employment, marriage and parenthood is harmful to women's and men's physical health. Other research in this area has looked at the effect of multiple roles on stress and psychological well-being (Kandel et al 1985, Thoits 1983). The functionalist position argues that the needs of the family and work require an allocation of incompatible roles; women are socialised to cope with the expressive needs of the family, while men are socialised to handle the instrumental world of work (Parsons and Bales 1956 quoted in Rossi 1968:28). This theory led to the belief that women who are employed, married, and mothers, are involved in potentially conflicting roles which would have a negative effect on their psychological well-being. Kandel et al (1985) argue that in contrast to this theory, the more recent notion of 'role strain' does not emphasise the contradiction between norms of family and work, but the role overload stemming from a combination of distinct roles that are not necessarily incompatible in their demands. It is this notion of role strain that is

tested by Kandel et al (1985).

In their study, Kandel et al (1985) give levels of self-reported depressive symptoms for women who occupy different roles. They found that strains and stresses are lower in family roles than in occupational or housework roles, but when they do occur they have more severe consequences for the psychological well-being of women. On aggregate, multiple roles are associated with *increased* levels of well-being. However, within this net result there are two opposing processes; multiple roles have beneficial effects on maritally induced stress, but are detrimental for stresses that result from paid employment.

These findings are supported by Thoits' (1983) study which, drawing upon symbolic interaction theory, investigates the relationship between multiple identities and psychological distress by comparing people with multiple identities to 'social isolates' (those with few identities). She did not find a curvilinear relationship between the number of identities and level of distress which would have suggested a role overload effect. She therefore concludes that multiple identities do not necessarily result in role strain.

The results from these three separate studies (Verbrugge 1983a, Kandel et al 1985, Thoits 1983) are in many ways surprising. However, these analyses may have overlooked more specific role combinations that are stressful and detrimental to health, and it cannot be ruled out that social selection acts as a factor (Verbrugge 1983a, Kandel et al 1985). In particular, the studies fail to acknowledge another role that women are increasingly being called to play, and that is as the carers of their elderly relatives (Finch and Groves 1980, EOC 1982b). The adverse affects of this caring role have been well documented (see eg. EOC 1980, Nissel and Bonnerjea 1983, Sainsbury and de Alarcon 1971).

Further, as Verbrugge (1983a) points out, the burdens and satisfactions that people experience in their roles - and how these influence health - need to be identified. She suggests the following objective indicators; number of constrained hours per week,

child dependency, and fraction of household income earned. Some possible subjective ones are; perceived time pressures, conflicts among roles, satisfaction with roles, sense of security, and voluntarism of employment status (Verbrugge 1983a:27). In other words, there is a need to look at the quality of roles as well as the kind and number of roles a person has (see also Froberg et al 1986, Baruch et al 1987, Popay and Jones 1989, Umberson 1989). As Baruch et al argue:

> Not all jobs are good for women - neither are all marriages, nor all parenting experiences (1987:134).

This is illustrated by the comparison of the anxiety levels of employed wives in Denmark, Finland, Norway and Sweden which found that only in Sweden is the mental health of employed wives good. Perhaps, as the author suggests, this is because of supportive social policies favouring women's work outside the home (Haavio-Mannila 1986).

A few studies have begun to consider these issues. Muller (1986a), for example, in a study of health and health care of employed women and homemakers suggests that it is not the number of activities that may be burdensome to women's health but the inability to choose one's roles and organise one's resources to meet their demands. Ross and Mirowsky (1988) have looked at the effect of parenthood on employed wives in terms of the type of childcare available, the difficulty of arranging childcare, and the husband's participation in childcare. Verbrugge (1983b) found that the degree of 'role burden', that is, of feelings of involvement and responsibility, as well as of role satisfaction, affects women's physical health. Barnett and Baruch (1985) found that women's reports of the quality of experience in roles, assessed by the balance between the positive and negative attributes they perceive, were more powerful predictors of stress indices and of psychological well-being than was role occupancy. A study by Umberson (1989) looked at the impact on parents' psychological well-being of both the quality of parent-child relationships and the level of demands placed by children on parents. Both were found to be strongly related. She also considered the factors which affect the quality of the relationship and the level of demands, such as age, marital status and sex of parent. Age of parent was positively related to quality of relationship, while divorced status was negatively related. The strongest

predictors of demands were sex and age of parents, with higher levels of demands for mothers than fathers, and an inverse relationship between age and demands.

Bird and Fremont (1991) hypothesise that women's higher morbidity levels result from less paid work and lower wages combined with more hours spent in household labour, child care, and helping others, and fewer hours of leisure and sleep. They argue that men and women have different social roles; men hold most of the highly rewarded roles. If social roles are operationalised as time commitments to various role-related activities, they found that when gender differences in social roles are controlled, being male is associated with poorer health than being female. Therefore they conclude that if gender roles were more equal, women would experience better health than men, more consistent with their greater longevity.

In their analysis of the General Household Survey, Arber et al (1985) distinguished between women in part-time and full-time employment, and between experiences of short-term and long-term illness. They found support for both the scarcity and the expansion hypotheses. The expansion hypothesis, that paid employment has beneficial effects on health combined with other roles, was supported for women without children, and for women over 40 with children. However, as there is evidence that ill-health reduces the likelihood of labour-force participation especially among women over 40, the direction of the relationship is unclear. When those reporting chronic illness were excluded, the association between being a housewife and poorer health (in terms of short-term illness) largely disappears. In contrast, the scarcity hypothesis, the strain of occupying multiple roles, was supported for women under 40 who work full-time and have children. These women reported higher levels of illness, although this was less clear among women working in professional and managerial jobs. The authors conclude therefore that full-time work for young mothers may be detrimental for their health, unless there are adequate financial resources to help with the burden of maintaining the multiple roles of housewife, mother and employee, or until the sexual division of labour in the home changes.

Clearly then our understanding of the relationship between multiple roles and health

is enhanced by looking in depth at the quality of roles and the context within which they are carried out. This understanding can illuminate our knowledge about gender differences in health.

Summary of literature on gender roles and health

What light does the literature on gender roles and health shed on the explanations of gender differences in health and illness? It does give some support to the hypotheses which emphasise that the different social roles which men and women have affect their health. The findings that women in paid employment have different health experiences to women not in paid employment may help explain why men and women have different health experiences. However, as I have already stressed, it is important that the context of these roles are taken into account. Similarly, Popay and Jones' findings (1989) that some lone fathers report more 'poor health' and higher rates of long-standing illness than men and women in couples, support the nurturant role hypothesis.

However, in order to 'explain', or at least find out more about gender differences in health, we need to know more about the processes which lie behind these findings. This was the intention of the present study. As I argued at the beginning of the section on gender roles and health, much of the literature on gender and health has ignored the relationship between social class and health. The final section of this chapter attempts to bring together the explanations for gender and class differences in health.

III GENDER AND CLASS INEQUALITIES AND HEALTH

Research on class inequalities in health among women reveals inconsistent findings, depending on the way women's social class is defined. To understand how occupational class is associated with women's health it is necessary to examine alternative ways of classifying women, and disaggregate women by activity status and marital status, since these are associated with health status. Just as the research on gender differences in health has had a 'social role' focus and ignored material

dimensions, research on differences among women of different classes has not taken account of social roles.

There is a roughly similar class gradient in mortality for men and married women classified by their husband's occupational class, but the differentials for married women are slightly less (Townsend and Davidson 1982, Whitehead 1987). There has been some work on women's mortality classified by their own occupation, although this is problematic since there is a dearth of information collected about women's occupational status at death registration. The UK census collects information on the current occupation of women who are economically active, but unlike men not in paid employment, housewives are not asked about their most recent job. In the OPCS Longitudinal Study, 62 percent of women aged 15-59 can be assigned a class based on their own occupation. These data show a weaker mortality gradient for women than for men, but a clear difference between manual and non-manual occupations (Moser and Goldblatt 1985). Unlike men, there is no gradient *within* either non-manual or manual classes. However, no distinction was made between different marital statuses or whether the woman was working part-time or full-time.

There has been very little other work on mortality differences based on women's own occupation. In comparison of women's occupational mortality in Scandinavia, Lynge and Andersen (1985) found smaller differentials between occupational groups for women than for men. But these smaller differentials for women are difficult to interpret because they refer to all women in employment regardless of family status and hours of work. These factors influence the nature of women's labour force participation and therefore the likely degree and pattern of health inequalities, as noted in the section of gender differences in health.

In the UK, research on differences in morbidity among women has primarily used the 'conventional' approach of defining women in terms of their husband's occupation. This approach reveals comparable, or slightly smaller, health differentials for women than for men. It has the advantage of classifying all women, unlike other studies of mortality which only analyse women in certain marital statuses or only analyse

employed women. It has all the disadvantages already described above.

Arber (1986) argues that the most appropriate occupation-based measure of class for studying inequalities in health is to use the class of the occupationally 'dominant' member of the household, as Erikson (1984) has suggested. The reasons for this are both theoretical and empirical. The theoretical question is whether life chances, in the form of health, are primarily determined by the actions and experiences of the individual woman in the labour market, or are to a greater extent influenced by the social and material circumstances of the family. Arber concludes that in a structural model of society, the primary measure of class must be a household-based measure of social class (1986:6).

The empirical question is which measure is the best discriminator in terms of distinguishing the healthy from the unhealthy. Using data from the GHS, Arber found that the 'dominance' approach produces steeper class gradients in health for both married men and women. The advantage of this approach is that it is applicable to all households and is not gender-biased. In addition, the wife's occupational class was shown to have a clear impact on the husband's health, irrespective of the husband's class. Arber concludes that findings from the 'dominance' approach and from the cross-examination of husband's and wife's class on health lend support to structural materialistic explanations of health. Health status is influenced by the class position of the household which is the result of the combination of the roles of both spouses in the labour market (1986:7).

Because of the problems of using occupational social class for women, Moser et al (1988) looked at women's mortality differentials in the OPCS longitudinal survey using a combination of indicators. These included information on marital status, own occupation (if married), economic activity and indicators of household wealth (housing tenure and access to a car). They found that high mortality was associated with working in manual occupations and living in rented housing with no car in the household. In contrast, low mortality was associated with non-manual occupations and living in owner occupied housing with a car. Among married and single 'unoccupied'

women, the disadvantaged women (rented housing, no car) experienced death rates two and a half times that of the advantaged group (owner-occupiers with a car). Smaller differences were found among married 'occupied' women. Moser et al conclude that these differences in women's mortality provide further evidence of the 'health divide' in England and Wales, and that to reflect accurately the relation between a woman's life circumstances and mortality it is necessary to utilise other measures than those based solely on occupation (1988:1224).

Conclusion

A review of the literature on gender and class inequalities in health has clearly highlighted the need for a *qualitative* study to uncover the processes behind gender differences in parenthood, health and illness. As Kandrack et al have argued:

> The question centres around whether more tinkering with existing methods will get us over the impasse that characterises the study of gender differences in health, or whether a significant refocussing of efforts is needed...Our methods and theories seem incapable of taking us beyond rudimentary statistical findings. We must now ask: should we continue with the present line of inquiry? (1991:588).

The present line of inquiry needs to take account of the effect of differences in social roles and material resources. As Arber has argued:

> There is a need to integrate the insights from role analysis within a structural framework (1991:425).

This study takes into account these issues and the way it does so is described in the following two chapters.

CHAPTER TWO

METHODS I : METHODOLOGY AND RESEARCH DESIGN

> We might attempt to develop *for* women analyses, descriptions, and understandings of their situation, of their everyday world, and of its determinations in the larger socioeconomic organisation to which it is articulated...This is to constitute the everyday world as problematic, where the everyday world is taken to be various and differentiated matrices of experience - the place from within which the consciousness of the knower begins, the location of her null point (Smith 1979:173, her emphasis).

Introduction

This chapter outlines the research methodology and research design employed in the present study, in the light of the background debates and theoretical issues discussed in Chapter One. First, the epistemological framework and methodological issues are defined and discussed. Secondly, the criteria used for selecting the study group are outlined. In the third section there is a description of the methods of data collection.

I THEORETICAL FRAMEWORK AND METHODOLOGICAL ISSUES

This is a small-scale study of 30 working class mothers and fathers using (i) repeated semi-structured interviews, (ii) health diaries and (iii) field notes to examine the relationships between gender, parenthood and health. The key methodological issues are: why a qualitative methodology was chosen; how the study is based on a feminist epistemology of knowledge; how it defines and measures health and illness; how it operationalises the concept of social roles; and how it combines qualitative and quantitative methods.

A. Why a Qualitative Study?

Most of the work that has been carried out on gender differences in health reviewed in Chapter One has been secondary analysis of large-scale health surveys (such as the Health Interview Survey in the US) or of other surveys which include some questions on health, such as the General Household Survey in the UK.

This work has been useful to some extent in providing a broad picture of gender

differences in health. However, as Clarke has argued:

> Despite the plethora of studies on sex and illness, one would have an exceedingly difficult task should one want to describe the differences in the morbidity experiences of men and women...[and]...when explanations as to the supposed differences are offered, the confusion mounts (1983:63).

More recently, as quoted in Chapter One, Kandrack et al (1991) have criticised the lack of clarity afforded by cross-sectional secondary data analysis.

In most of the empirical research reviewed in Chapter One, women and men are treated as two distinct categories and, moreover, each is treated as a homogeneous unitary group. To speak of differences between women and men, while ignoring differences of social class and ethnic identity as many of the studies do, is a fundamental flaw. As Brown and Harris argue, demographic group comparisons of themselves are not enough:

> What is required is their combination with concepts and measures dealing directly and in detail with the immediate (not necessarily contemporaneous) experience of the individual (1978:11).

In an attempt to 'resolve the impasse characterising the study of gender and health' (Kandrack et al 1991:588), I designed a qualitative, small-scale study to document the health experiences of mothers and fathers of young children by taking women's and men's '*lived* experiences' (McBride and McBride 1981:41) as the starting point. The study would thereby be able to analyse the processes which could help explain the differences and similarities found between the mothers and fathers.

B. A Feminist Methodology

The theoretical framework of the study, placing people's lived experiences at the centre, is based on feminist approaches to social research and ethnomethodological theory. The feminist position is best summarised by Rose who argues that:

> Within feminist theoretical production, the living participatory 'I' is seen as a dimension which must be included in an adequate analysis. (1981:368).

However, the tenets of ethnomethodology include eliciting the taken-for-granted assumptions and practices of everyday life and questioning and deconstructing them in the analysis (Hammersley and Atkinson 1983). This means problematising the everyday and questioning the obvious (Douglas 1971).

This reveals a tension in qualitative methodologies between putting the interviewees' explanations and interpretations at the fore and the researcher's role of analyzing these explanations and interpretations, while at the same time staying 'true' to the interviewees. The role of a sociologist is not only to describe what individuals say or do but also to make some judgement about the data as a whole, which the individuals themselves are unable to do. These judgements or explanations can be called the researcher's 'own imposition of meaning' and they can be empirically tested by seeing if they do in fact explain the data and if they can predict action (Oakley 1980:111). The researcher's 'own imposition of meaning' can also be important in highlighting:

> ...the essentially exploitative character of structures in which they [interviewees] are located (Finch 1984:84).

An important feminist contribution to the ethnomethodological notion of problematising the everyday is provided by Dorothy Smith (1979). She argues that a sociology for women should be based on everyday life as there is no theory that does not begin within the minute details of everyday existence (see quote at the top of this chapter).

This is similar to Silverman's (1985) arguments about the link between micro and macro research. He argues that micro research does not necessarily lack a macro or societal perspective. In the first place he argues that researchers need to take into account the broader social context within which the face-to-face interactions occur. Secondly, small-scale qualitative research can raise the broadest micro issues. Silverman (1985) quotes as an example a study by the anthropologist Mary Douglas (1975) whose work on the cultural universe of a Central African tribe enabled her to develop a theory about why some societies celebrate anomalous beings from the animal world and others place injunctions on them.

Why include men? How I am using a feminist methodology

Most of the literature on gender differences in health and illness is based on data collected from women on both their health and their partner's health, that is, by proxy. It is well known that proxy respondents tend to underestimate the morbidity

of the other person (Nathanson 1977). Therefore it seemed important in a study of gender differences in health to find out how men report their health. However, there are also theoretically-based reasons for including men.

Until now, most of the sociological work informed by the feminist perspective has focused on women in an attempt to redress the balance and make women 'visible' in sociology (eg. Oakley 1974, Ginsberg 1976, Finch and Groves 1983). More recently a few researchers have begun to look at men as fathers (eg. McKee and O'Brien 1982, Beaile and McGuire 1982). But as David Morgan has pointed out:

> We know more about wives and mothers than husbands and fathers; if the former are obscured from our vision by being too far in the background, the latter are obscured from our vision by being...too much in the foreground (1981:94).

Thus it was important to 'take gender seriously' (Morgan 1981) by including men not just as a matter of principle but because, by looking at gender differences in perceptions of health, health status and 'illness behaviour' of mothers and fathers, it would be possible to shed light on the broader sociological questions of gender relations and how they are organised in our society in the late twentieth century. In addition, in Chapter One I referred to Eichler's (1988) argument that it is 'gynocentric' to exclude men in their role as fathers from studies of the family. Further, if feminist research is to create a sociology *for* women rather than *of* women (Smith 1979), then men need to be included, particularly in studies of the private world of the home and the family, in order to highlight women's experiences. It is difficult to illustrate gender inequalities within households, if men are not included as research subjects.

C. Defining and Measuring Health and Illness

As the present study is based on people's 'lived experiences', it requires a broad definition of health, based on the World Health Organisation's (WHO) definition of health, and encompassing all aspects of physical and mental well-being, not just the absence of disease:

> A state of complete physical, mental and social well-being and not merely the

absence of disease or infirmity (WHO 1990:1).

This definition has its staunchest supporters and critics. It has been criticised for being utopian and impossible to operationalise (Cooperstock 1978), while others have argued that at least it underlines the fact that health is a multi-dimensional phenomenon (Hansluwka 1985), and some see it as a challenge (eg. Breslow 1972, Uemura 1984 both cited in Hansluwka 1985:1215).

The WHO has attempted to operationalise its original definition with the 37 targets in its goal of 'health for all by the year 2000' (WHO 1980, 1981). The WHO has tried to clarify its original definition, conceiving health as:

> The extent to which an individual or group is able, on the one hand, to realise aspirations and satisfy needs and on the other hand, to change or cope with the environment. Health is therefore seen as a resource for everyday life, not the objective of living; it is a positive concept emphasising social and personal resources as well as physical capacities (WHO 1981:15).

Expressed in this form, health is a complex concept and the growing acceptance of the social model of health has meant that health has become harder and harder to conceptualise. Further, this model leads us to measure something that is determined by the value of the society or social group concerned. Thus a universal concept of health is not only impossible to achieve, but it is also undesirable because it would exclude the differential experiences of social groups within society.

'Illness Behaviour'

The concept of 'illness behaviour' arose out of the critiques of the Parsonian model of the sick role (see Arluke et al 1979), and from the evidence of several empirical studies. Prior to the development of this concept, it was assumed that the majority of people perceived themselves as being normally healthy; while a minority were assumed to be equally aware that they were ill and would therefore seek help. This assumption began to be questioned (eg. Zola 1973) and surveys showed that the prevalence of ill-health was high throughout the community; the existence of signs and symptoms of ill-health throughout the population being the norm (eg. Wadsworth et al 1973).

These findings suggested that 'non-medical' factors may be influencing both the individual's perception of ill-health and the subsequent decision to seek medical care. It is the study of the individual's perception of and reaction to clinical disorder that has been described as 'illness behaviour'. Mechanic (1968) defined illness behaviour as:

> The way in which symptoms are perceived, evaluated and acted upon by a person who recognises some pain, discomfort, or other signs of organic malfunction (cited in Morgan et al 1985:78).

Traditionally there are two groups of approaches to the study of illness behaviour. The first are the *individualistic* approaches which have led to the development of a number of socio-psychological models of illness behaviour (eg. Mechanic 1962, 1968). The second are the *collectivist* approaches which have emphasised the differences in the values and attitudes to health among social groups which have implications for illness behaviour, as well as the particular social and situational forces which prompt or delay professional help-seeking. Examples include the studies of the role of cultural factors in explaining differential illness behaviour by Zbrowski (1952) and Zola (1966); the role of 'significant others' (Friedson 1970), and the influence of socio-economic status (eg. McKinlay 1972).

There have been major theoretical criticisms of the traditional approaches to illness behaviour which have come from those who favour the interpretist approach. This approach does not regard lay beliefs as in any way inferior to medical beliefs (eg. Helman 1981, Blaxter and Paterson 1982, Cornwell 1984). Many studies have assumed that medical explanations have a unique access to the truth, and so lay theories of illness are regarded as inferior to medical ones. These criticisms have resulted in some questioning of the basic assumptions of the traditional study of illness behaviour, and have led to an emphasis on questions such as 'what are health and illness?' 'Illness' and 'disease' are now regarded as two distinct, often conflicting concepts. Whereas 'illness' refers to subjective feelings of discontent experienced by the individual, 'disease' refers to the signs, symptoms and behaviours regarded by doctors as pathologically abnormal (Tuckett 1976). A person may think they are ill, while a doctor does not define them as diseased. Similarly, a doctor may define a patient as diseased while the patient regards him/herself as healthy. More recently

studies of illness behaviour have concentrated on the way people make sense of their body and bodily disturbances.

The present study takes an interpretative approach looking at parents' subjective perceptions of their experiences of health and illness. One aim of the study was to look at issues of positive health as well as illness. Thus as well as details about their illnesses or health problems, parents were asked 'do you ever feel really healthy?' Similarly, the study incorporates health as well as illness behaviour, so that parents were asked about diet, exercise, and other issues they might see as affecting their health either positively or negatively. Illness behaviour included visits to the doctor but also informal health care practices such as taking over-the-counter medicines, 'taking it easy', advice from friends and so on (see Appendix D for interview schedules).

Measuring Health and Illness

There are developments on three fronts in relation to measuring health and illness: (1) measurement and functional impact of 'ill-health'; (2) development of subjective health indicators; and (3) a shift from an indicators towards a 'characteristics' approach. 'Functional' indices focus on people's ability to function in their role and their capacity to carry out a variety of activities in their social, domestic and personal lives. There is a considerable movement towards such indices on the grounds that not only are they easier to measure, but they also represent a more social and holistic concept of health. Examples include the Sickness Impact Profile (Bergner et al 1981) and the Activities of Daily Living Measure (Katz and Akpom 1976). Moreover, there is evidence to suggest that 'function' represents an important aspect of lay concepts of health for some groups. For example, the working class women interviewed by Blaxter and Paterson (1982) defined health as 'being able to carry on' and 'being able to do my work'. The disadvantage of such functional or sickness impact measures is that different social groups have different levels of illness behaviour. Thus to describe the working class women in Blaxter and Paterson's study as 'healthier' than another group who are maybe more willing (and more able) to 'give in' to an illness would be inaccurate. Therefore, particularly for the study of inequalities, differences in

social values, circumstances and cultural norms confuse the interpretation of behaviourally manifested health states (Blaxter 1985).

Subjective health indicators differ from functional indices in that they emphasise the respondent's feelings rather than behaviour. These have appealed especially to feminist writers who are critical of the dominance of so-called 'objective' and 'scientific' observations which are often anything but objective and scientific (Ehrenreich 1974). Feminists see subjective measures of health as valid in themselves, and part and parcel of the vital task of challenging 'expert' definitions (whether they be male doctors or male sociologists) of women's experiences. They argue that the starting point of all health efforts should be that of describing the subjective, everyday 'lived experience' (McBride and McBride 1981).

Examples of a subjective health indicator include the Nottingham Health Profile (NHP) (Hunt et al 1986); the General Health Questionnaire (GHQ) (Goldberg 1978); and the Medical Outcomes Study Short Form (MOS-Short Form) (Stewart et al 1988). The NHP assigns uniform weightings to indicate the severity of disfunction, so it is questionable whether it provides a true reflection of lay people's subjective perceptions and evaluations of health (Morgan et al 1985:41). The GHQ was developed for the community screening of psychological problems and has been found to be effective in detecting mental health problems, although not their severity (Bowling 1988). The MOS Short Form was designed for use in surveying general health in clinical practice and research, health policy and evaluations, and in general population surveys. It assesses eight health concepts: limitations in both physical and social activities due to health problems; limitations in usual role activities due to physical health problems; bodily pain; general mental health (psychological distress and well being); limitations in usual role activities due to personal or emotional problems; vitality (energy and fatigue); and general health perceptions (Stewart and Ware in press).

Lastly, there has been a shift away from the obsession with indicators towards the 'characteristics' approach, organising the information into a 'health profile'. The

advantage of this approach is that it recognises the complexity of health status measurement, and Hansluwka (1985) suggests it may lead to a more carefully planned and organised array of data from which one can select and rearrange the data and transform them into 'indicators'. Further, since this approach demands precise specification, it may facilitate more accurate interpretation (Hansluwka 1985).

It is clear from this brief overview that measuring health and illness is fraught with theoretical and methodological difficulties. The search for a universal measure of health and illness is misdirected for two main reasons: different measures are needed depending on the purpose for which they are required and the audience that will make use of them. Secondly, different measures are needed to take account of different social values and cultural norms.

The broad definition of health employed in this study informed the way data on health and illness were collected and 'measured'. As the aim of the study was to explore the processes behind gender differences in health it was not appropriate to use any of the measures or indices I have discussed above, because I needed to listen and record parents talking about health and illness in their own words. However, data were collected on measures such as doctor visits and so on. Further, health diaries collected data on subjective perceptions of health status and experience of health problems and actions which were used as 'measures' of health and ill-health (see section on 'Qualitative-Quantitative Methodology' below).

D. The Concept of Social Role

The term 'social role' has been used extensively in the literature on gender and health. Researchers have attempted to explain gender differences in health and illness by the different roles which women and men perform (see Chapter One). However, the term 'social role' is rarely defined in this literature. One notable exception is a paper by Popay and Jones (1989) which outlines the history of the use of the term and calls for its reconceptualisation within a broader theoretical framework. The authors, drawing on work by Ralph Dahrendorf, begin by distinguishing between social position and social role. The former represents points in a field of social relations,

whilst the latter represents society's demands in terms of behaviour, appearance and character expected of the holders of a particular social position (Popay and Jones:1989:3). The individual must fulfill these demands as they cannot be ignored or rejected without 'sanctions' being applied which could harm the individual in some way. Implicit in this definition also, is that the definition and redefinition of the social role is determined by 'society' rather than by the individual. Thus, argue the authors, this concept of social role provides a descriptive label such as 'mother', 'father', 'housewife', 'paid worker' which is the way it is used in much of the research on gender roles and health.

Popay and Jones go on to summarise the two main criticisms of the use of the concept of social role: its association with functionalism; and the feminist critique of sociological concepts which derive exclusively from the public domain. Functionalist theories were based on the assumption that all social roles were taken up and retained voluntarily. Gender roles were seen as not only descriptive but prescriptive - that is, the way things should be in order for society to function effectively. These assumptions were criticised for ignoring the issues of inequalities of power between men and women and between different social classes.

Feminist sociological analyses were critical of concepts, including 'social role', which did not take into account the private domain. For example, work roles referred to paid work in the public domain, but ignored the unpaid work which women do in the home (Oakley 1974). Feminists have attempted to redress the balance by focusing on women's work ie. housework and childcare in the private domain (see eg. Land 1978, Boulton 1983, Ungerson 1983, Finch and Groves 1983). Popay and Jones warn, however, against the dangers of focusing exclusively on the private domain, and argue that the concept of social role could be used to analyse processes in both the public and private domains (1989:7). They reconceptualise the concept by analysing three dimensions of role demands they term labour, responsibility and performance, with reference to roles in both the public and private domains. They argue that the concept of social role must take into account the wider social relations within which the roles are located. Thus while women may share some common aspects of the

social role of 'mother', they will also have different experiences as mothers due to wider social relations of class, race, age, and so on.

The concept of social role in the present study attempts to cross the public-private divide by considering both women and men in their public and private roles, that is, as mothers and fathers; as paid and unpaid workers. An important aspect of the concept of social role is the ideological 'baggage' attached to it. In Chapter Seven therefore, the effects of parents' ideas about parenthood on their beliefs about the way it affects their health are explored. However, the concept of social role is also materially based, as it takes into account the resources available for an individual to perform her/his social role. Chapter Six considers the relationship between material and social resources and parents' health.

E. Qualitative-Quantitative Methodology

As Faraday and Plummer (1979) argue, the selection of the research methodology should always be determined by the goals of the research and the theories on which it is based. One of the early choices a researcher often has to make is whether to use a quantitative or qualitative methodology. These are usually seen as two distinct paradigms, which, theoretically, are incompatible (Brannen 1990).

The goals of the present study, and the theories on which it is based, determined that a combination of qualitative and quantitative methodologies were used to provide a richer and more illuminating data set.

Considerations of everyday processes, negotiation, practice and understanding involving nuance, subtlety, ambiguity and contradiction cannot be explored without sensitive, flexible and reflexive research tools. Hence indepth methods were chosen in order to elicit these everyday processes. A one-off interview, however 'indepth', would not be able to get beyond interviewees' 'public accounts' of their lives (Cornwell 1984, Backett 1990). Secondly, a longitudinal approach would enable me to look at the processes of change and how this affects health. Thirdly, I wanted to collect data on experiences of health and illness not just retrospectively but as they

occurred. Of course, unless I were participant observer, all accounts of experiences of health and illness would be retrospective to a degree, but less so if I were to conduct a longitudinal study as opposed to one-off interviews.

All this points to a qualitative rather than quantitative methodology. But there are good theoretical arguments for using a combination of methods. As Graham (1983) points out, quantitative research is seen to represent 'the male style of knowing' in its claim to be impersonal and objective, and in its compatibility with the masculine ethos of the public domain where it is usually used. In contrast, qualitative research has been labelled 'feminine' (see Oakley 1980:110); researchers adopt a more personal, subjective approach, working in the private world through categories, which appear to be more difficult to quantify. The critique of quantitative methods has led to a sexual division of research whereby qualitative methods are thought to be better suited to the structure of women's lives, while quantitative methods are reserved for the study of (and by) men (Graham 1983:136). This division, Graham argues, reinforces the tendency to analyzes women's and men's lives separately and:

> The wholesale adoption of qualitative research by and for women may thus reinforce the very divisions that feminists are seeking to destroy (1983:136).

Oakley (1980) has discussed the criticisms made of combining the two different approaches. She argues that where purely qualitative methods have been employed such as by the Chicago School in the US, they have been regarded as a valuable contribution. Criticisms have been made, however, when these 'feminine' methods have been combined with 'masculine' methods such as the use of statistical tests on small samples and the use of rating scales:

> Where the research has a 'feminist' orientation, the status of such a 'masculine' methodology is...in doubt (Oakley 1980:111).

As I aimed to study both women's and men's lives in their public and private worlds bringing together the micro and the macro, I used both methods. Thus in the present study the qualitative approach allowed interviewees' own interpretations and explanations to be recorded, and the quantitative approach could indicate the extent and patterns of inequality (see Brannen 1990:24). In fact, although qualitative

methods have been preferred by feminists, there is a history of the use of such methods by men, notably the Chicago School, which does not have a feminist stance.

It has been argued that the distinction between the qualitative and quantitative methodologies is an artificial one. Silverman (1985), for example, stresses the importance of simple counting procedures in qualitative research:

> Such counting helps avoid the temptation to use merely supportive gobbets of information to support the researcher's interpretation. It gives a picture of the whole sample in summary form, highlighting deviant cases and encouraging further qualitative analysis of regularities (p.17).

The use of quantitative techniques in the analysis of qualitative data is an example of where the two paradigms overlap. However at other levels, notably that of epistemology, there are differences as well as similarities (Brannen 1990). The main differences are summarised by Brannen and concern how, in theory, each paradigm treats data, data collection and data reporting.

The quantitative definition of data is the variables and variable categories which have been isolated and defined. These variables are chosen on the basis of certain hypotheses, developed before the study has begun, concerning the relationship between variables. In contrast the qualitative approach isolates and defines categories (rather than variables) and, as the research progresses, these categories are expected to change their nature and definition. For the former, variables are the vehicles or means of research while, for the latter, they are the product or outcome.

With regard to the collection of data, the two paradigms use quite different instruments. Whereas in the qualitative tradition, the instruments must be flexible and reflexive, in the quantitative tradition, the instrument is pre-determined and cannot be altered in the course of the study. As Brannen notes:

> Where questions for which data are sought allow respondents to respond readily and unambiguously to closed questions, a quantitative approach may be preferred. By contrast, where questions are likely to cause greater difficulty and imprecision, qualitative techniques may be called for (1990:3).

The third difference of data reporting concerns questions of inference and generalisability. In quantitative research the purpose is to discover how many and what kinds of people in the general or parent population have a particular characteristic. In qualitative research, however, the aim is to discover the categories and assumptions, not the just the incidence and frequency of particular characteristics.

The issue underlying the differences between these two paradigms is said to be their logic of enquiry, analytic or enumerative induction (the hypodeductive method). This distinction has been discussed at length by Denzin (1970), Hammersley and Atkinson (1983) and Mitchell (1983), but was explained by Znaniecki some sixty years ago:

> Enumerative induction abstracts by generalisation, whereas analytic induction generalises by abstracting. The former looks in many cases for characters that are similar and abstracts them conceptually because of their generality, presuming that they must be essential to each particular case; the latter abstracts from the given concrete case characteristics that are essential to it and generalises them, presuming that insofar as they are essential, they must be similar in many cases (Znaniecki 1934:250-1).

Although they have different starting points, Brannen (1990) argues that qualitative and quantitative both involve inductive and deductive reasoning. Quantitative research, for example, needs to go beyond statistical correlation and issues of representativeness to link two characteristics together in order to develop causal explanations. The relationship between two characteristics is a logical one and is not linked to representativeness or typicality (Mitchell 1983).

In practice, therefore, the distinctions between the two paradigms are not so clear cut. Qualitative researchers do not begin without any ideas about what they might find (ie. hypotheses). They are influenced by their prior knowledge of the literature, their own cultural assumptions and so on. The basis of the present study, for example, is the hypothesis that mothers and fathers have different (as well as similar) experiences of health and illness. However, the goals of the present study meant that the two methodologies were also explicitly combined in ways described below.

Combining qualitative and quantitative methodologies

a) Multiple methodologies

While the qualitative and quantitative approaches have been seen as two distinct paradigms, there are a number of researchers who have encouraged the use of 'multiple research strategies.' (Burgess 1982). According to this view, field methods that do not encompass observation, informant interviewing and sampling are seen as narrow and inadequate. The argument is that researchers ought to be flexible and therefore ought to select a range of methods that are appropriate to the research problem under investigation (Burgess 1984).

Thus in the present study I employed three different methods of data collection: semi-structured interviews, health diaries and field notes (see below for a detailed description of these methods). The reason for using different methods was to gain different versions of similar phenomena, not to reach some ultimate 'truth' through what Denzin (1970) has called the 'triangulation' of methods. Data collected from interviews might contradict data collected from the health diaries. For example, a father might say in an interview that he was in very good health and had few health problems. In his health diary, however, he might record a high level of health problems. This would not constitute a research *error* but a *finding*, because, as Silverman (1985) argues, actions and accounts are 'situated'. The sociologist's role is not to make judgements between interviewees' competing versions but 'to understand the situated work that they do' (Silverman 1985:105).

b) Open-ended and closed questions

Similarly, within each method a combination of qualitative and quantitative methods were employed. Both the interviews and the health diaries contained open-ended and closed questions. Once again the purpose of this was to tap different accounts and elicit contradictions. This can be illustrated with reference to the interviews. As this study is theoretically guided, it was not appropriate to have no interview structure whatsoever. A degree of structure is required for the researcher to be able to follow through issues, which her/his theoretical perspective suggests are likely to be important and which interviewees might not spontaneously cover, especially with such

a 'taken for granted topic such as health' (Backett 1990:64-5). However, it is also important to allow for and encourage the emergence of data suggesting a different theory. This is the essence of what Glaser and Strauss have called 'the discovery of grounded theory' (1967). It also allows the interviewer to ask questions, particularly about the obvious, which complete interviewee story-telling does not so readily allow. Thus in my study the first interview was quite structured, although it contained a number of open-ended questions, but the second and third interviews were much less structured. I did not decide what to ask in these follow-up interviews, until the previous ones had been completed. Although it has been argued that open-ended interviews allow interviewees to use their 'unique ways of defining the world' (Denzin 1970:125), it is also, as Hammersley and Atkinson (1983:110-11) have pointed out, somewhat naive to assume that open-ended or non-directive interviewing is not in itself a form of social control that shapes what people say.

c) Sampling methods

A combination of the qualitative and quantitative paradigms were used to determine sampling methods. The differences between the two paradigms in terms of analytic and enumerative induction mean that they have different approaches to sampling. Qualitative research often, though not always, employs theoretical sampling while quantitative work usually employs statistical sampling. The main issue in theoretical sampling is theoretical relevance. In statistical sampling the issue is representativeness and the inclusion of features of the context, which need to be taken into account because they are expected to vary systematically in the population under consideration, eg. social class. However, it could be said that sampling strategies based on social class, for example, do have a theoretical basis.

The sampling method in the present study was statistical in that families were chosen at random from a sampling frame (health visitor lists), but was 'theoretical' in that the families had to fulfil certain criteria: working class, two-parent family with one child aged between one and three years (see below for the reasoning behind these criteria). It was not theoretical sampling in the sense of a sample that includes a very diverse range of what one is attempting to study, in order to look at the similarities

and differences within the group to gain the variable dimensions of processes common to all of them (Mason 1987:109, Silverman 1985:113).

This argument for selecting a well defined group and looking for the similarities and differences within that group has also been put forward by Backett (1990). In her study of health within families, she chose to use two-parent, middle class parents with two children, because:

> ...by putting such careful controls on the small sample a degree of consistency in explanatory theories could be achieved (1990:68).

In exploratory research of this kind, the focus is on what happens to that particular chosen group of people, rather than on whether or not the patterns or processes discovered in this group are representative of society as a whole (see Mansfield and Collard 1988:40). However, this does not mean that the selection of such a study group need only be arbitrary and that the findings have no relevance outside those particular individuals. From my analysis of the study group, I attempted to identify the themes or processes which might themselves be generalisable because their mechanisms and components could be systematically documented. This is the essence of the validity of *process* (see also Mason 1987).

d) Presentation of data: using case studies

I have discussed how qualitative and quantitative methods of analysis may overlap. Sometimes, for example, it is important to aggregate qualitative data so that it can be described overall. However, given that the focus of this study is also on *processes*, these can make little sense when chopped up or boxed. Another way of analyzing and presenting qualitative data is in the form of case studies.

Case studies can take a variety of different forms (see Mitchell 1983) but in this study I used case studies in two main different ways. First, case studies are used to illustrate the categories, which I had developed from the data. Here it is important not to fall into the trap of what Faraday and Plummer refer to as 'verification by anecdote' or 'exampling' whereby:

> The sociologist's own story is given spurious support by the careful, judicious selection of examples drawn from the subjects who were interviewed; the sociologist provides little justification or accounting as to why he or she selects some quotations and not others (1979:787).

Thus it is continually important to check and re-check with the data that the categories are exhaustive. The case studies used in these instances may be short quotations or longer stories told by the interviewees.

Secondly I used what Mitchell (1983 after Gluckman 1961) describes as 'extended case study', which:

> ...deals with a sequence of events sometimes over quite a long period, where the same actors are involved in a series of situations in which their structural positions must continually be re-specified...the extended case study enables the analyst to trace how events chain on to one another and how therefore events are necessarily linked to one another through time (1983:194).

In a longitudinal study this last point is particularly important. To adopt this approach is to follow inductive rather than enumerative logic, because the use of a case study is not dependent on its representativeness of the whole group in terms of social characteristics, but rather on its particular capacity to identify a theme or process whose incidence and boundaries can then be traced for the whole group. As Mitchell argues:

> The extrapolation is in fact based on the validity of the analysis rather than the representativeness of the events (1983:190).

This type of case study is used in Chapter Six where particular parents are used in case studies to explore the complex relationships between material and social resources and health, and again in Chapter Eight. The cases were chosen not for their 'typicality', but rather because they did not fit the original pattern of relationships. From careful analysis of cases that do not 'fit' much can be learned about the processes overall. As Mitchell explains:

> There is absolutely no advantage in going to a great deal of trouble to find a 'typical' case; concern with this issue reflects a confusion of enumerative and analytic modes of induction. For general purposes, any set of events will serve the purpose of the analyst if the theoretical base is sufficiently well developed

> to enable the analyst to identify within these events the operation of general principles incorporated into theory. However there is a strategic advantage in choosing particular sets of events for study or exposition. It frequently occurs that the way in which general explanatory principles may be used in practice is most clearly demonstrated in those instances where the concatenation of events is so idiosyncratic as to throw into sharp relief the principles underlying them (1983:204).

II CRITERIA FOR SELECTION

There were five main criteria for selecting the study group. The families had to consist of two working class parents with one child aged between one and three years. They could be of any nationality or ethnic origin, although they had to be able to speak English and should have no major chronic health problem or disability. The reasoning behind these criteria and how they were operationalised is discussed below.

1. Family type

As the focus of the study is gender differences in experiences of health, the study group needed to contain equal or near equal numbers of women and men. Originally I had wanted to include one- and two-parent families in the study. However, it would have been difficult to obtain equal numbers of female and male one-parent families with young children, as the numbers of single male-headed households with young children are so small; in 1987 (the year data were collected) lone mothers formed 12 percent of all families with dependent children compared with the figure of one percent for lone fathers (*GHS* 1989). Thus the study group was restricted to two-parent families.

The category 'two-parent family' is not as straightforward as at first it might appear. Family structures are very fluid - children move from one- to two-parent families with some frequency (Kiernan and Wicks 1990). Further, a mother might define herself as a one-parent family for benefit purposes and yet be a two-parent family. But what defines a two-parent family? A man may be living with a woman and her child(ren) and yet contribute nothing to the running of the household, either materially or practically. On the other hand, a woman may be living on her own with her child(ren) and be receiving some financial and/or other form of support from the

child's father. Which of these is a two-parent family? I came across examples of both while trying to recruit my study group. Similarly I found households where the male partner contributed financially and practically, and also found women living on their own with a child who were given no support whatsoever by the father of the child (a much more common experience for female-headed households than that described above).

Given this problem of attempting to define two-parent families, I decided that the family type should be defined by the main carer of the child (usually the mother). Thus a mother who claimed single-parent benefit and who was cohabiting with the father of the child regarded herself as part of a two-parent family, even though she complained that the father contributed very little in the way of financial support for the child. This couple was included in the study. Another mother who lived alone with her child continued to have a relationship with the child's father and received a degree of financial support from him, but regarded herself as a one-parent family. This family was therefore excluded from the study. The definition of two-parent families included those couples who were cohabiting, and parents who were not the biological parent of their child.

2. Number and age of children

I decided to look at couples with their first child as this is recognised to be a critical time in the couples' individual lives and within their relationships (Moss et al 1986). A further advantage of interviewing first-time parents was that they would more easily be able to recall what their lives were like before they became parents and would therefore be able to highlight the differences between being a parent and *not* being a parent. The number of children was restricted to one per family as the number of children has been found to affect women's reported health status and utilisation of health services (Brown and Harris 1978, Verbrugge 1983a).

Restricting the study group to families with one child meant that this child would usually be young, as most couples who have children have more than one child; in 1987, 78 percent of couples with dependent children had two children or more (*GHS*

1989) and they have their second child within a few years of their first. For example by the time they were five, only 10 percent of the cohort in Osborn et al's (1984) study were 'only' children (p.301). Therefore the maximum age of the child at the time of the first interview was set at 36 months to enable the study to look at couples with first children. I decided to include those families where the child was over the age of one year, as the first 12 months have been the most closely researched (eg. Graham and McKee 1980, Oakley 1980, Moss et al 1986, 1987).

I also decided to exclude couples if the mother was known to be pregnant at the time of the first interview, as this might affect the mother's experience of health and use of health services.

3. Social class

As the focus of this study is gender differences in health, I decided to look at these gender differences within a particular social class while taking into account the differences in access to material and social resources within this group (see Chapter One).

A working class group of parents were chosen, because the experience of being a middle class parent (usually mother) has been extensively written about; and the growth in interest about fatherhood has mainly focused on the debate concerning the existence or otherwise of the 'new (middle class) father' (Brannen and Moss 1987a, Russell 1987). More importantly, data from the 1981 census on the class background of Britain's children suggest that most children still live in households headed by a parent whose present or last occupation was a manual one (Graham 1984:45).

Defining working class

The problem in defining families' and households' social class has been discussed in Chapter One. In the present study, the thorny problem of how to define 'working class' entailed theoretical and practical considerations. As Arber (1986) has argued, the main empirical question when comparing middle and working class populations is which measure of social class is the best discriminator in terms of distinguishing

the healthy from the unhealthy. In the present study I wanted to use a definition of working class that would distinguish these parents from their middle class counterparts in terms of experience of health and illness, but would result in a study group which contained a range of access to material and social resources.

The main practical consideration was that, however I defined working class, I had to be able to classify parents fairly easily, preferably from the information in health visitors' records (see 'Gaining Access' section in Chapter Three), otherwise this would involve time-consuming screening interviews.

As a way of avoiding the problem of defining household occupational social class taking into account both parents' social class (see Chapter One for discussion of this problem), I considered using housing tenure as the basis of my definition, by restricting the sample to those in local authority and privately rented accommodation. It would then be possible to choose one or two small areas or estates where I knew this form of housing predominated. However, as I began to look through the health visitors' records to obtain the study group, it became clear that I would not be able to find enough couples who fitted the criteria from just one or two small areas. Further, in the case of local authority housing estates, I could not be sure whether the property was rented or owner-occupied without conducting a screening interview. With the increase in owner-occupation, partly as a result of council house sales, from 49 percent in 1971 to 63 percent in 1987 (*GHS* 1989), it is no longer unproblematic to use housing tenure as an indicator of social class.

A second option was to use occupation as the indicator of social class. It is generally thought to be the best available measure of social and economic inequality and one which reflects the structured nature of inequality (Graham 1984:41). Despite its obvious limitations, occupation is the most commonly used indicator of social class in British research (Reid 1981:6) and the social class classification of occupations most frequently used in British surveys is the Registrar General's (RG) classification developed by OPCS (OPCS 1980). It was also a practical solution since information on the parents' occupations was usually available (though not always) on the health

visitors' records. This meant that a couple's social class could be determined without the need for a screening interview (however, see 'Gaining Access' section in Chapter Three). However, using this method meant that the problem of determining the family's social class using the occupational social class of the man and woman in the household had to be resolved (see Chapter One for discussion of these issues).

Following Arber's (1986) finding that the most appropriate occupation-based measure of class for studying inequalities in health is to use the class of the occupationally 'dominant' member of the household, the criteria for the present study group was that both parents had to be defined as working class in terms of occupation. This is a study of women at a point in their lives when they are less likely to be in paid work: in 1987-9 the economic activity rate for women with a youngest child under the age of five years was 37 percent (*GHS* 1989). However, they were likely to have been in paid work until the birth of this child and are likely to return to some form of paid work later in their lives (see Martin and Roberts 1984, Table 2.11 for a description of women's activity by the lifecycle stage). Therefore the occupational social class of the woman will affect the social status of the family as a whole. (The pattern of paid work for the women in my study group is described in Chapter Three.)

For men, using occupation as a definition of working class is fairly straightforward. According to Reid (1981) a common way of collapsing the six categories in the RG's classification is to divide them into two groups: the terms non-manual or middle class refer to classes I, II and III (non-manual); while manual or working class refers to classes III (manual), IV and V. However the RG's classification is inadequate for classifying women's social class for many reasons but mainly because it has the effect of upgrading those women who have junior non-manual occupations, which are classified as III (non-manual). An example is personal service work, which is dealt with inconsistently in the classification: shop assistants are in RG IIIN (non-manual), while telephonists and waitresses are classified in class IV (semi-skilled) together with semi-skilled factory workers. Further, men and women classified in the same class have different occupations and work situations. For example, 85 percent of women categorised in RG class V are cleaners, whereas only 10 percent of men in this class

are cleaners (Arber 1986). Men in class V are primarily labourers, railway porters, dustmen, road workers, road sweepers, lorry drivers' mates and messengers, occupations which contain virtually no women. Similarly in class II, two thirds of women are in lower professional occupations, whereas under one third of men in this class are in these occupations (Arber 1986).

The social class criterion used for the men in this study was that their present or last occupation had to fall into one of the manual classes, ie. III(M), IV or V. But the social class criterion used for the women was that their present or last occupation had to fall into one of the classes III(N), III(M), IV or V. Both parents had to fulfil these criteria to be included in the study so that, for example, a couple where the woman was a nurse (II) and the man was a carpenter (IIIM), and a couple where the woman was a typist (IIIN) and the man was a librarian (II) were not included in the study group.

4. Ethnicity/nationality

It is common for sociological studies not to include people who are other than white and UK born (eg. Brown and Harris 1978, Cornwell 1984, Mansfield and Collard 1988, Oakley 1980, Tivers 1985, Moss et al 1987), because they aim to have an homogeneous study group and want to exclude any cultural differences. This has been criticised by those who argue that these cultural differences are part of British and North American society and should not be ignored (Phoenix 1987, Reyes and Halcon 1988).

As my research was being carried out in a London borough with a multi-ethnic population profile, it seemed logical to include families from different ethnic backgrounds within the study group. This study was not intended to specifically look at the health of ethnic minority parents, and so I did not select the study group in order to include a certain number or a certain range of ethnic groups (cf. Mayall and Foster 1989:5). The study group was selected using the criteria discussed above at random from health visitor files (see 'Gaining Access' section) and ethnic minority families were included in this process. However, it is important to stress that some

of the criteria for the study group are biased against certain ethnic groups. For example, the criteria that the family should have only one child between the ages of one and three years and that the mother should not be known to be pregnant again is biased against Asian and Orthodox Jewish communities which have a tendency to have large families. Excluding one-parent families is biased against families of Afro-Caribbean origin who have a higher proportion of lone mothers than white and Asian families (see Haskey 1991:40). For a discussion of the ethnic composition of the study group see Chapter Three.

As I was doing all the interviewing and had no resources to pay for interpreters, all the interviewees had to be able to speak English.

5. No major chronic health problem

The final criterion for selection of the study group was that interviewees should not have a major chronic health problem or disability that affected their health status and use of services such as diabetes, multiple sclerosis and so on. One family, for example, was excluded from the study because of the father whose daily life was severely limited by a serious blood disorder.

III DATA COLLECTION

In this section the three different methods of data collection that I used will be described: field notes, semi-structured tape-recorded interviews, and health diaries. These methods were developed and tested in a pilot study, which is described at Appendix C.

1. Field notes

Field notes are an integral part of field research (Burgess 1984). Mills advocated that researchers should keep a journal in which:

> ...there is joined personal experience and professional activities, studies under way and studies planned. In this file you, as an intellectual craftsman, will try to get together what you are doing intellectually and what you are experiencing as a person. Here you will not be afraid to use your personal experience and relate it directly to various work in progress (1959:216).

Similarly many anthropologists have kept detailed field notes which include substantive, methodological and analytic considerations (Burgess 1982). Usually these have been kept hidden from view but some have had them published (eg. Malinowski 1967, Mead 1977, Geer 1964).

During the course of the research, I kept two sets of notebooks. One set is labelled 'PhD notebook' and contains personal ideas, thoughts, feelings and suggestions, which have been made to me about the study. It is on these notes that the section on 'The process of doing research' in Chapter Three is based.

The other set is labelled 'Interview Field Notes' and is a systematic record of every single contact that was made with potential or actual interviewees. When I first called round or telephoned to make an arrangement to interview people, I noted down what was said, the person's reaction (eg. keen, reluctant, etc.) and if I called round, what they were wearing, how they looked, etc. After each interview I went through the same process noting down what I felt about the interview, what was good about it, what I might have done better, how the interviewee looked, a description of their flat/house and the room where the interview took place, how they related to their child (who was often present), if there were any interruptions, their reaction to being asked to fill in a health diary and so on.

These notes were not restricted to observations about the interviewees alone, but also addressed issues of interaction between interviewer and interviewees in an 'autobiographical' style.

2. THE INTERVIEW

i) Interview design

Formally data were collected via a series of semi-structured tape-recorded interviews with 30 mothers and fathers living in two neighbouring areas in London in 1986-7. As with the pilot study, interviews took place in the interviewees' own homes. They lasted from half an hour to two and a quarter hours (the average interview time was 64 minutes). All the interviews were tape recorded, although in the final interviews

I also took notes to assist in the transcribing process (see 'Analysis' section).

The two main issues in the design of the interviews was how to interview the parents, that is, together or separately and what to include in the interviews.

Interviewing together or separately

From the pilot study (see Appendix C), the decision was made to interview couples separately in the main study, because I had found that they were more likely to agree with each other when interviewed together - perhaps wanting to present a 'united front', whereas when couples were interviewed separately it was much harder for them to do this. Mansfield and Collard (1988:44) in their study of newly married couples also found that interviewing couples together tended to give 'consensus accounts' in which one partner took the lead and then sought confirmation from the other. In the pilot study, interviewees were also much more likely to say critical things about their partner if interviewed on their own, compared with when they were together.

As the focus of the study is on gender differences, more importantly, I wanted to be able to gain the different perspectives and experiences of mothers and fathers, and this was harder to gain if they were interviewed together.

Content of interviews

The three interview schedules are attached at Appendix D. The first interview covered the following topics: personal characteristics, health status, use of formal and informal health services, health care practices (smoking, alcohol, exercise, etc.), sleep and tiredness, mental wellbeing, social contacts, childcare and relationship with child. Some of these questions were highly structured like those I used from the *GHS*, for example: 'In the past year would you say your health has been good, fairly good or not good?' Other questions were much more open-ended, for example: 'Do you ever feel really healthy?', 'What do you like about looking after your child?' and 'What don't you like about looking after her/him?'

The second interview, which took place approximately four months after the first one, covered questions about the period between the first and second interviews in terms of events in the interviewees' lives, any health problems they, their partner or their child had experienced and so on. Interviewees were also asked about their attitude towards local health services and how they organised domestic work. Finally, interviewees were asked more background questions about their education, access to transport and household income.

The third interview, which took place approximately four months after the second one, covered the same questions as the second interview in terms of events experienced by the interviewee, their partner and child. In this interview I also asked questions about motherhood and fatherhood, which may or may not have been previously mentioned by interviewees, for example: 'Do you think your relationship with your partner has changed since you had your child?'

However, in both the second and third interviews I also took along specific prompts, follow-ups and questions tailored from a preliminary analysis of the tape recording and field notes from the previous interviews with that interviewee.

The interview schedules provided a guide to the questions that needed to be covered in the interview to address the research hypotheses. Interviewees were encouraged to expand their answers and were prompted and, where necessary, asked further questions.

Questions were asked of both partners, even if some 'information' had already been obtained from the other partner. So, mothers and fathers, for example, might give different accounts of their child's experiences of illness or, as in one case, different answers to my questions about income. As with differences between one interviewees' interview and their health diary, these differences were not regarded as errors but as findings, because in part they would be expressive of the relational dynamics of the process I was seeking to uncover.

ii) Interview practice

There are a number of issues surrounding the interview practice and interaction, which is important to discuss. Indeed these issues will not be confined to the methodology chapter but will be discussed again in the chapters which represent the data. This is because interviewers' interaction with the interviewer constitutes data which need to be addressed in its contextuality (see Silverman 1985:161-2, Oakley 1981). The following observations have been taken from the detailed field notes described above.

Time and place of interviews

All interviews took place in the parents' homes, sometimes during the day and sometimes in the evening. Where possible I tried to interview couples one after the other to avoid one partner talking about the interview before the other had been interviewed. However, it was not always possible to do this, particularly where one partner worked shiftwork, as was the case in four of the couples. When couples were not interviewed one after the other, it was clear that they had discussed the interview. One father remarked when I asked him about his use of health services: 'She told me I'd have to have a good memory.'

I was careful to explain fully why I wanted to interview the couples separately, because some interviewees expressed concern that it was to check up on their 'answers'. Once it was explained to them most people accepted it and came to expect it in subsequent interviews. With some couples it developed into a ritual. I would interview the mother while the father was elsewhere in the house doing some DIY. While I interviewed him she would have a bath. We would then sit chatting together for a while.

However, interviewing the couples separately was not always unproblematic. First, some families' housing situations were such that it was not possible to interview the couple separately without the other having to go out. This was the case with Ruth Dobbs and Paul Edwards (these are pseudonyms - see Appendix E for list of families). I arranged to interview one of them when the other was at work, which was

possible because Ruth does shiftwork. Secondly, some of the women were very interested in what their partners were going to say, so made excuses to come in and out of the room where he was being interviewed. One woman even hid in the kitchen next door (both myself and her husband thought she was upstairs) to hear what her husband was saying. She gave herself away towards the end of the interview by bursting into laughter at something he said.

Once again these are not errors but findings, telling us more about the context within which these interviews took place. In the first place they are produced by the material and social context of these families' lives - shiftwork, overcrowded living conditions, etc. Secondly, they are a reflection of the gender relations between some of the couples, whereby the woman was clearly dissatisfied with the lack of communication by her partner about his feelings (see also McKee and O'Brien 1983:153). She hoped to 'find out something' by listening to my interview with him.

Interview style

The pilot study helped me to become more comfortable in the interview situation and practice the approach I wanted to take, which was a non-directive, non-judgemental one. Sometimes this was difficult to maintain, as I will discuss later. This non-directive, non-judgemental approach did not mean that I remained detached and uninvolved. I did become very involved with what people were saying and this was essential to the relationship I developed with them, which, in turn, was important for the research process.

I have already described how I used the questions as a guide to the conversation with the interviewee, and we often went off in all kinds of directions, according to what they raised. I found that the most important skill in facilitating this kind of responsiveness and in encouraging people to talk openly and freely was that of *listening* as well as hearing. It is all to easy to simply do the latter when the interviews are being tape recorded, and there is a danger that the interviewer forgets to carefully listen to what is being said, and therefore is unable to respond and follow up issues in the essential manner of creative interviewing. Listening also enabled me

to pick up the vocabulary of the interviewee and phrase questions in their own 'language'. As Mansfield and Collard (1988:46) argue, this is 'the essence of any conversation'.

Using a tape recorder

None of the interviewees objected to being tape recorded, although some were surprised that I should want to make a recording of the interview, as they felt they had nothing important or interesting to say. Usually once they had started talking they forgot about it very quickly. However, it is important to mention that on several occasions interviewees revealed very important pieces of information after I had switched off the tape recorder. For example, after I had finished the final interview with Paul Edwards and the tape recorder was off, he told me he wanted to leave his partner.

3. HEALTH DIARIES

How can a fuller picture of morbidity, short- and long-term disability and health actions be obtained that reflects more fully individuals' health experiences? One strategy is to ask individuals to report symptoms, disability and health actions as they occur in the form of a health diary. While diaries have been used widely in consumer expenditure surveys (eg. Sudman and Ferber 1971) and in studies of food consumption, travel and time use (eg. Cullen and Phelps 1975, Wallman 1984), they are a relatively rare and under-utilised instrument in health research (Verbrugge 1980:74, Freer 1980a). In the past, health diaries have been used mainly for three purposes: in methodological studies to compare reporting levels for retrospective and prospective procedures (Allen et al 1954, Mooney 1962); as memory aids to improve the recall of health events in a later retrospective interview (Dingle et al 1964, Smith and Mosley 1951); and as a primary data source (Haggerty et al 1975, Mechanic and Newton 1965, Freer 1980b, Pattison et al 1982, Murray 1985, Morrell and Wale 1976). However, as I have discussed earlier, the purpose of using health diaries in the present study in addition to interview data is to collect different types rather than 'more accurate' data.

Characteristics of health diaries

Two general formats for the diary are common: a ledger, with separate pages for different types of event, eg. visits to the doctor, taking a home remedy, or a journal in which details about a health event are all entered on the same page. Diaries vary in their emphasis either on pre-coded items, which the respondent simply marks, or open-ended items, which require written descriptions.

To date, the majority of diary studies have been conducted in North America, in urban areas with all white or predominantly white respondents. Usually respondents have an initial face-to-face interview about health before beginning a diary, but an interview at the end of the diary period is not common. Most diaries ask for reports of 'minor' symptoms which did not prompt restricted activity or medical care and 'major' symptoms, which did prompt restricted activity or medical care. Other items that are less common are expenses for medical care, preventive health actions, drugs taken, general rating of health, unusual or stressful events of the day. Most studies require entries only on days when health events occur, rather than on every day of the diary period. Diary periods have ranged from one week to 10 years but a common period is four weeks. Usually diaries are collected by the interviewer, rather than posted back by the respondents. Most studies have not compensated the respondents financially.

Finally, and most importantly here, the vast majority of diary studies have asked a female adult in the household, usually the mother, to record the health events for herself and all or some other members of her household. A rare exception is Verbrugge (1979a) who collected data from women *and* men in the household. Women have been used in health diary research since it has been assumed that they are better diary keepers than men, although there is no evidence to support this (Freer 1980a:279). This means that diary data for other members of the household is obtained by proxy, and it is well known that persons reporting their own experiences respond more fully than if these are reported by proxy. Also there are suggestions that respondents reporting only for themselves respond more completely than those who must report for others as well (Mechanic and Newton 1965:570). We therefore

have very little idea of men's subjective perceptions of their health and health behaviour, either from traditional health surveys employing retrospective interview techniques, which have used proxy reports of men's health (Clarke 1983) or from health diary studies. For a more detailed analysis of the advantages and disadvantages of using health diaries see Appendix F.

Design and content of the health diary

From the findings of the pilot study (see Appendix C), I decided to use a seven-day diary in the main study. This diary is divided into two pages for each day: the first page concerning the health and wellbeing of the respondent and the second the health and wellbeing of the respondents' child (see Appendix G for copy of diary). To encourage respondents to keep them, the diaries were made into booklets with bright covers.

The diary was designed to look at gender differences among parents in three main areas: individual's perceptions of health; the relationship between respondent's subjective description of their everyday lives and their perceived health status and behaviour; and the relationship between their perceptions of their child's health and wellbeing and their own perceived health status and behaviour.

1. Perceptions of health

Baumann (1961) describes three broad conceptions of health on which individuals base their perceptions of their own health status. These are a feeling-state conception, a clinical conception and a performance conception. The feeling-state conception describes how healthy an individual feels; for example: 'I feel fine' or 'I don't feel well today'. The clinical conception describes the symptoms the person uses to describe their state of health; for example: 'My back hurts' or 'I've got a stomach ache'. The performance conception is an evaluation of health based on behaviour; for example: 'I went to bed early' or 'I took some aspirin'. Since the emphasis of the present study is on the individual's health experiences, the health diary covers each aspect of Baumann's classification.

The feeling-state conception is covered by the first two questions in the diary, which are closed questions on how the respondent feels about the day in general and her or his health in particular (see Appendix G for health diary):

1. *What kind of day has it been for you?*
   (The respondent is asked to tick one of five answers: a very good day, a good day, an average day, a poor day, a very poor day.)

2. *How has your health been over the last 24 hours?*
   (The respondent is asked to tick one of five answers: very good, good, average, poor, very poor.)

Feeling-state is also covered by an open-ended question (question 3), which asks respondents to give details of any particular good or bad feelings. This question also covers the clinical conception by asking for details of health problems:

3. *Give details of any particular feelings (good or bad) or health problems you may have had today. Please also note down what you think caused the feelings/problems.*

Unlike other studies (eg. Murray 1985, Rowley 1986), I have not used a symptom list, as the General Household Survey's experience (see Cartwright 1983) has been that respondents record more symptoms when provided with a checklist. Murray (1985) sees this as an advantage and argues for a symptom list, because when asked to list their own symptoms many respondents are inhibited by their unfamiliarity with medical terminology; they may be reluctant to express in their own words some of the more 'personal' health problems. What Murray sees as an advantage I see as a disadvantage. It could be that respondents record more symptoms with a symptom list, because the list sensitises them to health problems they actually may not have had. Secondly, a symptom list cannot cover all possible symptoms, so inevitably some will be lost. Thirdly, I wanted respondents to describe their health problems in their own words, and thought that many might find this easier than relating to my description of them.

The performance conception is covered by question 4, which is an open question asking respondents to give details of any health actions taken in response to health problems noted in question 3:

4. *Did you do anything about any health problems you noticed?*

2. Relationship between everyday life and perceived health status

In questions 5 and 6, respondents are asked to describe the main events of the day and also if anything happened which made them feel good/happy or bothered/upset them:

5. *Things you did during the day:*
   Morning:
   Afternoon:
   Evening:

6. *Did anything happen today which made you feel good/happy or was there anything that bothered or upset you? Please write down here.*

3. Relationship between perceptions of child's health and own perceived health status

Under *About your child*, questions 1 and 2 are closed questions concerning the parent's perceptions of their child's day in general and their health in particular. Question 3 is an open-ended question asking for details of any health problems perceived by parent, and question 4 asks for details of any health actions taken on behalf of the child for problems noted in question 3.

Administration of the diary

After each of the three interviews with every parent, they were asked to complete their own diary for the following week. I collected 21 days of diary data from each parent from three different seasons of the year: autumn, winter and summer. Each parent filled in their own diaries for the same week as their partner so that direct comparisons could be made. The diary was carefully explained at the end of the initial interview. Parents were told that the diaries gave very useful information, which could not be obtained in an interview.

Given that better completion rates have been obtained by collecting the diaries, I decided to follow this method rather than asking respondents to post back their diaries. Arrangements were made to collect the diaries when I gave them to the respondents. I think that this method may also have encouraged respondents to stay in the study, as it meant that I had more contact with them.

This diary study is unique as far as I am aware, because it collects diary data from both men and women about their perceived health status and behaviour and their perceptions of their child's health and wellbeing.

Conclusions

Following from the limitations of most of the empirical research on gender differences in health and illness up until now (Kandrack et al 1991, Arber 1991), I designed a small-scale, longitudinal qualitative study to uncover the processes involved. The study is based on a feminist epistemology of knowledge taking people's 'lived experiences' as its starting point. As it is a study of gender differences in working class parents' experiences of health and illness, both mothers and fathers were interviewed, separately.

A broad definition of health is employed in this study based on the WHO's definition, encompassing all aspects of physical and mental wellbeing. I decided not to use any of the standardised measures of health because, as the aim of the study was to explore the processes behind gender differences in health, I wanted to listen and record parents talking about health and illness in their own words. However, data were collected on measures such as doctor visits and so on. Further, health diaries collected data on subjective perceptions of health status and experience of health problems and actions which were used as 'measures' of health and ill-health. This combination of qualitative and quantitative methods is used to study both women's and men's lives in their public and private worlds.

The families selected for the study group were two-parent, working class families with one child aged between one and three. As the focus of the study is *gender* differences, these differences are explored within a particular social class. Working class families were chosen because most children live in households headed by a parent whose present or last occupation was a manual one. 'Working class' was defined using the Registrar General's classification of occupations (OPCS 1980) taking into account *both* parents' occupational social class: the fathers had to be in groups III (manual) and below; the mothers in III (non-manual) and below.

Data from mothers and fathers were collected from three in-depth interviews with each parent over the course of a year, and three sets of seven-day health diaries. This combination of interviews and health diaries with a group of parents collecting data on their own and their child's health is unique. A detailed description of how the study was carried out is given in the next chapter.

CHAPTER THREE

METHODS II : THE LIVED EXPERIENCE OF SOCIAL RESEARCH

> There have also been some useful statements on methods of research, but with a few exceptions they place the discussion entirely on a logical-intellectual basis. They fail to notice that the researcher, like his informants, is a social animal...the real explanation of how the research was done necessarily involves a rather personal account of how the researcher lived during the period of study (W.F. Whyte *Street Corner Society* 1981:279).

The purpose of this chapter is to describe the process of carrying out the research study, and to describe the characteristics of the study group and the area in which they lived. The first section describes how I gained access to the study group. In the second section, the characteristics of the study group and the area in which they lived are described. Finally, the methods of analysis and some issues concerning the process of carrying out the research are discussed. In doing this, my aim is to present 'the real explanation' of how the research was done, acknowledging that I, like the group of parents I was studying, am a 'social animal' (see quotation at beginning of this chapter from W.F. Whyte, 1981). The everyday, lived experience of the research is an integral part of the analysis of the everyday, lived experience of the mothers and fathers I interviewed.

I GAINING ACCESS TO THE STUDY GROUP

Since the study required a small study group contained within a relatively small area of an 'inner' city, there were several options for locating such a sample. One option was through the health services - a general practice or health clinic; another was via the social services such as family centres, day nurseries or drop-in centres; thirdly, sample selection through private nurseries, playgroups or childminders might have been chosen. The option which provides the most representative sample is the general practice or health clinic, since a much higher proportion of the population is registered here than attends nurseries, playgroups, childminders and so on. For example, over 97 percent of the sample in Butler and Golding's (1986) longitudinal Child Health and Educational study had been visited by a health visitor at some point

in the child's life (p.271). It is possible to assume that the health visitor would have records for most of these children. As I wanted a working class sample, I needed access to a general practice or health clinic in a working class, or partly working class, area. Health visitors based at such a clinic were contacted via the Director of Nursing Services of a District Health Authority in London. Clinic A has five health visitors serving 1249 families (July 1986) in a mixed working class/middle class area (see below for description of area). For the main study sample, three of the health visitors allowed me to go through their files and pick out the families who appeared to fit the criteria. The list of families was then checked by the relevant health visitor to remove those who had moved or otherwise failed to fit the criteria. The two remaining health visitors, who did not give me access to their files, gave me the details of those families on their caseload who they thought fitted the criteria. This whole procedure took place between June and July 1986 and resulted in a total sample of 68 families, which was reduced to 45 families after being checked by the health visitors.

The names of families were then randomly selected (taking every fifth one on the list) in equal numbers from each health visitor, as they covered different areas. A letter was sent to each family seeking their permission to be included in the study (see Appendix H for a copy of the letter). Parents were given over a week to withdraw from the study before I either telephoned or called round to arrange the first interview. The letter explained the purpose of the research and emphasised its independence from the health services. Confidentiality was guaranteed by stating that parents' names would not be used in any report or publication of the research. These elements were reiterated when I spoke to the parents, and I also explained how the research would be disseminated ie. via this thesis, a report to the Health Authority (see Fulop 1987a), conference papers (see Fulop 1987b) and, possible publications.

After I had written to all 45 families on the list, I had a group of 12 families who fitted the criteria. I therefore needed access to a second health clinic to obtain more families. Access to clinic B was gained in the same way as to clinic A. Clinic B is situated in a predominantly working class area, approximately three miles from clinic

A in the same District Health Authority. The sampling method was slightly different at clinic B, because I did not have enough time to go through their files: the health visitors each gave me a list of all those families in their caseload who fitted the criteria. This process was less biased than at clinic A where the health visitors seemed much more keen to give me the names of 'good' mothers. At clinic B the health visitors, who were noticeably younger than at clinic A, seemed to understand the sample criteria much better and I am more confident that I got all the families who fitted the criteria, although two of the health visitors mentioned that they would not be giving me any of their 'at risk' families. This procedure resulted in a total sample of 30 families and they were contacted in the same way as above.

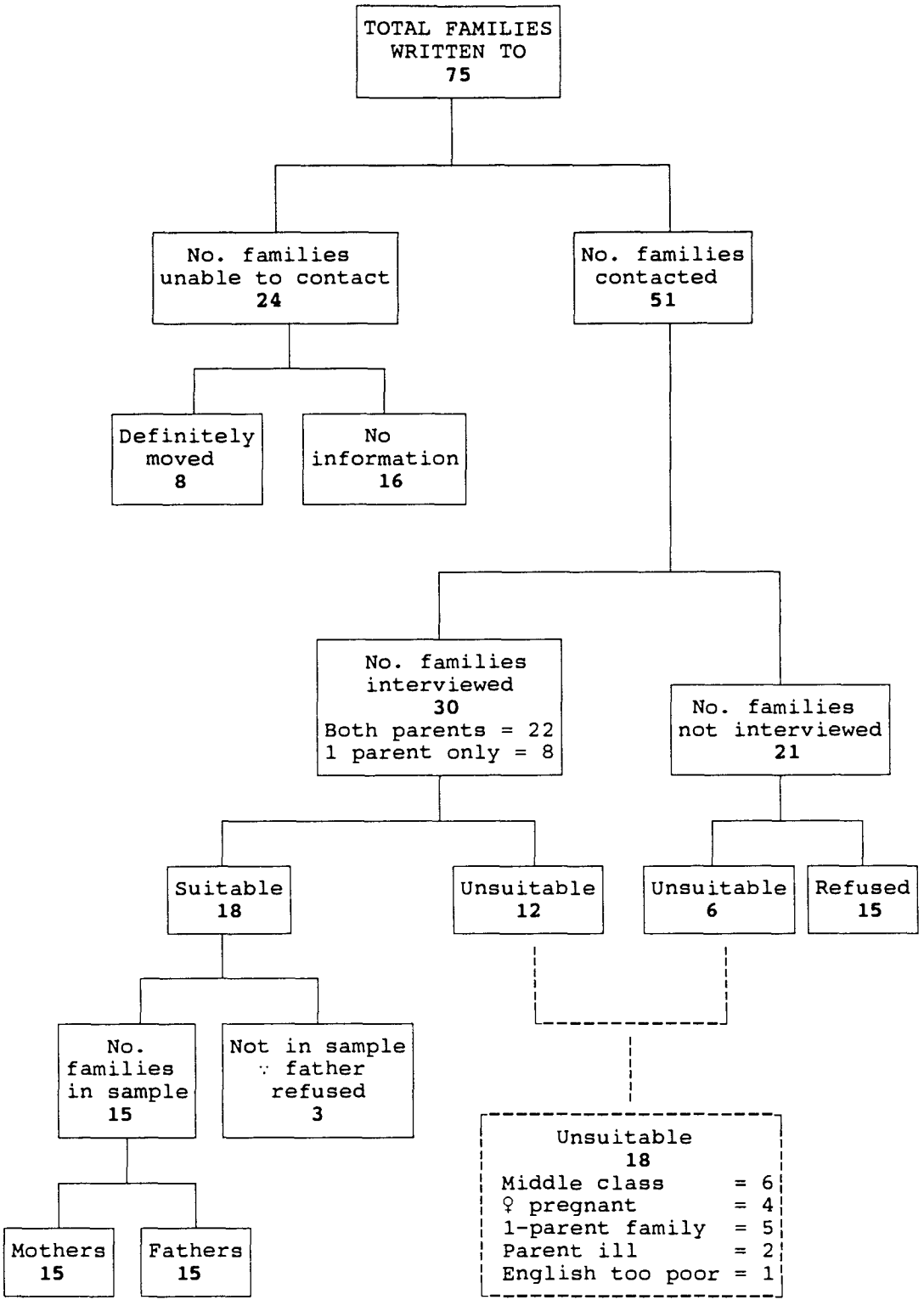
Response and non-response

To get 15 families in my study group, I wrote to 75 families, 45 from clinic A and 30 from clinic B. Twelve families came from clinic A and three from clinic B. The study group were obtained between October and December 1986. Figure 3.1 gives information on response and non-response rates.

The main problem in obtaining the sample was contacting the families once I had written to them. I was unable to contact 24 of the families I had written to (32 percent), either because I found out that they had definitely moved but did not know where they had moved to (n=8); or after five attempts at trying to contact them at different times of the day, I failed to contact them (n=16).

The next biggest 'loss' from the sample was from those families who refused to take part in the study: 18 of the families written to (24 percent) refused to take part in the study, which was 36 percent of the total contacted (n=50). Seven families (9 percent) withdrew before the deadline either by telephoning or writing to me; eight families (11 percent) withdrew when I contacted them either by phone or when I called round; and three fathers (4 percent) refused after I had interviewed their partners.

Figure 3.1: *How the study group was obtained*



Finally, 18 (24 percent) of those families I had written to could not be included in the study group, because they did not fit the criteria. This was because either the information on their files was not clear enough, or the health visitor had been mistaken in thinking they did fit the criteria. In six of these cases, I discovered they were unsuitable before I interviewed them, and was able to explain why I would not be interviewing them without offending them. In the remaining cases (n=12), however, I did not discover they did not fit the criteria until during the interview, or while I was arranging the interview, and it would have been unethical not to carry out the interview. Although in some of these cases I shortened the interviews, in others I felt that I could not because the respondent obviously needed to talk.

Of the 18 'unsuitable' families, 33 percent (n=6) did not fit the criteria, because either one or both parents did not fall into the correct occupational social class, ie. they were 'middle class', and I had been unable to ascertain this from their file; in 22 percent (n=4), I discovered that the woman was pregnant again when I interviewed her; 27 percent (n=5) were one-parent families; in two of the families one of the parents had a major medical problem which had not been written down on their file, and one family had to be excluded from the study because their English was not fluent enough.

It would appear from this that the type of family that I wanted for my study group, that is, a two-parent, working class family with one child aged between one and three is not very common in this area of London. However I never intended to have a 'representative' sample. I aimed to explore the processes behind the relationship between parenthood and health in a certain type of family which required an in-depth qualitative study using a small sample.

Problems with methods used to obtain study group

There were problems with both the methods used to obtain the study group:

a) asking the health visitor to give me the details of all her families who fitted the criteria;

b) going through the files myself selecting those families who fitted the

criteria.

With method (a) I could never be sure that the health visitor was giving me all the families who fitted the criteria. Some of the health visitors at clinic A seemed particularly keen only to give me what they considered to be the 'good' mothers, thinking that they would be of most help to me. For example, one health visitor said as she gave me the name of a family - 'she'll help you a lot, she's a good mother'. Even when I tried to explain that I was interested in all kinds of families this problem persisted. The health visitor who made this remark was one of the two health visitors at clinic A who did not give me access to their files but gave me the details themselves. Method (a) was used exclusively at clinic B but as noted above, I was more confident that the health visitors were giving me all the families on their case load who fitted the criteria, although I had no way of verifying this.

With method (b) there were various problems in interpreting what had been written on the file as described below:

i) Occupation - it was often not stated at all or sometimes just for the mother and not for the father. When it was stated it was often vague, eg. 'civil servant' or 'self employed', which made it impossible to classify. In these cases I asked the relevant health visitor if they knew the parents' occupations, and if they did not then I added them to my list and found out when I tried to arrange interviews.

ii) One- or two-parent family - this was fairly frequently unclear from the records. If they were recorded as a one parent-family I had to presume that they were, although they officially might have been for benefit purposes while actually being a two-parent family.

iii) Whether the mother was pregnant again was not written on the records and if the health visitor did not know, I added them into the sample and found out either when arranging or conducting the first interview.

iv) Change of address - in many cases the family had moved but this had not been recorded in the clinic notes. Unless the health visitor knew that they had moved, they were added to my list and I spent a lot of time trying to contact them.

v) Medical problems - these were supposed to be recorded in the file but in two of the families I contacted one of the parents had a major medical problem which had not been recorded in the file.

II DESCRIPTION OF STUDY GROUP AND AREA

This section describes the parents who participated in the study and the areas in which they lived. I begin by broadly describing the two areas where the families lived and then the study group's main characteristics. It is very important to have an understanding of the contexts in which the individuals in the study live and try to parent. This context includes not only the usual concerns of sociologists such as class, education and ethnicity, but also their individual biographies, which include these traditional concerns. As C. Wright Mills said:

> No social study that does not come back to the problems of biography, of history, and of the intersections within a society has completed its intellectual journey (1970:12).

The parents and their children have been given pseudonyms to ensure confidentiality. A brief description of the fifteen families can be found at Appendix E.

Description of the area

The study group was obtained from two health centres about three miles apart in the same District Health Authority. The health authority has the same boundaries as the borough, which is an inner-city borough, with many of the problems which that implies. The main characteristics of the borough that relate to the present study are shown in Tables 3.1, 3.2, 3.3 below. Data are from the 1981 census and so do not accurately reflect the situation at the time of the interviews (1986-7), but give an indication of the type of area.

Table 3.1: *Population of the Borough*

		%
Total residents	202,650	100
Aged 16-34	68,181	34
Born in New Commonwealth and Pakistan	37,880	19

Table 3.2: *Employment characteristics of the Borough*

UNEMPLOYMENT	
11% of all economically active residents	
FULL-TIME/PART-TIME WORKERS	
39% of total full-time employees are women	
87% of total part-time employees are women	
CHILDREN OF MARRIED WOMEN IN EMPLOYMENT	% (of children aged 0-15)
Working full time	16
Working part time	18

The borough has an east-west split, which reflects the differences in the areas served by the two health centres, one of which is in the eastern part of the borough and the other in the western part. The wards in the east of the borough have higher levels of deprivation, as measured by numbers of one-parent households, households living in local authority housing, households, with no access to a car, the proportion of unemployed people and so on. In contrast, wards in the west of the borough have higher proportions of owner-occupiers, households with access to a car, economically active residents in work and so on. The borough has a high proportion (19 percent) of residents born in the New Commonwealth and Pakistan; these communities are concentrated in wards in the east of the borough.

The two health centres therefore serve very different areas. The area served by health centre A is unusual in inner London in that it gives the impression of being a little town or village on its own. This is partly because it is not connected to the London Underground system, although it is served well by buses, but also because it is a fairly green and leafy area. The area has a definite centre where all the shops and

local amenities are situated. Although part of this area has always been fairly middle class, until recently it was a mainly working class area. However in recent years, like many other parts of London, it has undergone the process of gentrification and new young urban professionals have moved in. This has altered the character of the area, which now possesses wine bars, vegetarian restaurants and so on. However there are still some areas of council housing and a few opportunities for private rented accommodation, although this has considerably shrunk, as landlords sell off their properties to the developers to be converted into flats to be sold.

Table 3.3: *Household characteristics of the Borough*

	% (of all households)
Household composition under age 59-64	14
Single person aged 60-65+	14
Lone parent households	3
- no children	18
Married couple:	
- with children	14
- no children	25
Other households - with children	12
Households with no car	51
Households with 1 or more children aged 0-15	29
Households with 3 or more children aged 0-15	5

The health centre serves three wards, which themselves are quite different. One ward is predominantly middle class, with 46 percent of households being owner-occupiers; another is predominantly working class, with 40 percent of households in local authority rented accommodation; the third is more mixed, with less local authority but more privately rented and housing association accommodation. This last ward has a much higher proportion (20 percent) of residents born in the New Commonwealth and Pakistan compared with the other two (12 percent). This census definition of ethnic minority hides the large numbers of Greek and Turkish Cypriots living in the area. Eight out of the 12 families obtained via this health centre live in the predominantly working class ward.

The area served by clinic B, where the remaining three families live, has not

experienced the process of gentrification to the same extent, as it is a much poorer area. However even here the less well paid professionals are moving in. It has no definite centre, unlike area A, although it is served by London Underground. The two wards in this area have a higher proportion of local authority rented households (55 and 41 percent) and is generally more deprived than area A. There are more one-parent families (6 percent) compared with area A (3 percent), more households with no access to a car (60 percent compared to 51 percent), and more economically active unemployed people (13 percent compared to 10 percent).

Overall description of study group

The study group consisted of 15 two-parent families, with one child aged between one and three. All the families were working class, which was defined by using the Registrar General's Occupational Classification (OPCS 1980): the women were in class III (non-manual) and below; and the men were in class III (manual) and below (see Chapter Two for explanation of this).

Table 3.4: *Age of parents and children at time of first interview*

	Age range (years)	Average age
Mothers	20-32	26.5 years
Fathers	22-37	28.0 years
Children	1-2	17.5 months

Table 3.4 shows that the children were aged between 12 and 24 months at the time of the first interview and there were ten girls and five boys. The children's average age was 17.5 months at the time of the first interview. This table also shows that the parents were aged between 20 and 37 at the time of the first interview and their average age was 27. The mothers were aged between 20 and 32; their average age was 26.5. The fathers were aged between 22 and 37; their average age was 28.

At the time of the first interview, nine couples were married to each other and six were cohabiting (see Table 3.5). This balance between married and co-habiting

couples reflects the increase of cohabitation over recent years. Between 1979 and 1987 the percentage of women cohabiting between the ages of 18 and 49 rose from 3 to 6 percent (*GHS* 1989).

Table 3.5: *Marital status of parents and 'legitimacy' of children*

	At time of first interview: number of couples (%)	At time of birth of child: number of women (%)
Cohabiting	9 (60%)	7 (47%)
Married	6 (40%)	6 (40%)
Not known	-	2 (13%)

At the time of the birth of their first child, the mother's average age was 25.3 (range: 19.5 to 31.3). This is very close to the average for women in England and Wales married to men in social class III manual in 1985 at the time of first legitimate birth, which was 25.2 (OPCS Monitor 15 July 1986). The difference in these figures is that the OPCS figure is for 'legitimate' (ie. mothers married at the time of birth) births only; whereas in this study group at least seven of the children were born to unmarried mothers, six mothers were married at the time of birth, and for the remaining two mothers it is not known whether or not they were married at the time of their child's birth.

In terms of nationality, all except two of the parents were British; one mother was Canadian and one father was Irish (see Table 3.6). The majority (22) of the parents were white British who were born in Britain and whose parents were born in Britain. Six parents were of British nationality and either they or their parents had been born outside Britain; three parents were of Greek-Cypriot origin, one was of Turkish-Cypriot origin and two were Afro-Caribbean.

Table 3.6: *Nationality and ethnicity of parents*

Nationality	No. of parents	Ethnicity	No. of parents
British	28	White British/Other	23
Irish	1	Greek-Cypriot	3
Canadian	1	Afro-Caribbean	2
		Turkish-Cypriot	1
		Irish	1
TOTAL	30	TOTAL	30

As Table 3.7 shows, most (73%) of the families lived in public or private rented housing. This compares with 37% of the total GHS sample in 1987 (*GHS* 1989). At the time of the first interview, six lived in council homes; five in privately rented housing (one housing association and four private landlords); and four were owner-occupiers. At the time of the final interview, seven lived in council housing but one of these had applied to buy their flat and three others were planning to at some point in the future; four lived in privately rented housing and four were owner-occupiers. More than half of the local authority tenants were planning to buy their own home compared with the 21 percent of local authority tenants in the GHS who had considered buying in the two years prior to 1987 (*GHS* 1989).

That more than half of the local authority tenants were planning to buy their home corresponds interestingly with data from the 1987 GHS which found that 21 percent of local authority tenants had considered buying in the previous two years (*GHS* 1989).

At the time of the first interview, twelve of the families lived in flats or maisonettes and three lived in houses. Six families had no garden, four had access to a shared garden, and five had their own gardens. By the time of the last interview, eight of the thirteen families lived in flats and five in houses; one family who had not had any access to a garden now had one of their own.

Table 3.7: *Housing tenure and type*

	No. of families
Tenure	
Local authority housing	6
Privately rented	5
Owner-occupiers	4
TOTAL	**15**
Type	
Flat/maisonette	12
House	3
TOTAL	**15**
Access to garden	
Shared	4
Own	5
No access	6
TOTAL	**15**

Access to a car

As car ownership is used as an indirect indicator of wealth and command over resources (see eg. Fox and Goldblatt 1982), data were collected on this item. As Table 3.8 shows, a majority of families had access to a car. However, in two cases the car was rarely used because the families could not afford to run it. Access to the car within households was not equal as Table 3.9 shows.

Table 3.8: *Households' access to car*

	No. of families (n=15)
Access to a car	12
No access to a car	3

Table 3.9: *Who drives the car*

	No. of households (n=12)
Both parents drive car	3
Father only drives car	9
Mother only drives car	-

Employment

As would be expected, there were great differences between the mothers' and fathers' employment. At the time of the first interview nine of the mothers were full-time housewives, three had part-time paid employment and three had full-time employment. This pattern changed over the interview period as is shown in Table 3.10.

Table 3.10: *Mothers' employment over interview period*

	1st int (n=15)	2nd int (n=13)	3rd int (n=13)
Full-time housewife	9	5	5
Part-time employment	3	4	4
Full-time employment	3	4	4

From Table 3.10 we can see that there is a slight move into part-time and full-time employment by mothers as their children get older. This is fairly typical of mothers of pre-school children (Martin and Roberts 1984).

As Table 3.11 shows, most of the fathers were in full-time employment: at the time of the first interview twelve fathers were in full-time employment; two were in part-time employment and one was unemployed although he occasionally worked for a few hours at a time behind the bar in a pub. This pattern changed slightly too over the interview period. At the second interview, the father who had been unemployed had now found a job, although it was very insecure and so he was still officially unemployed (as revealed to me by his wife, not himself). At the third interview, the pattern was almost the same except that one of the fathers who had been employed part-time was now self-employed part-time with a view to going full-time; and one of the fathers with an 'unofficial' job now had an 'official' one.

Table 3.11: *Fathers' employment over interview period*

	1st int. (n=15)	2nd int. (n=13)	3rd int. (n=13)
Full-time employment	12	11	11
Part-time employment	2	2	2
Unemployed	1	-	-
Self-employed	-	-	-

Occupational Status

Using the Registrar General's Classification of Occupations (OPCS 1980), parents' present or last occupations were classified according to their social class. The limitations of using this system of classification for women's occupations has already been discussed (see Chapter Two).

As Table 3.12 shows, at the first interview, the majority of fathers were in social class III M (n=13), with just one each in classes IV and V. This pattern stayed constant throughout the interview period, except in the case of one man who had moved from III M to II by the third interview.

Table 3.12: *Fathers' social class*

Fathers' social class	1st int. (n=15)	2nd int. (n=13)	3rd int. (n=13)
III (manual)	13	11	11
IV	1	1	1
V	1	1	1

The social class of the mothers was very different (see Table 3.13) partly, of course, because of the way their occupations are defined. At the first interview, most of the mothers were in social class III N (n=10), one in III M, three in IV and one in V. This pattern also stayed fairly constant throughout the interview period, except that one mother had moved from social class IV to III by the third interview.

Table 3.13: *Mothers' social class*

Mothers' social class	1st int. (n=15)	2nd int. (n=13)	3rd int. (n=13)
III (non-manual)	10	8	9
III (manual)	1	1	1
IV	3	3	2
V	1	1	1

This crude analysis hides the movement into part-time and full-time paid work by

mothers and changes in job or promotions by mothers and fathers. At the second interview, four fathers had changed their jobs and one had been promoted. At the third interview, two had been promoted; one had become self employed; and one had changed his job. These promotions and changes in jobs involved increases in income which fathers felt were vital to their contribution to the family.

Income

At the second interview I asked the parents for details of their income. They were asked which of the income groups, shown in Table 3.14, their own and their partners' take home pay belonged to.

Table 3.14: *Income groups used in interview schedule*

Weekly Income (£)	
0-5	66-85
5-15	86-105
16-25	106-125
26-35	126-165
46-55	165-200
56-65	Over 200

Taking account of both partners' incomes and including state benefits, six couples had a total income of over £200. Six couples had a total of income of between £165 and £200 and one had an income of only £100 and were living off the fathers' savings until he was able to go self employed (see Table 3.15). Information on the income of the two couples who were only interviewed once, was not obtained.

Average full time wages for all men in the UK including overtime stood at £207.50 per week in April 1986 (*Low Pay Review No. 29*). The official definition of low pay is the gross equivalent income figure set down as the minimum subsistence level by Parliament. This is the equivalent income level of supplementary benefit (now income support) and in the year 1986/7 when the study took place a two adult, two child household needed to earn £119.22 per week to be left with an income after deduction

equivalent to what they would receive on supplementary benefit (*Low Pay Review No. 29*). The Low Pay Unit use their own benchmark of low pay which is two-thirds of the median male earnings. In 1986/87 this was £123.40 per week for a basic 38 hour week (*Low Pay Review No. 29*). Thus by these definitions, only two of these families were living below the poverty line.

Table 3.15: *Families' total income*

Weekly Income level	No. of families (n=15)
Over £200	6
£165-200	5
£106-125	1
£86-105	1
Not known	2
TOTAL	**15**
Below national average (£207.50)	7
Above national average	6
Not known	2
TOTAL	**15**
Below Low Pay Unit definition of poverty (£123.40)	2
Below official definition of low pay (£119.22)	1

However, these averages do not reflect the higher cost of living in London, nor do they reflect the parents' worries about money and making ends meet. All the parents mentioned concerns about money - and nearly all of them talked about the way lack of money restricted them in providing the kind of environment they would like to give to their children. These issues are discussed in Chapter Six, which analyses in more detail parents' access to material and social resources.

III ANALYSIS OF INTERVIEWS AND DIARIES

To a certain degree, the analysis of interviews and diaries were separate processes. However, the processes became interlinked at various points. For example, at the second and third interviews, issues were raised with interviewees, which not only came out of their previous interviews but also out of the health diaries. The analysis of one also informed the other. For example, when I found that the most commonly reported health problem in the diaries was 'tiredness', I went back to the interview data to further explore how parents had talked about tiredness (see Chapter Five). This is the essence of developing 'grounded theory' (Glaser and Strauss 1967).

This point also underlines the fact, as already emphasised, that analysis is continuous in the research process and starts long before one begins to read, index, cut and paste the interview transcripts, or code the health diaries. However, there was a procedure which I undertook when transcribing the interview tapes and afterwards, which was systematic and describable. Similarly, I can describe how the health diaries were analysed.

i) Transcribing the interviews

I finished the data collection with a total of 82 completed interviews (two couples had dropped out after the first interview). Due to time constraints, these interviews were not fully transcribed. The choice of which sections to transcribe was based partly on the analysis of the first interviews and partly on what I decided was important. During the third interviews, I took notes in addition to the tape recording, and later transcribed certain parts of these tapes on the basis of these notes.

ii) Post-transcription analysis

When the transcriptions of the first interviews were completed, I made several copies of each transcript, so that I could organise them in various ways. At first I applied the original interview schedule guide to the transcripts, so that the basic information could be clearly and systematically recorded in order to provide a series of descriptive outlines.

Following on from this, I looked in detail at each section of the interview and gradually built up analytic categories as I went along. These categories were made into files, and parts of interviews that fitted these categories were grouped together. Notes that I made in the process were attached to the relevant files. I also developed a cross-referencing system, which included relevant literature. Copies of field notes, which fitted the categories, were also attached to the files. This process of creating categories took place over a long period of time. The files kept collapsing and reforming and redividing, because this process of analysis is a constantly reflexive one of checking concepts and hypotheses against data, investigating data that do not fit, and refining the initial concepts. I listened to the second and third interview tapes over and over again to see how they contributed to categories already formed or how they suggested new categories should be formed. The relevant areas were transcribed.

In addition to the category files, each parent had their own file which contained all the transcripts plus copies of their health diaries and copies of the field notes that related to them. Thus I aimed to build up whole pictures of the parents from whom I had collected data. Simple counting procedures also took place, such as how many times interviewees had reported going to see their GP and so on.

iii) Analysing the health diaries

Some of the problems in analysing health diaries have been discussed above. I chose to use the day as the unit analysis, each day being a separate case. Thus while for the qualitative data there were 30 'cases' (parents), for the quantitative data relating to the health diaries the number of cases was equal to the number of completed health diary-days. If all 30 parents had completed the three diaries, this would have given 630 diary-days. However, as Table 3.16 shows, 21 parents completed all 21 days (three diaries), two parents completed 14 days (two diaries), four completed 7 days (one diary), and one father did not complete a diary at all. This gave 539 diary-days or 'cases'. There are, however, some problems with treating each health diary-day as a separate case. For example, it can be argued that if a father reported having a cold on one day, he would be more likely to have reported one on either the previous or the following day than another father who had not reported a cold on that day. Thus the diary-days can be argued to be linked to individuals so that they cannot be treated as separate cases. In addition, by aggregating the mothers' and fathers' reports of their children's health the children's health problems, for example, may be counted twice.

Table 3.16: *Number of health diary-days completed*

	No. of diary-days completed	Total no. of diary-days
No. of mothers		
12	21	252
1	14	14
2	7	14
15		**280**
No. of fathers		
11	21	231
1	14	14
2	7	14
1	0	0
15		**259**
TOTAL		**539**

The diary data were coded in the following way:

a) Kind of day for self and child - these were pre-coded items.

b) Reported health for self and child - these were precoded items.

c) Reported 'health problems' - whether the parent mentioned any sort of health problem ranging from tiredness, headaches, and sore throats to accident at work or depression. These were defined as 'health problem days' whether or not more than one health problem was reported. Child 'health problem days' were coded in a similar way.

d) Reported health action - whether the parent reported taking any sort of action for the health problem she or he had mentioned. This could be going to bed early or 'taking it easy' in response to tiredness or taking aspirin for a headache or cutting down on cigarettes in response to a 'tight chest'. Once again I did not take into account how many actions were taken per day. Reporting of action taken for child health problems was coded in a similar way.

These items were analysed by using SPSS-PC. Manual counts were also made of the types of health problems recorded and the types of actions taken in response to these problems. Statistical tests of significance were not applied to the health diary data because, as this was an exploratory study, it was not appropriate to apply such tests (Moser and Kalton 1971:446-7).

The process of developing categories, which was taking place with the interview data, was also applied to the health diary data. For example, parents were divided into

categories of high, medium and low levels of reported health problems (see Chapter Five). The diaries also contained qualitative material, which was treated in the same way as the transcripts of interviews. However, the health diary data, together with the interview transcripts provided a wealth of data and it was not possible to incorporate all the data analysed in the main body of the thesis, nor indeed to analyse all the data, particularly in the case of health diaries.

IV THE PROCESS OF DOING RESEARCH

In the positivist tradition of sociological research, the ideal researcher is seen as an objective, unbiased 'scientist' who tests hypotheses and whose personal experiences and beliefs do not in anyway impinge on the research process. But from the subject of research, to the methods of data collection and analysis, we make decisions which are not 'just' sociological ones but also personal ones. It is a masculine sociology which has delegitimised or even denied the subjective aspects of research in the past, while feminists have brought to the fore the importance of exploring the effect of our feelings on our research. There is a notable absence of a sociology of feelings and emotions (Oakley 1981). Hochschild (1975) discusses the reasons for this absence saying:

> Our society defines being cognitive, intellectual or rational dimensions of experience as superior to being emotional or sentimental. (Significantly, the terms 'emotional' and 'sentimental' have come to connote excessive or degenerate forms of feeling.) Through the prism of our technological and rationalistic culture, we are led to perceive and feel emotions as some irrelevancy or impediment to getting things done...Another reason for sociologists' neglect of emotions may be the discipline's attempt to be recognised as a 'real science' and the consequent need to focus on the most objective and measurable features of social life. This coincides with the values of traditional 'male culture' (p.281).

A feminist sociology is one which, among other things, acknowledges and has a place for the researcher's own identities, feelings and emotions which affect the research. This is not to say that research should be all about the researcher's feelings and emotions, nor that it should not be rigorous and academic; but that the researcher should make explicitly clear the biases she/he brings to the research. This section is

concerned with making explicit the 'biases' which I have brought to this piece of research and the way in which doing the research affected me, which in turn influenced the research.

There are two areas concerning the process of doing research which I will address. The first is the experience of interviewing, particularly repeated interviewing, and the relationships which developed between the interviewees and myself. Secondly, I will discuss my experience of being a woman interviewing women and men.

(1) Interviewing - an interactive process

Given that I rejected the positivists' notion of the interview as a research tool to generate data which hold independently of both research setting and the researcher, I felt it was important to follow the advice of the symbolic interactionists, ethnomethodologists and feminist sociologists who have encouraged researchers to reflect on their own status in the research interaction and make explicit how this might affect the data collected.

I also rejected the rules of good interviewing as specified by positivists in order to obtain 'unbiased' results (eg. Moser and Kalton 1971, Selitiz et al 1964). These rules are summarised by Moser and Kalton who said:

> There is something to be said for the interviewer who, while friendly and interested does not get too emotionally involved with the respondent and his problems...Pleasantness and a business-like nature is the ideal combination (1971:286).

In this section I will discuss some of the issues which arose from taking a reflexive approach generally, and then discuss in particular the issue of gender in the interview process, that is, of female interviewer interviewing women and interviewing men.

Repeated Interviewing

Easterday et al (1982) discuss specific problems of being a female field researcher by using observations from twelve of their own research studies. These problems include being patronised by men, being propositioned by them, and not treated seriously. They conclude with some suggestions concerning field tactics:

> A general rule we have followed has been to avoid personal involvement with subjects as intimate friends. Ethical and practical problems such as over-rapport suggest reasons for this rule. Generally, problems include researcher bias, data distortion and imitation, reactivity and observer effects (1982:66).

The tactics they suggest to manage potential 'over-rapport' include:

> ...equalising time with all people in the field situations, not discussing details of the research with the informant/friend, and by checking comments and behaviour of others in the field as a way to verify observer perceptions (1982:66).

I did not find these suggestions very helpful in my research for both practical and ethical reasons.

Even if I had wanted to remain detached from the interviewees, this would have been very difficult in the light of the fact that the interviews were repeated. Also, I collected the health diaries a week after each interview and this usually involved going in for 'a chat' which I later recorded in my fieldnotes. Thus it was very difficult for a relationship not to develop, and indeed, I think this 'transition to friendship' (Oakley 1981) facilitated the research process. One woman commented at the end of her final interview 'it's been more like having a friend round than a researcher' (see also Finch 1984).

At first I had to spend some time 'training' my interviewees to treat the interview as a friendly encounter rather than a formalised interview whereby I asked certain questions and they gave short, punctuated answers (see also Mason 1987:125). Once they got used to this approach, the interviews became much less formal, and were much more like having a chat with a friend. This was underlined by the hospitality that I was always offered: I was always offered cups of tea and coffee and many times I was offered food. Certain rituals were set up so that for example, when I interviewed Jill and Peter Smith I always interviewed Peter first while Jill took the opportunity to have a bath. Then during her interview, Peter would go and do some of the decorating. Afterwards the three of us would sit round having tea and biscuits. Similar routines were set up with other couples.

Being involved in people's lives for a year and listening to their accounts of the often

intimate details of their daily lives meant relationships developed between interviewer and interviewees to the point where regret at the end of the project was often expressed by the interviewees. Three of the women and two of the men with whom I had built up particularly close relationships invited me to continue coming round to see them after the project had ended.

As others have reported (Oakley 1981, Finch 1984, Mason 1987), the interviewees were keen to 'place' me. What sort of person was I and why was I doing this project? The question I was most frequently asked was 'do you have children?' When I answered in the negative I was then asked 'has this put you off?' or people commented 'I bet this has put you off'. I was concerned that my not having children might make it harder to build relationships with my interviewees. They might have, quite understandably, had the attitude 'what does she know?' when I showed concern, for example, about them being up all night with the baby. However, I did not find this to be the case. Instead parents, particularly mothers, expected me to be an expert on child-rearing because I was doing this research project. I was asked questions like 'do you think my daughter might be allergic to additives?' 'how can I stop my son emptying all the cupboards?' and so on. The textbook recipes on interviewing tell researchers to avoid answering respondents' questions. Like others (eg. Oakley 1981, Finch 1984) I think this is unethical and so answered questions about myself freely, gave information where I could, and referred parents asking for advice to their GP or health visitor etc. I tried to make it clear that I was not an 'expert', and instead attempted to assist them in feeling confident that their own ideas were 'expert' enough.

Parents' definitions of me as a 'expert' were clearly related to our relative class positions and different experiences of education system. The model which characterises the interviewer/interviewee relationship is that of an active/passive or a hierarchical dominant/subordinate relationship. This model is rejected by Oakley who argues that:

> The goal of finding out about people through interviewing is best achieved when the relationship of interviewer and interviewee is non-hierarchical (1981:41).

This might be an ideal to aim for but it is not, I think, possible to achieve. To deny the power imbalance which exists in the interview relationship by way of class, gender and ethnicity is not helpful (see also Cornwell 1984:13, Thorogood 1987:23). Age is another important issue, but in my study this was not an important one, as I was more or less the same age as the interviewees - I was aged 23 and the average age of the interviewees was 27.

The relationship between the class, gender, ethnicity of the researcher and the researched and its impact on the interaction is a highly complex one. The power relations in the interview complicates this one-dimensional view, so that as a middle class women interviewing working class women the relationship is affected by an identification which I had with the women and they had with me (see also Oakley 1981, Finch 1984). As a middle class woman interviewing men, however, I was both in a dominant and a subordinate position (see Scott 1984 for an analysis of the relationship between gender and status in the interview process). Further, in my study there is a third dimension: seven parents where not white British (three were Greek Cypriot, one Turkish Cypriot, two Afro-Caribbean and one was Irish). Just as it is important to acknowledge class and gender relations in the research process, so it is important to make explicit the issue of colour and ethnicity and how my colour (white) and ethnicity (Jewish) are part of the equation when interviewing white and black parents.

Contact with parents was maintained between interviews by sending them reminder letters that I would be wanting to interview them again together with a short progress report on the project. I also sent them Christmas cards and a card to their child on his/her birthday. This 'transition to friendship' was undoubtedly beneficial to the research, because many of the interviewees felt able to reveal to me painful and difficult experiences and feelings which were important to the understanding of the subject. It was also beneficial to many of the parents in that it allowed them to 'get things off their chest'.

However, this 'rapport' was not with its difficulties. My experience with one woman

whose husband left her after the interview illustrates the difficult and ambiguous role of the researcher. When I phoned to arrange the second interview, Lesley Fisher told me that her husband had left, and therefore she did not want to be in the project anymore. I asked if I could come round and see her anyway, which I did. We sat over tea while she poured out the story of how her husband had gone to live with another woman in Devon. She had been left with no money and had been desperately trying to get some help from the Department of Health and Social Security (DHSS). The roles of interviewer/interviewee disappeared and the situation became one of one friend giving emotional support to another. In that situation, a friend does not remain neutral and just listen. The expectation is that a friend will give something of herself in return - the relationship is two way. So with this sharing of experiences we had crossed some boundary between formal and informal relationships. Lesley asked me if I would 'pop round again' and so about a week later I did. To my surprise I found her husband had returned, so I asked if I could interview them both again. They agreed and we arranged a time. However, when I went round they were not in. I phoned and spoke to Lesley, who said she did not want to be interviewed: 'you know the situation and I don't want to talk about it'. In crossing the boundary I had perhaps gone too far, and now that her husband was back it was as if Lesley regretted telling a stranger the whole story. The boundaries between research and friendship can pose difficulties.

The 'transition to friendship' also led to problems when it came to finishing the interviews. I realised that this was going to be a problem when, after the pilot interviews, I felt a sense of loss, which surprised me, after saying goodbye to a couple of the women I had interviewed. I felt guilty for walking in and out of their lives with such apparent ease, and realised that if it was difficult for me it must surely be difficult for them having opened up to this stranger who they would not see again. But I also knew that it would make it much more difficult for me to write up the research if I maintained friendships with some of the families after the interviews had finished, so I decided to end contact with the families after collection of the last health diary. The close relationships I developed were almost exclusively with women - there was only man with whom I could say there was any relationship other than

that of researcher and researched. Not that the other men were not friendly, but they kept a distance and I probably maintained a distance. These behaviours are a function of the difficulty of a woman having a non-sexual relationship with a man in our society, particularly a married man.

The period after the year of interviews felt very empty. Suddenly I had my evenings free again and I was not quite sure what to with them. A year of intense social contact with people was followed by a year of intense isolation with just me, the interview transcripts and health diaries, and my word processor. I was now supposed to 'objectify' these parents and turn them into sociological constructs for the purpose of my own educational and career advancement. The periods of writing paralysis I had during that year were in part caused by my inability to stand back from the data. An excerpt from my PhD notebook (described in Chapter Two) reads:

> There is an inherent tension in the study between not wanting to impose definitions of eg. health, types of fatherhood etc and yet the very nature of research demands that I do this. I'm not sure how to cope with the dilemma of trying to retain parents' perceptions and feelings, whilst at the same time treating them as data which must be put in a form such that it can be analysed

This agony continued on and off throughout the analysis and writing up period and was interspersed with periods when I totally cut off from the parents I had interviewed and treated them as 'subjects'. This was particularly easy when I was doing the computer analysis of the health diary data. But when it came to analysing the interview data, who was I to represent what they had said to me? However, as Oakley has argued:

> While the language of rating scales (the word 'assess' for example) may convey the impression that it is the researcher who sits in judgement on the researched, he or she *is* better equipped through contact with the data to judge the grouping of individuals than are those individuals themselves (1980:111).

Hence I developed typologies of parenthood (see Chapter Seven) from an *analysis*, rather than just a *description*, of attitudes expressed by interviewees.

(2) A Woman Interviewing Women and Men

Some feminist researchers have discussed the processes involved when as a woman and a feminist they interviewed other women (eg. Oakley 1981, Finch 1984). Others

have described the processes involved in interviewing men (McKee and O'Brien 1983, Cunningham-Burley 1984, Cornwell 1984, Scott 1984). My experience of interviewing women and men sometimes corresponded with what other researchers have found and sometimes did not.

McKee and O'Brien (1983:151) compared their experiences of interviewing mothers and fathers about pregnancy, childbirth and childcare, and found that fathers had less to say and took less time to say it. In contrast, the length of interviews for mothers and fathers in my study was very similar. Both sets of interviews ranged from between half to two and a quarter hours, the average for women being 68 minutes and for men 61 minutes. However, as McKee and O'Brien (1983:152) point out, part of their study focused on expectant motherhood and fatherhood, and fathers are at one remove from the active processes and drama at that stage. They found interviews with the same fathers after the birth of their children were longer. It was at this later stage, ie. after the birth of the child, that my interviews were conducted.

McKee and O'Brien's experience was that the women they interviewed talked more openly than the men (1983:154). The pattern in my study was not quite as uniform as this. Some men clearly found it difficult expressing their feelings and did not really 'open up' in any of my contacts with them. However, this was also true of some of the women I interviewed, albeit fewer. Further, many of the men I interviewed did talk openly about their feelings, difficulties and so on, although again these numbered fewer than the women. The differences were in the ways they talked about certain topics such as health and childcare. This is explored in later chapters.

Many interviewees were nervous about the interview situation, especially at the first interview. However, it was noticeable that the women expressed more anxiety about whether they were 'doing it right'. I frequently had to reassure women interviewees that what they were telling me was I what I was interested in, and that there were no 'right' answers to the questions (this has also been noted by Finch 1984:72). Men did not ask for such reassurance.

I have already mentioned that the women were often interested in what their partners were saying in their interviews, whereas the men did not show this interest. Also, women were keen to know what other parents were saying. They wanted to know if they were 'normal' or 'typical' and if other parents experienced similar problems. This can be accounted for by the pressures on women to be 'good mothers' (New and David 1985), and women's experiences of the way health and social services agencies (amongst others) sit in judgement on their ability to mother.

Researchers have described how women with young children are 'captive subjects' for research as they are often at home during the day, and this situation is open to exploitation because these isolated, lonely people are eager to have someone to talk to (see eg. Finch 1984). For most of the interviewees in the present study, being listened to was not an experience they were used to in their normal daily lives, and was greatly appreciated. For some, particularly some men who had no-one to confide in other than their partner, being listened to was such a rare occurrence it made them feel uncomfortable. The experience of *really being listened to* is absent from many women's and men's lives.

McKee and O'Brien's (1983) experience of interviewing fathers was that the interviewer/interviewee relationship was not characterised by the active/passive or hierarchical dominant/subordinate relationship. The fathers they interviewed, particularly the lone fathers, frequently actively manipulated or 'controlled' the interview in different ways and for different ends. For example, the fathers seemed to 'use' the interview to 'get things off their chest', to meet problems of loneliness, to affirm their experiences compared with other new and lone fathers, and so on. In my study I found this true of many of the mothers and fathers that I interviewed, but there was no evidence of fathers being more manipulative than mothers.

McKee and O'Brien also describe how some of the lone fathers were more active in their attempts to control the interview. They did not readily 'accept' the interview format and seemed to be 'creating trouble' (1983:150). Only two fathers that I interviewed gave me any 'trouble' in such a way. One was in the pilot study; he was

rather hostile and would not answer all my questions. His wife did not speak English, which I did not realise until I had interviewed him. He acted as translator and insisted on censoring some of the questions and answering some of them himself. Another man I interviewed in the main study was excluded because he became hostile during the interview. He had been very friendly when I arrived, but part way through the interview he became very annoyed and answered my questions very curtly and abruptly, saying 'don't know' to most of them. He aggressively asked me what the study was about and claimed he thought it was about the borough and the local surroundings, although I had explained it to him on my arrival. I felt very threatened during this interview, particularly as his partner was not at home during most of it.

However, the vast majority of the interviews I conducted with fathers were characterised by the active/passive or hierarchical dominant/subordinate relationship. This made me feel more uncomfortable as many of them passively answered my questions briefly and to the point. I felt more relaxed when interviewees (more mothers than fathers) talked easily and often went off 'the subject'. The issue which McKee and O'Brien omit from their analysis is one of class. It is not possible to untangle the influences of gender and class in the analysis, but while issues of gender meant that most of the fathers found it more difficult to talk than most of the mothers, issues of class meant that I was still seen as the powerful, dominant figure even if in terms of gender relations I was not. In the pilot study and when trying to get the study group for the main study, I interviewed several middle class fathers. This was a very different experience: they talked much more easily; asked me why I asked them certain questions; asked much more detailed, technical questions about the research and so on. Thus the interviewer/interviewee relationship when a woman interviews a man should not be analysed only in terms of gender but also in terms of class and other factors eg. age, race etc.

Two difficulties I experienced in interviewing women and men as a woman and a feminist were first, the whole issue of sexuality in all its ramifications and secondly, the issue of loyalty to women. The issue of sexuality was raised in various ways. In the first place, I was concerned about interviewing men before I began, because of

the fear of possible sexual violation. With my study group of men I never felt threatened in this way, although on two occasions described above I felt extremely uncomfortable and powerless, and relieved when the interview finished. I do not know how different it would have been if I had interviewed men alone in their homes (see eg.McKee and O'Brien's description of interviewing lone fathers). In all but one of the interviews with men, their partner was present somewhere in the home, Secondly, I was concerned that the woman might see me as a sexual threat and dislike the idea of me interviewing her partner. Although this was never made explicit, I wonder if this was behind some of the women's attempts to be present at their partner's interview, in addition to wanting to know what he said.

The second difficulty is the issue of loyalty. Janet Finch has written about the identification between women interviewees and women interviewers:

> However effective a male interviewer might be at getting women interviewees to talk, there is still necessarily an additional dimension when the interviewer is also a women, because both parties share a subordinate structural position by virtue of their gender. This creates the possibility that a particular kind of identification will develop (1984:76).

I certainly felt this identification when women talked about the 'highs' and 'lows' of being a mother, their relationship problems and so on. I often found it difficult to identify with men's passionate feelings about football and other 'male' preoccupations. As a feminist researcher, one of my main aims was to make women's lives visible and thereby help explain gender inequalities in health and illness. This meant that my 'natural' inclination was to side with women. But I found that this conflicted with one of my other aims, which was to listen well to all the interviewees and take what they said as a version of reality. The conflict became most evident when couples began confiding in me about their relationship problems. With two couples in particular I was party to long complaints from both sides about the inadequacies of the other one. As in all interviews, I nodded sympathetically and generally gave the impression that I understood what they were talking about although I often, though not always, felt more sympathy with the woman. For a while I felt like a fraud: surely it was dishonest to show such sympathy to both sides? Faraday and Plummer

(1979:793) have also described how a researcher can feel hypocritical by moving from one group to another, agreeing with them both even though their views are wildly at odds with each other.

The issues of whether to remain silent is discussed by Faraday and Plummer (1979:792-3) and McKee and O'Brien (1983:158). The question is how far a researcher should leave unchallenged views offered by interviewees which the interviewer finds offensive. McKee and O'Brien (1983:158) found themselves listening to sexist remarks about women from lone fathers which they did not respond to. Faraday and Plummer, on the other hand, in their study of sexual 'deviants' challenge their interviewees when they made derogatory remarks about other groups of sexual deviants they were studying. This was often against their own interest in maintaining relationships with these interviewees (1979:793).

In my study I was on occasion confronted with the dilemma of whether to challenge sexist, racist and homophobic comments or stay silent. I found myself taking the McKee and O'Brien course of action, but feeling very uncomfortable (as they did) in the process. As they point out, these dilemmas are rarely discussed in traditional textbooks on methodology.

Conclusion

This chapter presents the 'lived experience' of this particular piece of social research. It describes how I gained access to the study group; their characteristics and that of the area in which they lived; and some of the key issues which arose in the process of carrying out the research.

Some of the problems in selecting fifteen working class, two parent families from health visitor caseloads for the study have been discussed: I had to write to 75 families in order to arrive at fifteen. These fifteen live in an inner city borough; mostly in privately or Local Authority rented accommodation; nine of them below the national average income and two below the Low Pay Unit's definition of the poverty

line.

I have described how the interview and health diary data were analysed, and have made visible the 'real explanation of how the research was done'. In particular, the issues of the 'transition to friendship' in repeated interviewing, and my experience of being a woman and interviewing women and men have been discussed. This is an important element of 'doing feminist research' and part of the data which form the rest of this thesis.

CHAPTER FOUR
PARENTS TALKING: MOTHERS' AND FATHERS' CONCEPTS OF HEALTH AND ILLNESS

> Over and above the physical demands and restrictions that mothers face, there is the added burden for most of feeling continually and ultimately responsible for the health, development and happiness of their children. However much help a mother may get in bringing up her children, she is still likely to feel that she is the person beyond whom there is no recourse or appeal, and who is answerable for whatever happens (Hughes et al 1980:18).

This chapter considers parents' ideas about health and illness and their subjective perceptions of how childcare affects their health. The chapter is divided into two sections. In the first section, parents' general concepts of health and illness are analysed in relation to findings from other studies on lay beliefs. In particular, differences between mothers and fathers are discussed. Secondly, the parents' subjective perceptions of how childcare affects their health are presented. The differences between the mothers' and fathers' views on the effects of childcare are analysed.

I PARENTS' CONCEPTS OF HEALTH AND ILLNESS

There are two main reasons for studying mothers' and fathers' concepts of health and illness. First, because lay concepts of health and illness can help to explain health and illness behaviour; and secondly, they may help to explain gender differences in reported health. Thus the gender differences in reported health and illness which are outlined in the following chapter, need to be viewed in the context of these parents' beliefs about health and illness and their beliefs about how childcare affects their health.

The literature on gender differences in health and illness reviewed in Chapter One has neglected the area of gender differences in concepts of health and illness, and how this may contribute to the differences between men and women in reported health.

Just as an understanding of lay beliefs may be important in explaining social class variations in health outcomes, they may also be important in explaining gender differences in reported health, which is the focus of the present study. As this study is based on data collected from a group of working class parents, I review below the literature on working class and social class differences in lay health beliefs (Herzlich 1973, Blaxter and Paterson 1982, Pill and Stott 1982, Williams 1983, Cornwell 1984, D'Houtard and Field 1984, Calnan 1987). However, while these studies have dealt with the issue of social class differences in perceptions of health and illness, none have looked at the issue of gender differences in this area. Most studies use a sample of only women (D'Houtard and Field 1984; Calnan 1987; Blaxter and Paterson 1982; Pill and Stott 1982) and those that interviewed women and men (Herzlich 1973; Williams 1983; Cornwell 1984) did not focus on gender differences to any degree. Cornwell has written a little about the differences she found between the women and the men but only in terms of perceptions of illness, not perceptions of health. Backett (1990), in her study of health within middle class families, does compare the health beliefs of the mothers and fathers.

In Chapter Two, I outlined the rationale for taking an interpretive approach to mothers' and fathers' experiences of health and illness. In this study, therefore, mothers' and fathers' health beliefs are placed at the centre, and are not seen as secondary to a medical view of health and illness.

Social class differences in health and lay health beliefs

The interpretive approach is an important one, but there is also a need to develop a framework whereby it can be shown how perceptions of health and illness are shaped by structural and cultural elements. The two examples discussed below are (i) the relationship between social and economic circumstances and lay health beliefs; and (ii) the hegemony of the medical model and its influence on lay health beliefs.

(i) The relationship between social and economic circumstances and lay beliefs

The social class differences in 'health' (as measured by mortality rates) are well-known (Townsend and Davidson 1982, Whitehead 1987). There are various

competing and complementary explanations for these differences (see Chapter Six), but the two main ones are the materialist or structuralist explanations and the cultural/behavioural explanations. The former explanations argue that there is a direct link between social and economic circumstances and health outcomes: the less favourable living and working conditions of manual workers expose them to a greater risk of contracting diseases, such as respiratory infections and to greater physical hazards, such as accidents.

The cultural/behavioural explanations give a more central role to health beliefs. They suggest that inequalities are in part derived from the health risks associated with the differences in the health-related behaviour of different social classes. For example, there is evidence that social classes IV and V make less use of preventive health services such as cervical smears and antenatal facilities than their middle class counterparts, but are also more likely to have heavier consumption of potentially health-harming substances such as tobacco and sugar.

These differences in social class patterns of health behaviour are explained in different ways. One type of explanation is complementary to the materialist explanation of social class differences in health. This structural approach suggests that constraints on resources such as time, energy and money limit the extent to which disadvantaged groups can use services or adopt health-enhancing practices (Graham 1984).

An alternative approach emphasises the importance of cultural factors, and suggests that differences in health-related behaviour between the social classes reflect the existence of culturally-transmitted beliefs. One example of this approach is the subcultural thesis, which argues that poorer groups have their own cultures where values are different (and by implication, inferior) to those in the mainstream society. Another example is the cycle of disadvantage theory, which argues that beliefs about health and health practices have been transmitted from generation to generation. These cultural approaches have been criticised because they play down the direct impact of structural forces, and also because they make *a priori* assumptions about the nature of beliefs without recourse to empirical examination.

Blaxter and Paterson (1982), in their study of health and health care in 58 three-generational families in a Scottish city, found very little evidence for a 'family health culture' or a persisting set of subcultural beliefs. Their study showed how material circumstances and the experience of ill health might influence conceptions of health and approaches to health maintenance. They found no evidence of a positive conception of health among their respondents. Illness was seen in functional terms, and a distinction was made between normal illnesses and more serious illnesses. The former were familiar and common ailments, which were an expected and accepted part of daily life. Some conditions were not defined as bad health at all, especially those associated with 'normal' stages of life - childbearing, the menopause, and 'wear and tear' over the years. Serious illnesses included cancer, heart disease and tuberculosis. This lack of a positive conception of health and the accommodation of minor illnesses is thought to explain why lower working class groups have a lower rate of participation in preventive health programmes than other classes. These conceptions are clearly influenced by the experience of a high prevalence of ill health among this group (Morgan et al 1985:92).

Cornwell too, concluded from her study of accounts of health and illness among working class people in East London that:

> The relationship people in the study have with health matters of all kinds is powerfully moulded by the practical constraints of work and family life which dominate their lives and the meanings these constraints hold for them (1984:123).

However, many of the studies that have been carried out on lay concepts of health have concentrated on one particular social group, so it is difficult to judge which aspects of beliefs are specifically associated with the social group and which are more applicable to the population as a whole. For example, Herzlich (1973) used a mainly middle class sample; and Blaxter and Paterson (1982) and Cornwell (1984) focused on working class people.

This problem was overcome more recently by research in both France and England that has examined the relationship between health concepts and social class.

D'Houtard and Field (1984) asked a sample of 4000 respondents in north-eastern France an open-ended question on what health meant to them. The responses were clearly linked to the socio-economic class position of the respondent, which was the most discriminatory variable. There was a gradient from the higher non-manual classes to the lower manual classes, the former conceiving health more in personalised, positive expressive terms, and the latter more in negative, socialised and instrumental terms.

A study of social class differences in health beliefs of women living in England did not find such clear-cut social class differences (Calnan 1987). But there was some evidence to suggest that working class women were more likely to use a uni-dimensional definition of health that might be described as a functional definition ie. 'getting through the day'; whereas the professional women were more likely to use multi-dimensional definitions that incorporated a wider range of elements, including being fit, being active and the absence of illness. These findings support the assertions made by researchers focusing only on disadvantaged groups, that adverse social and material circumstances may have led people to operate predominantly with functional definitions of health (Blaxter and Paterson 1982). In other words, people in difficult material and social circumstances are so busy 'coping' and 'getting through the day' that they do not have time to develop more abstract notions of health.

While these studies have shown that working class people have different concepts of health and illness from middle class people, they have not been able to show whether this is the same for women and men.

(ii) The hegemony of the medical model and its influence on lay beliefs

As yet the comparative literature on lay concepts of health and illness in industrial societies is not very extensive (Herzlich 1973, Blaxter and Paterson 1982, Pill and Stott 1982, Williams 1983, Cornwell 1984, D'Houtard and Field 1984, Calnan 1987), but there are some common themes. One of these is the hegemony of the medicalised definition of health as the absence of illness, and the consequent difficulties lay people have in defining what they mean by 'health' and 'being healthy'. As Cornwell (1984)

argues, this is not surprising given that Western medicine does not have a definition of health apart from health as the absence of disease.

This is to some extent confirmed by my interview data in which some parents saw health purely as the absence of illness and had great difficulty in talking about positive conceptions of health. In order to try and get at positive concepts of health I asked interviewees several questions such as 'do you ever feel really healthy and if so what does it feel like?' and 'in an ideal world, how would you like to feel health-wise?'

Ideal Health

Some parents found this question very hard to answer and could not really conceive of a situation outside their present experience. Dawn Abbot, for example, answered:

> I would like to feel how I do now, you need some bad days so that you can cope with them

and Louise Bevin said:

> I think I'm OK as I am really. I get done what I want to do so...

Robin Ingram said:

> Like I do now...I'd like to go to sleep a bit earlier (laughs). Reason I feel healthy now is 'cos I slept last night.

However, other parents did express a much broader concept of health than just the absence of disease. This included their mental well-being, their environment, and their health care practices such as eating and smoking. Nigel Abbot has an imaginative view of how he would like to feel healthwise:

> I'd like to wake up in the morning 'n' not ache at all, like no aching limbs, breath fresh air...I suppose in an ideal world I'd like to live in a nice log cabin in Sweden or Switzerland, half way up a mountain with plenty of fresh air 'n' feel fit...I wanna go somewhere like that where you can breath really *good* air...

Paul Edwards' vision of his ideal health is a mixture of his wishing he could change

his individual behaviour and wanting general improvements in his environment:

> I'd like to feel I didn't need to take tablets, stimulants or drugs, I'd like to feel I didn't need to take any vitamins as well, I'd like to feel I got all my nourishment and vitamins etc from food I like. I'd also like all my meals to be on the table for me but I suppose I'd have to provide the money for them to be there. I'd just like to be in good shape and I'd like to live in a town, I suppose the air's pretty clean round here. I'd like not to work in a dust warehouse, but I don't think I'd like to give up smoking. I don't ask a lot but um, admittedly cigarettes do you harm, some people more than others and I'm prepared to take a gamble. I don't see myself living a very long time. So I'd like to be able to smoke. I'd like to be a little bit broader as well -I'm rather under weight for my size.

Rosemary Ingram also saw her ideal health as being able to change what she sees as her unhealthy practices:

> I don't know what you mean...how would I want to feel?...I wouldn't want to smoke...I wouldn't eat junk food, which I don't eat much junk food anyway...I don't know. I'd just like to feel healthier.

Interestingly, some parents used different concepts of health at different times in the interview. Lesley Fisher, for example, had a rather restricted view of her ideal health which was another version of the 'getting through the day' concept of health:

> I'd like a lot of natural energy, I'd like to get up in the morning, I don't mind feeling tired at night - it's just the energy really and I feel I could conquer everything else if I just had the energy.

But at other points in the interview, Lesley used a much broader concept of health. When I asked her what effect looking after Hazel had on her health she replied:

> It's got a lot to do with the mind...you just can't relax, that's what a child takes out of me, you know, that's it...it mentally drains you 'n' then it comes physical, yeah I think it does start with the mind, if I could block it out I'd be all right, but I can't you know, I don't believe you should just ignore it.

For most of the mothers the vision of their ideal health was one of 'getting through the day', or they were satisfied with their health the way it was. Julie Thomas, for example, said that she would not want her health to be any different, even though she had said she felt 'quite healthy' only at weekends: 'I wake up 'n' I'm in a good mood 'n' I generally feel quite healthy' but her vision did not extend to her wanting to feel like she did at weekends all the time. It is as if mothers do not *expect* to feel really

healthy all the time and indeed do not feel they *deserve* to feel this way. This is perhaps best summed up by Jill Smith, who said:

> I wouldn't like to be so tired as much obviously, but then that's my job.

Most of the fathers had much more ambitious visions of their ideal health. For Andrew Wicks, his ideal health was:

> Having the energy to get up, go out and enjoy yourself. Suppose to be in the countryside, by the seaside, sunshine, run about, play games with her in the countryside, you know, like I used to when I was a kid, belting round all over the place.

This contrast between mothers and fathers is perhaps best illustrated by the different ways in which Patricia Morgan and Ed Newton talked about what they felt like doing when they feel really healthy. Ed Newton said on those days when he wakes up feeling 'on top of the world' he feels like going out:

> First thing I do is look at the weather 'n' I think right I've gotta go out...just say like last Tuesday, I got up, said come on, went down to the Science Museum 'n' the British History Museum, we was out all day, went to Hamleys...didn't cost a lot of money, bought one of 'em run-around tickets...'n' the museums are free, we was in there hours, you know, it was just something that was nice. I s'pose you get up 'n' you have your mornings don't yer?

His partner, Patricia, has different priorities:

> You get the odd day where you're just full of beans...I 'ad one a couple of days ago where I just, um, you just wake up 'n' everything's O.K. You just bubble along 'n' you just go through the day...when I get like that I like to stay in, I like to stay indoors 'n' get more work done, sort of do the house 'n' that cos then when you do sit down at the end of the day 'n' you realise what you've got through you can oooh that's when you just wanna go to sleep: die (laughs).

These gender differences relate to one of the themes common to these studies: health interpreted as 'functional ability' and 'capacity to work' (see Blaxter and Paterson 1982, Cornwell 1984, Pill and Stott 1982). As Cornwell (1984) argues, however, it is not enough to know that this is a definition of health without knowing about the nature of work that people do and their relation to it. She uses the example from her

study of the different definitions of work employed by the men and women. While they shared a common perspective on work and its moral significance, to the men 'work' means their 'job' whereas to the women (most of whom also had jobs) 'work' means 'housework and childcare'. Therefore the conditions of what men and women take to be their work are not the same, and the constraints operating on them when they feel unwell are also different. The demands of employment are usually more containable than the demands of childcare and housework, so that for the men in Cornwell's study the important question was whether or not they felt they could continue to go to work, and as long as they were able to, they did what they called 'working it off'. The women's response to feeling unwell was very different - they talked about 'carrying on' and 'doing what they've got to do'. Instead of trying to 'work off' their symptoms as the men did, the women tried to accommodate their symptoms in order to keep going. If they could not succeed in containing their symptoms and were unable to 'carry on', then they readily consulted a doctor in the hope of getting something that would put them back on their feet looking after the children.

I have similar findings in my study. Simon Cartwright, for example, talked about 'ignoring' his symptoms so that they went away and, as has already been shown, many of the mothers' concepts of good health were about 'coping' and 'getting through the day'.

Happiness and Health

Calnan (1987) found in his comparison of middle class and working class women that the majority of women in both groups believed one had to be happy to be healthy. But working class women were more likely to believe that unhappiness interfered with health, and they referred to unhappiness as 'pulling you down' or 'dragging you down', whereas middle class women incorporated happiness into their definition of health because their definitions included a 'mental aspect' as well as a physical one. In my study, although the parents often included a 'mental aspect' as part of their concept of health, it was most often in the negative sense of the mind dragging them down physically (see the example of Lesley Fisher above). Deborah Jessop is another

example of this:

> I'd like to feel myself, sometimes when I feel when I get tired I can't be myself, I can't be what I consider to be a fairly sort of happy and lucky person and sometimes I feel that I get dragged down and I can't feel like what I want to be.

A few parents, however, did include happiness in their positive conception of health. Simon Cartwright said he feels healthy most of the time and when I asked him what that felt like, the definition of health which he implicitly employed was a positive conception of general well-being and happiness rather than not being ill:

> ...erm (pause) well, just happy. Things are going for me quite well, I feel that my life is moving in the right direction...I'm very happy with my marriage you know, I've got a lovely baby, we've got no financial problems.

Feeling Really Healthy

There were no substantive differences in the mothers' and fathers' descriptions of where and when they felt really healthy. There were two main categories in answer to the question 'do you ever feel really healthy?'. One category were those parents who said they 'never' felt really healthy (7 parents). Louise Bevin said:

> Well, I never feel as though I could go and run round the block twenty times, no (laughs). But I feel OK, I never feel dreadful.

The other main category were those parents who said they felt really healthy when they were on holiday or were generally out and about and not stuck indoors (7 parents). Lesley and David Fisher had recently come back from holiday when I interviewed them and they both said that the time they felt really healthy was on holiday. Jill Smith said:

> The time I mainly feel healthy is when I've been away from it all. Like last Saturday Peter took Katy off my hands completely and I went shopping with my sister and I came back and it was lovely. Needless to say I missed her...purely just to get away from it, you know, as much as I love her, I'm sure you're like that with anyone as much as you love them and care for them, it's nice to be on your own sometimes. Well, not on your own but away from the things you know.

Another group of parents (5) said that they felt really healthy all the time. These

parents were very defensive about admitting anything was wrong in any area of their lives, especially their and their child's health. Daniel Oliver said:

> Yeah, yeah, I don't feel too bad, I can walk anywhere, run a certain distance, that's all...I feel like that most of the time.

There was a group of parents (5) who were very fatalistic about when they felt really healthy. They said they either woke up 'feeling on top of the world' or they did not, and they did not seem to feel they had any control over it. When I asked Jane Vernon if she ever felt really healthy, she answered:

> Really healthy?...Some days you get up and the sun is shining, you look out of the window and think oh, it's a nice day today, I'll go out and do so 'n' so. Yes I do sometimes.

The other two categories of answers to this question are parents who said they felt really healthy at a specific time of day, mainly in the morning (4), and those parents who said they felt really healthy when they were taking part in some form of physical exercise (3). There were two parents who said that how they felt health-wise was very much dependent on the weather and that they felt really healthy in warm, sunny weather.

Public and Private Accounts of Health and Illness

The idea of the hegemony of medicine and the medical model of health led Cornwell (1984) to develop her distinction between public and private accounts. Public accounts refer to answers to formal questions such as 'In the past year would you say that overall your health has been good, fairly good or not good? whereas private accounts are when people recount stories about their own or other people's personal experiences. Public accounts are also characterised, Cornwell argues, in terms of their overriding preoccupation with questions of acceptability and legitimacy. This argument holds for public accounts of other matters but is more complicated with health and illness because they are moral categories (Blaxter and Paterson 1982). Also, there is a public hierarchy of authorities in relation to health which is topped by medicine. Thus public accounts of health and illness not only have to be acceptable to the 'public' (the person listening) but also have to be legitimate with respect to

medicine (Cornwell 1984). However, Cornwell argues, the differences between public and private accounts of health and illness do not neatly correspond to a difference between medical and lay concepts of health. That is, public accounts do not only produce medical accounts and private concepts of disease do not reflect only lay concepts of illness. Public accounts, she says, contain both lay and medical concepts, and switch between them, depending on the form of legitimation which is most applicable to the subject and the context in which it is being discussed. But in both types of account, professional medicine is the final authority which establishes whether an illness is considered 'real' and therefore legitimate, or 'not real' and therefore illegitimate.

I would suggest that in the case of discussing parenthood and health there is an even greater preoccupation with questions of acceptability and legitimacy because of the moral ideology surrounding parenthood, particularly motherhood. This leads to a greater disparity between the public and private accounts, especially with regard to parents' accounts of their child's health. This is illustrated by the defensiveness with which parents talked about their children's health, and the lengths to which they went to assure me that their child was healthy, because their child's health was perceived as a reflection on the quality of their parenting (see also Blaxter and Paterson 1982). Parents, particularly the mothers, took longer to reveal their private accounts of parenthood because of the moral constraints on mothers expressing difficulties.

In order to get at parents' public accounts of their own health, I used the GHS question 'in the past year, would you say that overall your health has been good, fairly good or not good?' This question is very limited, but it does provide a guide to parents' public accounts of their subjective perception of overall health status.

Most parents saw their health the past year as having been fairly good or good, but more women than men felt their health had been not good (see Table 4.1).

Table 4.1: *Perceived health status in the year before first interview*

	Mothers	Fathers	Total
Good	7	6	13
Fairly good	4	8	12
Not good	4	1	5
Total	15	15	30

It was interesting to see how parents responded to this question as a way of getting them to talk about their health and compare it with other ways they talked about their health. The majority of parents (23) were able to answer the question immediately within the confines of one of the three categories (good, fairly good, not good); but a significant minority (7) needed prompting to encourage their answer into one of the three categories. The former group were mostly women while the latter group were mostly men. This could be explained by women's tendency to be more compliant compared with men, and the fact that women, especially new mothers, are more used to being asked about their health, particularly by health professionals. Most parents (21) answered the question by just using one of the three categories while the remainder, mostly men, elaborated their answers without prompting. It was unclear in four cases in which category to place the respondent's answer.

Explanations of perceived health status

The GHS question was followed up by asking parents why they thought their health had been good, fairly good or not good in the past year. I wanted to see which factors parents spontaneously mentioned as being important in explaining their health status. Parents who perceived their health in the past year as good or fairly good found this a difficult question to answer, as they tended to take their good health for granted. Those who reported not good health or health problems found it easier to explain their health, because they had needed to develop explanations for themselves and others.

These 'public' explanations fell into five categories, one or more of which were used by parents to explain their health status (see Table 4.2). In fact, most parents used more than one of the categories shown in Table 4.2, illustrating that for them health is not a unitary concept. Moreover, it is important to emphasise here, that these were only the initial explanations that parents used, and that later in the interview and subsequent interviews other, often more 'private', explanations were employed.

Table 4.2: *Explanations of perceived health status in the past year*

NB. Parents could use more than one explanation.

	Mothers (n=15)	Fathers (n=15)	Total (n=30)
Fatalistic	7	6	13
Child-related	9	1	10
Positive	8	1	9
Negative	1	0	1
Own behaviour	2	6	8
Positive	1	3	4
Negative	1	3	4
Job conflict	1	4	5

In their public accounts of their health status, the mothers and fathers put forward different explanations. The fathers explained their health or ill-health in terms of the conditions of paid employment; specific illnesses they had experienced; and in terms of their own individual behaviour. In contrast, the mothers were more likely to explain their health or ill-health in terms of their experience of mothering. Both mothers and fathers were equally likely to use 'fatalistic' explanations in talking about their health status, that is, the belief that good health is a product of nature, a matter of luck and something over which they have no control.

The dichotomy between childcare and paid work, and mothers' and fathers' explanations of their health, reflects their different *primary* roles. This is despite the fact that many of these fathers are involved in childcare and many of the mothers have paid employment. This dichotomy has been noted by others, particularly among

working class parents (eg. New and David 1985, Russell 1983, Simms and Smith 1982, Backett 1987, O'Brien 1982).

(1) Fatalistic Explanations of Health

Like other studies (Blaxter and Paterson 1982, Cornwell 1984) these interviews showed the belief that good health is a product of nature, a matter of luck and something over which people had no control. Thirteen parents (seven mothers, six fathers) explained their good or fairly good health in the past year either wholly or partly in this way. Included in this category are those parents who could not explain their health and so did not regard themselves as having control over it. These parents considered themselves 'naturally' healthy except for 'the usual' colds and 'flu which they saw as things which everyone got.

Joanne Land explained her 'good' health in the past year in this way:

> I dunno...nature's reasons reason...I dunno, I mean, I don't think I've ever been really ill you know.

And Joe Harris explained his 'fairly good' health in the previous year by:

> ...just my ordinary constitution, not normally that - not normally very ill often.

However, this deterministic view of health was frequently coupled with the individual responsibility explanation (see below), as in the following example given by Simon Cartwright:

> I'm not a sicky person, I'm quite fit...I don't really abuse my health, not that much.

(2) Child-related explanations of health

Ten parents (nine mothers, one father) mentioned their child as a factor affecting their health status over the previous year either in a positive or in a negative way. This was with respect to childcare work and/or the pregnancy and childbirth. Negative affects of children on health were described by nine parents (eight mothers and one father). Alison Grange, for example, said:

> Well I s'pose, I don't know, the only things I've suffered from - I mean it's

> been - it has been hard, I don't know if you're gonna ask more questions about that - but with a baby, a new baby, and it has - it is - an awful strain for us, 'cos she's been like hyperactive and everything else, and it has been very difficult, so...a kind of depression, I s'pose. Every now and again you sort of feel a bit nnah - then you get back on top again, and you're O.K., but - um - I haven't really been sort of anything in particular, it's just every now and again you think - oh - and every thing seems to be getting on top of you, and it's just - yeah - kind of depression, and then...I've only been ill, I think, twice sort of, with the 'flu or something and I was really...felt very ill, was in bed for a couple of days, if that. Other than that it's basically the same as usual. Just lack of sleep - things like that - that gets you down in the end, after a year of it, and no sleep, it begins to show in your health I s'pose.

and the one father, Nigel Abbot, who mentioned his child as affecting his health negatively said:

> Yeah it's been fairly good I s'pose. A bit tired...I wouldn't put it down to work no, not totally. He drains you a lot 'n' I tend to force myself to keep going sortta thing...'cos I know things have to be done...

His wife, Dawn Abbot, was the one mother who explained her good health in the past year in terms of her child. She said 'running after John keeps me fit (laughs)'. But this kind of remark was made at other points of the interviews by other parents. While other parents did not mention their child as having any effect on their health, one mother, Louise Bevin, asserted that her daughter had made no difference to her health even though I had not specifically asked her about this at that point:

> It's no different to it's ever been, you know, Sarah hasn't made any difference to it at all.

(3) Individual Behaviour/Responsibility Explanations of Health

This explanation was used to explain good and not so good health status by eight parents (six fathers, two mothers). Four parents mentioned behaviours which affected their health in a positive way such as keeping fit, eating well, not abusing their health and ignoring illness when it came. Tim King, for example, said:

> Well, I keep fit, eat well most and - you know I'm active because I do a lot of sports, you know...I'm not sort of overweight for me age or...(laughs).

Four parents mentioned behaviours which they believed had a negative effect on their health. These included smoking, drinking, taking drugs, not wearing warm enough

clothes, and more generally not looking after oneself. Andrew Wicks said:

> I wish I could give up smoking, it makes the chest hurt, I'm always coughing. I try and cut down every now and then but it's not easy...occasionally it's too much drink and if I get out for a late drink sometimes and I over do it, otherwise my health's all right. I'd like it to be improved. I've had no serious illnesses, I just feel I'm burning the candle at both ends.

(4) Conditions of Paid Employment as a Factor in Explaining Health

Five parents (four fathers, one mother) mentioned their job as a factor in explaining their health, either in the form of stress and tiredness or accidents that occurred at work. Ruth Dobbs, who works nights in a casino as a croupier supervisor, explains her poor health in terms of:

> ...the hours I work and the stress, because I do find I get very tired and it's hard to concentrate at work even more so now since all I do is sit and watch something...and like the first month I did this job, I had a constant headache and I know it was stress, a sort of stiff-neck headache, you know...

Matthew Thomas works as a carpenter:

> I've always been healthy but the last year or so I've had a lot of little accidents - cut me fingers 'n' things...I've had stitches for the first time...

(5) Health explained in terms of specific illness experiences

Five parents (all fathers) explained their health in terms of specific complaints they had experienced in the past year including a 'kidney and blood disorder', 'gout', 'problems with my nerves', or 'motorbike accidents'. These were often legitimised by references to the medical profession. Tony Bevin, for example, said that his health was fairly good and when asked for the reason for this said:

> er...I don't know how to explain it really...even the doctor can't find...I worry a lot...I have a lot of problems with my nerves sortta thing, that is basically it really.

Two mothers explained their less than good health in the past year by the after-effects of childbirth.

Absent from these initial, spontaneous explanations of their health status were references to the material and social constraints within which they had to parent and

care for their own health and that of their child. However, these were referred to in their private accounts of health and illness and were used to explain children's health and ill-health, and were also referred to when they talked about parenting and parenthood.

Another common theme in the literature on concepts of health is that health and illness are often seen as moral categories (see Blaxter and Paterson 1982, Cornwell 1984). Health is a 'good' quality, and most parents were eager to stress how healthy there were (ie. not ill). Conversely, illness is seen as a state of spiritual or moral malaise. These moral categories took a particular form in my study whereby parents were very keen to stress how healthy their children were and to play down their illnesses as 'minor'. Nigel Abbot, for example, tries to play down his son's eczema when I ask him when John was last ill:

> His baby eczema, if you wanna class that as ill, it doesn't affect his health in any way, it's just a rash he has...it's just a skin thing, it's not bad.

Nigel, like many other parents, is very keen to stress that John is developing 'normally' and he tells me about when the health visitor last came to visit:

> ...just the usual 16 monthly check or whatever check it is, the development test I think it is so that was about six months ago, they just checked on him for...how he was getting on, whether he was starting to communicate...whether he could...just to general make sure his arms 'n' legs were all moving correctly...co-ordination 'n' all that, piling bricks on top of each other 'n' that sort of thing, which he did very successfully without any problem.

II PARENTS' PERCEPTIONS OF HOW CHILDCARE AFFECTS THEIR HEALTH

I have discussed Cornwell's (1984) distinction between public and private accounts of health and illness. I suggested that in the case of parenthood and health there is an even greater concern with acceptability and legitimacy because of the moral ideology surrounding parenthood, particularly motherhood. This is evidenced by the disparity between some of the parents' public and private accounts of how childcare affects their health. The following section describes parents' public accounts elicited when they were directly asked 'do you think caring for a child affects your health in any

way?' Parents' more private accounts of the health effects of childcare were sometimes at variance with their public ones, and these are described in the section on the relationship between meanings of parenthood and health in Chapter Seven.

While other studies have looked at the effect of motherhood on women (eg. Oakley 1979, Boulton 1983, Graham and McKee 1980) and the effect of fatherhood on men (eg. Backett 1987, Russell 1983, McKee 1982), none of these studies have conceptualised these effects in terms of health.

Table 4.3. *Parents' perceptions of effect of childcare on health*

	Mothers (n=15)	Fathers (n=15)	Total (n=30)
Caring for child: affects health - YES	9	8	17
Caring for child: affects health - NO	6	4	10
Affects partner more than me	0	3	3
Childcare has positive effect	6	8	14
Childcare has negative effect	9	6	15

NB. Numbers under childcare has positive or negative effect refer to number of responses rather than number of parents

(i) Childcare affects health

Table 4.3 shows that over half (n=17) of parents said that caring for a child affected their health. This group consisted almost equally of fathers and mothers (8:9) and most parents mentioned both positive and negative ways caring for a child affected their health; although three parents (all mothers) saw the child as having only a negative effect and two parents (both fathers) saw the child as having only a positive effect. Within this group more fathers than mothers (8:6) mentioned positive ways and more mothers than fathers (9:6) mentioned negative ways.

(ii) Childcare does not affect health

Ten parents (six mothers, four fathers) felt that caring for a child did not affect their

health, but only two of these (one mother, one father) did not give any examples of ways their child affected them. The remaining eight gave examples (positive and negative), but did not see these as coming under the rubric of health. Louise Bevin said:

> Well, I suppose when I say I'm sometimes anxious it's usually for her, you know...certain things like if she's ill or whatever. That affects you whereas obviously it wouldn't if you didn't have any.
>
> NJF: And do you think that affects your health?
>
> I don't know. I don't really think it does - I don't think it's affected my health at all, no...if she's ill or whatever or if she cries and you don't know what's wrong with her, that sort of thing, that gets you anxious...erm, I don't really consider that as health though really.

And Jane Vernon said:

> No, she doesn't affect my health...she makes me tired but that's not your health is it?

Some parents thought that the question only referred to detrimental health effects so they answered 'no' but gave examples of how their health was affected in a positive way, for example, Matthew Thomas said in answer to the question 'do you think caring for a child affects your health?' said:

> *No*...no, not really...quite the opposite really...I think having Christine's made me feel a lot better.

And Daniel Oliver said 'No, we enjoy it.'

(iii) Affects partner more than me

Three fathers answered the question by saying that caring for a child affected their partner more than them, although they did acknowledge that it had some effect on them. These fathers saw the care of their child as having negative health consequences for their partner because she had the main responsibility for childcare. Joe Harris, for example, answered the question like this:

> For me personally, probably not. But whoever's taking care of them, full-time taking care of them, like Alison, almost certainly.

Positive and Negative effects of Childcare on Health

An analysis of the ways in which parents said that caring for a child affects their health can be divided into the positive and the negative effects (see Table 4.4). To some extent, though, this negates the ambivalence with which some of the parents spoke about these health effects; some cannot so easily be classified as a positive or a negative effect because the parents did not speak about them in this way. It is important to stress here that this division is made according to whether the parents themselves saw the effect as a positive or a negative one. For example, while one father saw the restriction to his social life as a negative effect, another one saw it as a beneficial one as it meant he drank less beer and did not stay out so late. The positive and negative effects of caring for a child which parents did not regard as affecting their health have not been included in the analysis below, since the starting point for the study is parents' subjective perceptions of the effect of children on their health. This has to take account of parents' own definitions of health.

Table 4.4: *Parents' public accounts of effects of childcare on health*

NB Numbers refer to number of responses rather than parents.

	Mothers (n = 15)	Fathers (n = 15)	Total (n = 30)
a) **POSITIVE EFFECTS**			
Health 'side' effects	5	9	14
Change in risk behaviour	0	3	3
Positive emotional effects	3	2	5
TOTAL	8	14	22
b) **NEGATIVE EFFECTS**			
Tiredness	6	5	11
Demanding and stressful	5	2	7
Anxiety and worry	3	3	6
Restrictions	2	3	5
Neglect self	2	1	3
TOTAL	18	14	32

a) **Positive ways of caring for a child affects parents' health**

The fathers talked more about the benefits to their health of caring for a child than the mothers did. This group of fathers feel that parenthood has led them to adopt healthier lifestyles and to take more care of themselves. This finding was also reported by Simms and Smith (1982) in their study of young fathers. The beneficial effects of caring for a child fall into three broad categories: health 'side effects'; conscious changes in risk behaviour; and positive emotional effects.

(i) Health 'side effects'

Fourteen parents (nine fathers, five mothers) talked about how they had made a change in their 'lifestyle' in order to provide their child with a healthy environment. This has the positive side effect of being good for their health.

For example, a number of parents spoke of how they regularly took their child to the park which is also beneficial to them in terms of fresh air and exercise which they would not otherwise get. This was also mentioned in relation to taking the child swimming. Another beneficial effect of taking a child out and about was getting the chance to meet other parents. Lesley Fisher said:

> Well, since we had her I'm doing everything different to what I used to do and there are a lot of positive things um, not so much now the weather's started to get bad but we always used to go over the park regularly and to me that was like fresh air. I mean you don't ever go over the park on your own really, and the swimming again I probably wouldn't have started that, but I'm getting into that...

and Matthew Thomas said:

> Well...like I used to drink a lot but now...er, we don't go out, I stay in 'n' that...when it was the summer we'd go out all over the place I'd take Christine round the park 'n' play in the park...come home from work, pick Christine up and go straight over the park every night...I dunno...I just feel that, to what I used to do - go to the pub straight from work...I'm sure it's a lot more healthier...

Other beneficial 'side-effects' are cutting down drinking and eating 'healthier' food or eating more regularly, as Rosemary Ingram put it:

> If I was at home on my own I wouldn't bother with lunch or, you know, preparing myself a lunch, or preparing myself a breakfast. Because I've got to do it for the baby I make sure that you know I eat when she eats. Not only

> that, I've got the evening meal to prepare when my husband gets home, so I'm better off with a child because I'm not you know sort of lazing around or I'm not at work um...I've got to do it...so I'm better off that way.

For Andrew Wicks, one of the beneficial 'side effects' was giving up his very tiring job as a long distance lorry driver to take care of his daughter two and a half days a week:

> It's caused me to give up my job, it's caused me to stop all that larking that was doing me in.

(ii) Conscious changes in risk behaviour

Three fathers talked about changes they had made in their risk behaviours because of their new responsibilities as a father. David Fisher said he takes less risks on his motor bike:

> I think it affects my health in that if I do anything I think about it whereas before I'd just go out and do it and suffer the consequences afterwards. But now for instance if I'm out with me mates on the bikes and they want to take them up to 100-120 I'll think before I do it, you know make sure it's on motorways whereas before I'd do it round London...in that way yeah, you think about things before you do them 'cos you know if anything happens to you, you got responsibilities...

Robin Ingram was working as a baggage handler for an international airline company at the time he answered this question and he said:

> ...before Elizabeth was born I didn't particularly care that much...er, I would lift up anything, do anything but now I do take it a bit easier, I don't go in so much for dangerous work... [NJF: Why's that?] I've got to take care of meself 'cos I've got Elizabeth now.

While Matthew Thomas said:

> I think having Christine's made me feel a lot better, made me feel like I should look after meself more...take care a bit better of the future.

(iii) Positive emotional effects

These were mentioned at other points in the interviews by other parents, but five parents (three women, two men) considered their greater satisfaction and self-esteem resulting from being a parent as contributing positively to their health. Two fathers

spoke about how being a father made them feel proud while three mothers and one father (who was unemployed at the time) said that having a child stopped them getting depressed and made them feel happier. For Ruth Dobbs, who had had difficulties conceiving, having a child has given her a new found contentment:

> When I say I get depressed about things it's nowhere near as depressed as I would have been, I think, cos I've got him. He's like (pause) he makes everything worthwhile, all this hardship you go through, at least I've got him...before I had nothing 'n' I think I got more depressed about not having a baby...I've got this sense of well-being developed from having a kid, it's lovely, it's like having a love affair, you know, you've got this contentment inside.

Deborah Jessop said

I don't find myself um...sort of slipping into sort of real melancholy as I might have used to, because you just...er, because it's very self-centred and...um, it's given you something outside of yourself to care about and so it's a big happiness in your life really.

b) Negative ways caring for a child affects parents' health

The negative health effects of child care were easier for parents to articulate, but although they were mentioned by three quarters of parents, only a third talked in detail about these at this stage in the interview. However, when parents were asked what they did not like about looking after their child, two-thirds of mothers talked about the stress and frustration of caring for a demanding child. There are clearly cultural and ideological constraints on parents talking about the difficulties they experience while parenting. When parents did talk about the negative effects of childcare they often played them down, saying things like 'its *only* the lack of sleep' (my emphasis). Some parents underplayed the negative effects by stressing the positive ones. Dawn Abbot, for example, after telling me about the tiring nature of childcare and the lack of sleep, she concluded that:

> He's done me a lot of good I think, you know sort of health-wise. I haven't really been ill or anything...

Although some mothers also talked about the positive effects of childcare on their health, more mothers than fathers talked about the negative aspects - the tiring, stressful and demanding nature of their role.

The fact that it is the parents who have the primary responsibility for child care (ie. the mothers) who are the ones most likely to experience negative health effects is not surprising. What is interesting, however, is that because fathers are so rarely asked for their views we do not know what they think either about the effect on them or the effect they think it has on their partners. In this study group, it is the fathers who played the greatest part in childcare who talked about its negative health effects both on themselves and on their partners. It is their own involvement in childcare which gives them an understanding of the effects it has on their partners.

Only four fathers spontaneously mentioned negative health effects of childcare on their partners although all but one mother mentioned negative effects. These four fathers are all in the 'modern' or 'new Dad' group (see Chapter Seven). The most striking divergence of views was shown by Diane and Simon Cartwright. Diane Cartwright said:

> It's very stressful having children...*very*. And you think to yourself "calm down, don't be so uptight about it" but you can't, you've got yourself so het up, because it's just one thing after another you can't seem to sit down and relax 'n' unwind.

Her husband said of her:

> ...'cos she's at home, she doesn't have to work as well so she has time for the baby and she's still relaxed in her own way, I wouldn't say she's under pressure...

The five main negative health effects of childcare discussed by parents are considered below.

(i) Tiredness

This was the most frequently mentioned negative health effect of childcare in answer to my direct question - it was mentioned by eleven parents (six women, five men). It was also the most frequently reported health problem in the diaries (see Chapter Five). Parents differentiated between tiredness caused by lack of sleep because their child wakes in the night and tiredness caused by childcare work. Seven parents mentioned tiredness caused by lack of sleep, three parents talked about the tiring nature of childcare work, and two parents felt both were negative health effects.

Deborah Jessop, for example, sees the main negative health effect as the lack of sleep:

> It's the lack of sleep...there are other reasons why you don't get enough sleep, but you could always catch up...sometimes you can't...I mean you get, your body accustoms itself to it after a while...on the whole now she's in a fairly good pattern, so I suppose...but it's the accumulated tiredness...

Peter Smith also mentions the sleepless nights:

> ...the negative side is any nights that you do lose sleep. They already have - they will catch up with you after a while...

When I asked Peter's wife Jill if she thought looking after their daughter Katy affected her health in any way she said:

> ...only lack of sleep when she's a bit naughty in the night, I mean naughty - not that she's upset or anything like that. She's at the stage now where she's had enough sleep and she wants to play in the middle of the night with mummy, you know (laughs)...

For Dawn Abbot, it was the childcare work which was tiring and now her son John is able to do more for himself she feels less tired:

> I s'pose maybe before I was feeling tired 'n' that but as I say he's getting much more independent now, feeding himself...before I used to have to hold the bottle, now he holds it himself...so maybe I can't think back to them days, it's very hard to think back 'cos it goes so quickly. Maybe I was feeling tired then, but I didn't realise it but *now* I feel better for it 'cos maybe I'm not doing so much for him you know although I'm still dressing him and bathing him...

(ii) Demanding and stressful nature of childcare work

Eight parents (five mothers, two fathers) talked about the demanding and stressful nature of childcare work which is physically and mentally 'draining'. Considering the constraints against talking about the difficulties of looking after a young child, this figure is quite high. Five of these were mothers and two of the fathers spoke about it in relation to their wives rather than themselves. One of the fathers is Paul Edwards, who is one of the fathers most involved in childcare (see Chapter Seven). Diane Cartwright finds looking after her daughter Nicole very demanding:

> Yeah, I think it makes you feel very stressful...so in turn by the time my husband gets home 'n' I've had a particularly bad day with her 'n' I've been ranting and raving all day then I suppose I'm not as nice as I should be to him because you know...you've had such an awful day.

(iii) Anxiety/worry

Six parents (three mothers, three fathers) mentioned the anxiety and worry caused by having a child, especially when the child is ill, but one mother and father did not regard this as being detrimental to their health. Ruth Dobbs expressed her anxiety like this:

> NJF: Do you think caring for a child affects your health?
>
> Yes, because they're a worry. I don't regret any minute of it - I love him so much. He *is* my life, he is my health, I really feel it for him. (pause) anything wrong with him affects me ten times more than anything wrong with me.

Tony Bevin has 'a lot of problems with my nerves' and I ask him if this has got worse since his daughter Sarah was born:

> I tend to worry about her, yeah definitely.
>
> NJF: Is that day-to-day things or when she's ill?
>
> Yeah, I mean, obviously it increases when she's ill but even day-to-day things...
>
> NJF: What sorts of things?
>
> The main worry I have with her well, I think we have with her is like sort of any baby, is choking, she's always picking things up and putting them in her mouth...and you have to be careful. But I mean you don't worry that much that it affects your life, it's just a sort of natural worry I think.

Tony's wife Louise also thinks worry is the main negative effect, although she does not consider this to be a health issue:

> Well, I suppose when I say I'm sometimes anxious, it's usually for her you know, certain things like if she's ill or whatever or if she cries and you don't know what's wrong with her. That gets you anxious...erm, I don't consider that as health though, really.

(iv) Restrictions

Five parents (three fathers, two mothers) talked about the way having a child restricted them in the things they want to do for themselves. They talked about

wanting more time to themselves. Diane Cartwright, for example, said:

> I wish I could just sit down and do things that *I* enjoy doing...I mean obviously if you have a baby you care for it 'n' it comes first but umm I'm not the type of person that is just contented with that I *need* something for myself as well.

Deborah Jessop would also like more time for herself:

> I don't always have so much time for myself - you don't put so much effort into - I mean care for your hair or your nails or your face, those sort of things. I mean, I find I have to make an effort sometimes to - you know, you want to really clean your face properly all that sort of thing, like bother to put moisturiser on or anything like that...I mean it's just, it's an effort to do it, and you have to have a bit more time to actually sort of pamper yourself I suppose...

Others, like Ben Land spoke of how having a child means he is restricted socially:

> And you're tied down socially - he's not old enough for babysitters and you don't wanna burden your parents all the time. Socially I don't think children really fit in. Plus, I mean that's what you gotta decide when you're gonna have a child whether you really wanna give up your social life. OK, say we're gonna have a baby, if you're not prepared to give up your social life then I don't think you should have 'em.

(v) Neglect their own health

Three parents (two mothers, one father) said that a negative health effect was that they were so taken up taking care of their children that they neglected their own health. One of these was Joanne Land, who said:

> I feel that he comes first, and I don't neglect myself but I put mine back, you know, and I suppose it could get worse. It could do, I think , if you let it, you know, I dunno.

Other negative effects which were brought out at this stage, but also at other points in the interview, were the effect on the couples' relationship with each other; the transmission of illness from child to parent; the lack of privacy in cases where the child slept in the parents' bedroom; and some mothers expressed their feelings of guilt about not caring for their child full-time because they have a job outside the home.

The relatively small number of parents who are prepared to talk about the negative effects in their public accounts illustrates the cultural and ideological constraints on

parents admitting their difficulties. Even those parents who do, show a great ambivalence in speaking about their difficulties as parents and feel they have to justify themselves. Alison Grange, for example, has had a very difficult time with her daughter in the first year not sleeping, but there is a deep ambivalence in the way she talks about it which is shown in the extract below. She started off by telling me how difficult it has been, but then realises that this 'sounds awful' and so tries to backtrack by suggesting that she has been exaggerating. She tries to explain the negative effects by saying she has been unlucky having a 'difficult baby' and also by considering the possibility that she and her partner are to blame:

> ...with me, for the first year as it has been very, very tiring and - er- and that, you know, maybe feel a bit run down and every thing else, so yeah, I don't think it's done anything positive for my health (laughs) really, no I don't think so. Sounds awful, don't it, but I'm - no - not really - just been very hard, so um, that's all. Well, not, I s'pose, wasn't that - really - maybe I'm ... maybe I'm making it sound too - too - oh I dunno - it's been a shock - it's been a big shock to my system, having a baby and I didn't realise how much work it involved, I didn't think, you know, that's the main thing. I thought they - mind, a lot of babies are a lot easier - a lot of people are lucky you know, they don't realise what it's like to have a difficult baby, you know. I got friends of mine and they sort of say there's no such thing as a difficult baby, Alison, you know, difficult baby, it's the parents. And that really annoys me 'cos we done everything...well, p'raps, p'raps we have done, you know, over-stimulated her and things - er - know, we've - we've tried to be the sort of perfect parents and do everything right and everything and think when she was tiny showing her so much attention - p'raps, p'raps we did do it wrong - no, p'raps we should have left her, cry in a corner or some - but we never did that, she's *never* been allowed to cry for long at all you know, so in that way, yeah.

Lesley Fisher has also had a very difficult time but finds it easier to talk about the way in which her daughter is very demanding. Even so she still feels that it's something that she just must accept because 'it's natural':

> I mean like if I fancy a long relaxing bath, she's usually in it pulling my boobs up and down (laughs) or whatever. I mean it's funny, I mean I think it's a lot to do with the mind and when you've got someone yap yappin' in your ears, pulling you...she's very, she's still, because I breast fed 'er, she's still fascinated with my boobs and she can't sit next to me without squeezing them and that to me, like the yak yakkin' and the pulling it just, (sighs) you can't relax - that's what a child takes out of me you know um, that's it , and I just look at her and say well that's natural, it's a healthy kid so...

Conclusions

Parents' concepts of health and illness contribute in an important way to explanations of gender differences in health and illness. These have not been considered either by the literature on lay health beliefs or the research on gender differences in health and illness.

There were clear differences in the way mothers and fathers talked about health and illness. The mothers had a more 'functional' approach to their definition of health - 'getting through the day' - whereas the fathers had a more ambitious definition. Connected with this is the finding that the mothers explained their health or ill-health in terms of their experience of mothering; whereas the fathers explained it in terms of the conditions of their paid employment. As Cornwell (1984) found, the parents' different definitions of work (women as 'housework and childcare'; men as their 'job') therefore relate to their ideas about health and illness. Thus parents' social roles have an important impact on how they conceptualise health and illness; and this relates to their reported health levels and the action they take for health problems (see Chapter Five).

The mothers perceived childcare to have more of a negative effect on their health; whereas the fathers perceived it to have more of a positive effect. This relates directly to the different meanings of parenting and parenthood which these parents have (see Chapter Seven). For the women, motherhood entailed *either* responsibility for childcare 24 hours a day, *or* the responsibility to organise alternative childcare and often guilty feelings about being in paid employment. Whereas for most of the fathers, fatherhood meant assuming financial responsibility for their families. As most of the fathers were involved less in the day-to-day stressful caring tasks of caring for a child, they could appreciate the more positive aspects of being a parent.

However, mothers and fathers both talked about the positive and negative effects of childcare on their health. This reflects the co-existence of the benefits and hazards of parenting which has been found in studies of motherhood (eg. Oakley 1979, Boulton 1983).

In the next chapter, I analyse the way in which parents' public accounts of health and illness are mirrored by their private accounts of self-reported health and actions.

CHAPTER FIVE
MOTHERS' AND FATHERS' HEALTH PROBLEMS AND THEIR ACTIONS

> The sexual division of labour which operates both inside and outside the home is another factor that determines the nature of people's experience of illness. The men and women involved in the study had very different responses to feeling unwell which were largely structured by their position in the sexual division of labour. The demands of employment are usually more contained, and more containable, than the demands of housework and childcare (Cornwell:1984:139).

Introduction

In the last chapter I analysed the mothers' and fathers' health beliefs and their public accounts of how childcare and other social roles affect their health. In this chapter, the focus is on the parents 'private' accounts of the effect of childcare and other social roles on their mental and physical health. The data on parents' reports of their health problems and the actions they took for these problems are also presented.

The data show how the different social roles taken by mothers and fathers affect their health. The data confirm the parents' own beliefs, as presented in Chapter Four, that it is the mothers' private world of childcare and housework which has the greatest influence on their experiences of health and illness; whereas it is the father's public world of paid work which has the greatest influence on theirs. This is an important contribution to the sociomedical research on gender differences in health and illness which has not considered in detail, the *processes* by which social roles affect health from the parents' own perspective. It also extends the sociological work on motherhood and fatherhood by reconceptualising the effects of these roles on health, and brings together the public world of paid work with the private world of domestic work.

This chapter is mainly based on data from the health diaries. These provide a rich source of detailed material about the parents' experiences of health and illness and the

context within which they occur. While the interview data can provide information about 'bigger' health events such as contact with health services, the health diaries reveal much 'smaller' events such as taking an aspirin for a headache or resting in response to feeling tired.

First, the parents' reporting of their health status, health problems and actions is presented. Secondly, I analyse the gender differences in these reports, focusing particularly on tiredness. Thirdly, the gender differences in the relationship between the reporting of the child's health and the parents' own health is presented. Finally, the parents' reporting of their children's health is discussed.

I PARENTS' REPORTS OF HEALTH PROBLEMS AND ACTIONS

1) The 'ice-berg' of ill-health

Comparing data from the interviews and the health diaries confirms the 'ice-berg' theory of ill-health, which argues that the extent of ill-health is much greater than that revealed by use of health services (Dunnell and Cartwright 1972, Horder and Horder 1954, Logan and Brooke 1957, White et al 1961).

Table 5.1: *Parents' contacts with health services*

No. of contacts with health services	No. of parents (n=26)
0	8
1	6
2	5
3	1
4	3
5	1
6	2

Parents were asked about their use of health services (GP's, hospitals, dentists but excluding check-ups) from the month before the first interview to a week after the last

the whole study, the average was just under two contacts for this period. The breakdown of this figure is shown in Table 5.1.

However, this contrasts with the number of health problems reported in the diaries (see Table 5.2). Parents reported a health problem on one in every three days and reported taking an action in response to these health problems on one in every six days (overall, action was taken for every other health problem). The finding that a health problem occurs every three days concurs with results from other studies, although their data was collected only from women (Alpert et al 1967, Roghmann and Haggerty 1972, Morrell and Wale 1976).

Table 5.2: *Number of health problem days*

Total no. of health diary days	539
Total no. of health problem days	179
% days on which health problem reported	33%

The number of health problems reported, shown in Table 5.2, also contrasts with the way parents reported how they felt about their health overall each day and the day in general, shown in Table 5.3. On 71 percent of days parents reported their daily health as very good or good and only on 6 percent of days did they report their daily health as poor or very poor. This contrast indicates that the people in this study group, as in others, take a certain degree of 'ill-health' for granted.

Table 5.3: *Parents' reports of daily health and kind of day*

	No. of days (n=539)			
	Very good/good	Average	Poor/very poor	Missing
Self-reported health	383 (71%)	113 (21%)	32 (6%)	11 (2%)
Kind of day	302 (56%)	183 (34%)	49 (9%)	5 (1%)

The finding that these parents reported their daily health as very good or good on more than two-thirds of days and yet reported a health problem on one-third of all

more than two-thirds of days and yet reported a health problem on one-third of all days, indicates that they expect and tolerate a certain degree of 'ill-health' as part of considering themselves healthy. Alternatively, they do not see 'health problems' however defined as being relevant to their general 'health'.

This is confirmed by the interview data which show that the respondents consider themselves 'healthy' as long as they only get the 'usual' health problems such as coughs, colds and so on. In answer to the question (as in the GHS) 'how do you feel your health has been in the past year - good, fairly good or not good', one mother answered:

> Fairly good...I've had an awful lot of colds 'n' things since I've had Mary to be honest (laughs). But apart from that I've been quite well really.

The alternative explanation is also supported by some of the health diary and interview data which shows that some parents do not regard 'tiredness' as a health problem, although this is how I coded it because it is such an important component of mental and physical health and well-being.

An analysis of how parents felt about their kind of day found that parents reported 56 percent of their days as very good or good and only 9 percent of their days as poor or very poor, showing that the parents did not feel as positive about their days in general as about their health. This could be because they did not see the health problems they experienced as being connected with their overall health and yet it impinged on how they felt about the day in general. For example, feelings of tiredness were coded as a health problem when [perhaps] they were seen by the parents as affecting the kind of day they had rather than their health. This point is illustrated by material from the interviews and health diaries. Jane Vernon, for example, said in answer to the question 'do you think caring for a child affects your health?':

> I don't think it affects my health - no I'm sure it doesn't...it makes me tired but being tired isn't exactly your health.

On one day of her health diary Suzanne Oliver said she had a poor day overall and a very good health day. She answered questions three and four like this:

3. Details of any particular feelings (good and bad) or health problems you may have had today. Please also note down what you think caused the feeling/problem.

Felt tired towards the evening.

4. Did you do anything about any health problems you noticed?

No health problems today.

On one day in the same week her husband, Daniel Oliver, said he had an average day and a good health day. He answered questions three and four like this:

3. Details of any particular feelings (good and bad) or health problems you may have had today. Please also note down what you think caused the feeling/problem.

A bit tired today from working a bit too hard.

4. Did you do anything about any health problems you noticed?

Had no health problems today.

2) Types of health problems reported by parents

The types of health problem reported in the diaries were coded as far as possible according to how they were described by the parents themselves. The coding was not straightforward as there is much room for interpretation, as there is with interview data. In order to reduce the number of categories of problems, some types of health problems have been put in the same category. For example, I have put 'depression' in the same category as 'feeling low' and 'lethargic' as I am interpreting these as similar feelings, although I have no way of knowing whether the parents would see it like this. Further, health problems are presented in terms of numbers of days rather than numbers of incidents which may have lasted more than one day. Table 5.4 shows the most commonly reported health problems.

Cold symptoms refer to 'runny nose', 'blocked up nose', 'sore throat' and 'flu'. Other less commonly reported health problems were 'mouth ulcers', 'piles',

'hayfever', 'gout', 'bleeding during intercourse', 'abnormal vaginal discharge', 'ovaries hurting', 'tight chest' and 'painful wisdom teeth'. These findings are very similar to those of Morrell and Wale (1976) in their health diary study of 198 women aged 20-44. Their five most commonly reported symptoms were 'headache', 'changes in energy/tiredness', 'backache', 'cold' and 'disturbance of emotional response'. However, they had a separate category for 'sore throat' and 'cough', which I put together with other cold symptoms.

Table 5.4: *Types of health problems*

Health problems	No. of days reported
Tiredness	65
Headaches	31
Cold symptoms	27
Depression/low mood	14
Physical injury sustained through work	10
Stomach ache/upset	9
Period pains	8
Backache	4
Hangover	4
Other	7
Total	**179**

Types of Health Actions

From an analysis of the health diary data it is possible to construct a detailed picture of the type of actions parents took in response to health problems. This analysis reveals how important 'home remedies' are in the day-to-day management of health and illness particularly in comparison with use of formal health services. As Table 5.5 shows, on half of reported health problem days, no action was taken.

Not surprisingly, 'resting' (which includes taking it easy, slowing down, going to bed early) was the most commonly reported health action given that the most reported problem was tiredness. Although resting was usually in response to feeling tired, it was also reported as a response to headaches and cold symptoms.

Table 5.5: *Types of health actions*

Health action	No. of days reported (%)
No action	89 (50%)
'Resting'	28 (16%)
Non-prescribed painkillers	21 (11%)
Other non-prescribed remedy	20 (11%)
Change in behaviour	8 (5%)
Taking prescribed medication	7 (4%)
Contact with health services	6 (3%)
Total	**179 (100%)**

Parents reported taking non-prescribed painkillers (eg.paracetamol, aspirin, 'headache tablets' etc.) at least once on 21 of the health problem days in response to headaches, cold and 'flu symptoms and period pains. 'Changing behaviour' refers to cutting down cigarettes, taking exercise, not eating and so on.

II GENDER DIFFERENCES IN PARENTS' SELF-REPORTS

The mothers described their kind of day in a more positive way than the fathers. Women reported 65 percent of their days as very good or good compared to 48 percent for men (see Table 5.6, Figure 5.1). But the differences become more apparent when these figures are broken down: the mothers were more likely to describe their days as being very good or good whereas the fathers were more likely to describe their days as good or average.

Table 5.6: *Gender differences in parents' kind of day*

	Kind of day (%) (n=539)	
	Mothers (no. of days = 280)	Fathers (no. of days = 259)
Very good	56 (20%)	22 (8%)
Good	126 (45%)	100 (39%)
Average	78 (28%)	105 (41%)
Poor	16 (6%)	26 (10%)
Very poor	3 (1%)	2 (1%)
Missing	1 (0.4%)	4 (2%

These results are mirrored by those for self-reports of daily health, shown in Table 5.7 and Figure 5.2: the mothers were more likely to describe their health as very good or good whereas the fathers were more likely to describe their health as good or average. This finding is in contrast to other studies which have found that women are less likely than men to rate their health good (Maddox 1964, Hollnagel and Kamper-Jorgensen 1980, Gofin et al 1981). However, these studies are not based on health diaries and used different populations, such as the elderly (Maddox 1964); and 40 year olds (Hollnagel and Kamper-Jorgensen 1980).

Table 5.7: *Gender differences in parents' daily health*

	Self-reported health (%) (n=539)	
	Mothers (no. of days = 280)	Fathers (no. of days = 259)
Very good	91 (33%)	26 (10%)
Good	119 (43%)	151 (58%)
Average	49 (18%)	62 (24%)
Poor	11 (4%)	13 (5%)
Very poor	6 (2%)	0 (0%)
Missing	4 (1%)	7 (3%)

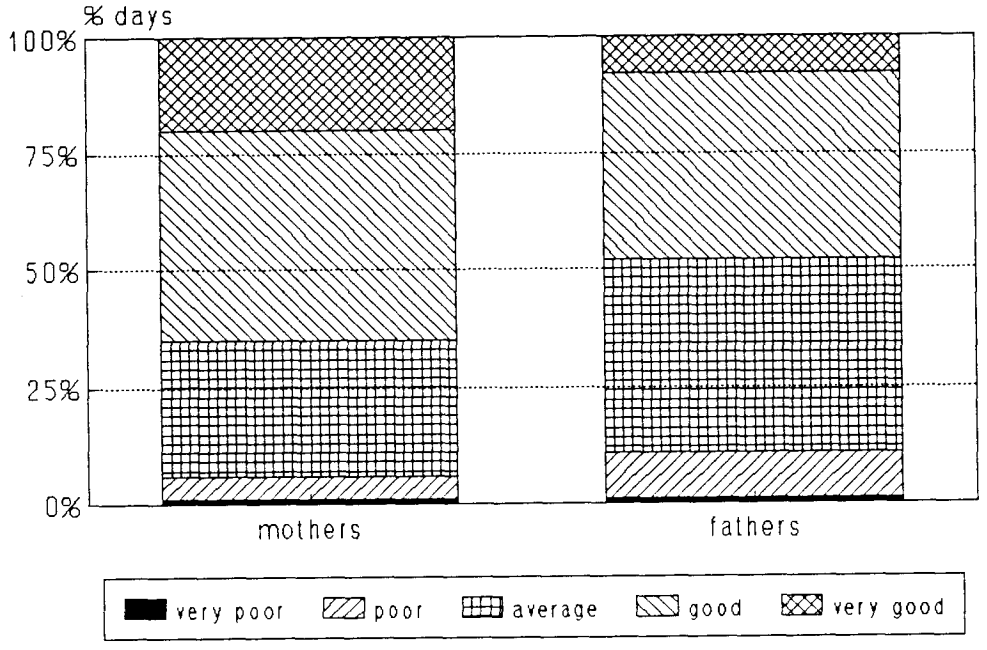


Figure 5.1: *Gender differences in kind of day*

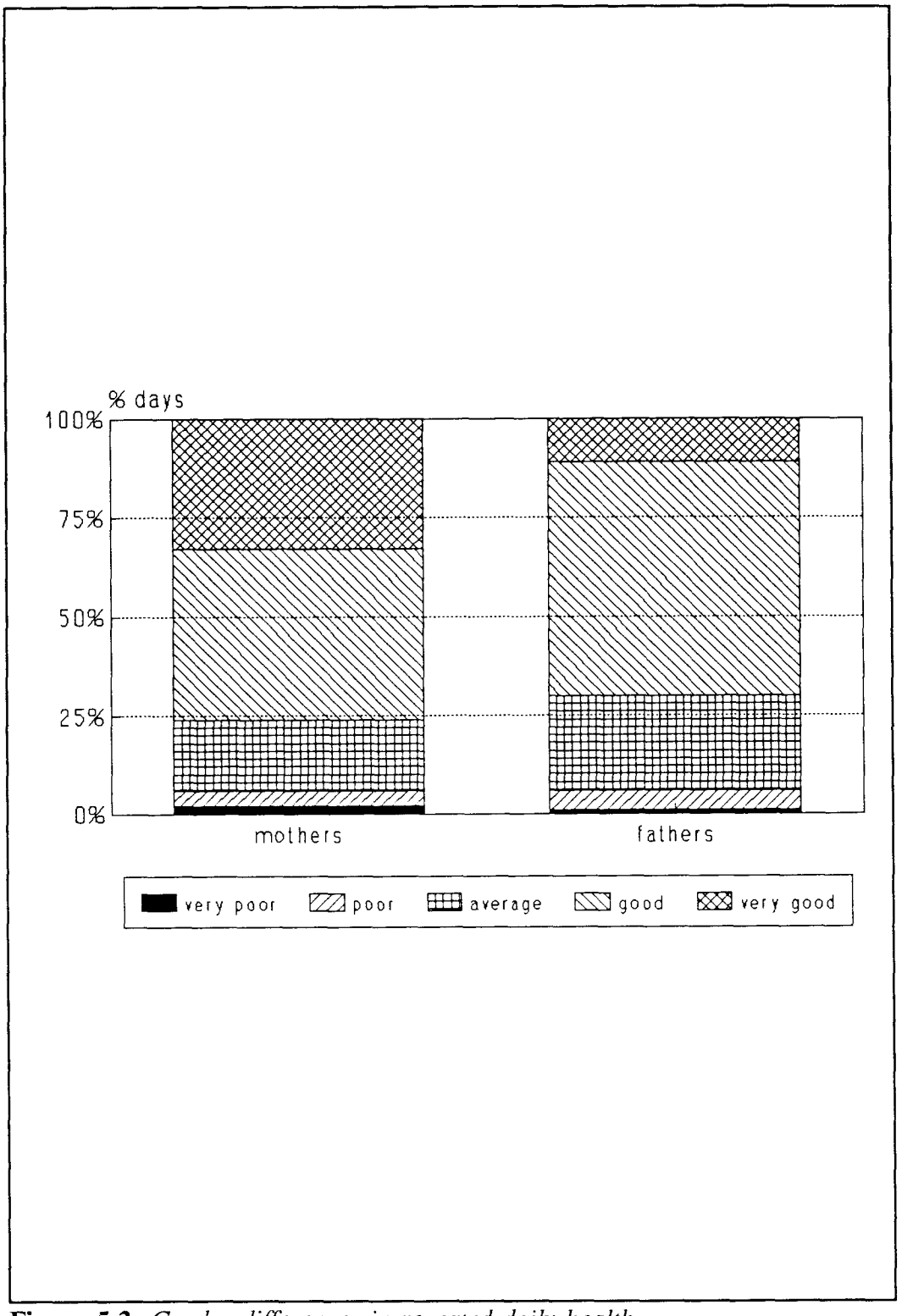


Figure 5.2: *Gender differences in reported daily health*

These data contrast markedly with the number of health problem-days reported by the parents. The mothers reported many more health problems than the fathers, even though they reported their health more positively (see Figure 5.3). The mothers reported health problems on 40 percent of days (one in 2.5 days), whereas the fathers reported health problems on 26 percent of days (one in every four days).

The difference between the mothers' and fathers' reporting of health problems is also shown in Table 5.8 below where parents have been divided into 'low', 'medium', and 'high' reporters of health problems. There are three times as many mothers in the 'high' category as fathers.

Table 5.8: *Gender differences in number of health problems*

No.health problem days (total possible = 21)	No. of Mothers (n = 15)	No. of Fathers (n = 15)	Total (n = 30)
Low (0-4)	4	5	9
Medium (5-7)	2	7	9
High (8+)	9	3	12

NB. The health problem days of parents who did not complete 21 diary-days were calculated *pro rata*. The father who did not complete any diary-days was put in the 'high' category, based on the number of health problems he recorded in his interviews.

As the mothers experienced more health problems, it is not surprising that they reported taking more actions overall; but fathers were also less likely to take action for a health problem than the mothers (see Figure 5.4). This could be because mothers have more pressure on them to be seen to be coping than men, and therefore take some form of action for their health problem so that they can 'carry on'. As Jane Vernon remarked:

> You're not allowed to be ill...I mean you just can't, OK I've had the odd cold but other than that I've been quite well. I don't know what would happen if I was quite ill, 'cos even if you're feeling lousy they [children] expect you to be as normal...

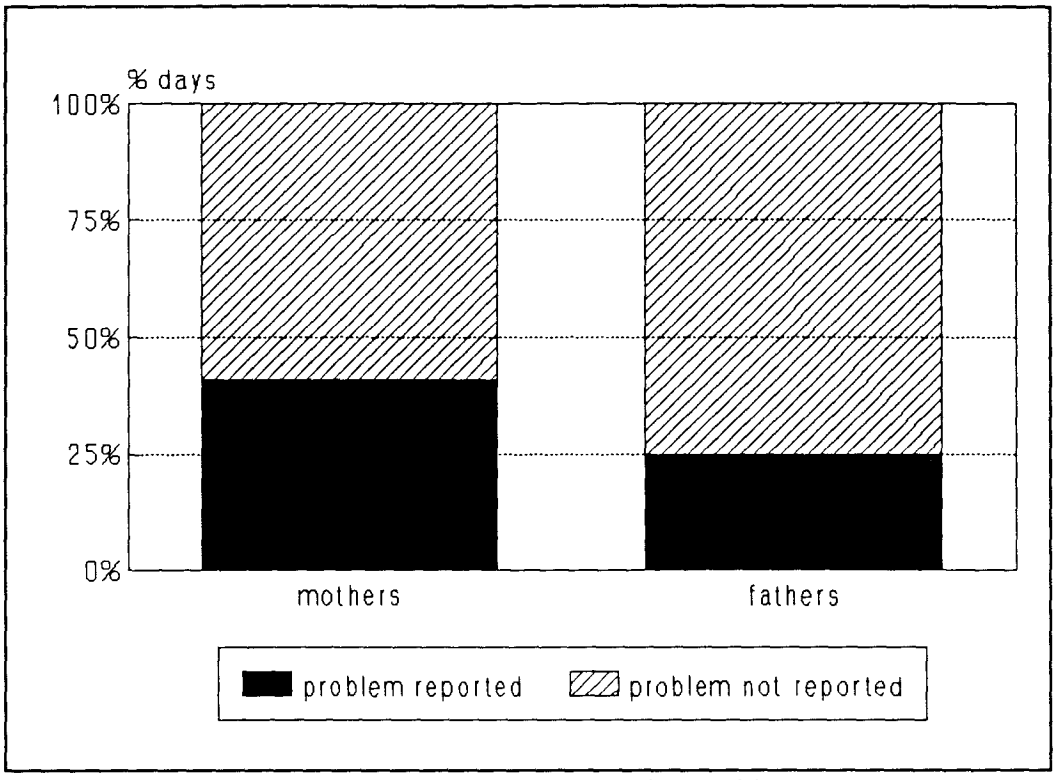


Figure 5.3: *Gender differences in reporting health problems*

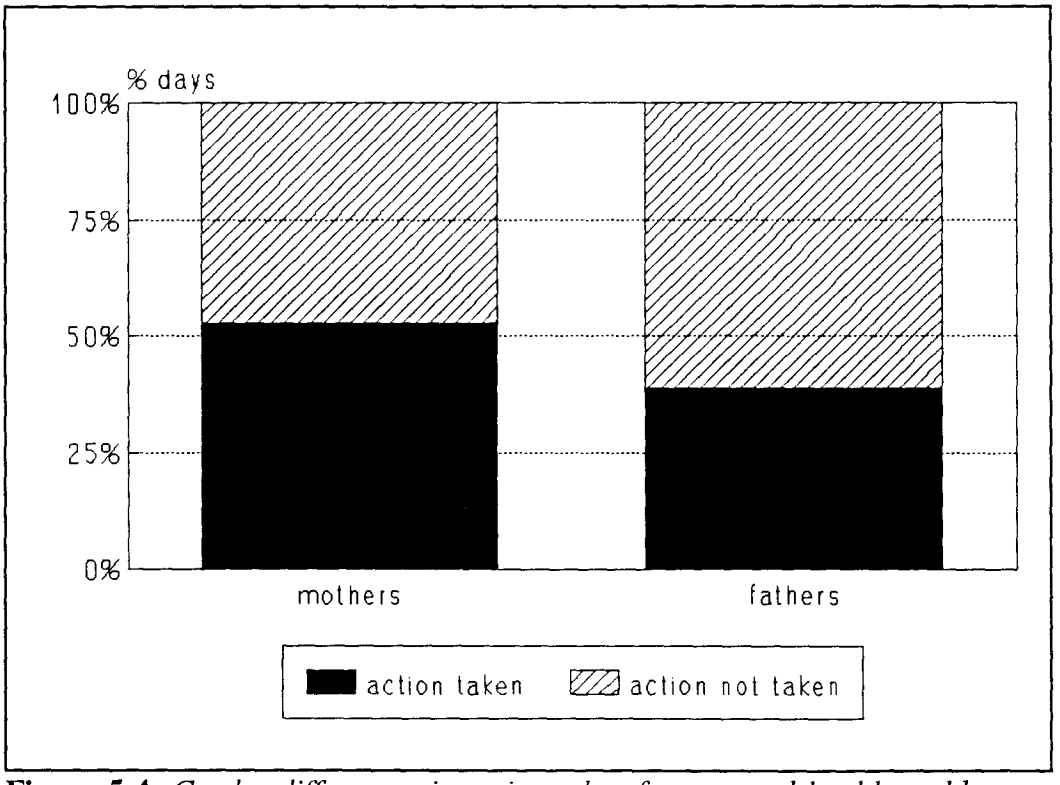


Figure 5.4: *Gender differences in action taken for reported health problems*

Alternatively it could be because women are more sensitive than men to those health problems which have less effect on them. Others have argued that the higher rates of reporting illness and GP consultation among women compared with men is due to women's greater sensitivity to and acknowledgement of day-to-day fluctuations in their health (Mechanic 1978, Briscoe 1987).

Gender differences in types of health problems

Mothers reported 'headaches' and 'depression' on twice the proportion of days as fathers, and 'tiredness' on nearly one and a half as many days (see Table 5.9). This does not include the days on which they may have had these problems but refer to them as 'period pains'. Mothers also reported a slightly larger proportion of cold symptoms than fathers. This relationship between caring for young children and higher rates of depression has been found by many other studies (eg. Richman 1976, Gove and Geerken 1977, Brown and Harris 1978, Graham and McKee 1980, Cleary and Mechanic 1983). These studies focused on the psychological effects of childcare on health and did not consider the effects on physical health. Further, they only considered women's experiences of motherhood and did not capture men's experiences.

Table 5.9: *Gender differences in types of health problems*

Health problem	No. of days (n = 539)	
	Mothers (no. of days = 280)	Fathers (no. of days = 259)
Tiredness	40 (14%)	25 (10%)
Headache	22 (8%)	9 (3%)
Cold symptoms	17 (6%)	10 (4%)
Depression	10 (4%)	4 (2%)
Stomach ache	5 (2%)	4 (2%)
Physical injury	2 (1%)	8 (3%)
Hangover	2 (1%)	2 (1%)
Backache	3 (1%)	1 (0.5%)
Period pains	8 (3%)	-
Other	3 (1%)	4 (2%)
TOTAL	**112 (40%)**	**67 (26%)**

The only type of health problem reported on more days by fathers than mothers were physical injuries which men reported they had sustained at work. On the second day of his second diary, Tony Bevin fell off a ladder at work. On that day he recorded it under the section 'did anything happen today which bothered or upset you?' and said he had no health problems that day. On the following day, under health problems he wrote 'my back and shoulder hurting from fall', and under health actions he wrote 'went for X-ray'. He did not perceive of the accident as a health issue until it affected him in some way. Paul Edwards also reports an injury he sustained at work: 'pulled a muscle in my right arm due to carrying large heavy display boards'.

In her summary of American research on differences in women's and men's health in the past 15 years, Lois Verbrugge (1985) found that women have more frequent illness and disability, but the problems are typically not serious (life threatening) ones. In contrast, men suffer from more life threatening diseases, causing more permanent disability and earlier death for them. The first part of this statement is confirmed by my analysis of the health diaries which shows the mothers reported more of these problems. But Verbrugge (1985) makes the important point that women and men essentially suffer from the same types of problems; what distinguishes them is the frequency of those problems, which is illustrated by Table 5.9 above.

These variations in the frequency of different types of illness reported by men and women have been found by other studies. For example, Kennedy (1987) cites a Danish population study of 1,050 40 year olds, 41 percent of women and 25 percent of men felt 'tired at present' (Norrelund and Holnagel 1979). In this case it is not that women get tired and men do not, but that women get tired more frequently. Numerous studies have shown higher rates of depression in women than men (Weissman and Klerman 1977), although it must be noted that depression has been defined in many different ways, and differently to my study where in the health diaries it is a subjective assessment by the parent of their current mood rather than an 'objective' assessment of a symptom or syndrome. The differences in reporting of depression need to be put into context of other measures of distress which include 'acting out' strategies used more (in the past) by men, such as drinking alcohol,

smoking, violent behaviour and so on (Mechanic 1978). There were a few instances in the diaries of men reporting that they got drunk to 'drown their sorrows'.

A detailed analysis of the context within which parents reported health problems illustrates the relationship between gender roles and health and illness. I have already shown how the men reported more physical injuries sustained at work. In addition, the men often accounted for other health problems such as headaches and tiredness by their experiences at work. Daniel Oliver, for example, said on one day of his health diary: *'a bit tired today from working too hard'* and on another day: *'had a headache because of row with foreman'.*

Mothers, on the other hand, did not use the concept of 'work' as much to account for their health problems, although often it was childcare work or housework which they cited as the cause of the problem. Deborah Jessop described one of her mornings in her diary like this:

> *Had breakfast together, did dishes, took Jenny swimming then took her up the shops, paid the bills, did the supermarket shopping.*

Under any health problems, she wrote:

> *Felt a bit tired this afternoon probably from the active morning we had.*

On one of her diary days, Diane Cartwright reported a 'poor' day overall and that her health had been 'good'. Under any health problems she wrote:

> *I felt really tired today, and Nicole was more than a handful which made me very depressed.*

Lesley Fisher wrote on one of her days which she reported as 'average' overall and 'average' in terms of her health:

> *At the end of the afternoon I felt tired and down because the flat still looked a mess and I hadn't prepared dinner or done any washing or ironing, which I should have done.*

After a busy day of childcare and housework, Suzanne Oliver wrote:

> *Felt very tired in the evening, had a bad headache, as I was on the go all day.*

Thus 'work' for both men and women is a major cause of health problems, particularly tiredness. However, the mothers do not conceptualise childcare and housework as 'work' in the same way as men see their paid employment. The different way 'work' is structured for women and men is reflected in the different levels of health problems they report and the type of actions they take, and is particularly evident in the way they talk about tiredness.

Tiredness

Sleep and tiredness were major issues for many of the parents, especially the mothers. Tiredness was the most mentioned negative health effect of childcare and the most commonly reported health problem in the health diaries (see also Popay 1988).

As well as spontaneously talking about tiredness, parents were also directly asked about tiredness and sleep. At the first interview parents were asked whether they felt tired 'yesterday or today' and over two-thirds of parents said yes. Twelve of the thirty parents had had their sleep disturbed the night before by their children waking up. The degree to which they were disturbed varied. Lesley Fisher, for example, told me:

> Well, she doesn't need any attention but she wakes up and comes into our bed and just goes straight back to sleep - she does it every night.

Dawn Abbot and Julie Thomas, however, only got four hours and five hours sleep respectively because their children were teething. Others like Alison Grange, Deborah Jessop and Tim King rarely get a night of uninterrupted sleep and it takes its toll - Deborah describes the previous night:

> We were probably in bed for eight hours, but it was, we did, I did get up in the night for her. I'm a bit of a light sleeper so it's sort of disrupted, it's not always eight solid hours...so I get tired.

Like Popay (1988), I found differences in the way mothers and fathers talked about tiredness. On the whole, mothers were more affected by lack of sleep than fathers, some of whom said they needed less sleep. Nigel Abbot says that he has got used to needing less sleep because when he was unemployed he used to stay up all night playing snooker:

> ...so I'm used to an erratic sleeping pattern so...when I'm tired I don't feel as tired as maybe Dawn would in the same situation...I do get shattered sometimes but I just keep going, you know I can go through it, no problem...

Ben Land told me:

> I don't need a lot of sleep. I can go to bed at sort of twelve and up at half past six and I'm OK. I'm not really tired.

Unlike his partner, Alison Grange, Joe Harris says that a year of broken sleep:

> ...doesn't bother me really...getting quite used to it.

Lack of sleep was not the only cause of tiredness. Parents also accounted for their tiredness that day, or more generally, by their work. This was mentioned more by fathers than mothers. Ben Land, for example, works as a car mechanic and explains his tiredness, saying:

> It's usually a hard day at work, that's something where I've had to do a lot of running around or something, you just think about a lot of things whereas we're usually fitting things, you know. Or you get problems at work, they're the sort of things that take it out of you mentally. And I've got to the stage now where I get a lot of problems, you know, trusted a lot more than a lot of the other blokes, being sort of the top sort of mechanic. I tend to get more of the problems than other people, so, makes you more tired that way.

For Nigel Abbot and Ruth Dobbs, their shiftwork means they do not get enough sleep.

More mothers than fathers, however, explained their tiredness by the demands of childcare. Jane Vernon says she feels tired 'most of the time' and says it is partly because Mandy wakes up early in the mornings and also because:

> I think I do more during the day, I mean I say I don't do much exercise, planned exercise, but I do walk a lot more now than I used to. I mean Mandy and I walk miles, we walk up to Ally Pally, up to the park or around the shops, whereas before I might get the bus or hop on the train I walk now. So we do a lot and I think just having a child that's quite demanding - makes you tired in itself.

Joanne Land says she gets tired easily partly because she does not sleep well at night:

> But also in the day, I mean, I'm - I s'pose - I go out with him, I never stop. I mean I never just sort of sit down, so, yeah, I'm on the go all the time and I do get tired. I've always got something to do.

Some mothers also told me how the way they sleep has changed since their children were born. They sleep much more lightly so that they can listen out for their children in the night. Jill Smith said:

> And now of course I sleep very light which you do as a mum because of the baby waking up, you hear the slightest thing...

Her husband also mentioned this.

Parents were also asked if they ever felt they had no energy and some parents distinguished between feeling tired and having no energy. Louise Bevin, for example, said:

> Like sometimes if we're just in all day you know I get a bit...like I can't be bothered to do anything, but that's not really because I'm tired but because I'm just lazy (laughs). It's not really to do with her...

Jill Smith says she might get tired but she cannot afford to have no energy:

> I wouldn't say it's a lack of energy because when you're a mum you've got to get on with it regardless but no, I don't think I've a lack of energy, I'm just tired, you know.

Some of the fathers and mothers who work outside the home say they sometimes come home from work with no energy. But both Ben Land and Julie Thomas say if they feel like this, they make an effort as this is one of the few times they get to play with their children. Ben Land says:

> I can come home from work sort of exhausted and then I don't want to play with him. Yeah, I can only play with him sort of ten, fifteen minutes rather than an hour, something like that...I don't let it happen too often 'cos they're the only two hours I get to see him. Two and half, three hours whatever it is that I see him, I try to make the most of it.

Julie Thomas feels similarly:

> I can always find it from somewhere, I try very hard, like I haven't really felt well the last couple of nights...to be honest, when I'm working I probably only see Christine for two and a half hours a day probably...I hardly see her at all really, I do try 'n' make the effort, even if I don't feel like it...'cos I mean I do miss her...she's at a nice age at the moment.

Gender differences in types of reported health actions

Just as mothers are more likely to take action for a reported health problem than fathers, a more detailed analysis of health actions taken shows differences between mothers and fathers with regard to the health actions they took (see Table 5.10).

Table 5.10: *Gender differences in types of health actions*

Health action	No. of days health problems reported (n=179)	
	Mothers (no. of health problem days = 112)	Fathers (no. of health problem days = 67)
No action	50 (45%)	39 (58%)
'Resting'	22 (20%)	6 (9%)
Non-prescribed painkillers	15 (13%)	6 (9%)
Other non-prescribed remedy	14 (13%)	6 (9%)
Change in behaviour	3 (3%)	5 (8%)
Taking prescribed medicine	4 (4%)	3 (5%)
Contact with health services	4 (4%)	2 (3%)

Mothers reported resting, going to bed early and so on over three times more than fathers, although they had reported feeling tired on only twice as many days. It would appear from this that mothers get more time to rest and relax than fathers, but a closer examination of how mothers reported 'taking it easy' reveals a different picture. The mothers do not feel entitled to 'rest' at any particular point in the day. If they feel fit and healthy, they feel that they should be able to work the whole day and evening, hence they have written comments in their diary like 'relaxed in the evening' under action taken for health problem - the assumption being that they should in fact be doing something in the evening and not be relaxing at all. Mothers feel that there is so much to do in the house that they cannot afford to relax, and that the evenings should be used for jobs such as ironing which are impossible to do in the day with a small child around: 'a woman's work is never done'. They regard 'putting their feet up' in the middle of the day as a luxury, whereas fathers do not report this kind of action as they take it for granted that they will get time to relax

when they are not at work. Therefore one of the reasons that fathers report tiredness less often than mothers could be that they have more rest.

When I asked Jill Smith if she ever felt she had no energy she said:

> ...no, because I feel tired but I wouldn't say it's a lack of energy because when you're a mum you've got to get on with it regardless...

These behavioural differences point to different ideas women and men have about 'work' and 'rest' (see also Cornwell 1984:139).

The fathers tend to view 'work' as their participation in paid employment in the public sphere which is confined to a limited period of the day. Their home is a place where they can rest and relax which is something they are entitled to after a hard day's (or night's) work outside the home. For example, on one day in his diary Paul Edwards wrote under 'any health problems':

> *Quite tired this evening. Probably due to excess work at the moment and not much sleep this week.*

Under 'did you do anything about any health problems you noticed?' he wrote:

> *I'll probably have a lazy day at home tomorrow.*

This is not to say that fathers did no work in the home - many were involved in on-going decoration/refurbishment of their homes and most contributed to other domestic work such as childcare and housework to some degree. However, their attitude towards this domestic work was markedly different from the women. They do not see it as a 24 hour a day responsibility, but rather more often as an intrusion into the precious time they can spend at home away from their jobs.

Mothers reported taking painkillers on twice as many days as fathers, which corresponds with the finding that mothers report more than twice as many headaches as fathers, plus mothers often reported taking painkillers for period pains. Mothers reported taking more non-prescribed remedies than fathers, but they reported similar numbers of changes in behaviour and taking of prescribed medication.

With regard to health service contacts, an analysis of health diary and interview data

over the nine month period of the study (n=26) shows that while the mothers contacted the health service an average of three times (range: 0-6), the fathers contacted them on average only once (range: 0-4). Table 5.11 shows that most of the fathers were either not in contact with the health services at all or only in contact once over the nine month period. In contrast, most of the mothers were in contact at least twice.

Table 5.11: *Gender differences in number of contacts with health services*

No. of contacts	No. of mothers (n=13)	No. of fathers (n=13)
0	1	7
1	3	3
2	4	1
3	0	1
4	2	1
5	1	0
6	2	0

The greater use of informal and formal health services by mothers reflects their greater reporting of health problems. In the case of 'home remedies', however, it may reflect the pressure on mothers to 'carry on' with their chores, and always have constant attention for their child, so they will take a headache tablet, for example, when they start to feel not in the best of health, because it is so important that they can continue.

III GENDER DIFFERENCES IN THE RELATIONSHIP BETWEEN CHILD'S HEALTH AND PARENTS' HEALTH

It appears that there is a greater relationship between the mothers' and child's reported ill-health than between the fathers' and child's reported ill-health. This relationship could be either way: the child's health could affect the mother's health or it could be that the mother's health affects the child.

Table 5.12: *Gender differences in relationship between child's health problem and parents' health problem*

	Child health problem			
	Reported by mothers		Reported by fathers	
	Yes (n = 69)	No (n = 189)	Yes (n = 45)	No (n = 210)
Mothers' health problem:				
Yes	34 (49%)	71 (38%)	-	-
No	35 (51%)	118 (62%)	-	-
Fathers' health problem:				
Yes	-	-	12 (27%)	53 (25%)
No	-	-	33 (73%)	157 (75%)

Table 5.12 shows that on days when a mother reported her child as having a health problem, the mother is more likely to also report having a health problem than on days when a child is not reported as having a health problem. There was very little relationship between the fathers' reporting of the children's health problems and fathers' reporting of their own health problems.

Similarly, Table 5.13 shows the relationship between the parents' reporting of their child's health and their subjective assessments of their own health. On days when mothers reported their child having a problem, mothers were less likely to say their health had been very good or good and more likely to say it had been average, poor or very poor than on days when a child was not said to have a health problem. There was no relationship between the the fathers' reports of their children's health problems and their subjective assessments of their own health.

However, both mothers' and fathers' feelings about their day in general are related to their child's health problems. Mothers and fathers reported fewer very good and good days and more average, poor and very poor days on days when their child was reported as having a health problem than on days when their child was not reported as having a health problem. Further, both mothers and fathers reported more days with upsetting events on days when their child was reported as having a health problem than on days when their child was not reported as having a health problem.

Table 5.13: *Gender differences in relationship between child's health problem and parent's daily health*

	Mothers (no. of days = 280)		Fathers (no. of days = 259)	
	Child health problem (n = 69	No child health problem (n = 189)	Child health problem (n = 44)	No child health problem (n = 210)
Very good	14 (20%)	72 (38%)	6 (14%)	22 (10%)
Good	29 (42%)	81 (44%)	23 (52%)	125 (61%)
Average	18 (26%)	28 (15%)	15 (34%)	47 (22%)
Poor	6 (9%)	4 (2%)	-	13 (6%)
Very poor	2 (3%)	4 (2%)	-	3 (1%)

Parents' perceptions of child's health and well-being

The parents felt more positive about their child's health and well-being than about their own. As Table 5.14 shows, on 83 percent of days, the children's health was reported as being very good or good; and only 4 percent of days were they reported as poor or very poor.

Table 5.14: *Parents' reports of child's daily health and wellbeing*

	No. of days (n = 539)		
	Very good/good	Average	Poor/very poor
Child's health	447 (83%)	70 (13%)	22 (4%)
Child's day	420 (78%)	102 (19%)	17 (3%)

The children's kind of day was also reported by parents in a more positive way than their own: 78 percent of child days were reported as very good or good and only 3 percent of days were reported as poor or very poor.

The children were reported as having a health problem one every 4 days and action was taken for these health problems on one in every seven days; that is, parents more

often took action for their child's health problems (in two out of every three cases) than for their own (one in every two). The mismatch between how parents reported their children's overall health and the number of health problems the children had, is put into context by the interview data which shows that parents expect a certain amount of illness in their young children and regard this as part of being a healthy child. In answer to the question 'how do you think your child's health has been over the past year - good, fairly good or not good', one father answered:

> ...fairly good considering her age...she is quite young, you know,you expect babies to be ill in that way, it's no more than I would have expected.

The dichotomy between parents' reports of their child's overall health as good and the high numbers of child health problems reported can also perhaps be explained by the parents' need to describe their children as healthy as discussed in Chapter Four.

Types of health problems reported by parents in their children

The different types of health problems reported by parents in their children are shown in Table 5.15. The term 'cold' once again includes 'runny nose', 'coughing' and 'sore throat'; and 'other' includes 'chicken pox','cold sore', 'headbanging', and 'cradle cap'.

Types of health action parents take for their children

The types of action parents took for their children when they perceived them to have a health problem is shown in Table 5.16. Liquid paracetamol was used for a variety of health problems; especially colds, teething, high temperatures. Only one child was given prescribed medication during the course of the diary period - penicillin for a throat infection - which had been prescribed before the diary period. During the diary period only one child was taken to the doctors. Under the rubric 'other' is included 'kept him awake', 'gave bottle', 'phenergan', 'smacked him', 'nappy rash cream', 'bath with salt', 'took to doctors', 'antiseptic cream', 'calamine lotion'.

Table 5.15: *Types of children's health problems*

NB Parents could report child having more than one health problem on one day.

Type of health problem	No. of days (n=539)
Cold	44
Teething	16
Tired	8
Irritable	7
Sickness/diarrhoea	6
High temperature	4
Accident	4
Throat infection	4
Not sleeping	3
Sore bum	3
Other	5
Total	**104**

Table 5.16: *Health actions taken for children*

Health actions taken for children	
Action	No. of days
Liquid paracetamol	23
No action	18
Cough linctus/syrup	15
Vapour rub/vaporiser	9
Teething gel	7
Early to bed	6
Cuddles	5
Prescribed medication	5
Sponged him/her down	3
Other	13
Total	**104**

Gender differences in reporting child health

Mothers were more likely to report their child's kind of day and their child's daily health as very good or good, whereas fathers tended to report both as being good or average (see Tables 5.17 and Figures 5.6 and 5.7).

Table 5.17: *Gender differences in reporting child's daily health and wellbeing*

	Very good	Good	Average	Poor	Very poor
Child's day (% days)					
Mothers (n=280)	93 (33%)	141 (50%)	40 (14%)	6 (2%)	0 (0%)
Fathers (n=259)	36 (14%)	153 (59%)	62 (24%)	3 (1%)	5 (2%)
Child's health (% days)					
Mothers (n=280)	127 (45%)	116 (41%)	25 (9%)	11 (4%)	1 (0%)
Fathers (n=259)	55 (21%)	151 (58%)	41 (16%)	11 (4%)	1 (0%)

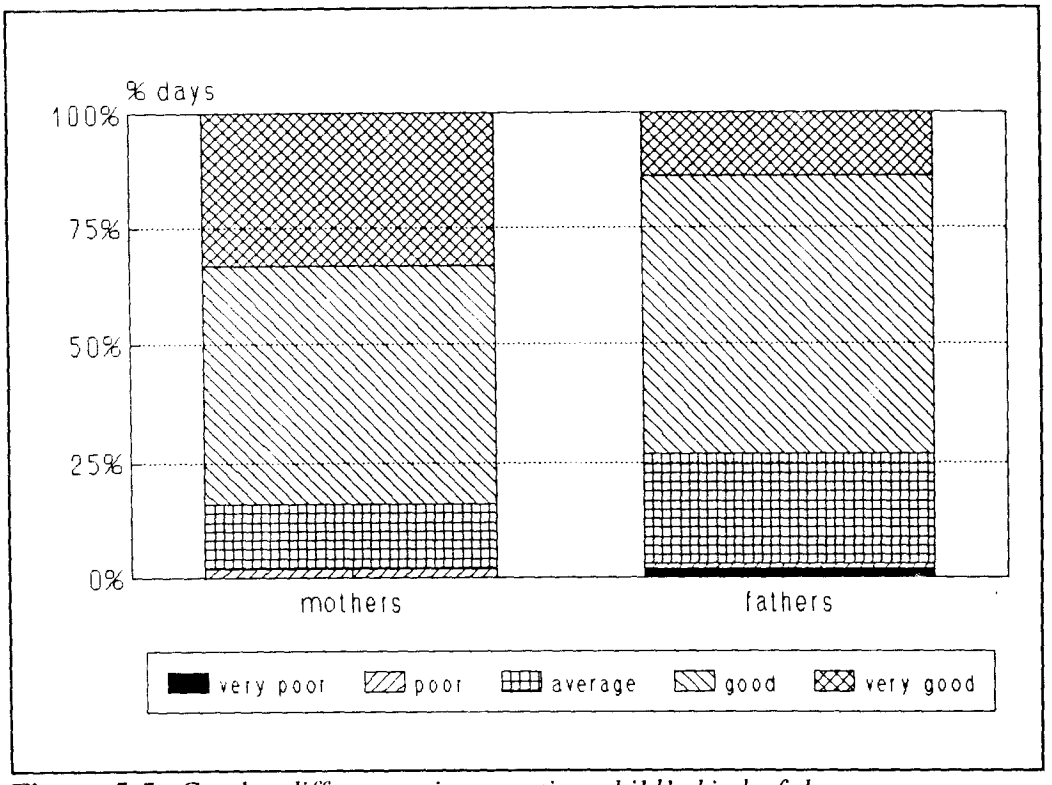


Figure 5.5: *Gender differences in reporting child's kind of day*

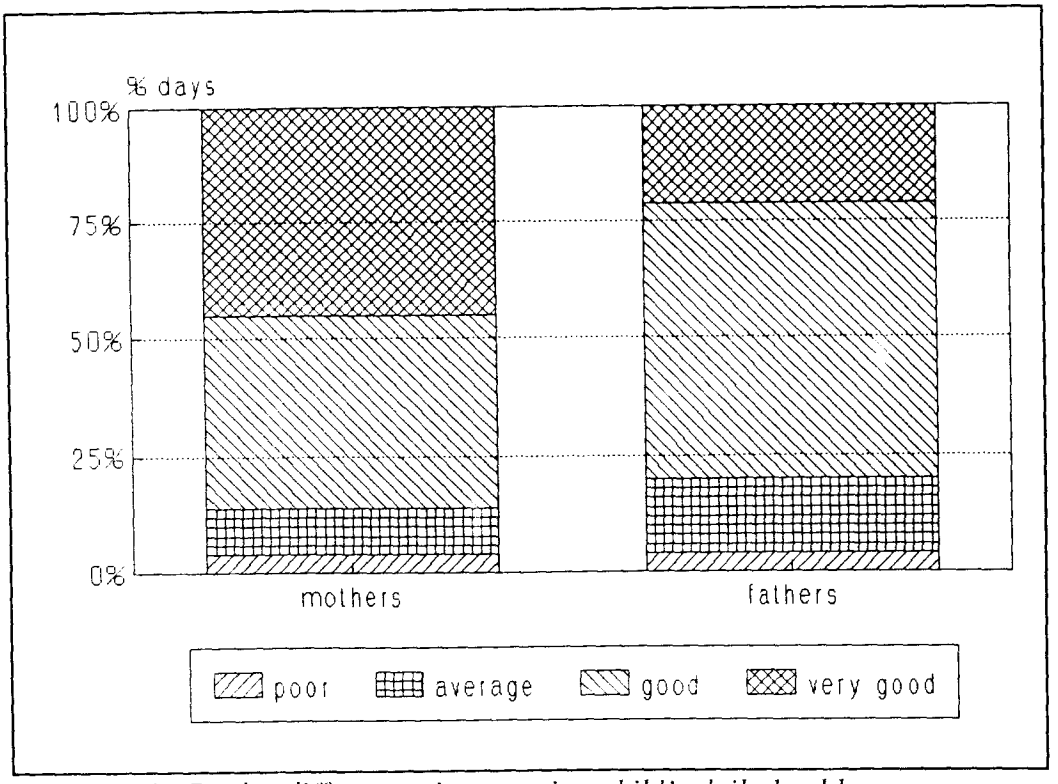


Figure 5.6: *Gender differences in reporting child's daily health*

Table 5.18: *Gender differences in reporting of child's health problem and taking action for problem*

	Mothers (no. of days = 280)	Fathers (no. of days = 259)
Child health problem	69 (25%)	44 (17%)
Child health action (% health problem days)	52 (75%)	20 (45%)

As Table 5.18 shows, there are small gender differences in parents reporting health problems in their children, but there are large gender differences in reporting taking action for the child's health problems. Mothers reported taking action for 3 out of every 4 health problems whereas fathers reported action being taken for less than half the child's health problems. This is not to say that fathers noticed health problems in their children and did not take action, but rather that fathers were aware of their

children's health and ill-health (mostly through reports of the mother) but they did not take responsibility for dealing with it, either because they were not present or, even if they were, the responsibility was still primarily the mothers' (see also Kerr and McKee 1981).

Differences in reporting by sex of child

NB. Parents reported 357 health diary-days for girls and 182 for boys. Percentages in this section refer to these totals.

Parents of boys (n=10) and parents of girls (n=20) did not differ in their reports of their own daily health, whether they had a health problem or not; whether or not they took action for a health problem; or whether they reported something which had made them feel good or which had upset them. The only variable which showed a relationship with between the sex of child and the parents' well-being was how the parents reported their day overall. Parents of girls reported more very good and good days overall than parents of boys (61 percent compared with 48 percent of diary-days). Parents of boys reported more average, poor and very poor days overall than parents of girls (53 percent compared with 39 percent of diary-days).

Parents reporting of their child's health and well-being differed very little by sex of the child. Girls (n=10) were reported to have slightly more very good and good overall day than boys (81 percent compared with 74 percent of diary-days), and boys (n=5) were reported to have slightly more average and poor days than girls (23 percent compared with 19 percent of diary-days), but reporting of daily health, whether the child had a health problem and whether action was taken for the problem were very similar for boys and girls. This is in contrast to other findings which report boys to be more 'troublesome' than girls (Osborn et al 1984); and boys to be more liable to acute sickness than small girls and the nature of sickness is taken more seriously (GHS 1973:299). However these findings are based only on mothers' reports of their children so have to be compared with the mothers' reports of their children in the present study (see below).

Gender differences in reporting by sex of child

NB. Mothers reported 183 diary-days for girls and 94 for boys; fathers reported 174 diary-days for girls and 88 for boys. Percentages in this section refer to these totals.

The mothers of boys (n=5) reported having more than twice the number of very good overall days and poor and very poor days than the mothers of girls (n=10), who report mostly good and average days. The fathers of girls (n=10) reported more good and very good overall days than fathers of boys (n=5) (53 percent compared with 39 percent of diary-days), and fewer average, poor and very poor days (48 percent compared with 61 percent of diary-days). There were few differences by sex of child between mothers and fathers reporting of own health problems, health actions and whether something had made them happy or upset them. Mothers of girls and boys reported few differences in their child's day, their daily health or the number of health problem-days, although mothers of boys (n=5) reported their children as having more poor and very poor health days than the mothers of girls (n=10), confirming other studies (eg. Osborn et al 1984). But mothers of girls were more likely to take an action for their child's health problem than the mothers of boys.

Fathers of boys and girls reported their kind of day fairly similarly, but reported the boys as having more very good and good health days and the girls as having more good and average health days. This is a direct contradiction to the way mothers reported their son's health and needs some explanation. Henshall and McGuire (1986) review the evidence of fathers' greater concern that boys conform to their gender-role stereotype (Newson and Newson 1968, Langlois and Downs 1980, McGuire 1982) and this could explain why in the present study fathers report their sons as fit and healthy ie. strong and macho rather than weak and ill ie. feminine.

Fathers reported boys and girls as having similar number of health problem days, but fathers of boys (n=5) were more likely to take action for their child's health problem than the fathers of girls (n=10). This corresponds with other findings which show fathers to have more interest in newborn sons than daughters (Woollett et al 1982). After reviewing these studies Henshall and McGuire (1986) conclude that:

> It seems likely that fathers' greater interest in boys may help them to cope with difficult male infants (p.156).

It is interesting also to note at this point that the fathers of sons (n=5) were more likely to be more involved in childcare than the fathers of daughters (n=10), but the numbers are of course very small. Again, this coincides with other findings that fathers pay more attention to sons (Parker 1981, Kotelchuck 1981).

Conclusions

The finding that women report more health problems than men concords with many other studies that show women to report more acute and chronic conditions than men (Nathanson 1975, Verbrugge 1976). However, it is difficult to compare studies because they use different measures of morbidity.

This gender difference has been explained in two ways: either it is a 'real' difference and women experience more health problems than men; or it is an artefact and women report more health problems because it is culturally more acceptable for them to do so. However, the second explanation is difficult to uphold in this case in the light of the finding that these mothers reported their overall health more positively than the fathers. This would appear to point to the first explanation that women experience more health problems, but the reason they report their health more positively is that they *expect* to experience more health problems.

The first explanation is also supported by the finding that it is those mothers who experience the most frustration and stress who report the higher numbers of days with health problems. However, from these data it is not possible to 'prove' one explanation against another because it is likely that there is something in both explanations: it could be that women are more aware of their health and able to report problems more freely because it is more culturally acceptable for them to do so *and* they experience more health problems. There is a paradox in that while the mothers report more health problem days than fathers, the subjective assessments of their health and their kind of day in general are better than the fathers. This is in contrast to other studies which have found that women report their health less positively (Maddox 1964, Hollnagel and Kamper-Jorgensen 1980, Gofin et al 1981). These mothers more readily take action for their health problems, particularly in the form of 'home remedies' such as painkiller etc. Both these findings illustrate how important it is for mothers to cope, to be seen to be coping and to *believe* they are coping.

Graham (1982) has pointed out how crucial the concept of 'coping' is to our understanding of motherhood as it is a way of:

> ...linking women's experiences to our analysis of the ideological and material structures which sustain them (p.102).

She defines motherhood as a state of perpetual coping, because the qualities that social scientists have uncovered in their studies of bereavement and sickness (and described as coping) are ones which mothers are expected to display all the time.

This kind of research, particularly by feminists, which stripped away our cosy images of motherhood and revealed it to be difficult, demanding, isolating and depressing work, as it is structured in our society, (see eg. Richman 1976, Graham and McKee 1980) is politically extremely important. However, important as the concept of coping is to our understanding of motherhood, there is another way of explaining why women report their days in general and their overall health so positively while reporting such high levels of health problems. These women may enjoy being mothers not just because it is socially valuable (in some respects) but because it is enjoyable in and of itself, despite all the difficulties it entails. Adrienne Rich, writing about her own experiences of motherhood, expresses the ambivalences and conflicts felt by many others:

> My children cause me the most exquisite suffering of which I have any experience. It is the suffering of ambivalence: the murderous alternation between bitter resentment and raw-edged nerves, and blissful gratification and tenderness (1977:1).

The mothers in this study also express this ambivalence in different ways. Jane Vernon said of her daughter:

> I like the character she's turning into, she's really getting a personality of her own, she can make you laugh, she can make you angry, she can make you downright frustrated, she can make you feel a lot of things but she's really turning into a person now, a little person, and she's good fun to be with...

When I asked Julie Thomas if there was anything she did not like about looking after her daughter, at first she said there was nothing, but then she went on for several minutes about the difficulties and frustration of trying to keep their flat clean with a child of 18 months running around:

> I mean there are times when she drives me crackers...she can be really irritating (laughs). No, no, she can be really messy sometimes 'n' she can always be in the wrong place at the wrong time...she's terribly messy with her

> eating, I mean I seem to spend hours cleaning her high chair 'n' it's just exactly the same the next day, I don't know why I bother...no, I really enjoy her.

In their day-to-day lives mothers have a great deal of work to do such that, as I have shown, they feel they should work all hours of the day. When they 'relax' they comment on this as a 'health action' rather than perceiving it as a daily 'right' as the fathers do. This may go some way to explaining mothers' higher reporting of tiredness, which, in turn may account for their higher reporting of health problems overall. This supports the nurturant role hypotheses ie. that women's caring role causes them to become run down and more susceptible to illness.

The finding that the child's health is more closely related to the mothers' health than the fathers' health also supports the nurturant role hypothesis. This points to the explanation that it is due to their mothering role that women report more acute and chronic conditions than men. (Although it could be that the mothers are affecting the health of their children.)

Gender differences in the reporting of child health and well-being reflect those of self-reports and could be because the fathers are less willing to use the extreme terms of very good and very poor. Alternatively, the finding that the mothers reported their child's health more positively than the fathers did, could be because there are stronger moral and cultural pressures on mothers to have 'healthy' children, as it reflects on them more than it does on fathers. However, this did not hold true for the boys, whom the fathers perceive as much healthier than the mothers do, possibly because the fathers (need to) perceive their children as conforming to the masculine gender-role stereotype.

CHAPTER SIX

RESOURCES FOR PARENTHOOD: GENDER DIFFERENCES IN HEALTH

> We share the bathroom and toilet with the rest of the house and they're freezing cold. I think I'm gonna start washing him in the sink because it's too cold to take him out there now...In fact he didn't go in proper bath till he was about a year old 'cos it's so cold out there. (Ruth Dobbs)
>
> I see my dad quite regular 'cos he lives local but my mum lives in Wales so I p'raps only see her two or three times a year and I could see - see her every day and someink 'cos when you're out shopping you see loads of girls with their babies and their mums and think ahh I wish, you know, 'cos these silly little problems, like I'm saying you get depressed - if your mum was there, life would be a lot easier to have your mum round the corner. But she's not, so yeah, it's a shame I'd like that, I would like her to be nearer... (Alison Grange).

In Chapter One I discussed how studies on gender roles and health have ignored the issue of material resources; and research on class inequalities in health has focused on men and largely ignored gender differences (Popay and Bartley 1987, Arber 1991). This chapter, therefore, analyses the relationship between material resources and the health of the mothers and fathers in this study. It also analyses the relationship between different kinds of social support and the health of the mothers and fathers.

As the focus of the study was gender differences in health among parents, it was limited to working class families in order to try to minimise the differences in access to material resources. However, this group of working class parents are by no means homogeneous with regard to material resources. Thus it became important to analyse these differences to see how they related to parents' health and if they could contribute to the explanation of gender differences in health experiences.

In this chapter I shall first outline the evidence which links material resources to health, before going on to explore the differences within this study group in material resources and what, if any, relationship these have to their health. The gender

differences within this relationship will be analysed to see if mothers' and fathers' health experiences are influenced by differential access to material resources.

1. Inequalities in Health - the evidence

The link between material conditions and health is one which has been of concern for a century or more. It is well known that the reductions in mortality from infectious diseases from the mid-nineteenth century were achieved not only by the success of medical science, but also by the improvements in nutrition, the public health measures which led to better sanitation and a purer water supply, and the limitation in family size (McKeown 1979). Epidemiologists' work was very important in demonstrating the link between living standards and health and this led to a concern about the relationship between poverty and ill-health typified by the concern at the turn of the century with the quality of recruits to the Boer War (Thane 1982).

In the last ten years, a number of reports have documented the pattern of health inequalities (Townsend and Davidson 1982, Whitehead 1987, Marmot et al 1978, Fox and Goldblatt 1982, Fox et al 1984, Blaxter 1990, Thunhurst 1985, Townsend et al 1984, Townsend et al 1986). Whether social position is measured by occupational class, or by assets such as house and car-ownership, or by employment status, a similar picture emerges. Those at the bottom of the social scale have much higher death rates than those at the top. This applies at every stage of life from birth, through to adulthood and well into old age. All the major killer diseases now affect the poor more than the rich (as do some of the less common ones). Those lower down the social scale also experience higher rates of chronic sickness and their children tend to have lower birthweight, shorter stature and other indicators suggesting poorer health status (Whitehead 1987).

Not only do lower occupational classes have higher death rates, but they also experience more sickness and ill-health throughout their lives. Analysis of the 1984 General Household Survey (1986) reveals rates of limiting long-standing illness for the unskilled manual group more than double those of the professional group for both men and women. The gradient is not quite as steep, but still marked for long-standing

illness without limitation; while for acute sickness the differential is only evident at ages over 45 (Whitehead 1987).

However, these findings are based on *male* occupational social class - *women* are marginal and are included primarily as married women classified by their husband's occupation. This assumes that the social position of the wife is that of her husband and ignores the issue of inequalities *within* families (see eg. Goldthorpe 1983, Parkin 1972, Delphy 1979); and the unequal distribution of material and social resources within households (see eg. Pahl 1983, Land 1983, Brannen and Wilson 1987).

There is a roughly similar class gradient in mortality for men and married women classified by their husband's occupational class, but the differentials for married women are slightly less (Townsend and Davidson 1982, Whitehead 1987). There has been some work on women's mortality classified by their own occupation, although this is problematic since there is a dearth of information collected about women's occupational status at death registration. The UK census collects information on the current occupation of women who are economically active, but unlike for men, housewives are not asked about their most recent job. In the OPCS Longitudinal Study, 62 percent of women aged 15-59 can be assigned a class based on their own occupation. These data show a weaker mortality gradient for women than for men, but a clear difference between manual and non-manual occupations (Moser and Goldblatt 1985). Unlike men, there is no gradient *within* either non-manual or manual classes. However, no distinction was made between different marital statuses or whether the woman was working part-time or full-time.

Because of the problems of using occupational social class for women, some researchers have used household based measures which are applicable to all households. Fox and Goldblatt (1982) suggest housing tenure and number of cars as indicators of the social class of households. For men these indicators show as strong associations with mortality as social class and provide more discriminatory power for women's mortality than social class based on women's own occupation (Moser and Goldblatt 1985).

Moser et al (1988) looked at women's mortality differentials in the OPCS longitudinal survey using a combination of indicators. These included information on marital status, own occupation, (if married), economic activity and indicators of household wealth (housing tenure and access to a car). They found that high mortality was associated with working in manual occupations and living in rented housing with no car in the household. In contrast, low mortality was associated with non-manual occupations and living in owner occupied housing with a car. Among married housewives the single women showed the greatest differentials - the disadvantaged groups experiencing death rates two and half times that of the advantaged group. Smaller differences were found among married women with an occupational class.

Such studies all point in the same direction and indicate that however poverty or social disadvantage is measured, the link with men's and women's ill-health is clear and consistent.

2. Explaining health inequalities

The correlation between occupational social class and health needs to be explained. The Black Working Party (Townsend and Davidson 1982) examined the evidence on causes of these differences under four main headings: artefact; health selection; cultural/behavioural; and materialist/structuralist explanations. Whitehead (1987) reviews the four possible explanations of inequalities in health put forward by the Black Report in the light of the new evidence and concludes that the inequalities are genuine and cannot be explained away by the artefact explanation or by the theories of natural and social selection.

The weight of evidence continues to point to explanations which suggest that socio-economic circumstances play the major part in subsequent health. The evidence that health damaging behaviour is more common in lower social groups continues to grow, especially concerning smoking and diet. There is also a growing body of evidence that material and structural factors like housing and income can affect health. More importantly, several studies (Burghes 1980, Cole-Hamilton and Lang 1986) have shown how material and structural factors limit the choice of lifestyle. It

is this set of studies which illustrates most clearly that behaviour cannot be separated from its social context: certain living and working conditions appear to impose severe restrictions on an individual's ability to choose a healthy life-style (Whitehead 1987).

2.1 Unemployment and Health

The unemployed in the 1980s, as in previous decades, tend to have poorer health than those in work. Higher death rates for the unemployed have been found by various studies including the British Regional Heart Study of 1978-80 (Cook et al 1982) and the OPCS Longitudinal Study which found particularly high levels of lung cancer and suicide (Moser et al 1984).

The unemployed have also been shown to have higher rates of reported illness by the GHS 1984, and poorer health and development has been found in the children of the unemployed (Maclure and Stewart 1984). Studies in Britain since 1980 have provided strong evidence that unemployment can cause a deterioration in mental health (Banks and Jackson 1982, Warr 1985). The evidence that unemployment *causes* physical ill-health and suicide is less conclusive, although the OPCS Longitudinal Study provides evidence of excess mortality which cannot be explained away only by occupational class factors or selection effect.

2.2 Housing conditions and health

Poor housing conditions have been found to have a negative effect on health including the reporting of more long-standing illness, more recent illness, more symptoms of depression and more respiratory conditions (Keithley et al 1984, McCarthy et al 1985). Martin et al (1987) found that children living in damp houses had higher rates of respiratory symptoms, which were unrelated to smoking in the household, and higher rates of symptoms of infection and stress. Other studies have looked at the design of housing estates and how they contribute to 'social malaise' among inhabitants (Coleman 1985), depression in isolated women and serious accidents among children (Department of Environment 1981).

Popay and Bartley (1987) argue that research concerned to explain women's

experience of ill-health in different social classes and compared with men, needs to take into account the labour carried out at home, and regard the home as a workplace:

> It is a workplace which disproportionately 'employs' women and in which workers may be exposed to a range of physical, chemical and psychological health hazards - comparable to, not different from, those identified in the formal labour market (1987:17).

Using data from the London Living Standards Survey they looked at the labour conditions of men and women in the formal and the domestic sectors in relation to Townsend's Index of Occupational Deprivation. Noting the limitations of this approach, they found that on four out of six indices they used (air pollution, damp, temperature extremes, and no WC access) women appear to 'labour' in more advantageous conditions in the formal sector than they do the domestic sector.

2.3 Income and health

As Graham (1984) has pointed out, studies of the health behaviour of families rarely discuss the issue of family finances. The focus instead is on the culture and social location of families: on their health beliefs and on their relationship to wider networks of family and friends. The issue of money and its relationship to the health practices of families is a highly complex one. It is also a question about which it is difficult to collect detailed and reliable data and which is politically sensitive (Whitehead 1987). But it is a crucial dimension of family health care. To be meaningful, all sources of income would have to be assessed, including the value of fringe benefits, property etc. and such statistics are not readily available in this country.

A preliminary analysis has been carried out by Wilkinson (1986) on occupational incomes and mortality in 22 occupations, comparing 1951 and 1971. Over this 20 year period, those occupations which had increased their income relative to average earnings, tended to experience a relative decrease in mortality rates. In occupations where income had gone down relative to the mean, mortality rates tended to go up relative to the mean. As Wilkinson notes, this work will have to be repeated and extended before firm conclusions can be drawn.

Another study has looked at the effect of income on children's height. A study of families in poor areas of London in 1973-6 found that a low amount of money spent of food per person per week in a household was highly correlated with poor growth in children (Nelson and Naismith 1979). Other studies have looked at the *indirect* effect of income on health, for example on choice of diet and eating habits. People from low-income households tend to eat less fruit, vegetables and high fibre foods, and more fat and sugar than people from high income households (Cole-Hamilton and Lang 1986).

Studies of why this should be so have found lack of money to be a major factor restricting food choice as well as limiting the quantity of food consumed. For example, a study of 65 families living on supplementary benefit in 1980 (Burghes 1980) found that some parents went without food to provide enough for their children, and lack of money was frequently cited as the reason for lack of fruit and vegetables in their diet.

While these studies have looked at inequalities between families, there is growing evidence of the unequal distribution of income between men, women and children *within* households (see eg. Pahl 1983, Wilson 1987), and unequal distribution of food (eg. Delphy 1979, Charles and Kerr 1987).

2.4 Social Support

There appears to be agreement among the academic and lay populations that something about social relationships can be good for health. As long ago as 1897 Durkheim (1951) observed that social integration protects people from health disasters and, as Oakley (1988) notes, within the sociology of health and illness 'social support' has become the buzzword of the 1980's. The question is what is it about social support which is good for health?

What is Social Support?

There are numerous definitions and ways of measuring social support. It can be defined as membership of a religious organisation or having a close confiding

friendship; it can refer to emotional support, practical help, information, or financial help. Such an amorphous concept is also fraught with measurement difficulties. Spurious assumptions are made such as that the married gain more support than the unmarried or that those with four friends are more supported than those with one. Many studies do not take into account the quality and personal meaning of relationships and that family and friends may create as well as relieve stress (Madge and Marmot 1987). They also do not consider that different people might perceive the need for different of levels of support.

There are four main hypotheses which have been tested in relation to social support and health: (1) social support has a direct positive effect on health; (2) it affects health indirectly by lessening the negative effect of stressful life-events; (3) it may decrease the risk that a person will become exposed to stress and health hazards; (4) it may aid recovery from illness. In their review of the evidence, Madge and Marmot (1987) conclude that there is evidence for all four hypotheses. While most of the literature demonstrates the link between social support and health, questions about *how* this might be so have only just begun to be asked. The relationship is a complicated one and not simply that poor health is 'caused' by low levels of social support (Oakley 1988).

Do poor levels of social support interact with other stressors in producing susceptibility to poor health outcomes or do they act independently? There is a problem with looking at social support and life-events because these life-events themselves may result in losses or gains in social relationships. For example unemployment and bereavement on the one hand and engagement and a new job on the other ie. social support before and after a life-event may be different and should be taken into account (Madge and Marmot 1987). Also, it is possible that the protective effects of social support may operate through other intervening processes, for example a person's social support resources may affect the occurrence of stress, the way they cope with it and adapt to it; or it may influence their self-esteem which in turn affects behaviour or it may alter their mood, either protecting from or enhancing stress effects (Oakley 1988).

Social Support, Stress and Social Class

It is often assumed that lower social classes have fewer resources of social support and experience more stresses. A study by Oakley and Rajan (1991) found that working class women were less likely than middle class women to report being involved in supportive social relationships and close contacts with kin. Brown and Harris (1978) in their study of depression found that their sample of working class mothers reported significantly more severe life-events than their middle class counterparts. They also identified a significant role for social support (in this case defined as a 'confiding relationship') in mediating between life stress and risk of depression: 10 percent of women with a confiding relationship became depressed after acute stress compared with 40 percent of women without such a relationship. Working class women were significantly less likely to report a confiding relationship with their partners and were more likely to have experienced the death of their mother before the age of 11 - one of the four vulnerability factors in Brown and Harris's model. In fact, most of the class difference in depression is due to the greater likelihood of working class people having one of the four vulnerability factors (the other three being lacking an intimate relationship, having three or more children under the age of 14 and not having employment outside the home) rather than risk of experiencing what Brown and Harris refer to as a 'provoking agent'.

Social Support and Health

Studies of social support and mortality consistently point to the conclusion that social networks and their characteristics are important for longevity. The Alameda County Study (Berkman and Breslow 1983) and the Tecumseh Community Health Study (House et al 1982) have shown an association between social networks (including marriage, contacts with friends and relatives, church and other group affiliations) and mortality from all causes. These studies also found a cumulative impact of social support because risk of death from several causes (ischemic heart disease, cancer, cerebrovascular and circulatory diseases and 'all other causes of death') increased with each decrease in social connection. The people at greatest risk of death were those with very few social contacts of any kind.

While the link between social support and mortality is clear, the findings in relation to morbidity are contradictory, for example the work on heart disease and social support (Madge and Marmot 1987). There is also a large literature on the psychological effects of social support which consistently reports the findings that the absence of social support is associated with increased psychological distress (see Leavy 1983 for a review).

II THE CURRENT STUDY

I have chosen two dimensions on which to look at the parents' material resources: income and housing; and three dimensions of social support: help with childcare; other practical support; and emotional support from people other than their spouse.

1. Income

Given the problems of defining these families in terms of social class, income is a better indicator of the economic position of the families and allows for differentiation between them. Unfortunately questions concerning income were only asked at the second interview stage which means that only cross-sectional data on income are available. Also, as two couples were only interviewed once, no data were collected on their income.

The study group has been divided into three income groups: high, medium and low calculated on the basis of joint gross weekly income (see Table 6.1). High income is over £200 per week, medium income is between £150 and £200 per week and low income is under £150 per week. These divisions are to some extent artificial but the parents did also naturally fall into these groups. The terms 'high', 'medium' and 'low' are, of course, relative to the sample. Those on 'high' income could hardly be said to be on high income by any objective, national standard as average full-time wages for all men including overtime stood at £207.50 a week in April 1986 (*Low Pay Review* no. 29); but the definition of low income is fairly close to the gross equivalence income figure set down as the minimum subsistence level by Parliament (see Chapter Three).

Table 6.1: *Parents' income levels*

Joint income level	No. of parents (n = 30)
High (£200+)	10
Medium (£150-200)	10
Low (below £150)	6
Not known	2

NB Those on medium and low incomes fall below the national average full-time wages for men of £207.50 (*Low Pay Review* no. 29).

2. Housing

The housing conditions of the families in the sample vary considerably, not just in terms of type of tenure but also in quantity and quality. As a measure of housing conditions I have used the 'bedroom standard' employed by the GHS. This is a more refined measure of overcrowding than the person per room measure as specified in the 1957 Housing Act (*GHS* 1989:207). It allocates a standard number of bedrooms to each household in accordance with the following rules:

a. each married couple was given one bedroom;

b. any other person aged 21 or over was given one bedroom;

c. persons aged 10-20 of the same sex were given one bedroom per pair;

d. any person aged 10-20 left over was paired with a child aged under 10 of the same sex; if no pairing was possible, he or she was given a separate bedroom;

e. any remaining child under 10 were paired off, with one bedroom per pair, and any remaining child was given a separate bedroom.

The standard can be related to the actual number of bedrooms available for the sole use of the household. Those households who have bedrooms in excess of the standard can be said to under-occupy their accommodation, while those falling short of the standard can be considered to live in over-crowded conditions. Using this standard, the families in the present study would require two bedrooms in order to meet the standard. As Table 6.2 shows, of the 15 families, eight equal the standard (ie. 2 bedrooms), four fall one below standard (ie. one bedroom) and three are one above

standard (ie. 3 bedrooms).

Table 6.2: *Families' housing conditions: difference from bedroom standard*

Difference from bedroom standard	No. of families (n = 15)
Below standard (1 bedroom)	4
Equals standard (2 bedrooms)	8
One above standard (3 bedrooms)	3

Other measures of housing conditions include structure and condition (damp, stability, natural light); equipment and services (WC, water supply, drainage, artificial lighting); environment (pollution, noise, open space, traffic); privacy in multi-occupied dwellings (sharing facilities, sound insulation). The families which come out poorly on these measures are the four which fall below the bedroom standard. For example, Alison Grange and Joe Harris live on the fifth floor of a council block in a one bedroom flat which has a damp bathroom. Patricia Morgan and Ed Newton live in a privately rented one bedroom flat above a shop which is on a very noisy main road.

3. Measures of health

I am using two measures of subjective health in this section. The first is reported health in the year before the first interview ('good', 'fairly good', 'not good') and the second is the level of health problems reported in the health diaries. These were divided into three levels - low, medium and high (see Chapter Five, Table 5.8).

4. Relationship between material resources and health status

It is clearly very difficult to untangle the relationships between the different material resources and their effect on health. However, these data do clearly show the link between quality of housing and health; and between the level of income and health.

a) Housing and health

Table 6.3 shows that those parents living in overcrowded conditions were more likely

to report 'not good' health in the last year and a high number of health problems in their health diaries. Parents living in average or above average conditions were more likely to report their health as 'good' or 'fairly good' in the last year and a low or medium number of health problems in their diaries.

This does not mean that it is their housing conditions which 'caused' parents to experience a high or low number of health problems - there are many other factors which may be involved including the other material and social factors which I am going to look at. However, the link between housing and reported health is apparent.

Table 6.3: *Parents' health status and housing conditions*

	No. of parents (n = 30)		
	Overcrowded	Average	Above average
Health in last year			
Good	1	7	4
Fairly good	3	8	2
Not good	4	1	0
No. of health problems			
Low	1	7	3
Medium	3	7	2
High	5	2	1

Gender differences in relationship between housing and health

As Table 6.4 shows, in terms of reported health problems and health status, there is a greater relationship between the mothers' health and their living conditions than with the fathers' health and their living conditions.

Taking the four couples who live in below average living conditions, the mothers report more 'high' levels of health problems and worse health in the past year than the fathers (see Table 6.4). However, there are some confounding factors: for example, three out of four couples are also on low income.

Table 6.4: *Health status of parents in below average housing conditions (n=8)*

	Health problems	Health in past year
Mothers		
Ruth Dobbs	High	Not good
Lesley Fisher	High	Not good
Alison Grange	High	Fairly good
Patricia Morgan	High	Not good
Fathers		
Paul Edwards	High	Fairly good
Joe Harris	Medium	Fairly good
Ed Newton	Low	Not good
David Fisher	Low	Good

Further, the gender differences are apparent in the way the mothers and fathers talked about the effect their living conditions have on their lives. Not many of the parents directly made a link between poor housing and health, but some did make clear the effect it has on their lives. Parents were asked if they liked living in their flat/house. Some couples talked about the problems they have living where they do in similar ways, for example Ruth Dobbs and Paul Edwards. Ruth said:

> I did when I was single, it's great for a single person but now no, 'cos there's no door to the bedroom there's no privacy whatsoever and consequently cos there's no door there you can't put him down like most people do at 9 'O' clock in his own little room. You try putting him down and he just screams his head off. Midnight it was last night and it has been for about the last week...also, when I'm on nights most of the week I know I have to get up for him in the morning, but on Fridays his dad gets up and gets him breakfast and I should by rights be able to sleep through but it's impossible...

Paul said:

> No, I don't like living here, no. When it was just me and Ruth, I think it was all right but I don't think it's just the flat, in fact the whole house is very unsafe but I don't think a flat's a good idea for a child. There's a lot of little nooks and crannies that you can get access to too easily and plug sockets and things like that. Plus I don't know if Ruth told you about the men upstairs - they're sort of opposed to children's footsteps and so they get their backs up sometimes. Plus I don't think there's enough privacy from them for the sort of kid to go to sleep at night, you've got to turn the television down that kind

> of thing, um there's no sort of privacy for us cos he sort of shouts at everything and...um, yeah it's just impossible to keep clean.

Similarly, both Joe Harris and Alison Grange complain about living in their small flat on the fifth floor. Joe said:

> Not particularly. I'd like a place of my own, that's the main reason, I suppose, and it's - the area's not particularly nice, that's the main reason [the immediate area or the area as a whole?] No, actually it's just this estate really. If we was just around the corner, perhaps - and if we was in a house, I'd be quite happy about it, and it's small, as , well. you haven't any room. We got too many things all packed in with - you know, we could do with another few rooms to put things in, get things out of the way...and you've got nowhere to go to get out of the way yourself.

Joe's partner, Alison said when asked if she had any major worries at the moment:

> Just this flat - moving out of here is my main one 'cos it does depress me, I don't like living here. That's the main thing. Nothing else really...just getting ourselves together to get out of here, you know.

Other couples however, illustrate the different ways mothers and fathers talk about their living conditions. This is shown most dramatically by Patricia Morgan's experience. She and her partner, Ed Newton, live with their son Benjamin in a privately rented flat above a shop on a busy main road. The flat contains one room which is divided by a curtain into a sitting room and bedroom where they all sleep. The flat has a kitchen but they share the bathroom with the flat upstairs. At the first interview it is the lack of privacy which Patricia dislikes most about the flat:

> ...I hate living in this flat. I can't stand it, but I can't get a council flat so I - at the moment we're waiting because the council might be compulsorily purchasing the building so, crossed fingers, we might um actually end up being council tenants.
>
> NJF: Can you tell me a bit more about why you don't like the flat?
>
> Well, it's the room really, cos Benjamin shares the bedroom with us. Also, as you can see, there's not a bit of privacy, you know, you can't switch off from Benjamin at all, you know. He can't be in a separate part of the house, he's there all the time...you can't turn the telly on too loud because it might wake 'im up or whatever. But, I mean we manage reasonably well, y'know...I only lose me cool every now and then (laughs) apart from that we sort of work it out okay...It's quite big really, I suppose, it's not that small. It's

better than living in one room...you know, at least we've got the kitchen.

By the time of the second interview, however, things have become desperate. Patricia became pregnant again and felt that there was no way she could have another child in the flat. She rang the council to find out if having another child would help their entitlement to council accommodation and found out that it did not. She told them that this would mean she would have to have the pregnancy terminated. When they appeared unmoved by this she became very angry. Patricia reluctantly had the pregnancy terminated and was very depressed afterwards. She then heard from the council that she could move into a two bedroom flat on a notorious council estate in ten months' time:

I've been trying for a council place banging my head against a brick wall. They've offered me, well, they've *told* me I've got to go to Broadwater Farm...it's not till about ten or twelve months 'cos there's a waiting list

NJF: How do you feel about that?

I'm disappointed 'cos I don't like being told that I've got to go there, they said if I don't take it...plus I suffer with bad nerves as well, the whole idea of going there I don't like so...but if that's all they're gonna offer me, if it's the only way I'm gonna get Benjamin his own room I'm gonna have to take it...I've got something else at the moment, I'm trying to do an exchange with my brother. He's got a three-bedroomed council house at the back of Tesco's so what I'm trying to do is an exchange with him...if I get it I'll be *extremely* happy 'cos I really don't want to go to Broadwater Farm.

NJF: Where will your brother go?

They're gonna buy their own house but we'll have to tell the council lies and that they're gonna move in here and pretend that we're gonna do a mutual exchange, then I move in there but they won't move in here. 'Cos they won't just let me take over the premises, they don't let you do things like that, you have to be sneaky, but if it's the only way I'm gonna get it done, I'm gonna have to do it. It's a really nice home, it's got a little nursery at the back so I'll be well happy if I get it...

NJF: Is that the nursery you were trying to get Benjamin into?

I'm not sure which nursery 'cos when I was looking for a council place I started...I went back to them...valium 'n' antidepressants 'n' that 'cos it was all getting on top of me. They were trying to do some work here 'n' Benjamin was diagnosed as having chronic asthma 'n' they were trying to knock down

> the partition here and make it back into a bedsit, but they wanted to leave me here while they were doing the work 'n' everything 'n' I said you can't carry out the work while Benjamin's here 'cos they wanted to knock walls through upstairs 'n' all the dust would affect Benjamin. And I had *such a terrible time* it was unbelievable trying to get them to listen to me 'n' they were treating me like a stupid kid, sending me from one place to another, in the end I just cracked 'n' went back to the doctors 'n' got antidepressants 'n' all that. In the end I went to the Law Centre 'n' the guy down there sorted it all out - he's been doing it for me 'n' since then it's been OK 'cos they're actually listening 'n' talking to me rather than ignoring me. Since then I've been OK - I took the antidepressants back to the doctors 'cos I didn't need 'em...I was just so frustrated, nobody was listening to me...you get to the stage where you think you've got no control over your child' health or nothing 'n' I was getting depressed about it...the sick thing about it all was that I fought 'n' fought 'n' fought for a month 'n' I ended up taking it out on Benjamin you know, I'd shout at him 'n' I'd think why did I shout at him, it's not his fault...'n' that's when I tried to get him into a day care centre...he's got nowhere to stay here, he gets all his toys out 'n' you try to keep it reasonably tidy, I mean I know it's impossible to have a tidy home when you've got kids but you like it to be *reasonable*...but he's got nowhere to put his toys, we've got no cupboard space...I'll just be glad to see the back of this place...

During his first interview, Patricia's partner, Ed, expresses unhappiness about living in their flat for similar reasons. At the second interview, however, he focuses more on how he now is no longer unemployed and what this means for him. He does not mention the problem with the building work, nor the issue about Patricia's termination.

Several other families are undertaking decorating and building work and the women are much more dissatisfied with the chaos that this causes. It is often a point of tension between the parents. Deborah Jessop is frustrated at the length of time it is taking her partner, Tim, to complete their kitchen and he feels 'put upon' by her to finish it more quickly.

These gender differences are a reflection of the different emphasis women and men place on their public/private worlds which, in turn, are determined by the different roles they have. The mothers are at home more than the fathers and their domestic role as the main carer of the child and 'homemaker' mean that it is more important for them that their home is of a certain 'liveable' condition. Patricia Morgan

illustrates clearly above how the home can be conceptualised as one of the resources a mother utilises to maintain her child's health (see also Mayall and Foster 1989) and, how for mothers, it is their *homes* which are their working conditions (see also Kowarzik and Popay 1989).

b) **Income and health**

The link between income and reported health is shown by Table 6.5. Parents on high and medium income levels were more likely to report their health as good or fairly good in the last year, whereas parents on low incomes were more likely to report their health as fairly good or not good. The relationship between income and number of reported health problems is not quite so striking, although parents on high incomes reported lower numbers of health problems whereas parents on low incomes reported high numbers of health problems.

Table 6.5: *Parents' income and health status*

	High income parents (n = 10)	Medium income parents (n = 10)	Low income parents (n = 6)
Health in last year			
Good	5	5	0
Fairly good	4	5	3
Not good	1	0	3
Level of health problems			
Low	5	2	1
Medium	3	5	1
High	2	3	4

Similarly to housing conditions, these parents did not explicitly articulate a relationship between income and health. However, for many of them it was a very important issue in their lives and a focus for worry and concern, although there also seemed to be a reluctance on behalf of many parents to talk about it. Only eleven out

of the thirty parents talked directly about their money worries; which is surprising given that the majority of them were on below the national average full-time wage for men.

Parents on low incomes did not talk more about financial worries than those on higher incomes, but they talked about it in different ways. Ruth Dobbs (low income) talked about how her depressions are caused by her financial worries:

> I was very depressed about a month ago...I'm still worried about money - I don't know where Christmas presents are going to come from this year...
>
> NJF: Was your depression connected with your worries about money?
>
> The money, the job, the headaches I was getting due to the job...it's basically the money. My wages have gone down 'n' I was relying on that extra money and I've just got not money for nothing - everything just goes on bare necessities like him, his nappies; me getting to work; food 'n' that's it. I've got nothing left for meself which I'm used to having 'n' that extra £200 a month, I *had* that extra, I could then think about getting winter clothes for 'im...luckily I've got all his winter clothes cos I wouldn't be able to get them now. I haven't got any winter clothes for meself, that's depressing me...

Deborah Jessop and Tim King have a 'medium' level of income but Deborah also has financial concerns:

> It's a lot on our minds whether I should try and work full-time. I mean it's financially, it's around financially although I wouldn't say we have to watch every penny at the moment. The income we have at the moment from my part-time job and Tim's full-time job covers our bills and mortgage and everything but I mean there's not a lot to spare and so we think about it a lot. I'm trying to imagine the actual practicalities of what it's going to be like if I work full-time and how I could fit it in...I don't actually want to spend less time with Jenny so I'm trying to work out how I could do different hours...

Diane and Simon Cartwright are on a 'high' income but they currently have cash flow problems until they sell the flat downstairs which they have converted. Diane has financial worries but clearly they are of a different order to Ruth Dobbs:

> When we sell the flat downstairs it'll be OK but at the moment there's a lot of outgoing money and you know, a lot of bills 'n' things you have to pay for when you do conversions...
>
> NJF: Does it get you down?

> Very rarely do I let it get me down, I just think as long as we're happy and healthy it's OK, it'll pass, it's just a temporary state and it'll pass. But you know you do get the odd occasion when you think God I'd really like to go to the shops 'n' not have to look the other way 'n' be able to buy yourself something. But as I say it's very rare because you just get it in your mind that you haven't got the money and you can't spend it, it's as simple as that...

Gender differences in relationship between income and health

Unlike with housing conditions, there are no gender differences in the relationship between parents' reported health and income levels. As shown in Table 6.6, both mothers and fathers on low incomes report poorer health; and both mothers and fathers on high incomes report better health.

Table 6.6: *Gender differences in relationship between income and health status*

	Low income		High income	
	Mothers (n = 3)	Fathers (n = 3)	Mothers (n = 5)	Fathers (n = 5)
Health in past year				
Good	0	0	3	2
Fairly good	1	2	1	3
Not good	2	1	1	0
Level of health problems				
Low	0	1	3	2
Medium	1	0	0	3
High	2	2	2	0

Six mothers and five fathers talked about their worries and concerns about money. However, there was a qualitative difference in the way mothers and fathers talked about money. The fathers talked about it in a way which reflected their role as main 'breadwinner' for the family: they tended to take responsibility for thinking about money in the long-term as well as the short-term.

This reflects other findings that households often separate the control and management of money, and that these two dimensions are separated along gender lines (Pahl 1983, Graham 1986, Wilson 1987). The control of money is more likely to be a male than a female domain. This involves making key decisions about how much money individuals within the family will have and what items of expenditure they will take responsibility for. The management of money is more typically a women's job. This involves implementing the financial decisions of the individual who controls the money; for example shopping, paying bills and so on. The financial arrangements of the majority of these parents were organised along these gendered lines.

For example, both Lesley and David Fisher talked about their financial concerns but David takes on more responsibility for the long-term future of the family. He said:

> My main worry is the one I've always had - how to make more money...it's always on my mind cos I've got ambitions and plans for the future so everything I do is like taking step to where I want to get to.

In contrast, his wife Lesley said:

> I wanna get a job because of the money - it's not so much we're short of money, we've got enough for the essentials but there's things that I can't buy that sort of gets you down sometimes 'cos I always used to have money.

Dawn Abbot said that she does not worry about money whereas her husband Nigel does:

> I know he worries about money, he might not admit it...like tonight he's more or less saying we'll manage and I say we'll be OK cos I'm not earning money you see 'n' you get used to the extra money coming in, don't you? And I'm saying don't worry we'll be OK. I mean it just buys the extra things as long as we can survive, that's the main thing...there's a lot of people worse off than us who haven't even got roofs over their heads so I think we're lucky really.

When I asked Nigel if he had any major worries he said:

> No...I make sure the bills are paid, we pay all our bills, no problem.

Jane Vernon and Andrew Wicks both work part-time and share the care of their daughter Mandy. However, Andrew still sees it as his responsibility to provide for the family in the long-term. Jane does not express any worries about money while

Andrew said his major worry was:

> ...knowing what I'm going to do next for money...I'm using up my savings and I don't know whether to buy my own lorry or what I'm going to do in the future. And that's tied in with - if I get my own lorry it means I've got to go away again and I miss those two and I worry about Jane having to cope by herself, and so, you know. Because it upsets her to have to cope the whole time by herself. So that is the problem, I don't know what to do yet. And the amount of expense of buying a lorry is a lot of worry - it's a huge commitment.

5. Social Support

I have already discussed some of the methodological and conceptual problems of measuring social support. The key question is social support for what? Therefore I chosen to look at social support on three dimensions: help with childcare; other practical help; and emotional support in the form of confiding relationships. In each case parents were asked what help they had in these areas from those they mentioned in their social network (ie. family, friends but not spouse) and whether they felt they needed more.

As Madge and Marmot (1987) have pointed out, there is a problem with taking subjective measures of social support because they are likely to be affected by how a person feels physically and psychologically, as well as by the objective nature of their social support. But these subjective feelings are precisely what are important in a study of people's lived experiences.

a) Social support and health

The three areas of social support I have analysed are childcare; other practical support; and emotional support.

There is some overlap between these areas: four parents said they wanted more support in just one area; eight parents said they wanted support in two areas; and one parent said they wanted more support in all three areas (see Table 6.7). Twelve parents said they did not need more support in any of these areas. There was no

relationship between these aggregated categories of support and reported health and there were no clear gender differences. The differences become apparent when each area was analysed separately.

Table 6.7: *Parents' social support*

Type of social support	No. of parents (n=30)	
	Enough help	Would like more support
Child care	21	9
Other practical	22	8
Emotional	20	10

a) **Childcare**

As I have described above, 21 parents (10 mothers and 11 fathers) felt they had enough help with childcare and only 9 (5 mothers and 4 fathers) said they would like more. This is despite the fact that just over half the sample have only a little or no help with childcare, as Table 6.8 shows.

Table 6.8: *Parents' support with childcare*

Amount of childcare	No. of parents	No. of parents want more help
A lot	2	-
Some	12	2
A little	8	5
None	8	2
Total	**30**	**9**

Gender differences in need for more support with childcare

Four out of the five mothers who said they wanted more help with childcare reported high levels of health problems and the fifth mother reported a medium level. It is clear from the way these mothers talk about their need for more help with childcare how their lives would improve if they had access to it. When I asked Alison Grange,

for example, if she would like more help with childcare she said:

> Oh yeah, definitely. I mean like I say if my family were nearer it would be great...you know, just have somebody that you could say 'I gotta dash up the shops for twenty minutes, could you watch her?' I haven't got anybody like that really, on my doorstep that I could trust and could feel free to ask, you know.

Deborah Jessop said:

> Well, it would do us good to get out a bit more and then we'd need a babysitter to come here...

These mothers all have 'modern' ideologies of motherhood which would allow them to express a need for help with childcare. For the 'traditional' mothers it would not be consistent with their ideology to say that they wanted more help with childcare (see Chapter Seven).

Three of the four fathers who talk about needing more help with childcare do so with respect to their partners rather than themselves. When I asked Joe Harris if he thought they needed more help with childcare, he said:

> ...probably more for Alison's sake really...be a lot easier if she had a couple - even once a week or a couple of times a week where she could have somebody look after the baby and then she could go and do what she likes and she'd probably be a bit happier so I'd probably be a bit happier as well. But...I don't really see her often enough for it to bother me.

Thus the relationship between need for childcare and reported health is not relevant to these fathers. However, Andrew Wicks, the one father who says he would like more help with childcare for himself as well as his partner is one of the two 'new Dad' fathers (see Chapter Seven). He reports a high level of health problems.

b) Other Practical Support

Eight parents (five mothers, three fathers) said they would like more help with other practical support, for example help with domestic tasks such as cleaning, decorating and so on. Seven of these eight parents reported high levels of health problems and six reported 'fairly good' or 'not good' health in the last year. There were no gender differences in the relationship between needing more practical support and reported health. Five of these parents said they also would like more help with childcare.

c) Emotional Support

In his review of the literature, Leavy finds that women tend to have more supportive relationships than men, especially intimate and confiding ones. This, he says, is not surprising as:

> Traditionally, women have been reinforced for placing high value on nurturing family interactions and environments, and lower value on life in the workplace (Leavy 1983:15).

In the present study, there was no relationship between lack of a confiding relationship and reported health for either mothers or fathers. But not only did women appear to have more supportive relationships, there was also a qualitative difference in the way they spoke about these relationships. Six fathers had no-one to confide in other than their partner, compared with three mothers who only had their partner to confide in: two of these mothers' families live far away.

When I asked the fathers about their family and friends, they tended to speak in a matter of fact manner and without interest - this was obviously not an important subject for them. This was not because the men generally spoke less excitedly and with less feeling than the women because they did speak very enthusiastically and in great detail about subjects that did interest them, for example football. The fathers who were present at the birth of their child spoke with enormous depth of feeling about this moving experience. Joe Harris, who usually spoke in a very understated way, became a different person when I asked him about the birth of his daughter. His eyes lit up and he laughed:

> I was there...it was absolutely brilliant...it was the best experience watching her have the baby.

Some of the men do not seem to need so many people to confide in as the women do. Seven fathers do not confide in their friends but restrict their confidences to their partner and family. Ben Land illustrates this apparent self-containment expressed by these men. When I asked him 'how many people do you know that you can talk to really frankly and openly about almost anything?' he said:

> I try not to do that. Like to keep meself within the family really. Talk to my wife. If it's about my wife - I don't know - I could probably talk to my mum and dad, but I've got a tendency not to talk, you know, I don't really want them to know my business. I'd rather just get on and not bother anyone, or anything like that, so I very rarely, if at all, do talk to anybody else. I sort of just think it over meself really, or something like that. Or maybe ask someone in a roundabout way about how to get out of a problem. Never directly - oh, I've gotta do this, I've gotta do that. So I don't really talk it over with anybody really.

Ed Newton said:

> There's only one person I talk to and that's Patricia. I've tendency not to talk to people...because it doesn't matter what you say to people, usually it gets twisted (laughs) and, er, I dunno I just don't like people knowing my business I s'pose...I don't really talk to me mum 'n' dad 'n' things like that...bottle it up I s'pose...I talk to Patricia more than anything, 'cos we're lucky we're friends, we're not just sortta lovers we're friends as well 'n' I can talk to her as a friend, if I've got a problem I talk to her about it...

More women than men confide in people outside their family and those who do not, seem to feel the need more. Deborah Jessop, for example, is from Canada and her close friends are all there. She wishes she had a close, confiding relationship in London. Dawn Abbot's close friends are in Norwich and her lack of close friends in London is part of her motivation to get a job:

> That's another reason for going out to work because I...I'm at the stage now where I need to go out to work to meet people, but people who haven't necessarily got little babies (laughs). It sounds bad, I keep going on about this. I'm not fed up with John or anything but I've got to the stage where I need to know...there's more to life than children, you know. It sounds totally bad really, um, I just need to get out to meet people.

Although the mothers appeared to have more supportive relationships in terms of having people to confide in, the fathers had greater access to their social networks. They went out with friends much more than the mothers did. For most of the mothers, a night out with a friend was a rare treat which involved a great deal of planning and forethought, whereas most of the fathers went out several times a week with their friends to play football or snooker or have a drink down the pub. In the two weeks preceding the first interview, eleven fathers and only four mothers had

been out in the evening without their partner or child. Seven fathers regularly go out once or more a week to the pub or social club or to participate in a sport. Only one mother had a regular night out. The fathers take it for granted that they are able to do this whereas some the mothers see it as a great privilege. Alison Grange commented:

> ...you can't do anything without thinking of that other person any more...it doesn't matter for the father, I don't think, 'cos they can still do that, no matter how good they are, they can still say I'm off round the pub at ten 'o' clock a night and they go for a couple o' pints, where I have to prearrange everything that I do.

Multiple Deprivation

The relationship between material and social resources and health is complicated by the finding that many of the parents in this sample who live in poor conditions and on low incomes also have poor levels of social support. As Oakley (1988) argues, the relationship between class, support and stress seems to amount to a situation of multiple deprivation.

Alison Grange and Joe Harris, for example, live in a damp one-bedroomed flat on the fifth floor of a council block. They are on a 'medium' income. They have no childcare or other practical support and Joe has no confiding relationships outside his family and wishes he had more friends. Alison reports 'fairly good' health in the year before the first interview and a high number of health problems during the study period. Joe reports 'fairly good' health in the last year and a medium number of health problems in his diaries.

Ruth Dobbs and Paul Edwards live in a one-bedroomed private rented flat on a low income. They have no childcare support from friends or family, although their son Mark is at a childminder's five days a week. They have no other practical support and Paul has no confiding relationships. Ruth reports 'not good' health in the year before the first interview and a high number of health problems in her diaries. Paul reports 'fairly good' health in the last year and a high number of health problems in his diaries.

Jane Vernon and Andrew Wicks live in a three-bedroomed housing association flat on a low income. Although the flat is spacious, a very busy railway line runs right past it and when the trains go by, as they do every few minutes, the noise is deafening. They rarely get childcare or other practical support, although they do have a very strong and close network of friends who provide a lot of emotional support, and are the only couple where the childcare is really shared. Jane reports 'fairly good' health in the year before the first interview and a medium number of health problems in her diaries. Andrew reports 'fairly good' health in the last year but a high number of health problems in his interviews (he did not fill in a health diary).

Deborah Jessop and Tim King live in a two-bedroomed flat which they are struggling to buy on a 'medium' income. Their daughter Jenny is looked after by a childminder while Deborah is at her part-time job as a play leader. Tim's mother visits every Sunday and looks after Jenny while Deborah does the housework and Tim and his brother do the decorating so have more support than some. But they both wish they could have more help with childcare so that they could spend more time together. Deborah's family and friends are in Canada where she comes from and she lacks a confiding relationship in London. Deborah reports 'fairly good' health in the year before the first interview and a high level of health problems over the study period. Tim reports 'good' health over the last year and a medium level of health problems during the interview period.

In order to explore the processes behind the relationship between material and social resources and health, it is necessary to look at some case studies which do not appear to fit the pattern described above. For example, the cases of parents who live in good housing and on high incomes but report poor health. What are the factors which might explain this? Similarly, are there any cases of parents in poor material social circumstances who report good health and which factors might explain this?

There are three parents who live in relatively good quality housing and on 'high' incomes but who either report 'not good' health in the last year or high numbers of health problems. They are all mothers. Diane Cartwright and Jill Smith feel they

would like more support while Rosemary Ingram feels she has enough support in these areas. Diane Cartwright and Jill Smith report 'good health in the last year but a high number of health problems, while Rosemary Ingram reports 'not good' health in the last year and a low number of health problems.

Case Study One: Diane Cartwright

When I first interviewed Diane Cartwright she was living in the top flat of a house that she and her builder-husband had bought to convert into two flats and sell so that they could buy their own house. Their daughter Nicole was aged 2 at the time of the first interview. By the second interview they had moved into their new house. They appear to be one of the best-off families in the study group, in terms of their material possessions and by the fact that they buy property, convert it and sell it. But the venture they are involved in puts them under a great deal of financial strain and, ironically, Diane talks about money worries and financial restrictions much more than other parents who are much less well-off. Diane is a full-time parent by choice.

Diane and her husband, Simon, seem to have a good relationship. Diane talked about her husband sharing with childcare tasks when he is not at work. When I asked her about last weekend she said:

> Well obviously her Dad's at home so there's two of us looking after her so I don't see her as much as I would see her if I were by myself with her...
>
> NJF: So it's less stressful at weekends?
>
> Yeah, definitely.

Diane has sole responsibility for domestic work - she does all the cooking, laundry and cleaning although they do the shopping together and Simon looks after the care and maintenance of the car which only he drives. Simon does not help with housework when he is working at weekends but if he is not:

> He'll do something little like hoover the flat and cook breakfast for us, maybe help clear up lunch...I wouldn't mind a little bit more help but I don't think it bothers me, but who wouldn't like a little bit more help?

Responsibility for the care of Nicole is more shared. Although Diane says it is more hers because she is with Nicole all day, she describes her husband as:

> ...a pretty good Dad, I mean he idolises her...when he comes home in the evening no matter how tired he is they always romp all over the carpet 'n' are together most of the night, playing...it's great, it just gets her away from me for a long time.

However, although Simon participates in childcare he does not seem to be aware of the stress and strain Diane is under when she is looking after Nicole by herself during the week. When I ask him if he thinks looking after Nicole affects Diane's health he says:

> No, I don't think so cos she's at home, she hasn't got to work as well so she has time for the baby and she's still relaxed in her own way, I wouldn't say she's under pressure.

Whereas when I ask Diane if she thinks caring for Nicole affects her health she says:

> Yeah, I think it makes you feel very stressful...so in turn by the time my husband gets home 'n' I've had a particularly bad day with her 'n' I've been ranting 'n' raving all day then I suppose I'm not as nice as I should be to him because you've had such an awful day...it's very stressful having children...*very*. And you think to yourself 'calm down, don't be so uptight about it' but you can't, you've just got yourself so het up because it's just one thing after the other, you can't seem to sit down and relax 'n' unwind.

When I ask Diane if she ever gets angry, and if so who with, she says:

> Mainly with Nicole that's trying to destruct an £800 stereo, she has got us to get the video mended twice...she has had the T.V. repair man in, she has broken the cordless telephone, that was £70. She just does the most ridiculous things 'n' that's when I just *scream* cos I can't believe she's doing 'em. I know she's a baby 'n' she doesn't understand, but oh my! That's who I get angry at most.

Despite the fact that she acknowledges that being a mother affects her health, Diane reports 'good' health in the last year and explains it by saying:

> I just think I'm quite a healthy person really, I've never had any bad illness, I'm not prone to colds or anything like that.

But in her health diaries, Diane reports a high number of health problems (one every three days). The majority of these (7 times over 21 days) are 'feeling tired', although

when asked about feeling tired during the day in the interview she says:

> I do sometimes...if Nicole's been a bit of a headache starting from the minute she wakes up in the morning and it makes my head a bit tender, you know (laughs) 'n' I have to go a bit slow. But em..no, I wouldn't say that on the whole I get tired easily.

This case study is a good illustration of the importance of taking subjective measures of social support because although 'objectively' she appears to be well supported (and she is compared with other parents in the study group), she feels she needs more. She sees her parents, who live nearby, once a week and they are always available and keen to babysit for them when they want to go out. Her siblings also babysit occasionally. But when I ask her if she feels she has enough help with looking after Nicole or if she wished she had more, she says:

> I'd like someone to take her off my hands a little bit more...so that I've got a free day from her or a free afternoon cos then I could either use that time for myself knowing that I'm not going to be disturbed or use it to do a lot of housework that's been piling up 'n' start 'n' not stop until I'm finished. Whereas if she were here I'd have to stop 'n' start, stop 'n' start you know, 'mummy I want milk, mummy I want a drink, mummy I want something to eat', you know, so it's a bit frustrating 'n' you end up not doing as much as you would do if they weren't here.

Although Diane and Simon have quite a few friends they see in the evenings, Diane says she sees someone during the day only about once a week and wishes it could be more:

> I do sometimes feel that during the day when I'm alone with Nicole if I feel depressed or upset about something I feel I'd like to speak to an adult friend who I can talk to who would understand what I'm saying 'n' obviously I can't talk to the baby 'n' she can't answer me back so I do feel I would like to be with somebody sometimes.

Like most of the other mothers, Diane gets very few opportunities to go out on her own with friends. Between the first and second interviews she went out once on her own with a friend:

> I went to the pictures the week before last with my friend. That was lovely, it was really nice not to have to think about what she [Nicole] was doing,

worry about her, it was absolutely lovely. And all it was was the pictures.

This quote clearly shows how Diane wishes she could spend more time away from her daughter.

When I interviewed Diane for the third time, Nicole had started going to playschool four mornings a week and Diane is feeling 'a bit saner'. She can now go shopping on her own and can do the housework without interference. Diane says Nicole is 'much calmer' when she comes home from playschool and Diane spends 'better time' with her, for example that day they had spent the afternoon painting together. Interestingly, Diane reports fewer health problems in this final diary (two compared to seven over the previous two diaries). Although I do not think it is possible to say her health was improved by Nicole going to playschool, it certainly made a difference to her life.

This case study shows that material comforts do not necessarily ease the stress and strain of caring for a young child and the importance of social support in this area. It is not possible to say that Diane's perceived lack of social support 'causes' her ill-health, but it seems likely that the stress of caring for a small child would have been lessened if she could have shared the burden more.

Having looked at a case study of a parent who is relatively well-off materially but reporting poor health I wanted to look for cases of parents who were badly off materially but reporting good health to see what might account for their good health. This proved much more difficult. None of the parents on low income and in poor housing reported good health or low numbers of health problems so I turned to those on 'medium' levels of income which are still relatively low. There was no obvious pattern amongst these parents: of the ten parents on medium income, eight were living in average or below average housing. Two of these reported poor health, three reported fairly good health and three reported good health. It is these last three that I am interested in: Dawn Abbott, Tim King and Helen Price. They had different levels of social support. Dawn Abbott has poor social support in terms of help with childcare and confiding relationships but she reports 'good' health and low number

of health problems. This may hide a higher level of health problems, because in her interviews she talked a lot about feeling depressed and suffering from severe headaches. Tim King reports 'good' health in the last year and a medium number of health problems. He feels they could do with more help with childcare. Helen Price reports 'good' health in the last year but a high number of health problems. Most of these health problems were reported in the final diary which was filled in shortly after her brother was killed in a car accident when she was obviously very depressed. So overall I am taking her health to be good. Helen is the only case of good health, poor material conditions and good social support and offers an interesting contrast to Diane Cartwright.

Case Study Two: Helen Price

Helen Price and Sam Roberts are the only Afro-Caribbean family in the study group. When I first interviewed Helen Price she had recently moved from a one-bedroomed council flat in an undesirable tower block to a two-bedroomed one on the ground floor of a small block. The flat was in very poor decorative condition and Helen and her partner, Sam, were spending a lot of time redecorating it. For the first few months that they lived there their daughter, Annie who is aged 17 months, was sleeping in the same room as them while they decorated her room. This room was also used as a living room.

Sam Roberts is a builder and Helen Price works part-time as a nursery assistant and is also doing a Pre-school Playgroups Association foundation course at evening classes. Their joint gross income is between £150-200 a week ('medium'). They have a good relationship and Helen feels Sam contributes a great deal to childcare and domestic work, although she says he could do more. They share the shopping, she does the cooking and the laundry, he does most of the cleaning and:

> He does help a lot with her. He cares a lot about her, it's uncanny, you don't expect them to care so much for their children or help as much as but he does help a lot with her. He doesn't do the washing for her but if he cooks he cooks for all of us 'n' he cleans up after her, he baths her, he puts her in her pyjamas, he'll make her bottle up - I have to be fair he helps a lot. I would say it's 49:51, something like that.

Helen's mother looks after Annie while Helen is at work. Helen would rather work full-time but has not considered Annie independent enough for her to do this yet. As well as the support she gets from her mother, Helen also gets a lot of help from Sam's mother and her own sister. Sam's mother helps with the decorating and also has Annie to stay for several days at a time. Helen is very close to her sister who also has a young child:

> We both bring up our children together cos my daughter's 4 months older than hers, that's how we planned it, so they'd grow up together so I don't have to have another one straight away (laughs).

Both Helen's and Sam's family are very close to each other and Helen and Sam spend a lot of time with their families. Helen has just one close friend outside her family because she prefers to rely on her family and she counts her sister as her best friend. Helen and Sam also appear to have a good relationship, and Sam is very involved in Annie's care and upbringing. The support Helen receives from her family is not just one way, she feels that a number of her family are dependent on her for emotional support. Helen sees herself as very well supported in terms of help with childcare, other practical help and confiding relationships. Despite her relatively poor material circumstances, Helen reports her health as 'good' during the year before the first interview. She accounts for her good health in the following way:

> I think maybe it's cos I'm happy...when you're happy you keep well.

Helen talked about childcare affecting her health in a very different way to Diane Cartwright, she said:

> She keeps me on the go...while carrying her I put on a lot of weight but I think I'm losing it now forever running after her, so I think that's the only way she affects my health...[any other good or bad ways?] She aches my arms so I'm sooner or later gonna get tennis elbow cos I carry her everywhere, I don't use the buggy. That's the only thing as far as she's concerned.

Helen reported feeling tired fewer times in her health diary than Diane Cartwright (twice over 21 days compared to Diane's seven times) and although in her interview she said she does get very tired she says this is since they moved and because of all the decorating she has been doing.

However, Helen reported a high level of health problems but most of these occurred in the final diary which was shortly after the death of her brother in a car accident and can be explained by the depressed state she was in. As the eldest of four siblings she was put under a lot of pressure at this time to support her mother and other members of the family.

Although Helen is in much poorer material circumstances than Diane, her access to greater social support especially in terms of childcare may account for her reported better health. Helen's work is also very important to her, giving her a sense of self-esteem and direction. When I asked her what she liked about her job she said:

> The atmosphere's really great, I get along with all the people there...my supervisors give me time to do courses..so..I'm lucky like that, I think that's what I like about it...my supervisors put me through college 'n' every-thing...so it's all right, that's what I like about it.

CONCLUSIONS

Despite this group of parents being working class there is wide variation in the families' access to material resources. Across the study group there appears to be a link between quality of housing and reported health, and a link between income level and reported health.

However, there are gender differentials in these links. The two areas which show gender differences in the relationship between material and social circumstances and health are housing conditions and support with childcare. In both these cases, there is a clear relationship for the mothers between poor housing conditions and perceived lack of support with childcare and reported poor health.

The link between quality of housing and reported health is stronger for the mothers than for the fathers. This reflects the differential importance placed on the private world of the home by mothers and fathers. The mothers' parenting and homemaker roles mean that the home is more important to them than to the fathers' whose primary role as 'breadwinner' means that the public world of work takes precedence.

The gender differences in the relationship between income and health are not so clear. There were no gender differences in the relationship between reported health and income levels. However, there were differences in the way the mothers and fathers talked about how important money was to them. The fathers tended to see the long-term financial security of their family as their concern, which once again reflects their primary role as 'breadwinner'.

There is also a degree of concentration of deprivation whereby those families in poor material circumstances have low levels of social support. By looking at case studies it was possible to explore some of the processes behind the complex relationship between material and social resources and health. For a mother who lives in relative material comfort, a lack of social support particularly help with childcare, can lead to stress and strain and therefore poorer health; whereas a mother in poorer material circumstances who has a lot of social support, particularly help with childcare, may report better health.

Material resources in terms of housing and income should be taken into account when analysing gender roles and their relationship to differences in health and illness. For this group of parents, the quality of housing needs to be considered as a factor in explaining how the mothers' and fathers' social roles result in different health experiences.

CHAPTER SEVEN

TYPOLOGIES OF MOTHERS AND FATHERS: THE RELATIONSHIP BETWEEN PARENTHOOD AND HEALTH

> The general conclusion can best be summarised by saying it all depends on the woman. If she has no particular outside interests and finds her work in the home satisfying and absorbing then she must develop her interests from that as the centre. But if she has a pronounced bent in some other direction in which she has already achieved some measure of success then I am sure that it is essential both for her own satisfaction and for the happiness of her family that she should use all her talents to the full. With a little forethought she will find that most things are possible. (Margaret Thatcher, 1954 quoted in *The Guardian* 21 March 1990)

In this chapter I present three typologies - one for mothers, one for fathers, and one for couples - which provide an understanding of the relationship between parenthood and health. First, I present an analysis of the meanings of parenting and parenthood held by this group of mothers and fathers, before going on to develop the three typologies.

The meaning of parenthood

What does being a parent mean to mothers and fathers? Parenthood is a gender blind term because it does not take into account the different meanings and realities of being a parent to mothers and fathers, and the way that childcare is structured in our society. In the interviews I explored with parents what being a parent meant to them and found that there were clear gender differences.

I have distinguished between the meaning of *parenthood* and the meaning of *parenting* following Boulton's (1983) distinction between women's immediate response to looking after their children (what I have called 'parenting') and the sense of meaning, value and significance they experienced in thinking about their lives as mothers (what I have called 'parenthood').

For the mothers, becoming a parent meant that the whole pattern of their day changed

whereas for most fathers this was not the case. For fathers, becoming a parent meant that they 'grew up' and became 'more mature' as a result of their new-found responsibilities which mainly took the form of financial responsibilities. Like the fathers in the study by Simms and Smith (1982), it gave them 'something to work for'. Sam Roberts said his life had changed:

> ...'cos I've got someone relying on me you know sort of I can't make major decisions in haste ie. my job. I couldn't go into work tomorrow 'n' 'cos I feel like it, jack it in 'cos it's not only me I've got to think about now... It's made me more ambitious, I mean I was ambitious in the first place but it's made me even more sortta eager to get on so I can get things done for her...

Although some mothers also felt more 'responsible' and 'grown up', they stressed the way their daily lives had changed and in particular the way their lives were much more routine and constrained.

Alison Grange emphasises the way her life is constrained in a way that her partner's is not. She says her life has changed:

> ...a lot, from you can't - things like when you know just run round the corner and get a paper, and you can't do that. That's total- it totally changes your life altogether really, you can't do anything without thinking of that other person any more...it doesn't for the father, I don't think 'cos they can still do that, no matter how good they are, they can still say I'm off round the pub at 10 'o' clock at night and they go for a couple o' pints, where I have to sort of prearrange everything I do...

Another theme which was apparent was the way in which some parents felt that becoming a mother or father had led to a change in the way they see the world. They felt that they had become more aware of the environment within which they lived as a place to bring up children. Of particular concern were local schools. Nigel Abbot was especially vehement about this:

> I mean before I wouldn't even have though about moving out of London, but now, I mean, I wanna get out for him. I don't want him to go to school in London really. I want him to go to a school out of the way, where he can go to a pleasant school, where he doesn't have to hear about muggings and rapings every day of the week...It changes you in that respect, it changes you...I mean like there's this thing at the moment in the paper about the council putting these gay books in schools. Now, I mean, if I didn't have any kids, it wouldn't bother me in the slightest, but now I've got him, there's no way I'm letting my kid go to a school where he can pick up a little book with two gays in it...

Becoming parents involved both parents in a great number of changes in their everyday lives and in their long-term plans. The type and degree of change depends on the type and level of responsibility for childcare, which is gender specific. For eight of the women in the sample, but *for only one man*, becoming a parent meant giving up paid employment either wholly or partly to accommodate their new role. Five women gave up their jobs completely and three went part-time. Three women carried on in full-time paid employment after the birth of their child, but one of these changed from being a legal secretary to a childminder so that she could care for her daughter at home. Four women were unemployed before the birth of their child and became full-time mothers and housewives afterwards. For the majority of men, although their employment status did not change as a result of their becoming fathers, their attitude towards their work changed. They felt that they now had to stick at their job because of their financial responsibilities whereas before they had felt free to 'jack it in' if they got bored of it, as Matthew Thomas put it:

> You can't just pack your job in now because...you got Christine [his daughter] whereas a job a couple of year ago to me, if I didn't like it I just used to say 'I don't like it, I'm not gonna do that'. Now I wouldn't even think of doing that...

Whereas for most of the men in the study group, fatherhood entailed the assumption of responsibilities, particularly financial, to their families, for most of the mothers it meant something different. Responsibility for mothers meant 24 hour a day childcare, or the responsibility to organise alternative care and often guilty feelings about being in paid employment; not having time to oneself and not even having the time to be ill as Jane Vernon commented:

> You're not allowed to be ill if you've got a baby (laughs). I mean you just can't, OK I've had the odd cold but other than that I've been quite well. I don't know what would happen if I was quite ill, 'cos even if you're feeling lousy they expect you to be as normal, really...

The changes which becoming a parent involved also depended on the situation prior to becoming a parent. Therefore attitudes towards and the meanings of motherhood or fatherhood differed accordingly. This is something which has not been considered by, for example, Boulton (1983).

For Alison Grange, for example, becoming a mother was 'unplanned' and resulted in a dramatic change from being a single person living on her own to living with her partner and becoming a mother almost overnight. For Ruth Dobbs becoming a mother was the fulfilment of a long-hoped for dream so that difficulties she experienced as a mother were seen in terms of her job, her living conditions or her partner but not her child. For Suzanne Oliver becoming a mother meant a great improvement in her living conditions - she and her husband had been living with her mother, and having the baby meant they were able to move out into a housing association flat. For Patricia Morgan and Ed Newton the way they felt about their living conditions altered dramatically after they became parents. They considered their privately-rented flat adequate for two of them but totally inadequate as a home to bring up a child. Ruth Dobbs and Paul Edwards had similar feelings about their flat. Tony Bevin and Simon Cartwright, two uninvolved fathers, did not consider that their life had changed very much at all.

Attitudes to parenting and parenthood change over time as children grow and develop and situations change. As this is a longitudinal study I was able to explore this. In the first interviews, many parents, especially mothers, commented that their children were becoming more independent and needed less direct supervision, for example they could feed themselves. For most mothers this was liberating, whereas others expressed some regrets. These comments continued over the second and third interviews especially with regard to the child's increasing level of understanding and expressing him/herself. Fathers particularly said they enjoyed their child more and could relate to them better.

The meaning of parenting

Parents were asked what they liked and then what they did not like about looking after their child. When asked what they liked about caring for their child, both mothers and fathers talked about the enjoyment they get out of caring for a small child by playing with them, watching them learn and grow up and how much fun they are. A typical response was made by Diane Cartwright who said what she liked about caring for her daughter was:

> ...just being with her and enjoying her. You know, playing with her 'n' you know seeing all the new things that she does 'n' watching her grow up really. Whereas if I worked and she was with a babysitter I'd miss all that.

However, the mothers were more likely to talk about enjoying child care tasks such as feeding, bathing and changing while the fathers were more likely to talk about what being a parent meant to them in abstract notions of parenthood, especially that the child was *theirs*. This difference is shown by the following two comments. Dawn Abbot, for example, enjoys:

> Just generally seeing to him...and being with him and playing with him. I like to make sure he's clean and fed and everything...Like I say, I'm in a sortta routine with him and I like to feel at the end of the day 'oh well, that's all done'...

A typical father's comment was made by Robin Ingram who said:

> Well, she is fun, I mean...to know that it's your own kid and your flesh 'n' blood, 'bout the best thing.

This is not to say that mothers never talked in more abstract ways but that the fathers did so more. There were also differences between mothers and fathers when they were asked what they did not like about looking after their child. Almost two-thirds of the mothers talked about the frustration and stress of looking after a demanding child: the conflict between housework and childcare (see Oakley 1974); the lack of time to oneself and so on. Julie Thomas admits that:

> There are times when she drives me crackers...She can be really irritating (laughs)...she can be really messy sometimes 'n' she can always be in the wrong place at the wrong time...she's terribly messy with her eating, I mean I seem to spend hours cleaning her high chair 'n' it's exactly the same the next day, I don't know why I bother, no, I really enjoy her.

Deborah Jessop said:

> Umm...well, sometime I would, I would like some time to myself...umm - I know I get my running but I'd like to go down the West End by myself - it's irritating because you can't do what you want to do.

Only two mothers mentioned specific child care tasks such as feeding and changing as things they did not like, and five mothers said there was nothing they did not like.

This is in marked contrast to the fathers, only six of whom talked about the frustrating and stressful nature of looking after a child. Ed Newton, for example, said:

> Sometimes I lose, I do lose me patience wiv 'im but it's because he's not well 'n' he's whinging...I can't stand people that whinge (laughs). I know he's only a little baby but I get annoyed 'cos I don't know what's the matter wiv 'im, that's basically...it's frustration more than anything.

Six fathers mentioned specific child care tasks - mainly changing nappies - which they did not like. This was interesting, as what it actually meant was that they were not involved in these tasks. Daniel Oliver made it clear what he did not like:

> ...his dirty bums, poopy bums, that's all, they stink, I gotta get out of the room sometimes.

Two fathers mentioned the restrictions placed on them by fatherhood, mainly socially, and only three said there was nothing they did not like.

There is a very strong feeling among the parents that it is their responsibility to look after their child *all* the time, and if they are not they are failing as parents. Nigel Abbott said:

> Well *no*, we don't need any more [help with childcare], I mean we're just the same as any other family really, you know, you've got a little one, you bring him up.

Other parents talked about how they were very fussy about who they let look after their child. Louise Bevin said:

> I'm a bit funny, I wouldn't let *anybody* look after her. It would have to be somebody like his mum or my mum or one of my family.

And Jill Smith, who is herself a childminder, said she and her husband only let his mother look after their daughter Katy:

> We won't have anyone else looking after Katy. That's probably being possessive first time parents I suppose.

The ideology of the private nuclear family which must be self-sufficient and self-supporting is so strong (see also Brannen and Moss 1991) that even mothers who were under a terrible strain looking after their children alone were loath to ask for

help. Lesley Fisher, for example, said:

> Uhh, it's available to me, um like his parents work so it's not available during the day, uh yeah I do, I choose to do it this way, even though it kills me I've just got this set idea of how, p'raps because my mum was always at home umm and always there, I want to be always there for Hazel, even though I like her to be with as many different people as possible as well.

This resistance to asking for help was expressed most powerfully by Alison Grange:

> The thing is with me, see - a lot of people offered to help me when I was going through this sort of - mmm - I felt depressed and everything, but I always felt guilty about letting people, and I - I've never got over that yet. I can't sort of, you know, let them get on. I've had another friend, Cathy, and she sort of came round, and she said let me take her out for a walk, you know, you have a rest, lie down and relax - but I, I find it hard, you know, and we was talking about that the other day, kinda - you don't like to think that - you know, you don't want your friend to be sort of having to put up with her - she's screaming and going berserk out in the street for hours - you don't want them having to walk round like that and them having to have it, you'd rather take it on yourself. So - um - even though people have offered, I don't really take 'em up on it, p'raps I should, but I don't.

Those mothers (and some fathers) in full-time work felt even more strongly that they should look after their child when they were not at work. Matthew Thomas said:

> We never really leave Christine with anyone else. If we're at home we look after Christine...I wouldn't like...if I'm not working I'm not gonna give Christine to someone else to look after, I'm gonna take Christine out, I'm gonna take her with me...I'd like to take her to work, we're thinking about having a creche at work, on the industrial estate...It would be a really good idea, we should really do that.

The only legitimate help that these families feel they can ask for is from their families so that those who are close to their families but live far away feel they are missing out. Jane Vernon said:

> I'd like my mother to have more time but she's still working and I'm working and this and that, it's not possible at the moment. I think I've only left Mandy with my mother once for a night...

II THE TYPOLOGIES

From the analysis of attitudes expressed about parenting and parenthood above, I have constructed a set of typologies which can be applied to this group of mothers and

fathers. These typologies have partly developed from the data in the manner of what Glaser and Strauss (1967) have called 'the discovery of grounded theory'. That is, the categories are ones I found in the data and are not ones I had imposed prior to the data being collected. But the categories also partly developed out of certain theoretical considerations. First, these typologies have been developed from a re-analysis of the much-criticised functionalist view which regards the needs of family and work as necessitating an allocation of complementary roles: women are socialised to cope with the needs of the family, while men are socialised to handle the instrumental world of work (Parsons and Bales 1956). This theory led to the belief that women who are employed, married and have children are involved in potentially conflicting roles which would have a negative effect on their psychological well-being. These theories are based on the assumption of role consensus, that is the assumption that all social roles are taken up and retained voluntarily. Gender roles, for example, are viewed as not only descriptive but prescriptive - male and female roles were presented as functional for society as a whole and therefore accepted as the best way for things to be (Popay and Jones 1989). Whilst not accepting the prescriptive argument of the functionalist theories, the idea that people might experience conflict between their roles was not one I thought should be dismissed.

Table 7.1: *Mothers' reported health and employment status*

	Employed full-time (n = 3)	Employed part-time (n = 3)	Non-employed (n = 9)
Health in past year			
Good	1	1	5
Fairly good	1	2	1
Not good	1	-	3
No. of health problems			
Low	1		3
Medium	-	-	1
High	2	2	5

On the one hand, some researchers argued that the combination of parental, marital and employment roles was a source of role strain or conflict for women (eg. Cleary and Mechanic 1983). Others argued the benefits of 'role accumulation' (Nathanson 1980, Verbrugge 1983a, Kandel et al 1985, Haavio-Manila 1986). In the present study, there was very little difference in reported health between the employed and non-employed mothers, although a slightly higher proportion of non-employed mothers reported 'high' numbers of health problems (see Table 7.1).

Secondly, I have discussed Verbrugge's (1983a) work on multiple roles and health (see Chapter One). She suggests that the following subjective indicators should be taken into account when considering the effect of multiple roles and health: perceived time pressures, conflicts among roles, satisfaction with roles, sense of security and voluntarism of employment status (1983).

The categories I have developed have taken some of these elements into account, particularly conflicts among roles, satisfaction with roles and voluntarism of employment status. Some research has shown how the voluntarism of employment is linked with health. Waldron and Herold (1986), for example, found that women whose desire to work was fulfilled were in better health than housewives who would have preferred to work (see also Townsend and Gurin 1981, Baruch et al 1985, Muller 1986a). Brannen and Moss (1991) in their study of dual-earner households also found a relationship between a lack of congruence between employment preferences and actual employment status and psychological distress. However, they argue that congruence is itself a product of other factors such as low commitment to employment or perceived lack of support from a partner. Further, the relationship between congruence and psychological distress may operate either way: the psychological distress related to combining paid employment and motherhood in an unsupportive social and ideological context may result in a lack of congruence; just as a lack of congruence may 'cause' psychological distress (Brannen and Moss 1991:135-137).

In this chapter the idea of role conflict is extended to incorporate an analysis of the

conflicting or complementary relationship between the ideologies of parenthood and the actual roles these mothers and fathers had taken on. If parents experienced conflict between their ideology of parenthood and their actual roles, I hypothesised that this would have a negative effect on their psychological well-being and therefore on their health. Similarly, the voluntarism of their roles would affect their health; that is, parents' subjective perceptions and accounts of health and ill-health would be affected by their ideology of parenthood and the voluntarism of their social roles.

In addition, I hypothesised that not only would the congruence between parents' ideology of parenthood and their actual role affect their health; but also the congruence of ideology within couples would affect the quality of their relationship with each other and their reported health.

The women's meanings of motherhood as described above are negotiated within the context of the dominant, prevailing ideologies of motherhood in 1980s Britain. As Brannen and Moss argue:

> One of the main themes that have constituted the dominant ideology of motherhood in the post-war years (is) that when children are small, 'normal' motherhood is a full-time activity precluding employment, and that the mother has the major responsibility for all aspects of the child's development (1991:92).

Although this theme has not remained unchanged - for example, the proportion of women who agree with the statement that 'a married woman with children under school age ought to stay at home' has decreased from 78 percent in 1965 to 45 percent in 1987 (Jowell, Witherspoon and Brook 1988) - 'the ideology of motherhood in the 1980s emphasised women's continuing major responsibility for children' (Brannen and Moss 1991:93). The ideologies of the mothers in this study, and whether they were congruent or at variance with their social roles, formed the basis of the typology of mothers.

The issue of congruence of ideology and social roles was not a pertinent one for these fathers. This issue, which formed the basis of the fathers' typology, is one which researchers into gender roles in the family have usually conceptualised as 'fathers

helping out with childcare and domestic responsibilities' (see eg. Young and Wilmott 1973, Oakley 1974, Boulton 1983, Brannen and Moss 1991). On the one hand, this conceptualisation reflects the reality that women have primary responsibility for childcare and domestic work whether they are full-time mothers (Boulton 1983) or have paid employment (Rapoport and Rapoport 1971, Brannen and Moss 1991). On the other hand, if one conceptualises this issue as 'helping out', one is in danger of promulgating the assumption that childcare not only is but *should be* women's responsibility. Therefore I have tried to conceptualise fathers' childcare work in terms of the more neutral concept of 'involvement'. The fathers were divided into categories according to how involved in childcare they were, and whether increased involvement resulted in 'role strain'.

As Table 7.2 shows, there are two broad categories of mothers: those who believe they should be full-time mothers and those who believe there is more to life than looking after a child and that they need some other interest. The latter group is a mixture of full-time mothers and those in paid employment; while most of the former group are full-time mothers. Only with a third of the mothers is there no conflict between their feelings about motherhood and their actual circumstances.

Table 7.2: *Typologies of mothers and fathers*

	'Traditional'	'Modern'	'New Dad'
Mothers (n = 15)	7	8	N/A
Fathers (n = 15)	8	5	2

The fathers can be divided into three categories according to their level of involvement in child care (see Table 7.2): those who are only involved at a very superficial level, for example playing with their child but not taking part in the day-to-day management and care ('traditional'); those that are involved beyond this superficial level and who take part in the day-to-day management and care of their child by putting her to bed, feeding and bathing, and taking the child to the clinic or doctor ('modern'). The third group are those fathers who take sole responsibility for

childcare part of the time; that is, those couples where there is 'shared care' ('new Dad'). The term 'new Dad' has been used in contrast to the term 'new man' because the latter has been criticised as 'a true creation of the media' (Hearn 1987:5), and one which does not take into account the relative lack of change on the part of men in many areas (Hearn and Morgan 1990:16). The terms given to the types of fathers and mothers (see below) are used as Weberian 'ideal types'.

The issue of congruence between ideology and social roles does not apply to as many fathers as mothers since fewer of them are in conflict with their roles. However, there are two fathers who would like to be more involved with childcare than they are and feel restricted by their responsibility to earn money, and one father who resents his degree of involvement. There is also another father who is unemployed who experiences a lack of congruence between his ideology of fatherhood and his social role as 'breadwinner'.

Relationship between the meanings of parenthood and parenting and health

It seemed likely that parents' attitudes to parenthood and parenting would be related to their perceptions of how childcare affected their health. They might also be related to parents' actual health status. However, health status as 'measured' by reported health status for the previous year and the number of health problems recorded in the diaries cannot be accounted for only by parents' attitudes to parenthood. The determinants of a person's health status are manifold and include biological, social and environmental factors. These interlock in a complex manner such that it is very difficult to unpick them. The purpose of this section is not to 'prove' that parents with certain attitudes to parenthood are less healthy than others with different attitudes, rather to explore the processes which lie behind the relationship between the beliefs parents have about parenthood and parenting and the perceptions of their health. In this section, I will first discuss the relationship between ideologies of motherhood and perceptions of health and then look at fathers' involvement in childcare and its effect on their health.

MOTHERHOOD AND HEALTH

In the case of mothers, the relationship between their ideologies of motherhood, their perceptions of the effect of childcare on health and their reported health status is a complex one. The key issue is whether their ideology of motherhood corresponds with their actual situation. If their ideology of motherhood is congruent with their actual circumstances, then they perceive fewer negative health effects of childcare than if there is a gap between ideology and circumstance. Thus mothers who believe they should stay at home full-time to care for their child and are doing so, perceive fewer negative health effects of childcare than mothers who share the same belief but who are in paid employment. Similarly, mothers who believe there is more to life than caring for their children full-time and do work outside the home, perceive fewer negative effects of childcare than mothers with the same belief who are at home full-time. However, there is a hierarchy within this relationship, within the two groups of mothers whose situations are not congruent with their ideologies, the mothers who do not share the full-time motherhood ideology perceive greater negative health effects of childcare than those that do.

There are thus four categories of mothers

i) 'Traditional' ideology-congruent: *happy housewives* (four mothers)

ii) 'modern' ideology-discongruent: *unhappy housewives* (five mothers)

iii) 'Traditional' ideology-discongruent: *guilty 'working' mothers* (three mothers)

iv) 'Modern' ideology-congruent: *happy 'working' mothers* (three mothers)

In the descriptions of these 'ideal types', I have used the term 'working' as shorthand for paid employment. This does not, of course, mean that the full-time mothers do not work.

Was this relationship between ideologies and perceptions of health borne out by the mothers' actual health status? This was not straightforward. Most of the mothers who expressed congruence between their ideology and their actual situation did report 'good' health in the previous year and low numbers of health problems in their

diaries. Similarly, most of the mothers whose ideology is at variance with their present situation, reported a high number of health problems in their diaries and 'not good' or 'fairly good' health in the previous year (see Table 7.3 below). This concords with research by Townsend and Gurin (1981, quoted in Froberg et al 1986) which found that fulltime mothers and housewives who do not want paid employment outside the home are in better mental and physical health compared with housewives who would prefer to be employed.

Table 7.3: *Mothers' ideology and reported health*

	Congruent	Discongruent
Health last year		
Good	4	2
Fairly good	2	3
Not good	1	3
Level of health problems		
Low	3	1
Medium	2	1
High	2	6

For other mothers however, the relationship is not so neat and tidy. This is not altogether surprising since the mothers' reported health status and the number of reported health problems are not only related to childcare, but to other aspects of their situation, particularly their material and social circumstances (see Chapter Six). The complexities of this relationship are illustrated by Baruch et al (1985), who found that housewives who would have preferred to work outside the home suffered serious mental health consequences, whereas employed women who would have preferred to be at home did not. They suggest that the financial necessity of working may explain this finding. Further, this confused relationship reflects the contradictions expressed by these mothers which are discussed below.

Developing these typologies was not a straightforward process: the decision about the

type of categories and which mother went into which category was not clear cut. The mothers expressed contradictions and ambivalent feelings. However, these categories reflect the mothers' *public* responses to the direct question 'do you think caring for a child affects your health in any way?' This is where the expression of their ideology about motherhood is seen most clearly. If a mother believes she should care for her child full-time, she must support this belief with the public response that caring for her child does not have a detrimental effect on her health. What she says at other moments might contradict this. Similarly, a 'full-time' mother may say she wants to get a job at one point in the interview, but at another point say she believes she should stay at home full-time. These contradictions reflect the conflicting pressures on mothers to stay at home to care for their children, the financial pressures to earn money and the reality of the isolation and strain which caring for a child full-time induces. It is important to note at this point that there was one mother who did not appear to fit into any of the categories. Joanne Land is a full-time mother and at the first interview firmly expressed that this was what she thought she should be:

> I feel that now I've had the responsibility of taking on children, I feel that I should be at home with them. You know, I do plan to have more, so...I think they should be, I should be with them here at home.

However, unlike the other mothers who shared her ideology, Joanne is less ambivalent about expressing the negative effect of childcare on her health and she does not think that it benefits her health in any way:

> I feel that he comes first, and I do not neglect myself but I put mine back [her health], you know, and I suppose it could get worse...

Interestingly though, by the second interview Joanne has gone back to her old job for a few hours two days a week, leaving Stephen with a friend. I only discover this when I ask if anyone other than her or her husband has looked after Stephen. Joanne is at pains to point out that she has 'not really gone back to work', she is only 'helping out' and 'it's a few extra quid and a bit of independence for me'. She also stresses that she does not have to worry about Stephen because he is with her friend and, although she 'likes to get away', she could not leave him with a childminder whom she does not know. By the third interview, Joanne has stopped this part-time paid work because her friend is moving and cannot look after Stephen any more. She

'can't be bothered' to make alternative arrangements. This case highlights the conflicting feelings which many mothers have about whether they should take some form of paid employment or not. If they do take a job, there is the problem of finding childcare arrangements with which they feel happy.

i) Happy housewives (traditional-congruent mothers)

These four mothers believe they should stay at home full-time to care for their children and this is what they do. They perceive few negative health effects of childcare in their public accounts and tend to report more positive health status and fewer health problems (see Table 7.4).

Table 7.4: *Health status of the happy housewives*

	Health in past year	No. of health problems
Louise Bevin	Good	Low
Rosemary Ingram	Not good	Low
Joanne Land	Good	Medium
Suzanne Oliver	Good	High

Louise Bevin, for example, told me 'I'm planning to stay at home, I wouldn't palm her out to anybody.' Louise says her health has been 'good' in the last year and she reports a low number of health problems in her diary. When I asked Louise if she thinks caring for her daughter Sarah affects her health she said:

> When I say I'm sometimes anxious, it's usually for her, you know, certain things like if she's ill or whatever or if she cries and you don't know what's wrong with her, that sort of thing. That gets you anxious...I don't really consider that as health though.

Rosemary Ingram is committed to staying at home full-time with her children until they go to school, saying 'I'd rather look after them myself than have somebody else look after them.' When I asked Rosemary if she thinks looking after her daughter Elizabeth affects her health she says it affects her 'in a good way' because having to look after a child means that she has to look after herself. Unlike some other mothers,

I had to prompt Rosemary to think of any negative ways in which it affects her health:

> No, as I said before, only when she's ill it affects me in a bad way because I'm up all night with her as well...

Rosemary reports a low number of health problems but her public account of how caring for Elizabeth has a mainly positive effect on her health and her reluctance to talk about the negative effects, differs from her other, private accounts. When I asked her how her health has been over the previous year she says:

> Terrible! (laughs) No, I've not been the fittest person, I'm picking up now because I did lose one baby, we did, I did fall pregnant after Elizabeth but we lost that one. It was obviously 'cos I wasn't fit enough to carry the baby and it's also working 24 hours a day when the baby's ill (laughs) because I mean she's had a lot of colds and she picks up colds very easily from other children and that means waking up every night. But she's OK now, now she's getting much older...

Jill Smith is an interesting case - she chose to take on paid employment in the home as a childminder so that she can care for her daughter. When I asked her why she decided not to go back to her job as a secretary she told me:

> I don't agree with it. I mean for others, fine, but for me I'd rather stay and struggle with my daughter 'cos to me that is where I should be. But for others, I don't knock them 'cos I know some people have to work...but for me, no, I want to be at home with my daughter. That is why I do the childminding, just to bring in that little bit extra. To me it's a perfect way of working and bringing that little bit extra in and staying with my daughter.

Like the other mothers, Jill perceived fewer negative health effects of childcare in relation to her daughter. She played down the effects of the lack of sleep although the night before this interview she had only got five hours sleep:

> NJF: Do you think caring for a child affects your health in any way?
>
> Only lack of sleep when she's been a bit naughty in the night. And I mean naughty, it's not that she's upset or anything like that...yeah, that's the only way she affects me really, and of course, I suppose if you can become ill through worry when they're ill or something...but other than that, no.

Jill does however report a high number of health problems in her diaries and talks about often getting very tired. This she accounts for by her childminding work:

> It's very hard work, you can imagine, looking after three under-fives is very

hard work.

ii) Unhappy housewives (modern-discongruent)

These five mothers are at home full-time caring for their children and they are not satisfied with this situation. They perceive greater negative health effects of childcare and report less positive health status and more health problems (see Table 7.5).

Table 7.5: *Health status of the unhappy housewives*

	Health last year	No. of health problems
Dawn Abbot	Good	Low
Diane Cartwright	Good	High
Lesley Fisher	Not good	High
Alison Grange	Fairly good	High
Patricia Morgan	Not good	High

Alison Grange is at home full-time with her daughter Judith and is thinking about trying to get a job so that she and her partner can afford to buy a place to live. Her reasons for wanting a job are not just financial though:

> I'd like to get out and use - you know, 'cos you don't sitting at home with the baby all the time...You don't have to use your brain much. It'd be nice to do that again, so that way I'd quite like to get out.

She has had a difficult first year with Judith and accounts for her 'fairly good' health by the 'stress and strain' of looking after her. Alison reports a high level of health problems in her diaries and only describes negative health effects of looking after Judith:

> With me for the first year it has been very, very tiring and - er - and that, you know, maybe feel a bit run down and everything else, so yeah, I don't think it's done anything positive for my health (laughs).

Dawn Abbot is actively looking for a job but feels she has to justify it to me and clearly feels some guilt about it:

> I would like to look after John but it's a case of er [laughs] wanting to out to work and having to go out to work, you know.

and she went on to say:

> I'm at the stage now where I need to go out to work to meet people, but people who haven't necessarily got little babies (laughs) it sounds bad, I keep going on about this. I'm not fed up with John or anything but I've just got to the stage where I need to know...There's more to life than children, you know. I mean, it sounds badly really umm...I just need to get out to meet other people, you know. I want other interests like I say there's lots of things I'd like to do and one of them is to out to work to meet people and also to bring extra money into the home, you know, sort of help out, 'cos there's a lot of things we'd like to get you know so...that's all...and also if we wanna buy this place 'n' all we could manage on Nigel's wage but it would be a lot easier if I had a job as well so...

Patricia Morgan looks after her son Benjamin full-time and would very much like to get a job if she could get childcare:

> Well actually, I'd love to get a job if I could get him into a nursery or something, you know...'cos what happened was, my mum would normally look after him but she has epileptic fits, so she's a bit worried about being in the house on her own with him 'n' that, you know, in case anything happened. So we've opted out of that one. That's why I'm not really working.

Patricia accounts for her 'not good' health in the last year by the 'after effects' of having a baby:

> It takes a long time to...when you've had a baby, to settle - your body, you know, it changes so differently...

She views childcare as having both negative and positive effects on her health. The negative effects result from the frustration she feels when she is trying to do something and Benjamin is wanting 'too much attention'. The positive effects are that he makes her feel happy:

> If you're feeling low or something, you know, he makes me laugh a lot.

It is important to stress that many of these mothers expressed more ambivalence about their ideology than these categories seem to take into account. Some wavered between feeling they should stay at home to look after their child and wanting an outside interest. Lesley Fisher, for example, had a part-time job for about a month when her daughter Hazel was first born. Her sister-in-law looked after Hazel while she was at work and she was happy with that arrangement:

> There weren't any anxieties there, but I missed her. She always came back happy and well fed and all the rest of it, but I did miss her.

However, several times in the interview she mentions that she wants to get Hazel into a nursery so that she can get a job for 'the money, firstly, and I just want to get another interest'. When I ask her if she has any major worries she said:

> No, no major worries, I mean there's the silly little things like I wanna get a job because of the money - it's not so much we're short of money, we've got enough for the essentials but there's little things I like that I can't buy, that sort of gets you down sometimes, 'cos I always used to have money.

Later, however, when I ask her if she feels she gets enough help with looking after Hazel, she says:

> I choose to do it this way, even though it kills me I've just got this set idea of how, p'raps because my mum was always at home and always there, I want to be always there for Hazel even though I like her to be with as many different people as well.

These contradictions reflect the pressure mothers are under from cultural norms that they should stay at home and look after their children. Lesley has had a very difficult time since Hazel was born which she puts down to 'a sort of hormone upset...It just ran me down'. She describes her health in the last year as 'not good'. She complains of loss of appetite, having very little energy to do anything, feeling irritable and, the one she found most upsetting, losing her hair. Lesley graphically describes her lack of energy:

> When I do not an exhausting job, but when I do something that's quite simple like hanging those blinking curtains I try and I've been trying for the last year to make these curtains and I just cannot get up there, I feel as though I've over exerted myself. Because they used to keep saying to me it's probably because you're sitting down a lot or whatever that you feel it's an effort to do anything...I do feel like a lot of people do these things and I don't seem able to do 'em and I can do 'em, but I feel like I've killed myself afterwards.

She is also open about her irritable feelings:

> I do tend to be a bit ratty or jumpy at people, especially like family...I think that's actually one of the reasons why I'm a bit short-tempered and ratty at the moment is since I had Hazel. It's one of the reasons I gave up my job as well cos I was starting to hate everyone there.

Not surprisingly then, Lesley feels Hazel does have a negative effect on her health:

> ...it mentally drains you and then it comes physical, yeah, I think it does start, it all starts in the mind, if I could block it out I'd be all right but I can't you know. I don't believe that if a kid's pulling and tugging, I don't believe you should just ignore it. I mean if they're being naughty, yeah, but if they want

something you should just sort of get into it with them.

This negative effect is also reflected in the high level of health problems which she records in her health diary.

iii) Guilty 'working' mothers (traditional-discongruent)

Although these three mothers perceive more negative health effects of childcare than the 'happy housewives' but fewer than the 'unhappy housewives', their public accounts of their health problems place more emphasis on the circumstances of their job than on childcare. These accounts correspond with their ideology of believing that they should be full-time mothers. These mothers also report more health problems and less positive health status than the traditional-congruent (happy housewives) and modern-congruent (happy 'working' mothers) (see Table 7.6).

Table 7.6: *Health status of the guilty 'working' mothers*

	Health last year	No. of health problems
Ruth Dobbs	Not good	High
Julie Thomas	Fairly good	High
Jill Smith	Fairly good	Medium

Julie Thomas works full-time in a bank but would prefer to be at home looking after her daughter Christine:

> I don't particularly want to work but there's no way we could afford really for me not to. We could afford it but it would be just managing, it wouldn't be much of a life really. And also I have a mortgage at the bank as well so that's a bit of a noose round my neck.

As she is unhappy working full-time, Julie perceives the health problems she experiences as a result of her working rather than as an effect of childcare. When I asked her if she thought caring for Christine affected her health she said:

> No...I do get tired but that's only 'cos I'm working as well. I mean if I was at home all during the day, I probably wouldn't, well, that's easy to say, but it's the travelling that tires me actually, travelling to work and travelling home again.

But Julie explains her 'fairly good' health in the last year in this way:

> Well, actually I've had an awful lot of colds 'n' things since I've had Christine to be honest...I never used to have colds before I had her (laughs).

Julie reports a high level of health problems in her diary.

Ruth Dobbs also works full-time, but she works shiftwork in a casino. She would like to care full-time for her son Mark:

> I'm planning to clear all my debts and give up work altogether. I wanna spend more time with him.

Ruth accounts for her 'not good' health in the past year by:

> ...the hours I work and the stress because I do get very tired. I do think that it's lack of sleep, I never get like a full eight hours, what most people live on, I sortta get bits here and there: two hours when I get home from work and if I'm lucky four hours in the afternoon - that's when I'm working nights and the change over [with her partner] is supposed to be nice, like I'm supposed to sleep through but I can guarantee that if I'll have to be in bed by six I'll be woken up by ten 'cos all the noise he [Mark] makes makes me semi-conscious...

Ruth perceives the negative effects of childcare on her health to be associated with worrying about Mark's health, but she also feels there are a lot of positive effects as described earlier (see Chapter Four). She reports a high level of health problems in her diary.

iv) Happy 'working' mothers (modern-congruent)

This group of three mothers (plus Dawn Abbot after she gets a job) do not believe they have to be full-time mothers and they do have some form of paid employment outside the home. They perceive fewer negative health effects of childcare and report more positive health status than the two discongruent groups. However, they report more health problems than the other congruent group (happy housewives) (see Table 7.7)

Table 7.7: *Health status of the happy 'working' mothers*

	Health last year	No. of health problems
Deborah Jessop	Fairly good	High
Helen Price	Good	Low
Jane Vernon	Fairly good	Medium

Jane Vernon, for example, works part-time supervising mentally handicapped adults in a day centre. Her partner also works part-time and they share the care of their daughter Mandy. She said:

> I like working, I prefer to work. I didn't enjoy being at home all the time when I was at home. Now that I'm back at work I find that I'm much happier at home, it's just nice to get out a couple of days a week and do something different.

Jane does not feel looking after Mandy affects her health:

> I don't think it affects my health, no, I'm sure it doesn't. It makes me tired but being tired isn't exactly your health. As I say, we do a lot, we don't sit in all day - we go out and do things so at the end of the day I'm tired.

Jane describes her health in the past year as 'fairly good' and feels she does not have time to be ill with a baby.

Helen Price works part-time as a nursery assistant and now that her daughter Annie is 18 months old she would like to get a full-time job. She has very definite ideas about childcare and how it should be a shared responsibility between herself and her partner. Helen describes her health in the past year as 'good' and accounts for this by saying:

> I think maybe it's 'cos I'm happy...When you're happy you keep well.

She has a very positive view of the health effects of childcare:

> She keeps me on the go...forever running after her so I think that's the only way she affects my health. [Are there any other good or bad ways?] She aches my arms so I'm sooner or later going to get tennis elbow 'cos I carry her everywhere, I don't use the buggy - that's the only thing as far as I'm concerned.

Helen reports a low number of health problems in her diaries.

FATHERHOOD AND HEALTH

As has been described above, the fathers can be divided into categories according to their level of involvement in childcare: 'traditional'; 'modern'; and 'new Dad'. These categories were developed by analysing how both parents described their childcare responsibilities and how they were organised. The fathers' level of involvement was also evident in the way they described how their lives had changed since becoming fathers - some 'traditional' fathers said their lives had hardly altered since becoming a parent. Tony Bevin whose wife, Louise, has virtually sole responsibility for their daughter Sarah, told me:

> Well, I don't really think my life has changed really. No, nothing I've really noticed. I think I'm a lot happier since she was born, but no sort of drastic change.

The fathers' level of involvement is related to their perceptions of the health effects of childcare. The more involved fathers (ie. 'modern' and 'new Dad') perceive greater negative health effects. The less involved ones perceive few, if any, negative health effects to themselves, although some describe the negative effects it has on their partner.

As with the mothers, there is some relationship between the fathers' attitudes to parenthood and parenting and the number of reported health problems, although not health status in the past year. Table 7.8 shows a pattern whereby the more involved fathers report higher levels of health problems.

Table 7.8: *Types of father and health status*

	'Traditional'	'Modern'	'New Dad'
Low	4	1	0
Medium	3	4	0
High	1	0	2

However, for most of the fathers, parenthood is a less important factor in determining

their health than it is for the mothers. Other factors such as work conditions, social and material resources are probably more important in determining these fathers' health. This is evidenced by the contrasting way mothers and fathers account for their tiredness. While mothers are more likely to account for their tiredness by their experience of childcare, fathers are more likely to account for their tiredness by their experiences of paid employment (see Chapter Four). Using Cornwell's (1984) categories in a different sense, fathers used 'public' accounts and mothers used 'private' accounts to explain their experiences of health and illness.

(i) The 'traditional' fathers

Seven of the 15 fathers fall into this category. As they are only involved in childcare on a superficial basis it is not surprising that they perceive few, if any, negative health effects of childcare. Seven of these fathers mention no negative effects on their health, three mention positive effects and two describe the negative effects childcare has on their partner. As Table 7.9 shows, the 'traditional' fathers, health status is good.

Table 7.9: *Health status of the 'traditional' fathers*

	Health in last year	No. of health problems
Tony Bevin	Fairly good	Low
Simon Cartwright	Good	Medium
David Fisher	Good	Low
Joe Harris	Fairly good	Medium
Robin Ingram	Fairly good	Medium
Ed Newton	Not good	Low
Daniel Oliver	Good	High

When I asked Joe Harris if he thought caring for his daughter Judith affected his health he said:

> For me personally, probably not. But whoever's taking care of them, full-time taking care of them, like Alison, almost certainly.
>
> NJF: In what sorts of ways?

> Like the anxiety of looking after a child probably affects you mentally more than physically, more than any other reason
>
> NJF: Does it affect you in this way?
>
> No, I don't think I have responsibility often enough for it to affect me 'cos normally I only see her when I come home at the evening or at weekends. The rest of the time I go to work and get away from it, so it doesn't - it wouldn't tend to get on top of me. There's the sleep - as far as not getting enough sleep - it's not enough - it'd never be so bad as to affect your health.

Given that these fathers' role in childcare is limited, it is not surprising that the health effects they perceive are more positive than negative. I have already mentioned the different ways mothers and fathers talked about parenting: mothers said they enjoyed childcare tasks, whereas fathers talked about enjoying the fact that the child was *theirs*. The positive health effects of childcare which these uninvolved fathers felt were not the 'healthy side effects' of looking after a child which more involved fathers talked about (see below). They were the more abstract notions of positive aspects of the responsibility of parenthood. David Fisher and Robin Ingram, for example, both told me how they take fewer risks because they have the responsibility of looking after a child now (see Chapter Four). The implication is that their role is to financially support their children and they must take care of themselves in order to fulfil this responsibility.

(ii) The 'modern' fathers

These six fathers take part in the day-to-day care of their child by putting them to bed, feeding and bathing them and so on. They may sometimes take full responsibility for the child for a period of time; however the mother is the prime carer. These fathers perceive more positive and negative effects of childcare on their health than the 'traditional' fathers, and these effects relate more closely to the day-to-day care of the child rather than to abstract notions of parenthood. However, they do not report more health problems or poorer subjective health than the 'traditional' fathers (see Table 7.10).

Table 7.10: *Health status of the 'modern' fathers*

	Health in last year	No. of health problems
Nigel Abbot	Fairly good	Medium
Tim King	Good	Medium
Ben Land	Good	Low
Matthew Thomas	Fairly good	Medium
Peter Smith	Fairly good	Medium
Sam Roberts	Good	Low

Tim King describes the negative and positive health effects of childcare in this way:

> Well, like I says, it alters your lifestyle a lot because I mean - obviously I suppose Deborah, I don't know about Deborah but I mean it changed my lifestyle so I didn't go out as much, stay at home more and get to bed early. I used to go out a lot and now I can't sometimes, well, no, it's easier now she's getting older and we can have childminders and things like that. I mean in the early days, as I say, she's waking up in the middle of the night or something like that. It does affect you and you get tired and irritable you know. You go to work and you get more tired. And umm...that's about all I think...it's bound to affect your life, you know [laughs].
>
> NJF: Does it affect your health in any positive ways?
>
> Well, she's a lovely child, a nice little girl, like we're looking at her sometimes, you know, and thinking 'you're my daughter' - something like that, you know, you feel proud...and I take, we take her swimming or something, because she can swim with water wings on her own, 'cos we taught her. She seems to learn things pretty quick, whether we're biased or not I don't know, and you sort of feel proud of her. As I say, one of the proudest moments of my life was when she was born because I was there... It's an amazing experience.

Ben Land is aware of the effect looking after their son Stephen has on his wife, partly because he has experienced similar effects, and partly because the effect it has on her affects their relationship:

> It affects me wife more because she's with him all day and it gets you - it can - I mean, I've had him days when Joanne's gone out and it does get you down, there's no doubt about it. It's - umm - he demands your attention 24 hours a day really. And he needs it, so you gotta give it to him. It can - it can pull you down - it could pull anybody down...'cos she's had him all day it makes her edgy with me when I come home. She can sort of take it out on me. I mean that's when I lose my temper and things like that, if I - I dunno - something hasn't gone right in the day or something like that - I come home

> - I've had a puncture or something silly like that - the last thing I want is her nagging me - 'oh Stephen has done this or Stephen has done that, been a right sort of day - done this, he's done that, you know, pulled this apart...' And she's taking it out on me because I ain't there with her. But - that's all I really wanna do - just wanna be there to take the load off her.

Ben does in fact fulfil his wish to become more involved in looking after Stephen. Between the first and second interview he passed the examination (the 'knowledge') to be a London taxi driver. This enables Ben to work in the evenings so that he can take a greater part in Stephen's care during the day. According to Joanne Land, looking after Stephen has become more of:

> ...a shared responsibility. It's not one-sided any more, it's equal...when Stephen gets ill, he's learning to know what's wrong with him, whereas before he used to say 'what is it, what is it?' - but now he's learning.

Tim King found out what it was like to be a full-time father when he looked after his daughter Jenny for two weeks while on strike:

> I was at home for two weeks 'n' I had to look after Jenny 'cos we hadn't made any arrangements to take her back to the childminder as such 'n' we decided as I was on strike we couldn't really afford to take her back so...I found it very hard to just look after her all day, you know, on me own without being used to it, sortta thing.
>
> NJF: Did it surprise you how hard it was?
>
> Oh yeah, very hard, very hard...'cos she's at that age when she just wants constant attention all the time, you know, you can't even sit down and read a paper, you know, she wants to climb all over you...She just wants to play she's interested in things and also...lately she's been very clingy towards Deborah anyway, so I felt a bit rejected in some ways...'cos Deborah still wants me to do things with her but she won't...

(iii) The 'new Dad' fathers

There were two fathers who shared responsibility for looking after their children at the first interview stage - Paul Edwards and Andrew Wicks. They were subsequently joined by Ben Land. These fathers perceive the most negative health effects of childcare because they are the most involved. However, they represent contrasting situations: while Andrew Wicks has chosen to share responsibility for looking after his daughter with his partner, Jane Vernon - they both have part-time jobs - Paul Edwards is a reluctant 'new Dad'. This is reflected in the way they talk about the

effects of childcare on their health.

This is how Paul Edwards describes the effect of childcare on his health:

> ...mentally maybe not physically...because the things I want to do, I get terribly worked up inside when I can't do them, you know. Like at times I'd love to spend a Saturday pottering about under the bonnet of my car you know. But no way would I ever. Well, maybe when he's older but I can't because I haven't been able to for a year...I mean, I suppose on a Sunday he gets me out, we go for a walk where I probably wouldn't go for a walk, you know, I take him there in the car to the park, then we play about in the park when it's dry on Sundays. Yeah, I suppose he does me a...yeah, he gets me out. He maybe gets me to see a few people - I'm a loner really though. Otherwise, I mean, I don't get on with people, I don't like people on the whole, I'm a very unsociable person. I don't like meeting people...He gets me out, he gets me over the barrier a little because when you see little kids playing about you can't help but meet their parents. So I meet a few people when I take him out on Sundays you know. But I bottle things up a lot, it stops me from doing things and I don't think that does me, mentally, a lot of good.

Both Paul and Andrew report 'fairly good' health in the past year and a high number of health problems in their health diaries.

Andrew Wicks said looking after a child:

> ...makes you worry, yes of course, and you lose sleep - babies - in the middle of the night 'n' stuff, and you care, you don't care about yourself as much 'cos you're constantly worrying about them.
>
> NJF: Are there any good ways it affects your health?
>
> Yes, you cut down on your drinking so I don't get so tired with drink so much...and it's caused me to give up my job, it's caused me to stop all that larking that was doing me in...

The issue of congruence between ideology and social roles is not such a key one here as unlike the mothers, very few fathers are in conflict with their role. However, there are five fathers whose ideology and social roles are not congruent. Two fathers, Ben Land and Matthew Thomas would like to be able to play a greater role, while Paul Edwards resents his degree of involvement. Andrew Wicks and Jane Vernon share the responsibility for looking after his daughter Mandy by both working on a

part-time basis. Andrew resents that for financial reasons he will probably have to get full-time work and give up much of his present involvement. At the first interview, Ed Newton was unemployed and there was a lack of congruence between his ideology of fatherhood (financial provider) and his actual social roles. Ed got a job part-way through the study, and so it became possible to explore the differences in his perceptions of health between when his ideology and roles were discongruent and when they were not.

A JOINT TYPOLOGY: IDEOLOGIES OF PARENTHOOD, MARITAL RELATIONSHIPS AND HEALTH

The parents were also divided into groups according to their 'marital' relationship - 'good', 'average', 'poor' (see Table 7.11). This was a subjective assessment that I made of their relationship based on what they had told me about it. Those with 'good' relationships were those parents who had specifically mentioned that their relationship was very good and supportive. Those defined as having an 'average' relationship were those who did not specifically mention that their relationship was very good and supportive and who talked about the problems they had. Those with a 'poor' relationship were those who talked about having a great number of problems in their relationship and difficulties in resolving them.

Table 7.11: *Type of 'marital' relationships*

Type of 'marital' relationship	No. of couples
Good	8
Average	4
Poor	3

From Table 7.12 , it is possible to discern a relationship between the quality of marital relationship and congruence between couples of their ideologies of parent-hood. Where couples were in agreement ie. both 'traditional' or both 'modern' they

had 'good' or 'average' relationships. Where couples had differing ideologies, there were more 'poor' marital relationships.

Table 7.12: *Parents' ideologies of parenthood and 'marital' relationships*

Ideologies of parenthood	'Marital' relationship		
	Good	Average	Poor
Both 'traditional' (n = 3)	3	0	0
Both 'modern' (n = 4)	2	2	0
Mother = 'modern'/Father = 'traditional' (n = 4)	0	1	3
Mother = 'traditional'/Father = 'modern' (n = 4)	3	0	1

Thus the notion of 'role conflict' needs to be considered not just between mothers, but between parents. The group where the greatest conflict would occur is in the four couples where the woman has a 'modern' ideology and the man has a 'traditional' one. Although these mothers had 'modern' ideologies they were all full-time mothers ie. they were in the 'traditional-discongruent' group ('unhappy housewives'). Three out of four of these couples had a 'poor' marital relationship. Table 7.13 brings the typologies of mothers and fathers together showing where there are compatible and conflicting relationships.

All four of the mothers in the 'in conflict' relationships reported 'high' levels of health problems and two reported 'not good' health in the past year. Thus their poorer subjective health is related to both the discongruence between their ideology and situation and the discongruence between their ideology and their partner's. Not surprisingly, these mothers expressed the most criticism of their partners' contribution to childcare and household work.

Table 7.13: *Compatible and conflicting relationships between parents*

NB. Numbers in table refer to couples rather than parents.

Mothers (n = 15)	Fathers (n = 15)		
	Traditional	Modern	New Dad
Happy housewives	3	1	
Unhappy housewives	4	1	
Guilty working mothers		2	1
Happy working mothers		2	1

KEY

¦ ¦	Compatible
/ /	Less compatible
▒▒	In conflict

Alison Grange, for example, said of her partner Joe:

> I'd like to know that he was gonna do something...like some Sunday mornings he'll just sit in the chair not doing anything 'n' you're rushing to get out 'n' I have to wash the dishes, make the breakfast, get the baby bathed, and he's just sittin' there in his chair playing his guitar 'n' I think oooh I'll crack it over his head one time.

In contrast, Helen Price, who shares a 'modern' ideology with her partner Sam Roberts, said:

> He does a lot, more than a man usually does, he does help a lot with her (their daughter). He cares a lot about her, it's uncanny, you don't expect them to care so much for their children or help as much as much but he does help a lot with her. He doesn't do the washing for her but if he cooks he cooks for all of us 'n' he cleans up after her, he baths her, he puts her in her pyjamas, he'll make her bottle up.

The clash of 'gender ideology' was also found by Hochschild (1989) in her study of

dual-earner parents in the USA. Forty percent of marriages had discordant ideologies mostly between women who wanted equality both in the home and at work and men who accepted their partners working but expected them to remain primarily responsible for domestic work. Over 50 percent of women had tried to change how their domestic workload was shared, most unsuccessfully. Such domestic situations not only place additional stresses on women (and also, Hochschild argues, on men) but also on marriages:

> People who conclude that it is women's work that causes divorce look only at what women are doing [when] what contributed to happiness was the husband's willingness to do work at home (1989:212).

Conclusions

This chapter sets out three typologies - one for mothers; one for fathers; and one for both - which help explore the relationship between parenthood and health. For mothers the important factor was how far their ideology of motherhood was congruent with their actual situation. Thus it was not the combination of paid employment and childcare *per se* that related to their health experiences but whether or not their participation in paid employment or not concordes with their ideology of motherhood, ie. whether or not they should have been a full-time mother.

This extends the notion of 'role conflict' to incorporate an analysis of the conflicting or complementary relationship between the ideologies of parenthood and the actual roles parents perform. Where there was discordance between ideologies and actual situation (the mother was a full-time mother but wanted to leave some form of paid employment; or she was in paid employment and wanted to be a full-time mother) mothers reported a higher number of health problems.

For fathers, the main factor in how parenthood affected their health was how involved they were in childcare. The more involved they were the more health problems they reported. This extends the notion of 'role strain' to fathers, which was previously applied only to mothers.

In addition the concept of 'role strain' needs to take into account the congruence of ideologies *within* couples. Mothers with 'modern' ideologies whose partners had 'traditional' ideologies reported higher levels of health problems.

The research on gender roles and health based on large-scale surveys, up until now, has not been able to analyse the *processes* by which men's and women's social roles affect their differential health experiences. These typologies have enabled this analysis to highlight some of the mechanisms whereby parenthood affects men's and women's health.

CHAPTER EIGHT

EXPLAINING THE DIFFERENCES: MOTHERS' AND FATHERS' EXPERIENCES OF HEALTH AND ILLNESS

> Happy families are all alike; every unhappy family is unhappy in its own way (Leo Tolstoy (1878/1960:1): *Anna Karenina*).

Although data from my study were collected in a different way from other studies, they show similar patterns, that is, women report more health problems than men and are more likely to report taking action for these problems. However, the women in my study also evaluated their health more positively than men (see Chapter Five). This is related to mothers' expectations that health problems are an inevitable consequence of their role; they therefore, to some extent, take a degree of ill-health for granted. Further, while both mothers and fathers in poorer socio-economic circumstances reported more health problems, the mothers were more affected by poor housing conditions and lack of support with childcare (see Chapter Six).

In this chapter I analyse how far the data in my study can explain these gender differences. The data point to various explanations:

> (i) that men's and women's social roles explain their different experiences of health and illness ie. the fathers' health experiences are mainly affected by their role as 'breadwinner' and the conditions of their paid employment; whereas the mothers' health experiences are principally affected by their domestic role looking after their child and home. This role that the mothers have is one that makes it more difficult for them to adopt the sick role, and the demands placed on them are such that their ability to rest and relax is impaired. ie. 'role strain' (see Chapter One). When men take on this role, as in the case of the 'new Dad' fathers, they also experience the detrimental effects of role strain on their health.

(ii) The lack of congruence between ideology of parenthood and actual situation (ie. role conflict) experienced by some mothers explains their higher levels of reported health problems (see also Brannen and Moss 1991). The mothers who reported poorer health were the ones who either wanted to be a full-time mother but were actually in part- or full-time employment; or who wanted to have paid employment but were actually full-time mothers. For the fathers, this lack of congruence was not an issue.

(iii) The lack of congruence between some mothers and fathers concerning their ideologies of parenthood contributes to the role conflict experienced by some mothers. Mothers with a 'modern' ideology of parenthood with partners who had a 'traditional' ideology reported poorer health than mothers who shared their 'traditional' or 'modern' ideology with their partners.

(iv) While access to material and social resources can explain differences in health experiences within the study group, it can also explain differences between mothers and fathers. Housing conditions and support with childcare had a greater impact on mothers' experiences of health and contributes to their higher levels of reported health problems.

The rest of this chapter discusses how far the data from my study support three of the four hypotheses which have been cited to explain gender differences in health and illness. In the final section, I use four case studies to illustrate the various explanations for the mothers' and fathers' differing experiences of health and illness.

THE HYPOTHESES

As discussed in Chapter One, four main hypotheses have been propounded by others to explain the conundrum that 'women get sick and men die':

1. Biological differences between women and men.
2. Women report more illness because it is culturally more acceptable for them to do so.
3. The sick role is more compatible with women's other role responsibilities.

4. Women have more illness because their assigned roles are more stressful.

My study has collected data which can shed light on the last three of these - epidemiological studies have attempted to show how biological differences between women and men contribute to the gender differences in mortality and morbidity (see Chapter One).

Hypothesis Two: It is culturally more acceptable for women to report illness

Those who put forward this hypothesis argue that the gender differences in morbidity are not 'real', but an artefact of women's greater willingness to report illness because it is more socially acceptable for them to do so: 'the ethic of health is masculine' (Nathanson 1975).

It is hard to support this hypothesis with my data as women reported having more health problems than men, but evaluated their health more positively in the health diaries. However, in the interviews and the diaries it is apparent that the women more readily use the 'extreme' categories of 'very good' and 'not good/very poor' to describe their health and their day in general. It is possible that this is a function not only of gender differences in the way parents describe their health, but in the way they talk generally about their lives.

Other data from my study which cast doubt on this hypothesis are those from the health diaries which show that on days when men report a health problem, it has a greater effect on the way they report their day overall ie. they report it more negatively. This would seem to indicate a lack of pride in saying that their health problems affect their day overall. Alternatively, this could be because when men do have health problems they are of greater severity than women's. This points to the hypothesis that women are more sensitive to fluctuations in day-to-day changes in their health (Mechanic 1978, Briscoe 1987, Hibbard and Pope 1983), and therefore report more of the 'less serious' problems; whereas men report only the more 'serious' ones.

Hypothesis Three: The sick role is more compatible with women's other role responsibilities

This hypothesis focuses on the sociological implications of sex differences in 'fixed role obligations'. People who have many fixed role obligations (ie. ones that are difficult to reschedule) are expected to experience more role competition with the sick role and are less likely to define themselves as ill or take on the sick role (eg. 'I'm too busy to be ill'). Those that propose this hypothesis use it to explain the apparent higher rates of morbidity among women because they believe that, on aggregate, women have fewer fixed role obligations than men.

Although the women in my study are less frequently employed outside the home than the men, it is clear that they do not regard themselves as 'free' to reduce their usual activities when feeling ill - if anything they feel the reverse. Alison Grange feels her life is constrained by having a child in a way her partner's is not:

> It totally changes your life altogether really, you can't do anything without thinking of that other person any more...it doesn't matter for the father, I don't think 'cos they can still do that, no matter how good they are, they can still say I'm off round the pub at ten 'o' clock at night and they go for a couple o' pints, where I have to sort of prearrange everything that I do.

Jane Vernon contradicts this third hypothesis more explicitly:

> You're not allowed to be ill if you've got a baby (laughs)...'cos even if you're feeling lousy they expect you to be normal, really...

There are two propositions which arise from the fixed role hypothesis: first that women are more likely than men to seek treatment from health professionals; and secondly, that women are more likely to adopt the sick role in the home.

a) Women's greater utilisation of health services

Some researchers explain the higher rates of utilisation of health services by women compared with men by the hypothesis that since women have fewer work and time constraints on their behaviour, it is easier for them to reschedule their activities to visit the doctor (Mechanic 1978, Marcus and Siegal 1982, Nathanson 1975,1977, Verbrugge 1976, Cleary et al 1982).

In my study, over the nine month period, mothers had contact with the health services on average three times more than the fathers (excluding contacts made on behalf of their children). As women reported more health problems than men (one and a half times as many) this is not altogether surprising. It is important to note that just over half the mothers were employed full- or part-time during the course of the study. Thus even if their greater freedom from fixed role responsibilities in the domestic sphere is accepted, these women experienced the fixed role responsibilities in the public world of paid employment.

b) Women are more likely to adopt the sick role in the home

The second proposition which can be derived from the fixed role hypothesis is that women will be more likely than men to adopt the sick role in the home. The mothers in my study were more likely to take action for a health problem than the fathers. In particular, the mothers reported resting, going to bed early etc. more than three times as much as fathers, although they had only reported feeling tired on twice as many days.

It would appear from this that the mothers get more time to rest and relax than fathers, thus supporting the fixed role hypothesis. However, a more detailed examination of how mothers reported 'taking it easy' reveals a different picture. The mothers do not feel entitled to 'rest' at any particular point in the day and therefore 'putting my feet up' is seen as an action in response to a health problem, rather than part of the normal routine. The mothers feel that there is so much to do in the home that they cannot afford to relax - evenings should be used for doing jobs such as ironing which are impossible to do during the day with a small child around. In other words, 'a woman's work is never done'.

Fathers on the other hand do not report this kind of action so much, as they seem to take it for granted that they will be able to relax when they are not at work. The fathers tend to view work as their participation in the public sphere, which is confined to a limited period of the day. Their home is a place where they can rest and relax which is something they are entitled to after a hard day's (or night's) work outside

the home. This is not to say that fathers did no work in the home. Many were involved in on-going decoration/refurbishment of their homes and most contributed to other domestic work such as childcare and housework to some degree. However, their attitudes towards this domestic work was markedly different from those of the women. One reason, therefore, that fathers report tiredness less often than women is that they have more time for rest and relaxation and feel less guilty about taking it.

The hypothesis that women have fewer fixed role obligations, and can therefore more easily take on the sick role, does not explain the higher reporting of health problems and taking action for those problems, nor the greater use of health services among this group of women.

The greater use of health services, and home remedies, can more readily be explained by the mothers' view of health as 'getting through the day'. As the person with the main responsibility for the health and well-being of their child 24 hours a day, it is essential that they 'keep going' ie. 'cope' with their role. Therefore when they fear they are not going to be able to cope they take action, more usually at home but sometimes by using formal health services.

Hypothesis Four: The nurturant role hypothesis

According to this hypothesis, women in our society are generally expected to occupy a nurturant role, both performing the essential daily household tasks and taking on the major responsibility for the care of children, spouses and aged relatives. As a consequence most women will (1) find it more difficult than men to adopt the sick role completely, and (2) tend to experience the demands of others as excessive and as impairing their ability to rest and relax. Women are, therefore, apt to become both physically run down and to be unable to adopt the sick role successfully (Gove 1984:80). In particular, Rivkin (1972) found that women with pre-school children were less inclined to adopt the sick role.

The data from my study would appear to support this hypothesis in several important ways.

(i) Adoption of sick role

From what I have already said regarding the fixed role hypothesis it would seem that these mothers do find it more difficult than the fathers to adopt the sick role completely. However, they report using health services and taking actions at home for health problems more readily than men, because it is so important that they 'cope' with their role.

(ii) Mothers experience the demands of others as excessive

This consequence of the mothers' nurturant role is evident in both the interview and health diary data. The health diary data show that there is a relationship between the mother's and child's health: on the days when the child is reported as having a health problem the mother is more likely to also report having a health problem. There was very little relationship found between the reporting of the child's health and the fathers' reporting of their own health. This suggests that it is mothers' responsibility to care for their sick children which has a negative effect on their health, and is an important finding in support of the nurturant role hypothesis.

From the interview data, it is clear that some of the mothers experience the demands of their partner and child as excessive and feel they have a negative effect on their health. When parents were asked to explain why their health in the past year had been good, fairly good or not good, eight mothers (and only one father) explained why their health had not been very good by the negative effect of childcare. Two-thirds of the mothers when asked what they did not like about looking after their child, talked about the stress and frustration of caring for a demanding child.

Diane Cartwright said:

> It's very stressful having children...*very*. And you think to yourself 'calm down, don't be so uptight about it' but you can't, you've got yourself so het up, because it's just one thing after another you can't seem to sit down and relax 'n' unwind.

Joanne Land actually felt that caring for a child was so demanding that she neglected her own health. She said of her son Stephen:

> I feel that he comes first, and I don't neglect myself but I put mine back, you

know, and I suppose it could get worse.

Alison Grange had a difficult first year with her daughter Judith:

> But with a baby, a new baby, and it has - it is - an awful strain for us, 'cos she's been like hyperactive and everything else, and it has been very difficult, so...a kind of depression, I s'pose...Just lack of sleep - things like that - that gets you down in the end, after a year of it, and no sleep, it begins to show in your health I s'pose.

Some fathers also see caring for a child as having more of a negative effect on their partner's health. For example, David Fisher said when I asked him if he thought caring for a child affected his health:

> I wouldn't say it affects mine so much, more the wife's like I said not mine... But it's not like I never do anything for her, obviously the wife does more than I do, I mean like mother and baby, like the child does go to the mother a lot more if they're around more, so myself I don't think it affects me very much.

It is significant that the most commonly mentioned negative health effect of childcare was tiredness due to interrupted sleep and the tiring nature of childcare work itself. In the health diaries, tiredness was also the most commonly reported health problem by both mothers and fathers. But mothers reported tiredness on nearly twice as many days as fathers. This would seem to indicate that it is their nurturant roles which lead these mothers to experience more tiredness.

Thus motherhood is a key factor in these women's health experiences. However, over half of the fathers (the 'traditional' group) perceived few if any negative effects of childcare on their health. For the majority of fathers, parenthood was not such a key factor in their health experiences.

(iii) Fathers in the nurturant role

The data from the fathers is important in shedding light on the nurturant role hypothesis. If it is the most likely explanation for gender differences in morbidity, then the fathers more involved in childcare should experience greater detrimental health effects of this role ie. role strain.

This is borne out by the data: of the six fathers who reported the highest levels of health problems, five of these were 'modern' or 'new Dad'. Further, just as it is the less-involved fathers who told me that caring for a child affects their partner more than themselves, it is the more involved fathers who spoke of how childcare affected their health. Andrew Wicks, who shares the care of his daughter Mandy with his partner, said looking after Mandy affected his health because:

> ...it makes you worry yes, of course, and you lose sleep, babies, in the middle of the night and that stuff, and...you don't care about yourself so much 'cos you're constantly worrying about them.

Tim King is one of the 'modern' fathers and when I asked him if looking after his daughter Jenny affected his health, he said:

> Oh yes, it alters your lifestyle a lot because I mean obviously I suppose Deborah [his partner], I don't know about Deborah, but I meant it's changed my lifestyle so I don't go out so much, stay at home and go to bed early more than I used to. I used to go out a lot and I can't now sometimes, well,no, it's easier now she's getting older and we can have childminders...I mean you sort of, in the early days she'd wake up in the middle of the night or something like that. It does affect you and you get tired and irritable, you know. You go to work tired and you get more tired. And..um..that's about all. It's bound to affect your life you know.

Where the data do not support the hypothesis is regarding the relationship between the reporting of the children's health and the parents' own health. Whereas fathers overall showed very little relationship between the reporting of the children's health and their own health, I would have expected there to be a relationship between the 'modern' and 'new Dad' fathers' reporting of their health and the reporting of their children's health. However, there was no such relationship.

(iv) Ideologies of Parenthood

The data on parents' ideologies of parenthood provide an important development of the nurturant role hypothesis. The mothers whose ideologies are not congruent with their actual situation experience poorer health. It is not that paid employment either mitigates or exacerbates the detrimental health effects of women's parental role through the benefits of role accumulation or the adverse effects of role strain or role overload. Rather, it is how far a woman's experience of paid employment concords

with her ideology of motherhood ie. whether she has been able to choose to combine this role as 'wage-earner' with her other, nurturant roles. It would seem, therefore, that not only 'role strain' but also 'role conflict' is one of the mechanisms whereby some women report poorer health.

Further, some of the women whose ideologies were discongruent with their situation had partners whose ideologies were discongruent from their own. For example, four of the mothers who had 'modern' ideologies about motherhood were married to or cohabiting with partners who had 'traditional' ideologies. Their relationships with their partners were more difficult as a result, and this contributed to their experience of poorer health.

The notion of role conflict is not an important one in explaining these fathers' experiences of health and illness. But it does contribute to the explanation of why the mothers experienced poorer health than the fathers.

Therefore, while my data lend support to the hypothesis that women report more illness because their roles are more stressful than men's, account also needs to be taken of the ideologies that women hold about their roles and where there is *role conflict*, as well as the *type* of roles which women and men have.

(v) Material and social resources

The data which highlight the relationship between material and social resources and reported health also add an important strand to the nurturant role hypothesis. There were clear relationships for both mothers and fathers between low income and reported poor health; poor housing and reported poor health; and lack of social support in some areas and poor reported health (see Chapter Six).

When I analysed the gender differences in these relationships, I found that the relationships between poor housing conditions and poor health and between perceived lack of childcare and reported poor health were stronger for mothers than for fathers (see Chapter Six). These differences reflect the differences in social roles of these

mothers and fathers: the social roles which these mothers carry out means that the private world of home and children has a greater effect on their experiences of health and illness than it has for the fathers, for whom the public world of paid employment (or its absence) is more important.

Thus the structural context within which men's and women's social roles are carried out needs to be taken account of in any explanation of gender differences in health and illness as it differentially affects their health experiences.

Case study illustrations of the explanations

I have chosen four case studies to illustrate the various explanations for the mothers' and fathers' different experiences of health and illness. These include the parents' different social roles, the congruence between the mothers' ideology of parenthood and their actual situation, the congruence of ideologies within couples, and their different material and social circumstances.

Dawn Abbot and Louise Bevin have contrasting ideologies of motherhood. The former believes it is important for her to have interests outside the home, including paid work; whilst the latter believes she should stay at home and be a full-time mother. The four fathers illustrate the different levels of involvement in childcare which is evident in the study group. Paul Edwards and Nigel Abbot are 'involved' fathers to differing degrees; whilst Tony Bevin is very 'uninvolved'. Dawn and Nigel Abbot and Louise and Tony Bevin have compatible ideologies; while Ruth Dobbs and Paul Edwards and Patricia Morgan and Ed Newton are in conflict. The case studies also illustrate different material and social circumstances. Louise and Tony Bevin are materially relatively well-off with a weekly income of over £500. This compares with Patricia Morgan and Ed Newton, on social security, who have a weekly income of approximately £150 and they have their rent paid.

DAWN AND NIGEL ABBOT

Nigel is a 'modern' father; Dawn is initially an 'unhappy housewife' (modern-discongruent) mother, but by the end of the study she has become a happy 'working'

mother (modern-congruent). Their ideologies are therefore compatible and they have an 'average' marital relationship. They are in the 'medium' income category and they do not live in over-crowded conditions, according to the GHS bedroom standard (see Chapter Six). They both feel they have enough support with childcare and other practical support, but would like more people to confide in, apart from each other.

Dawn and Nigel illustrate the importance of ideological congruence for mothers and compatibility between couples. Dawn reported 'good' health in the last year and a low number of health problems. Nigel reported 'fairly good' health in the past year and a medium number of health problems.

They live in a small block of council flats which were originally firemen's cottages. The flat is fairly spacious and neatly decorated. It has two bedrooms, a lounge, kitchen, bathroom and toilet and shared use of a 'garden' which is all paved over with concrete. Their son, John, was 19 months old at the time of the first interview and Dawn and Nigel got married when Dawn was 6 months pregnant.

Dawn is 22 and comes from Norwich where all her family and friends still live and she moved down to London when she married Nigel. She is very close to her father and step-mother (her mother died when she was 11) whom she misses very much. When I first met Dawn she was a full-time housewife and mother. She was very dissatisfied with this and felt guilty that she felt dissatisfied. She was hoping to try and get a job in a store and had applied for some work over Christmas. Dawn felt very lonely and cut off from her family and friends in Norwich, and although she had some friends in London she had made them all through her son and she found it frustrating that all she had in common with them was motherhood. She frequently referred to times when she felt 'very down', and her husband also commented on this. Dawn also suffers from very bad headaches which she thinks is linked to taking the Pill. She had taken up driving lessons and she was very anxious to pass as this meant she could go to Norwich whenever she wanted.

When I next saw her she had not got the job in the store but had taken up

child-minding instead. She felt a lot happier having an interest other than her son although she found it very tiring and still wished she could get out of the house more. She had come off the Pill because now that John had become more independent she wanted to have another baby. Nigel did not seem so keen on the idea. Coming off the Pill had cut down her headaches. She was very disappointed to have failed her driving test and felt under a lot of pressure from Nigel to pass as he had 'let' her learn before he did.

At our last meeting Dawn had started working full-time in a local store and John was at a private nursery. She was really enjoying the job and meeting new people. She said that she had become much more organised about doing housework as she had to fit it in around her job. Although she found combining a job with domestic responsibilities tiring, she felt this was more than compensated for by the greater fulfilment she felt. She had gone back on the Pill again as she and Nigel had decided to wait till John was at school before having another child. This was also so that they could start saving to buy their council flat. Dawn seemed to regret this decision more than Nigel did. Going back on the Pill had brought her headaches back again which were particulary debilitating, especially if they occurred when she was at work.

Between the first and second interview, Dawn had passed her driving test which meant that she could go and visit her family in Norwich much more frequently as well as being able to visit friends in London more easily.

Nigel Abbot is 26 and works as a manager at a local snooker club. Although his passion for snooker is apparent from the cups on the mantelpiece and the picture of himself with the famous snooker player Steve Davis, Nigel is unhappy with this job as he feels it has no long term prospects. He also does not like working in a place which he says is full of 'losers, bums and people going nowhere fast'.

Nigel is a devoted father and is very close to his son, whom he and Dawn refer to as 'a real Daddy's boy'. He participates in childcare, not just in playing with John but also feeding, changing, bathing and putting him to bed. When John started

nursery after Dawn has got her job, Nigel originally took him there every day but he cried so much when Nigel left that Dawn had to take him because then he did not cry as much.

Nigel is concerned about his wife's emotional well-being and is keen for her to get a job as this will 'get her out of the house', which he sees as the cause of her 'feeling down'. Nigel finds his wife's moods difficult to handle and at the final interview he talks openly about the problems they have in their marriage and admits that if it was not for John they would not still be together.

Nigel was born and brought up in this area although his parents no longer live there. His parents are both remarried - his mother lives in South London and his father in Newcastle. Nigel has clear ambitions: he wants to get a job which pays better so that he can buy their council house. He hopes this will enable them to move out of London because, since becoming a father, he views London as dirty, squalid and a dangerous place for women and children. He blames this mostly on 'the coloured people who have moved in'. His main priority is to give John a good education which he does not feel is possible in the 'looney left' Borough where they live. He speaks vehemently against the local council and its black leader who he sees as responsible for homosexual propaganda in schools. He does not want his eight year old son coming home from school 'with his Pakistani boyfriend, speaking Punjabi'. At the final interview, Nigel had applied as a job as a casino croupier as he hoped he would earn more money this way.

LOUISE AND TONY BEVIN

Louise and Tony are a good example of a 'happy housewife' (traditional-congruent)/'uninvolved' father couple. Their ideologies are compatible and they have a 'good' marital relationship. They are also in relatively good material circumstances: they are in the 'high' income category; and live in a house equal to the bedroom standard. Neither of them feel they need more help with childcare and other practical support, but Louise says she would like more friends.

Their reported health reflects the combination of a 'compatible' relationship with relatively good material circumstances. Louise reported 'good' health in the past year and a low number of health problems. Tony reported 'fairly good' health in the past year and a low number of health problems. However, they experience a number of 'life events' during the study period which perhaps they would have found harder to cope with had they been in more difficult circumstances to start with.

They live in a council house which they are 'doing up' and plan to buy. It has two bedrooms, kitchen, living room and bathroom. It has quite a large garden. Tony Bevin is building an extension to the house which makes the kitchen bigger and will provide a dining room. They have been married for 3 years and have a daughter, Sarah, who is 14 months old.

Louise Bevin is 23 years old and formerly worked as a bank clerk before having Sarah. She was very pleased to give up work and has no plans to return, believing that it is her duty to care full-time for her daughter. She comes from a very large family in an outer London suburb which she would like to return to at some stage. She is very close to her mother and several of her sisters. At the time of the first interview they had only been living in the area for six months (they had been living in the area where Louise grew up) and so Louise wished she had more friends close by, especially with children Sarah's age. She plans to join a Mother and Toddler group when Sarah can walk properly and hopes to meet more parents with children Sarah's age this way. She had hoped she would meet other parents through the clinic but found the mothers who attended were very different to her, reflecting the social mix of the area:

> It's a strange area around here...They start their families at sort of 35 and they're much older than me and they seem to have completely different interests, of conversation and things like that...

Louise is very clear that her responsibility as a mother is to care for her daughter full-time. When I asked her if she intended to go back to work when Sarah was older she said:

> No, I'm planning to stay at home, I wouldn't palm her out to anybody.

When I asked her if she felt she got enough help with looking after Sarah or if she

wished she got more she said:

> No. I'm a bit funny, I wouldn't let *anybody* look after her. It would have to be somebody like his mum or my mum or one of my family. I wouldn't sort of...or a very good friend um...I'm a bit funny that way.

Louise and Tony have very traditional domestic arrangements: Louise does all the domestic work and child care tasks; Tony's involvement with Sarah is limited to playing with her.

Tony Bevin is 30 years old and works as an electrician for a local council but he also does a lot of private work. When he is not busy with his private work he spends a lot of time doing up their house. Tony was born and brought up in the area where his parents still live. His father has terminal cancer which is source of great upset and strain for him. He has what he call a 'nervous problem' which manifests itself in a digestive disorder which was diagnosed as a stomach ulcer during the interview period. He drinks and smokes heavily, which he is advised to cut down on when the stomach ulcer is diagnosed. He ignores this advice. Tony is involved in the organisation of a local social club which means he is out several times a week. Over the course of the study period, Louise goes to the social club more often, taking Sarah with her, but Tony is out much more than her.

Between the first and second interviews Tony and Louise had a very difficult time. Louise became pregnant but then had a miscarriage. This was very traumatic for her and left her feeling very depressed. Tony seemed less affected by it because he does not feel the baby to be 'real' until it is born. Also, Tony's father had taken a turn for the worse and has been told he only has eight or nine months to live. Their house was burgled just before Christmas and the day after Louise got out of hospital following her miscarriage, Sarah pulled a heavy piece of equipment on top of her - fortunately this did not turn out to be serious.

At the third interview they were much happier. Louise had come to terms more with her miscarriage and they were trying again for another baby. They had just been on holiday to the South of France with friends from the social club, which they really enjoyed. Louise talked at great length about how good Sarah was on holiday and this

was a theme throughout the three interviews: they are 'very lucky' to have such a 'good' baby. 'Good' includes well-behaved and healthy.

RUTH DOBBS AND PAUL EDWARDS

Ruth is a 'guilty working mother' (traditional-discongruent) and Paul is a 'new Dad' father - so their ideologies are in conflict. They have a 'poor' marital relationship and are in poor material circumstances: they are in the 'low' income category and live in a flat below the bedroom standard. Neither wants more help with childcare but would like other practical support. Paul would like more friends.

Ruth and Paul's poor reported health perhaps reflects the lack of congruence between Ruth's ideology and situation, their incompatible relationship, and their poor material circumstances. Ruth reported 'not good' health in the past year and a high number of health problems. Paul reported 'fairly good' health in the past year and a high number of health problems. However, they are also both on amphetamines which may have a detrimental effect on their health.

They live in a tiny private rented flat with their 18 month year old son, Mark. The flat is one very large room divided into a sleeping area and a living area, but there is no door between the two. Off this large room is a very small kitchen. The bathroom and toilet facilities are down one flight of stairs and are shared with the other flats in the house. Ruth and Paul are desperate to move into somewhere larger but cannot afford to buy and are low down on the council housing waiting list.

Ruth is 32 and is a croupier in a casino in the West End where she works three nights and two days a week. She did not expect to be able to conceive as she had 'blocked tubes' but was absolutely delighted to have Mark. She suffers from what she calls 'low moods', and looks thin and pale. Ruth explains her poor health in terms of the hours she works and the stress this entails. When she works nights she does not get home until 4am and then has to get up at 8am to take Mark to his childminder so that she can come back and get more sleep. Her sleeping during the day is hampered by

building work going on in the flat downstairs - the landlord is gradually doing up the flats in the house and selling them off. Ruth is therefore constantly exhausted. She talked the most in her interviews (never less than two hours) and wrote the most in her health diaries which she kept as a detailed account of the events and feelings in her life.

Ruth resents having to work full-time and wishes she could stay at home and look after Mark. She reminisces fondly about the time after Mark was born when she was still on maternity leave and says she just wants to clear her credit card debts and then she will give up work altogether or maybe work part-time.

Ruth has a very difficult relationship with her partner who willingly states that he never wanted to be a parent and refers to himself as 'the reluctant father'. Although he participates to a large degree in childcare - he looks after Mark when Ruth has gone to work in the evenings and during the day at weekends when she is also working - he does not contribute financially. Ruth therefore feels justified in claiming single parent benefit. Ruth and Paul have a difficult relationship which is evidenced in their accounts in the interviews and also in the health diaries. Ruth appears to have difficulties with relationships - she is estranged from her parents and also has a stormy friendship with her childminder.

Paul is 26 and works as a warehouseman four days a week. He chose to work four rather than five days because he feels he needs a day off a week to himself as his weekends are taken up looking after Mark. He hates his job and particularly the foreman. He is hoping that the firm will move and make him redundant so that he will be forced to look for another job. Paul talks in a very negative way about everything in his life except his son. Although he refers to himself as 'a reluctant father' he loves Mark greatly and speaks of him very fondly. This contradiction between not wanting to be a father and yet loving his son creates problems for Paul. He feels that Mark has changed his relationship with Ruth and that all the love he once felt for her has now gone onto Mark. Ruth often complains in the interviews and health diaries about how negative Paul is about everything - he does talk very

pessimistically about his own life and the world in general.

Paul is estranged from his father who left home when he was a young boy but he is in contact with his mother. During the course of the study she has a hysterectomy and it becomes clear that she has cancer which Paul is very upset about. He says he has no friends except the man who supplies him with amphetamines. While he was completing the second health diary this man goes missing and Paul finds him eventually in hospital.

Paul is also very pale and thin. At the first interview he tells me he takes amphetamines daily and has done so for years. He had unsuccessfully tried to give them up several times. He wants to give up because he thinks it is bad for his health and also very bad financially. Just before our first interview his supply had dried up and he had not had them for a week. When I next saw him he was taking less than half his previous dose every day and was sleeping more, but felt a lot more tired. He was, however, better off financially. At the third interview Paul said that the manufacturers had stopped producing the 5mg amphetamines so he had stopped taking them. For the first two weeks this was really difficult but he now feels the same as before except that he sleeps more. He is very pleased that his supply has been cut off and that he has had to give up. He told me at this point (because he thought I knew) that Ruth had also been taking amphetamines daily for years which were prescribed to her by a doctor in Harley Street. He is very worried about what will happen to her when her supply dries up which he knows it will, as he feels she is much more dependent on them than he is. He recounts the story of Ruth's time in hospital when she was giving birth to Mark and she did not have her amphetamine supply with her: he says she behaved really awfully and that her complaints about the nurses treating her badly are not surprising since they were reacting to her terrible behaviour.

At the final interview, Paul talks about wanting to leave Ruth and the situation they live in but he is not sure he can face losing Mark. He feels if he left he would never get to see Mark.

Mark is a very friendly, lively boy. However, Ruth describes him as a 'sickly baby'. He developed pyloric stenosis at two weeks which meant that he was bringing up all his milk and he had to be operated on. Then at about ten months he became very ill with sickness and diarrhoea which lasted a month. Ruth explained this by his negative experience at a childminder who, she thinks, put him in a playpen in a room by himself:

> I reckon it was stress in a little baby, you know, he really didn't want to go to that childminders - he used to scream as soon as we got to the street whereas the one he goes to now, he loves it.

Since that time Mark has been sick again several times and then in the week following the interview he had to go to hospital because he had severe diarrhoea and vomiting and was not eating. When I went for the third interview with Ruth and Paul, Mark was in hospital again this time for 12 days (2 of them in intensive care) with a non-specific virus/infection in his glands. We delayed the interview and by the time I did interview them Mark was still on penicillin and looked thinner, but was full of energy again.

PATRICIA MORGAN AND ED NEWTON

Patricia is an 'unhappy housewife' (modern-discongruent) and Ed is an 'uninvolved' father: their ideologies are therefore in conflict; and they have a 'poor' marital relationship. They are in poor material circumstances: they are in the 'low' income category; and their flat is below the bedroom standard. They would both like more support with childcare, and Ed lacks a confiding relationship other than with Patricia.

This case study clearly shows how the nurturant role hypothesis needs to incorporate congruence of ideology and access to material and social resources. Patricia's assigned role as 'mother' is more stressful due to Ed's lack of involvement in childcare and this is obviously exacerbated by the conditions in which she has to parent. As he was unemployed for a period of the study, Ed illustrates the importance of the 'breadwinner' role to these fathers.

Their reported health reflects their experience of 'multiple deprivation'. Patricia

reported 'not good' health in the past year and a high number of health problems. Ed reported 'not good' health in the past year and a low number of health problems.

They live in a small privately rented flat above a carburettor shop on a busy main road. The flat contains one room which is divided by a curtain into a sitting room and bedroom where all three of them sleep, and a kitchen and a bathroom down a flight of stairs which they share with the flat above them. They are desperate to move out as the flat is much too small and they are hoping that the council might compulsorily purchase the flat in which case they would become council tenants. Their son, Benjamin, was 18 months old at the time of the first interview.

Patricia is 24 years old and formerly a typist. She is a very warm, friendly and open woman who is keen to participate in the project. Patricia was born and brought up locally where her family still live. She is very close to her mother whom she sees on a daily basis.

Patricia left her job as a typist five years ago and has since not had what she calls 'proper jobs'; she has had jobs like waitressing 'off the tax'. She would like to get a job now if she could get Benjamin into a nursery. Her mother was looking after Benjamin when Patricia had a job a few months previously, but as her mother has epilepsy she does not think she should look after him on her own in case anything happened. Patricia says she would prefer a part-time job because of Benjamin's age:

> I think he needs that little bit more time.

At the second interview Patricia was feeling 'very low'. She had become pregnant but felt there was no way she could have another child in this flat. She rang the council to see if having another child would help their entitlement to council accommodation and found out it did not. When she said that this would mean she would have to have an abortion they said so be it. She had the pregnancy terminated and was very upset about it. She had also had a lot of problems with the flat because the environmental health department of the council were making her landlord do some structural work to the flat, because of the fire hazard, which involved knocking down walls. This

would have been detrimental to Benjamin's asthma. Patricia had a terrible time trying to stop this work being done until finally she got some help from her local law centre. While all this was going on she said that she felt 'so low' that she went to her GP who put her on valium and anti-depressants. When the work in the flat got stopped she took the tablets back to her GP and decided to get her life in order on her own. She blames her pregnancy on the stress she was under which made her forget to take her contraceptive pill. She now believes this problem has been solved because her doctor has put her on three-monthly injections of Deprovera and she thinks it is marvellous as it stops her menstruating completely.

Patricia is becoming increasingly desperate to move out. She says that Benjamin's bad behaviour is due to their poor living conditions - outside the flat he is fine but as soon as they return he starts screaming. The council have offered her a place on Broadwater farm in ten months time but Patricia is not keen to move there. She is hoping to be able to do an exchange with her brother who has a council house nearby. He and his wife are planning to buy somewhere but Patricia wants to tell the council that they are moving into her flat and she, Ed and Benjamin are moving into her brother's house.

At the third interview there has been a dramatic change. They have moved into Patricia's brother's house which has three bedrooms and a garden. Patricia is much happier and says that Benjamin's behaviour has changed completely now that he has space to run around and play. She is also very excited because she has managed to get him a place in the local nursery for a few months time.

Ed was born and brought up outside London and moved to this area a few years ago when his marriage broke up. He has two daughters from this marriage whom he does not have access to see. He is currently fighting a court case in order to change this. His father spent several years in prison when he was an adolescent which has had a considerable impact on him. At the first interview Ed was unemployed and working unofficially part-time in the pub across the road. He is very depressed about not having a job. Ed has recently been ill for several months with what he calls 'kidney

trouble and some kind of blood disorder'- he lost a lot of weight and was sweating a lot at night. He smokes and drinks heavily. Ed's ambition is to start a small business such as a bar or a restaurant.

At the second interview Ed is much happier as he now has a job working for a firm that does damp coursing. However, he is still not employed officially - 'off the books' - and therefore does not feel secure. The company does damp coursing for people who have council grants and he does not know how long this work will last for. As he is not 'on the books' they are still on supplementary benefit. He talks in great detail about how he felt before he got this job; how depressed and lethargic he had been and how much healthier he feels now. He also spoke of how he missed Benjamin and felt guilty about leaving him to go out to work every day. Ed is close to his son but does not take part in his practical day-to-day care. He admits to not having enough patience when Benjamin 'plays up' and says Patricia is much better in that situation. But he says that since he started work he is able to control Benjamin's temper much better because he is not with him all day - he doesn't know how Patricia manages him all day.

Ed is being taken to court for maintenance by his ex-wife which is clearly worrying him. He blames the sweating at night on these worries - he has been for tests but they have all proved negative. However, the difference between his mental state and Patricia's at this interview is very marked. Ed says he now feels he is fulfilling himself as a father and husband now that he has a job whereas before he felt he was not. He feels that things have improved for him '200 percent', whereas things for Patricia have not improved so much. He feels he has more control in their relationship now because he has more confidence to say what he wants to say and not just do what she wants him to do. He also talks with great feeling about wanting to move out of the flat and their plans to exchange with Patricia's brother. But he does not mention the problem with the building work nor Patricia's termination although he does tell me about her Deprovera injections which he is not so keen on.At the third interview Ed is also very pleased to have moved to their new home. He is still working with the same firm although he did have another period off which upset him.

He also still feels insecure about the unofficial nature of his job and very much wants to get this security. Both he and Patricia talk openly about the problems they have had in their relationship in the past and how things between them now are much better than they were. They talk about how they are more of a family now and more concerned with 'family-type' things such as getting their house decorated and furnished rather than seeing their friends down the pub.

Conclusions

There are three socially-based hypotheses which have been propounded to explain why women report more illness than men: (i) that it is culturally more acceptable for women to report illness; (ii) that the sick role is more compatible with women's other role responsibilities; and (iii) that women have more illness because their assigned roles are more stressful (the nurturant role hypothesis).

It is difficult to conclusively support one hypothesis over another and, in any case, they are not necessarily mutually exclusive. Overall, the data lend support to the nurturant role hypothesis, but biological differences cannot be ruled out as a contributory factor. It may also be the case that women have greater sensitivity to and acknowledgment of day-to-day fluctuations in their health (Mechanic 1978, Briscoe 1987).

While the data support the nurturant role hypothesis, there are important findings from this study which means that it should be modified. In addition to the idea of role strain, the hypothesis needs to take account of the notion of role conflict ie. the conflict between ideology and situation in order to explain women's experience of poorer health. Further, the hypothesis needs to take account of the structural context within which women and men carry out their roles: both mothers and fathers in worse socio-economic conditions reported worse health; but poor living conditions and lack of support with childcare had a greater negative impact on the mothers' health.

CHAPTER NINE
CONCLUSIONS

> The division of labour in the home clearly interacts with that outside it to produce health outcomes. The health effect of the domestic division of labour, reflecting gender inequality, varies according to other structural inequalities which determine the resources available to parents, their ability to take on other social roles and the socio-economic circumstances in which they live (Popay and Jones 1989:33).

1. Introduction

This chapter discusses the contribution of the current study to our knowledge of gender differences in health, and women's and men's experiences as parents. As discussed in Chapter One, there is a large body of literature on gender differences in health and illness which attempts to explain why 'women get sick and men die'. Very few of these studies consider these differences in the light of women's and men's roles as parents. This study makes a contribution to the sociology of gender and health/illness by focusing on how men and women *as parents* experience health and illness. In addition, this study contributes to the feminist-influenced studies of motherhood by making visible men's experiences of fatherhood.

The purpose of my study was to explore gender differences in health status, attitudes and behaviour within the context of the family, at the intersection between the so-called private world of domestic work and the public world of paid work. It makes a contribution to the understanding of how parenting affects health in this particular group of parents, and how this interacts with other social role responsibilities such as marital responsibilities, and unpaid and paid work. The study also makes a significant contribution to the sociology of health and illness, by looking at the existence and effects of lay concepts of health and illness within gender, as distinct from social class, groups.

There is a large body of literature on social class differences in concepts of health and whether these differences can explain class differences in health and illness behaviour

and therefore health status (eg. Calnan 1987, Blaxter and Paterson 1982, Pill and Stott 1982, Cornwell 1984, Herzlich 1973, Williams 1983, D'Houtard and Field 1984). However, there is no literature on gender differences in concepts of health which, given the differences in mortality and morbidity, is a strange omission. In the present study I looked to see how far working class parents' concepts of health and illness coincided with those discussed in the literature. But I also went on to see if the mothers and fathers had different concepts of health, and if this could be linked to their different experiences of health and illness.

The main focus of the present study is gender differences in health and illness and therefore I chose a working class group of parents. However, there were considerable differences among them in terms of access to material and social resources. As most of the literature on gender differences in health pays no attention to issues of material and social conditions, it was important to look at these and explore in what ways they might differentially affect the health of these mothers and fathers. One important, recent, exception is Payne (1991). She brings together the evidence on women's experience of poverty and women's experience of ill-health to try and explain why women suffer higher levels of illness and poor health during their lifetimes than men.

This study also makes a contribution to methodological issues in the sociology of health and illness. Most of the literature on gender differences in health and illness is based on the secondary analysis of large-scale data sets. These analyses set out the differences, but cannot look in detail at the processes behind the differences found. The present study has taken a small sample of fifteen families, consisting of both mothers and fathers. The aim was not to look for statistical differences but to explore in depth the processes behind the statistical differences found in more conventional, large-scale studies. The use of a mix of interviews and health diaries highlighted a range of factors. In particular, the use of health diaries and their collection of prospective data has thrown new light on gender differences in health and illness.

The purpose of this chapter is to summarise the main findings from my study, that is, the gender differences in the mothers' and fathers' attitudes towards and

experiences of health and illness, and to discuss the various explanations for these differences: mothers' and fathers' different social roles; their different ideologies of parenthood; and the effects of different levels of resources for parenting. In addition, I will outline the contributions this study makes to the debate on gender differences in health and illness, and discuss the implications for future research. Finally, I will outline the lessons I have learned from carrying out this research and, taking into account these lessons, how I might have done it differently.

2. Gender differences in parents' health and illness

This study found differences in mothers' and fathers' attitudes towards and experiences of health and illness and these are summarised below.

2.1 Concepts of health and illness

Whereas this group of parents illustrated concepts of health and illness found in other studies of working class groups, there were clear differences in the ways the mothers and fathers talked about health and illness.

The mothers expressed a more 'functional' concept of health ie. 'getting through the day' whereas the fathers had a more ambitious notion of their ideal health. The mothers explained their experiences in terms of health and ill-health in terms of their mothering role; whereas the fathers explained their experiences in terms of their social role as 'breadwinner' and the conditions of their paid employment.

Both of these findings relate to Cornwell's (1984) distinction between what work means to women and men. Even if they are both in paid employment, she found that for women 'work' meant housework and childcare whereas for men it meant their 'job'. Therefore the conditions of what men and women take to be their work are not the same, and the constraints operating on them when they feel unwell are also different. The demands of employment are usually more containable than the demands of childcare and housework so that for the men in Cornwell's study the important question was whether or not they felt they could continue to go to work, and as long as they were able to, they did what they called 'working it off'. The women's

response to feeling unwell was very different - they talked about 'carrying on' and 'doing what they've got to do'. Instead of trying to 'work off' their symptoms as the men did, the women tried to accommodate their symptoms in order to keep going. If they could not succeed in containing their symptoms and were unable to 'carry on' then they readily consulted a doctor in the hope of getting something that would put them back on their feet looking after the children. The mothers in my study also used health services more than the fathers.

The mothers perceived childcare to have more of a negative effect on their health; whereas the fathers perceived it to have more of a positive effect. In Chapter Seven, the different meanings of parenting and parenthood which these parents have were shown to be directly related to positive or negative feelings about health. For the women, motherhood entailed *either* responsibility for childcare 24 hours a day, *or* the responsibility to organise alternative childcare, often combined with guilty feelings about being in paid employment. In contrast, for most of the fathers, fatherhood meant assuming financial responsibility for their families. As most of the fathers were involved less in the day-to-day stressful caring tasks of caring for a child, they could appreciate the more positive aspects of being a parent. However, both mothers and fathers talked about the positive and negative effects of childcare on their health. This reflects the co-existence of the benefits and hazards of parenting which has been found in studies of motherhood (eg. Oakley 1979, Boulton 1983).

2.2 Health problems and health actions

The mothers reported more health problems and more readily took actions for these health problems than the fathers. However, the mothers also reported their overall health more positively than the fathers. This is probably because the mothers expect to experience a certain degree of ill-health and relates to their more limited concept of health as 'getting through the day' and how they 'cope' with their social role.

In addition, the finding that the mothers reported both their overall day and health more positively than the fathers may relate to the positive attributes of motherhood. Motherhood does confer a socially-valued status to women, especially women who

may not achieve conventional success in the public world of paid employment (eg. working class women). In fact, having a child is '*the* way to achieving full womanhood' (New and David 1985:14).

The mismatch between the mothers' positive reports of their health and day overall and their high reporting of health problems, reflects the ambivalent feelings that mothers have about looking after a child. It is on the one hand socially valuable (in some respects) and enjoyable in and of itself, and on the other hand it can also be intensely stressful and frustrating. As Simone De Beauvoir wrote:

> The fact remains that unless the circumstances are positively unfavourable the mother will find her life enriched by her child (1972:526).

2.3 Reporting of child's health

Mothers and fathers report similar number of health problems in their children but mothers report taking more actions for these problems. Fathers are aware of their children's health problems but they, and the mothers themselves, see it as the *mothers'* responsibility to take action for these problems (see also Graham 1984, Mayall 1986, Cunningham-Burley and Maclean 1991). The mothers' reported health is more closely related to the reporting of their child's health ie. they are more likely to report a health problem on a day they report one for their child than fathers are. Given that the fathers in this study take responsibility for taking action for a child's health problem less than the mothers, it is not surprising that mothers report more ill-health. This is the key to the nurturant role hypothesis.

Gender differences in the reporting of child health and well-being reflect those of self-reports and could be because the fathers are less willing to use the extreme terms of 'very good' and 'very poor'. Alternatively, the finding that the mothers reported their child's health more positively than the fathers did, could be because there are stronger moral and cultural pressures on mothers to be seen to have healthy children as it reflects on them more than it does on fathers. This is with the exception of the boys, whom the fathers perceive as much healthier than the mothers do, possibly because the fathers (need to) perceive their children as conforming to the masculine

gender-role stereotype.

2.4 Resources for parenting

Despite this group of parents being working class, there is wide variation in the families' access to material resources. Across the study group there is a link between quality of housing and reported health, and a link between income level and reported health. However, there are gender differentials in these links. The two areas which show particular gender differences in the relationship between material and social circumstances and health are housing conditions and support with childcare. In both these cases, there is a stronger relationship for the mothers between poor housing conditions and perceived lack of support with childcare and reported poor health, than for the fathers.

This stronger link for mothers between quality of housing and reported health reflects the differential importance placed on the private world of the home by mothers and fathers. The mothers' parenting and homemaker roles mean that the home is more important to them than to the fathers, whose primary role as 'breadwinner' means that the public world of work takes precedence. Thus poor housing will have a greater detrimental effect on mothers' than fathers' health.

The gender differences in the relationship between income and health are not so clear. There were no gender differences in the relationship between reported health and income levels. However, there were differences in the way the mothers and fathers talked about how important money was to them. The fathers tended to see the long-term financial security of their family as their concern which once again reflects their primary role as 'breadwinner'.

There is also a degree of concentration of deprivation whereby those families in poor material circumstances also have low levels of social support. By looking at case studies, it was possible to explore some of the processes behind the complex relationship between material and social resources and health. For a mother who lives in relative material comfort, a lack of social support, particularly help with childcare,

can lead to stress and strain and therefore poorer health; whereas a mother in poorer material circumstances who has a lot of social support, particularly help with childcare, may report better health.

2.5 A typology of mothers and fathers

This thesis sets out three typologies - one for mothers, one for fathers and one for couples - which help explore the relationship between parenthood and health. For mothers, the important factor was how far their ideology of motherhood was congruent with their actual situation. Thus it was not the combination of paid employment and childcare *per se* that related to their health experiences, but whether or not their participation in paid employment or not was congruent with their ideology of motherhood, that is, whether or not they felt they should be a full-time mother.

This extends the notion of 'role conflict' to incorporate an analysis of the conflicting or complementary relationship between the ideologies of parenthood and the actual roles parents perform. Where there was a lack of congruence between ideologies and actual situation (the mother was a full-time mother but wanted to have some form of paid employment; or she was in paid employment and wanted to be a full-time mother) mothers reported a higher number of health problems.

For fathers, the main factor in how parenthood affected their health was how involved they were in childcare. The more involved they were the more health problems they reported. This extends the notion of 'role strain' to fathers, which was previously applied only to mothers and shows the impact of caring for a young child in producing more health problems. In addition, the concept of 'role conflict' needs to take into account the congruence of ideologies *within* couples. Mothers with 'modern' ideologies whose partners had 'traditional' ideologies (ie. 'in conflict' relationships) reported higher levels of health problems.

3. Explaining these differences

The data from this study point to various explanations of the differences found in mothers' and fathers' experiences of health and illness: their different social roles;

their different ideologies of parenthood of the mothers; the compatibility of the mothers' and fathers' ideologies; and differential effects of material and social resources.

In Chapter One, three socially-based hypotheses were presented which have been put forward by researchers to explain the higher rates of reported illness among women: (i) women report more illness because it is culturally more acceptable for them to do so; (ii) the sick role is more compatible with women's other role responsibilities; and (iii) women have more illness because their assigned roles are more stressful. The data from the study were used to establish which one of these three hypotheses was the most significant.

Overall the data lend support to the last of these - the nurturant role hypothesis. That is, it is the mothers' and fathers' different social roles which lead them to have different experiences of health and illness. Whether the mothers are in paid employment or not, it is their role as 'mother' which has the greatest impact on their health; whereas for the fathers it is their role as 'breadwinner' which affects their health. The mothers experience their role as more stressful than the fathers, particularly with regard to the lack of opportunity to rest, and therefore report more health problems. In order to try and cope with their role, they also report taking more actions for these health problems than the fathers do for theirs. That the 'mothering' role has a significant negative impact on health is supported by the finding that the fathers more involved in childcare report more health problems than those less involved.

However, the data also show that the nurturant role hypothesis needs to be modified in several important ways. First, the hypothesis needs to incorporate the notion of 'role conflict', whereby the congruence between the mothers' ideologies of parenthood and their actual situation is taken into account, and also the congruence between the mothers' and fathers' ideologies. Secondly, the hypothesis needs to include an analysis of gender differences in concepts of health to help explain their different health experiences. Finally, the hypothesis should be modified to take into

account the structural context within which men and women carry out their roles, since although both the mothers and fathers in worse socio-economic conditions reported worse health, poor quality housing and lack of support with childcare had a greater negative impact on the mothers' health. Thus these mothers' assigned social roles are more stressful, *particularly* if they are also in conflict with their role, they are in an incompatible relationship, and they are living in poor material and social circumstances.

4. CONTRIBUTION OF MY STUDY TO THE DEBATE ON GENDER DIFFERENCES IN HEALTH AND ILLNESS

4.1 Theoretical contribution

The data from this study lend support to the nurturant role hypothesis and have been able to illustrate some of the *processes* by which women's nurturant role results in their higher levels of reported ill-health. For example, the qualitative data on 'tiredness' and 'resting' has shown that the mothers report more illness because they have fewer opportunities to rest and relax.

While the study data support the nurturant role hypothesis, the hypothesis needs to be modified, as described above. By providing data on gender differences in concepts of health, ideologies of parenthood, and the differential impact of material and social resources, this study has furthered our knowledge of why women report more health problems than men. The study has therefore managed to 'integrate the insights from role analysis within a structural framework' (Arber 1991:588).

In addition, the study has contributed to the body of feminist-influenced research on the experience of motherhood (eg. Oakley 1979, Graham and McKee 1980, Boulton 1983) and the research on men's experience of fatherhood (eg. McKee and O'Brien 1982, Beaile and McGuire 1982, Russell 1983) by bringing together the public and private worlds of mothers and fathers. Unlike most other studies, this study conceptualises the experiences of motherhood, fatherhood and other roles in terms of 'health' (see also Popay and Jones 1989).

4.2 Methodological contribution

(i) A qualitative study

Most of the work that has been carried out on gender differences in health has been secondary analysis of large-scale health surveys (such as the Health Interview Survey in the US) or of other surveys which include some questions on health, such as the General Household Survey in the UK.

This work has been useful to some extent in providing a broad picture of gender differences in health. However, as Clarke has argued:

> Despite the plethora of studies on sex and illness, one would have an exceedingly difficult task should one want to describe the differences in the morbidity experiences of men and women...[and].. when explanations as to the supposed differences are offered, the confusion mounts (1983:63).

More recently, Kandrack et al (1991) have criticised the lack of clarity afforded by cross-sectional secondary data analysis:

> Our methods and theories seem incapable of taking us beyond rudimentary statistical findings. We must now ask: should we continue with the present line of inquiry? (1991:588).

In most of the empirical research reviewed in Chapter One, women and men are treated as two distinct categories and, moreover, each is treated as a homogeneous unitary group. To speak of differences between women and men, while ignoring differences of social class and ethnic identity as many of the studies do, is a fundamental flaw. Many of these studies do not seem to be concerned with the lives people lead, but whether there is a statistically significant difference between, for example, morbidity rates in women with one role and women with three roles.

Therefore, in an attempt to 'resolve the impasse characterising the study of gender and health' (Kandrack et al 1991:588) I designed a study which aimed to document the health experiences of mothers and fathers of young children by taking women's and men's '*lived* experiences' (McBride and McBride 1981:41) as the starting point. The study would thereby be able to analyse the processes which could help explain the differences and similarities found between the mothers and fathers.

This in-depth study combining qualitative and quantitative methods collected data from a small group of parents over the course of a year. However, there is often an antipathy between quantitative and qualitative sociologists about the legitimacy of each others' methods. As Bryman (1984) has pointed out, this debate has confused the issue of differences in technique and epistemology:

> While the apparent debate between quantitative and qualitative methodology may have some meaning at the epistemological level eg. in terms of causal adequacy as against adequacy at the level of meaning, in the context of research practice there is no direct link between these precepts and particular techniques, since research typically comprises both elements (p.88).

The debate between qualitative and quantitative methods has also had a 'gender' angle to it. As Graham (1983) has pointed out, quantitative research is seen to represent 'the male style of knowing' in its claim to be impersonal and objective, and in its compatibility with the masculine ethos of the public domain where it is usually used. Qualitative research is seen to represent a female style of knowing: researchers adopt a more personal objective approach, working in the private world through categories which are difficult to quantify. This critique of quantitative methods has led to a sexual division of research whereby qualitative methods are thought to be better suited to the structure of women's lives, while quantitative methods are reserved for the study of (and by) men (Graham 1983). This division argues Graham reinforces the tendency to analyse women's and men's lives separately, and:

> ...the wholesale adoption of qualitative research by and for women may thus reinforce the very divisions that feminists are seeking to destroy (1983:136).

The contribution of this study to the feminist research on women was to go beyond this divide, and include the study of men's lived experiences. As I was studying both women's and men's lives in their public and private worlds, I transcended the qualitative-quantitative divide (if indeed there is such a division) and used both methods. Thus in my study, data from the health diaries were analysed quantitatively because each day of the diary could be used as the unit of analysis, but statistical tests were not carried out. Instead, these results were linked with qualitative data from both the diaries and the interviews which could illuminate the processes behind the quantitative results. This linking of qualitative and quantitative methods and data analysis led me to reach the theoretical position which I have outlined above, and

shed light on the relationship between parenting and health.

(ii) Use of health diaries

In order to gain a fuller picture of the processes involved in gender differences in health and illness, health diaries were used in this study. Mooney (1962) found, using data from the San Jose Health Survey, that estimates of the occurrence of illness based on a one-day recall were four times greater than those based on a calendar-month recall. However, diaries are a relatively rare and under-utilised instrument in health research (Verbrugge 1980, Freer 1980a).

As well as a more 'accurate' reflection of the occurrence of health problems and contact with health services, an important feature of the health diary is that it can place health events within the context in which they occur, such as the health of the rest of the family, other events, time and so on. For example in my study I looked at the relationship between the reporting of the child's health problems and the reporting of the parents' own health problems. Thus I found that a woman was more likely to report a health problem on a day when she had reported her child as having one, whereas there was no such relationship with the men's reporting of health problems. I also found that on a day when men reported a health problem they were more likely to report their day overall less satisfactorily, whereas this was not the case for women.

From the diary data, it was possible to look at the different types of health problems recorded by men and women and the different types of action they took for these problems. From the diaries it was clear that the main health problem reported by mothers is tiredness. Although this had been evident in some of the interviews (as I specifically asked about tiredness), the evidence was much more obvious in the diaries. Tiredness is one of those feelings which is much harder to remember after the event, although it seems that many of these mothers felt tired much of the time!

From the diaries I was able to gain a more detailed picture of the day-to-day lives of these parents. The diaries were able to collect data on structural influences rather than

just recording health problems, and in this way provided a richness of data which more fully reflected the individuals' 'lived experiences'.

5. Directions for further research

This study has furthered our knowledge about gender differences in health and points to some directions for further research. Further research is needed to determine whether the typologies of mothers and fathers are useful in the study of other kinds of households, such as lone parents and middle class parents. In addition, further research is needed to explore gender differences in health behaviours such as smoking, alcohol consumption and dietary habits.

(i) Lone parents

Both lone mothers and lone fathers experience poorer health than parents in couples, and there are differences in health between lone mothers and lone fathers (Popay and Jones 1991). In their analysis of data from the GHS, Popay and Jones (1991) found that on all measures, except long-standing illness, the poor health of lone mothers compared to that of lone fathers stands out. They argue that these findings relate to the poorer socioeconomic circumstances of lone mothers: they are less likely to be in employment and to be homeowners; and more likely to be living on low incomes and in receipt of means-tested benefits. In addition, lone mothers are more likely to be caring for a child under the age of five, and children of lone mothers are likely to be in poorer health because they are younger and also perhaps because they live in greater poverty (1991:85).

A study of the health experiences of lone mothers and lone fathers should also explore the issue of congruence of ideology with actual situation. This issue is likely to be even more pertinent for lone parents because, despite their increasing numbers, they are still a stigmatised form of household (Collins 1991).

(ii) Middle class families

Would the typologies apply to middle class families? The issue of congruence

between ideology of parenthood and actual situation for mothers might be different here as middle class 'career' women may have different attitudes to combining paid employment with childcare (see Brannen and Moss 1991). Backett's (1990) study of health in middle class families found that the women in paid employment were usually in part-time jobs taken on to fit in with looking after their families, thus there may not be so much conflict between ideology and reality.

The typology of fathers based on their involvement in childcare is as relevant to middle class fathers as working class ones: there is no evidence that middle class fathers are more likely to be involved in childcare (see eg. Boulton 1983, Russell 1983). The typology of fathers could therefore be used to explore the health experiences of middle class fathers.

(iii) Gender differences in health behaviours

This thesis has presented data on gender differences in health beliefs, illness reporting, and health actions. However, while data were collected on the parents' health behaviours concerning smoking, alcohol consumption and diet, this was not a central theme of the thesis. Graham (1990) has highlighted the importance of putting women's health behaviour in the context of their socio-economic position and gender roles. A study which explored the health behaviours of women and men (within the same households) in the context of their structural position and gender roles would further our knowledge of gender inequalities in health and our knowledge of health behaviours.

6. Lessons learned

There are several lessons I have learned from carrying out the study and I outline below how I might have done it differently. In selecting the study group, I attempted to sample for *similarities* between the parents so that I could focus on gender differences (see also Backett 1990). Popay and Jones (1989) in their study of parenthood and health selected their case studies for *diversity* between the families in terms of income, number and ages of children, employment status, and lone or two-

parent families. There are advantages and disadvantages with both methods. As Backett (1990) explains in her study of health within families which used two-parent, middle class parents with two children:

> ...by putting such careful controls on the small sample a degree of consistency in explanatory theories could be achieved (1990:68).

However, it is difficult to construct a hierarchy of the different explanations of the differences in health experiences between mothers and fathers in terms of their importance. Therefore, I think it would be illuminating to take the case study approach further and have a more diverse study group in terms of types of families. This would mean theoretically sampling on the basis of my explanations for gender differences eg. 'incompatible' and 'compatible' couples; mothers with compatible and conflicting ideologies; middle and working class families; lone and two-parent families; 'traditional' families where the mother has prime responsibility for childcare and role reversal families.

This would allow a more detailed exploration of the explanations for the differences in health experiences between mothers and fathers which I have identified, and to enable an analysis of their relative importance.

Secondly, it would have been useful to supplement my qualitative study with a number of more detailed statistical analyses. For example, a larger scale questionnaire survey of parents would have yielded more background data. Unfortunately, resources available to a graduate research student in terms of time and money did not allow for this.

Thirdly, I decided not to use a standardised measure of health such as the Nottingham Health Profile or MOS-Short Form because I needed to listen and record parents talking about health and illness in their own words (see Chapter Two). However for several reasons, I think it would be useful to supplement data obtained via the interviews and health diaries with a standardise measure. I used data from the interviews and health diaries in order to obtain different versions of parents'

experiences of health and illness rather than compare them to reach some ultimate 'truth'. Similarly, it would be interesting to use one of the standardised measures of health which are usually used only in large-scale surveys (eg. the national health and lifestyle survey, Blaxter 1990) in order to set my findings in context, *and* use qualitative data to shed light on findings from a standardised measure. In addition, using a standardised measure which has been used with other groups would allow me to compare my study group with others.

Conclusions

With the benefit of hindsight, these 'lessons' have been learned. They do not detract from the findings of this study, which make an important contribution to the sociology of gender and health. By documenting the 'lived experiences' of thirty mothers and fathers, this study has shed new light on why women report more ill-health than men. It is a feminist piece of research which is not just *of* women but *for* women because, by making visible men's experiences of fatherhood, it highlights women's main responsibility as carers and its negative effects on their health.

This study did not use any of the standardised measures described above, because I aimed to listen to the parents' own experiences, and to give voice to them. This is theoretically important, because the emphasis on 'lived experiences' has highlighted the importance of ideologies in relation to reported health, which could not have been shown by standardised measures.

In documenting the 'lived experiences' of parents of young children, I have also developed my own 'lived experience' as a social researcher by applying feminist methods to a question which has previously been monopolised by the socio-medical perspective. This thesis is therefore as much about methodological issues, as it is about substantive findings, and has proved to be a challenging research experience.

APPENDIX A

MARITAL STATUS, GENDER ROLES AND HEALTH

The relationship between mortality rates and marital status is well known. In all developed countries, the unmarried have significantly higher death rates than the married, and this differential is much greater for men than for women (Nathanson 1975, 1977, Verbrugge 1979a). Non-married mortality rates are especially larger for causes related to 'life style' behaviours such as smoking, alcohol consumption and automobile driving. Divorced people have especially high rates, followed by the widowed, and then single people (Verbrugge 1979b).

There are three main reasons put forward for these data. First, the belief that married people are happier and less stressed than the non-married. This prevents them from engaging in behaviours which have high risks of illness and injury. Secondly, it is believed that people in poor health have difficulty marrying (and remarrying), so the married group is 'selected' for good health. Kisker and Goldman (1987), in their international comparison of mortality differentials by marital status, found that much of the excess mortality of the never-married group in France, Japan, and England and Wales is due to an important selectivity effect ie. health conditions appear to deter some persons from entering marriage. Finally, married people are thought to have more social support for their health problems. This improves their chance of recovery from illness or injury since there are people at home to provide care (Verbrugge 1979a). This last point is more applicable to men than women, as it is well known that women are expected to care and do care for their sick (and able-bodied) spouses (Cochrane and Stopes-Roe 1981, Land 1978, Finch and Groves 1980, Oliver 1983). This is confirmed by the findings of Kisker and Goldman (1987) which indicate that marriage selection is more important in explaining differentials for females than for males, ie. 'unhealthy' women find it harder to get married than 'unhealthy' men, presumably because 'unhealthy' men can find women to look after them while 'unhealthy' women experience difficulty in finding men to do the same.

While sex mortality differentials by marital status are reasonably well established, this is much less true of differences in reported illness and in the use of health services (Nathanson 1977). The married of both sexes have lower morbidity rates than the unmarried in most studies of morbidity based on data collected in the GHS and Health Interview Survey (HIS) (Nathanson 1977). Morgan (1980) cites a study in the 1950's in England and Wales which drew attention to the over-representation of non-married people among hospital patients (Abel Smith and Titmuss 1956).

It has been suggested that regarding health status the married state is less advantageous to women than to men (Gove 1972, 1978, Gove and Tudor 1973, Cochrane and Stopes-Roe 1981). This concurs with Bernard's (1972) view that each marriage actually consists of two - his and hers. While marriage in its traditional form is generally beneficial to men, it is detrimental, emotionally and mentally, to women. Interestingly, Rosenfield (1980) found that whereas in traditional marriages (husband employed, wife at home) women reported higher levels of depression than men, the position was reversed in non-traditional marriages (both spouses employed). The finding was not supported, however, in the further study (Roberts and O'Keefe 1981). Nathanson (1977) in her study using HIS data from the US and GHS data from the UK could find no consistent evidence that the protection afforded by marriage against morbidity was differential for men and women. However, the author herself notes that these generalisations concerning patterns of morbidity and medical care use are based on scattered evidence and 'should be regarded with appropriate caution' (1977:20).

It has also been hypothesised that the lower morbidity rates for the married compared to the unmarried is a function of differences in illness behaviour. Married people have more time constraints due to work and family activities, and are therefore less able to take on the sick role (Rivkin 1972, Verbrugge 1979b).

Most of the work on marital status has focused on its effect on mental health and psychological well-being rather than physical health. We have already seen how women are more vulnerable to depression than men, but Gove (1972) has shown that

this holds only for the married population. It has been argued that marriage does not necessarily provide a protection from psychological disturbance but may offer some people an alternative method of coping with problems, which is often unavailable to the unmarried (Cochrane and Stopes-Roe 1981). It is important to remember, however, that for many women marriage is actually harmful; a significant proportion of all wives are systematically beaten by their husbands (Dobash and Dobash 1980, Pizzey 1974, Hanmer and Saunders 1983).

Gove, Hughes and Style (1983) found that marital status was the most powerful predictor of mental health; measured in terms of happiness, life satisfaction (home and overall), and a mental health balance scale; the best off were the married followed by the never married and then by the formerly married. For home-life satisfaction and happiness, the relationship between marital status and mental health is much stronger for men than for women. However, for overall life satisfaction and the mental health balance scale, the relationship is only slightly stronger for men than for women. Since they found relatively little difference in the mental health of never-married males and females, this would suggest that it is the marriage itself which is determining the mental health of married men and women, rather than that women who get married are in poorer mental health than men who get married. Perhaps an obvious, but important finding of this study is that it is the quality of the marriage and not the marriage *per se* that links marriage to positive mental health (see also Brown and Harris 1978). This point has been ignored by other studies on marital status and health (eg. Verbrugge 1979b). In turn the quality of a marriage is affected by other social factors such as the presence or absence of children, employment, income and so on. Hence there is great variation in the mental and physical health of married women and men.

APPENDIX B

EMPLOYMENT AND WOMEN'S HEALTH

The influx of women into the labour market initially generated concern that paid employment might increase health risks for working women as compared to housewives. This was because it was hypothesised that men's higher rates of employment and exposure to occupational hazards might explain some proportion of their higher mortality rates and shorter life expectancy. If so, then women's increasing participation in paid employment might be accompanied by declines in these health parameters. This has not found support in empirical research (LaCroix and Haynes 1987). It should be noted however that it is difficult to distinguish empirically between employed and non-employed women as there is considerable movement between the two groups, particularly over the course of the life-cycle. This is evident in my own study (see Chapter Three) and a study in West Germany by Kleese and Sonntag (1987).

Employment has been found to have a positive effect on the health status of married women, especially as a protection against depression (Brown and Harris 1978, Cochrane and Stopes-Roe 1981, Nathanson 1980, Rivkin 1972, Waldron 1980, Kandel et al 1985, Verbrugge 1983a, Hibbard and Pope 1985). This has been attributed to the self-esteem and feelings of accomplishment that come from engaging in a socially-valued activity, and to the social contacts that work provide (Ginsberg 1976, Nathanson 1980). In contrast, housework has been found to be a devalued and socially isolating occupation (Bernard 1972, Oakley 1974). This perspective has led to the prediction that employed women will be physically and mentally healthier than housewives (Bernard 1972, Gove and Geerken 1977).

This has been supported by health survey data which have found that employed women report better general health, fewer symptoms and chronic conditions, have fewer days of bed rest and restricted activity than women not in the labour force (Marcus and Seeman 1981, Rivkin 1972, Nathanson 1980, Waldron 1980). Employed

women have also been found to have substantially lower death rates than housewives (Passannante and Nathanson 1985). Similarly, studies of women's mental health show that employed married women report fewer symptoms of mental illness than do housewives and report greater life satisfaction, greater self acceptance, and less depression (Gove and Geerken 1977, Gove and Tudor 1973, Rosenfield 1980). Roberts and O'Keefe (1981), however, found no differences in depression between employed women and housewives. It is possible, of course, that rather than employment 'causing' variations in health status behaviour, it is health status that causes variations in labour force participation ie. women in poorer health are 'selected out' of the labour market. Waldron et al (1982b) found that poor health has a substantial effect on women's labour force participation and that this is a major reason why women not in the labour force have poorer health than those in the labour force.

An alternative hypothesis is that women are protected from stress by their confinement within the family, and that women's entry into the labour force may increase their exposure to sources of stress that have historically afflicted males, with negative consequences for the health of employed women (Waldron and Johnson 1976 quoted in Nathanson 1980). They assume of course that stress is bad for one's health which is not necessarily the case. Haynes and Feinleib (1980), for example, found that employed women experience more daily stress and marital dissatisfaction than housewives. Three other studies have questioned the protective effects of employment. Waldron et al (1982) in an analysis of longitudinal data for middle-aged married women showed no evidence that on average, labour force participation had either harmful or beneficial effects on general health (quoted in Waldron et al 1982b); and Aneschensel et al (1981) found no difference in depression levels between employed women and housewives. In a study of gender inequalities in health in Norway, Denmark, Finland and Sweden, Haavio-Mannila (1986) found that while combining family and work for women was not associated with higher rates of physical morbidity or mental hospitalisation, employed wives had higher anxiety than those of men and non-employed wives.

These two perspectives have focused on the relationship between employment and

illness, rather than illness behaviour. A third perspective focuses on the consequences of women's employment for their illness behaviour. From her earlier hypothesis that women's responses to symptoms of ill health would vary with the number and character of other role obligations (Nathanson 1975), Nathanson (1980) predicts first, that employed women will be relatively less likely to take any action in response to perceived symptoms than housewives. Secondly, that women with heavier role obligations will respond to perceived symptoms by visiting a physician, while women with fewer responsibilities will more likely take self-treatment at home. These predictions were supported by her analysis of Health Interview Survey data from the US, and confirm the findings of Rivkin (1972).

When the 'housewife syndrome' first began to be viewed as a major public health problem (Bernard 1972:63), it was assumed that employment was uniformly beneficial to women (eg. Cochrane and Stopes-Roe 1981, Verbrugge 1983a). However, most investigators now recognise that the relationship between employment and women's health is dependent on first, the type of job - how much stress it entails (or other health hazards such as carcinogens, infectious agents etc.), and how much social support and integration it provides (Haynes and Feinleib 1980, Waldron 1980, Hibbard and Pope 1985); and secondly, the woman's family situation (Nathanson 1980, Waldron 1980, Aneschensel et al 1981).

Women's occupational health has rarely been the subject of study partly because of the tendency not to collect data on women's occupations and to rely instead on those of their husbands or fathers; and partly because 'too often job-related stress has been considered the exclusive problem of the male worker' (McBride and McBride 1981). Thus we know little about the health effects of different types of employment for women (Froberg et al 1986). However, as part of the Framingham Heart Study, Haynes and Feinleib (1980) found that coronary heart disease (CHD) rates for female clerical workers (married with children) was almost twice as high as rates for non-clerical workers or housewives. LaCroix and Haynes (1987) extended the findings from this study to compare the effects of occupational conditions among men and women. They found that self-reported 'high-strain' employment could predict future

CHD events for women but not for men. In another heart disease study, Sorensen et al (1985) examined the relationship between certain job experiences and job heart disease risk factors for both men and women. They found that these particular job experiences (work hours, deadlines and occupational mobility) do not have numerous or powerful effects on heart disease risk factors for either men or women, and therefore they question the supposition that women's occupational advancement and increased exposure to job pressures will increase their risk of CHD. A study of employed men and women in the US (Muller 1986b) found that unrewarding and unattractive occupations entered by those with limited choices have a negative association with health, and women are concentrated in these less desirable jobs. This interpretation corresponds with findings by Waldron and Herold (1986) of better health for those whose desire to work was fulfilled, compared to housewives who would have preferred to work, and Verbrugge's (1982) finding that dissatisfaction with one's work status is adverse to health.

Another important factor concerning women's health and employment is the social support and integration gained through employment. Hibbard and Pope (1985) found that when they compared housewives and women employed in jobs with little social support and integration, health status differences fell below statistical significance.

The effect of employment on a woman's health status depends, very much on her domestic situation. Nathanson (1980) found that the relative importance of employment as a predictor of perceived health status is substantially greater among separated or divorced women than among women in other marital status categories. She also found a significant interaction between children and employment; employment is more important to the perceived health status of women without children (see also Parry 1986). Nathanson explains this finding by suggesting that children can be regarded as alternative sources of self-esteem and social ties to employment. However, this finding might also be explained by arguing that the presence of children is detrimental to women's health, especially if the mothers are also employed outside the home. Haynes and Feinleib (1980), for example, found that coronary heart disease rates were high among employed women who were or had been married - especially those

who had three or more children, and Kandel et al (1985) found that parenthood exacerbates occupational stress. Parry (1986) found that although employment had no overall effect on the mental health of a sample of working class mothers, for mothers at higher risk of psychiatric illness because of life event stress, there is more evidence of paid employment effects, consistent with findings from Brown and Harris (1978). Parry (1986) hypothesises that having paid employment outside the home increases the threshold of the level of life event stress that can be tolerated before psychiatric problems result.

The relationship between employment and health, therefore, is not as simple as it might at first appear. Women (and men) may be 'selected out' of the labour force by ill health; and for those in the labour force, employment may have positive and/or negative effects. It may provide opportunities for social support, self-esteem, and social identity - a possible health enhancing situation. At the same time, intrinsic job characteristics and the work environment may be sources of stress - a possible health risk. Finally, employment will have different effects on a woman's health depending on her social class and family situation.

APPENDIX C

THE PILOT STUDY

Aims of the Pilot Study

The pilot study was designed to explore the following:

(a) negotiating access to parents;

(b) the interview schedule, and my interview technique;

(c) the 14 and 7 day health diaries

(d) interviewing parents together and separately.

The pilot study took place between June and August 1986. A sample of ten couples was drawn from clinic A as described in Chapter Three. The health visitors sought permission from the mothers over the telephone to give me their names and addresses. A letter (see Appendix H) was written to each couple, addressed to both parents, explaining more about the project and giving them an opportunity to withdraw. One couple withdrew within the deadline and one father refused to be interviewed although I had interviewed his partner. After the deadline for withdrawing had ended, the parents were contacted either on the telephone or by calling round.

The first interviews

These were carried out using a pilot interview schedule which developed into the schedule shown at Appendix D. Nine interviews were conducted altogether; four couples were interviewed separately plus the woman whose partner had refused to be interviewed; and four couples were interviewed together.

After each interview, the parent(s) were asked if they would fill in a health diary. This meant that if the couple had been interviewed on different days, their diaries were not filled out for the same week(s). A 14 day and a 7 day health diary were used at this stage for comparison; six parents were given 14 day diaries; nine parents were given 7 day diaries; and three parents refused to take one (see Appendix G for a copy of the final health diary used). The health diaries were collected either by

asking the parents to send them back (they were given a stamped addressed envelope), or I arranged to collect them. Four of the six 14 day health diaries were returned, although two of these had not been filled in completely; and six of the nine 7 day diaries were returned.

The second interviews

These interviews were carried out with five of the parents from the first round, four weeks after the first interview. I had aimed to interview six parents but one father, although willing to be interviewed again, never had any time to see me.

After each interview, the parents were asked to fill in the modified 7 day health diary (see Appendix G). This time, couples were asked to fill in their diaries for the same week so that if they had been interviewed on different days, they were given the diaries at the end of the interview with the second parent. The diaries were then either returned by post or collected. The five parents, plus the father I was unable to interview, filled in and returned their diaries.

Issues raised by the pilot study

a. Negotiating access to parents

The initial contact was almost always made with the woman. When a couple were going to be interviewed together the arrangement was usually made with the woman; and where a couple were going to be interviewed separately an interview was arranged with the woman and then at the end of that I asked if it would be possible to interview her partner. I realised that it was problematic to rely on the woman to negotiate and arrange the interview with her partner, not least because he would then see the study as something that chiefly concerned her.

From the experiences of the pilot study, I decided that in the main study I had to present the study to both parents very clearly as concerning both of them, and arrange with each of them directly when I would interview them.

b. Interview Schedule and Interview Technique

The first pilot interview schedule was too long. The length of interviews ranged from one hour and ten minutes with a mother on her own; to 2½ hours with a couple together, and even 2 and a quarter hours with a father on his own. Several of the parents commented on the length of the interview, and so the schedule was modified to reduce it in length. Some of the background data questions were transferred to the second and third interviews for the main study (see Appendix D).

Another problem with the first interview schedule was the question order. Having all the 'factual' questions at the beginning meant that it took a long time before I got to the questions about health which were supposed to be the main subject of the interview. The questions were therefore re-ordered for the main study, putting some of the background questions towards the end of the interview so that the questions on health were nearer the beginning.

Many of the questions were too 'closed' and did not allow or encourage the respondent to tell his or her 'story'. I realised that mostly due to my inexperience of interviewing, I had stuck too rigidly to the schedule which had been designed to be used as a guideline rather than as a formal questionnaire. I needed to be much more flexible in the way I asked the questions and how I followed them up with other questions.

Some of the questions were unnecessary and intrusive and were usually revealed spontaneously at another point in the interview - particularly those on marital status - and so they were taken out of the interview schedule for the main study. Other questions provoked a defensive response, especially those on feelings about parenthood - it was difficult to strike a balance between allowing the respondent to express feelings which engender societal disapproval (eg. negative feeling about parenthood), and yet not make the respondent feel defensive. The phrasing of these questions was altered for the main study, and I was careful to let the respondent see that I did not want to make value-judgements about what they said and make it easier for them to say things that they felt would be criticised in the outside world.

c. Health Diary

The use of the health diaries was successful in terms of the willingness of the parents to fill them in and the quality of the data which they provided. The 7-day health diary proved to be more successful than the 14-day one because the parents' enthusiasm appeared to wane after about 6 or 7 days and so the data for the second week was not so detailed as for the first week. Therefore for the second round of pilot interviews a 7-day diary was used.

For the second pilot interviews the form and layout of the diary was modified (see Appendix G). Many diaries use closed questions, because although I had originally wanted to use open questions for the richness of data they can provide, I decided to use a combination of open and closed questions so that people who might be put off by having to write down answers in full could just tick a box for some of the questions and it might encourage them to keep filling in the diary. I also wanted to be able to compare a respondent's answers to the open and closed questions.

The layout of the diary was changed by separating the questions on the respondent's own health from that of their child's to facilitate easier completion by the respondent. Some new questions were added. To further encourage parents to complete the diaries, they were made to look more attractive by giving them bright covers and making them into booklets.

From the pilot study it was clear that a better response was obtained to the diaries if they were personally collected rather than asking the parents to return them by post. Although this was much more time consuming, I decided to use this method of collection in the main study. It also meant that I was having more contact with the parents and this might help to keep them in the study.

d. Interviewing Couples Together and Separately

From the first round of pilot interviews it appeared that I got different data when I interviewed couples together compared with when I interviewed them separately, although at this stage I had not interviewed the *same* couple together and separately.

Couples were more inclined to agree with each other when I interviewed them together, perhaps wanting to present a 'united front'. Whereas when I interviewed them separately, it was much harder for them to do this, especially if I interviewed them one after the other. Parents were much more likely to say critical things about their partner if interviewed on their own compared to when they were together.

These ideas were explored further in the second pilot interviews when three parents whom I had previously interviewed with their partners were interviewed alone.

However, interviewing couples separately is not unproblematic. First, the couple may not live in a situation where it is possible to interview them separately without having to ask the one of them to leave their home. Secondly, I found that even in situations where it was practical to interview parents fairly comfortably, the partner not being interviewed often found an excuse to wander in and out of the room, sometimes staying to listen to great lengths of the interview. For the main study, I decided that I would have to explain more carefully the reason for interviewing the couples separately and be more flexible about expecting it to be possible every time. (See Chapter Three for further discussion of this issue.)

APPENDIX D

INTERVIEW SCHEDULE I

NAME OF RESPONDENT :

DATE OF INTERVIEW :

TIME OF INTERVIEW :

WHO WAS PRESENT :

INTRODUCTION

Thank you for agreeing to participate in my study. As you may remember, I am interested in parents' experience of health and illness. Some of the questions I ask you may not seem to be directly about health and illness, but I need to collect information on a wide variety of things that may affect your health or the way you think about it. There are no right or wrong answers to the questions. I am interested in how you feel and experience health and illness. You can answer the questions in as much detail as you wish. I would like to remind you that all the information you give me is treated with the strictest confidence. If at any time you wish to ask me anything about the study or about the questions I am asking you, please do not hesitate to do so.

1. BACKGROUND DATA

First of all I would like to ask you some basic background questions which I need before I ask you about your health.

1. a. You are _____(name of respondent), is that right?
It's just that sometimes the health centre have people down under a different name...

b. Could you tell me your date of birth and the date of birth of your child?

c. What's his/her name?

d. Is _____(child's name) your only child?

2. ETHNICITY

Could you tell me your nationality and where your parents came from originally?

2. PAID EMPLOYMENT

a. Are you doing any form of paid work at the moment?
(If no go to 3.1 P.T.O.)

IF IN PAID EMPLOYMENT

b. What is your current main occupation?

c. Could you tell me what this involves (supervision of other employees, hard physical labour etc.)

d. What kind of firm or institution do you work for - what kind of product or services does it produce?

e. How long have you been in this job?

f. What was your previous job?

g. How many hours did you work last week (incl. overtime)?

h. Has the number of hours you work changed since _____(child's name was born? (If no go to 5.j)

i. Why is that?
How do you feel about that?

j. Are you planning to change jobs in the near future?

k. What do you like about your job (if anything)?

Is there anything that you don't like about your job?

IF NOT IN PAID EMPLOYMENT

l. What was your last job?

m. How long ago was that?

n. Did you choose to leave your job or did you become unemployed?

0. (If left voluntarily) Are you planning to return to work when _____(child's name) is older?

Why is that and when?

p. (If became unemployed) If you could get a job would you take it or would you prefer to care for your child full-time?

q. (If not looking for a job) Would you look for a job if you could get someone to look after _____(child's name)?

r. (If looking for a job) What sort of job are you looking for? (ie. whether p/t or f/t as well as type of work)

4. HOUSING

Now I'd like to ask you some questions about your home...

a. How long have you lived here?

b. Is this flat/house rented?

c. (if yes) From the council?

d. (if not rented) Are you buying it?

e. Could you describe your home for me in terms of number of rooms etc.?

f. Does anyone else live here apart from you, your partners and _____(child's name)?

g. (If yes) On what basis?

h. Are you happy living here? Are there things you'd like improved? eg?

i. Do you like living in this area?

j. Is there any particular reason why you live in this area? eg. near work, family etc. (get details of whose work and whose family)

k. Could you tell me if you have any of the following in your home:

telephone
washing machine
tumble drier/spin drier
vacuum cleaner
(deep freezer)
(dish washer)

l. What form of heating do you use?

5. HEALTH STATUS

Now some questions about your health...

a. In the past year, would you say that overall your health has been good, fairly good or not good?

b. Could you tell me what you think the reason for this is?

c. What about _____(child's name)? Would you say her/his health in the past year has been good, fairly good or not good?

d. What about your partner? Would you say that her/his health has been good, fairly good or not good?

e. Do you have a long-standing illness, disability or infirmity? By long-standing, I mean anything that has troubled you over a period of time.

(If no go to question 5.g)

f. (If yes) Does this illness or disability limit your activities in any way?

g. (repeat questions e. and f. re: child and partner)

h. In the past 2 weeks, have you had to spend all or part of the day in bed due to illness or tiredness?

i. What about the 2 weeks previous to that?

j. (repeat questions h. and i. re: child and partner)

k. When was _____(child/s name) last ill?
What happened then?
(check list: whose decision was it to give medicine/go to doctor's, who actually gave medicine, took child to clinic etc.)

6. USE OF HEALTH SERVICES (FORMAL)

I would like to ask you some questions about your use and experience of the medical services.

a. In the past month, have you visited the doctor or nurse on behalf of yourself? (If yes) Why? Was that your local G.P.?

b. And what about in the last year? (get details of no. of times and why)

c. What about on behalf of _____(child's name)?
Last month? (get details of no. of times and why)

Last year? (get details of no of times and why)

(If yes) Can you remember if on any of those occasions you asked the doctor anything about yourself? (get details)

d. Have you had any reason to go to hospital either as an outpatient (on a daily basis) or as an inpatient (staying overnight) in the

last month?

last year?

If YES Find out if under NHS or private)

e. (Ask question d. re: child and partner)

f. Has a doctor, health visitor or other member of the medical services visited you or your partner or _____(child's name) at home in the

last month?

last year?

g. Have you had any other contact with the medical services such as dentist, chiropodist etc. in the last month?

If YES Where was that? (find out **exactly** which dentist)

Did you have to pay for that?

h. Do you have any trouble with your teeth?

h. What about your partner or child?

i. Are you regularly prescribed any form of drugs/medicines?
(If no go to question k.)

j. (If yes) Could you tell me what for?
How long have you been prescribed that?

k. What about your partner or _____(child's name)?

l. Have you, your partner or _____(child's name) made use of any non-National Health (ie. private) services in the last month?
Last year?
eg. osteopath, homoeopathist etc

7. USE OF HEALTH SERVICES (INFORMAL)

a. Do you take any non-prescribed, bought-over-the-counter medicines such as aspirin, cough mixture, laxatives, vitamins etc.?

b. Have you used anything like this in the past 2 weeks? (try and get exact amounts)

c. (repeat question a. and b. re:child and partner) P.T.O.

d. (If used for child) Who gave her/him the medication?
Whose decision was it to give it?

e. Do you ever consult/talk to/get advice from anyone about your own or your child's health?

f. Who? What about? Can you remember the last time you got advice from someone about your own or your child's health? Did you follow this advice?

g. (If last time wasn't in last 2 weeks) Can you remember if you've

talked to anyone like this in the last 2 weeks?
Last month?
(get details of with whom, about what, if advice followed etc.)

8. HEALTH CARE PRACTICES

a. Would you say you did anything to positively keep healthy?

b. (If no) Would you like to be able to do something like this?
(get details of what and why they can't do it now)

c. Do you smoke at all?

(If no go to 8.f)

IF SMOKES

c. How many cigarettes do you smoke per day?

d. Do you ever find that a cigarette does you instead of a meal?

e. Have your smoking habits changed since _____(child's name) was born?

f. Does your partner smoke?

g. Do you drink any alcohol?

(If no go to J.)

h. (If yes) What do you drink mainly: beer/lager; wine; or spirits?

i. How often do you have a drink?
(define a drink as one measure of spirits, one glass of wine or ½ of beer/lager)

j. Could you tell me what you ate yesterday, starting with breakfast and

working through to supper and including any snacks between meals? Was that typical?

k. What did _____(child's name) eat yesterday? Was that typical?

l. Was _____(child's name) breast or bottle fed? Why?

m. Who decides what meals you have?

n. Do you eat what you'd like to eat or does a shortage of money limit you at all?

o. Do you take part in any form of exercise or sporting activity either inside or outside the home, however informal?

p. (if yes) Why? (eg. enjoyment, health reasons, trying to lose weight)

q. (if no) Would you like to be able to? (if yes) Why don't you?

9. TIREDNESS/SLEEP

a. Have you felt tired after yesterday or today?

b. Is that usual?

c. (If did feel tired) Why do you think you felt/feel tired?

d. How many hours sleep did you get last night?

Is that typical?

e. Do you feel this is enough?

f. Did _____(child's name) disturb your sleep last night?

g. Do you have any difficulty in getting to sleep?

h. Do you ever wake up in the night for no apparent reason?

i. Do you ever wake up early and not able to get back to sleep?

j. Does _____(child's name) sleep with you?

k. (if yes) Why is that? (shortage of space, comfort etc)

l. How do you feel about that?

m. Do you ever feel you have no energy? When? Why?

10. WORRIES/ANXIETY/DEPRESSION

a. Would you say you had any major worries at the moment?

b. (if yes) What sort of things are you worrying about?

c. Do you suffer with your nerves at all?

d. Would you say you were depressed at the moment? (If no P.T.O.)

IF YES OR APPEARS DEPRESSED

e. Do you worry about things a lot?

f. Are you having headaches at the moment?

g. Do you have difficulty relaxing at the moment?

h. Do you feel fidgety and restless, so that you can't sit still?

i. Do you find that a lot of noise upsets you?

j. Are there times when you feel very anxious or frightened?

k. Do you try to avoid seeing people?

l. What has your appetite been like recently?

m. Do you feel lethargic at the moment - as though you haven't got any energy?

n. Have you been more irritable than usual recently?

TO ALL

o. Do you ever get angry?

IF YES

p What about? With whom?

q. Do you feel able to express this anger adequately?

11. PERCEPTIONS OF HEALTH

a. Do you ever feel really healthy?

b. (if yes) What does it feel like? And when is it?

c. In an ideal world, how would you like to feel health-wise?

d. Do you think caring for a child affects your health?

e. In what ways? (positive as well as negative)

12. SOCIAL CONTACTS

I am interested in all kinds of things that may affect health, including those that may make life easier for you. One of these is having other people around to help/talk to when you need them. I'd like to start off by asking you about your family...

A. Your parents

Are your parents both alive and if so do you see them at all?

IF EITHER ALIVE

How often do you see them? Your mother? Your father?

Do you get on well with them? Your mother? Your father?

When you see your parents are they able to help you out in any way? eg. by looking after _____(child's name), shopping, housework, decorating etc.

B. YOUR PARTNER'S PARENTS

Are your partner's parents both alive and if so do you see them at all?

IF EITHER ALIVE

How often do you see them? Her/his mother? Her/his father?

Do you get on with your partner's mother?
Your partner's father?

When you see them are they able to help out in any way eg. babysitting, housework, decorating etc.?

C. BROTHERS AND SISTERS

Do you have any brothers or sisters?
How many brothers?
How many sisters?

Does your partner have any sisters or brothers?
How many sisters?
How many brothers?

How often do you see them?

How well do you get on with them?

When you see them are they able to help out in any way eg. babysitting, shopping, cooking, decorating, housework etc.

D. YOUR PARTNER/HUSBAND/WIFE

Do you and your partner tend to share the same kinds of leisure interests or not?

What about friends Do you tend to have friends in common, or do you each have your own friends, or is it a mixture of these two?

Have you and your partner had an evening out by yourselves without_____ (child's name) in the last 2 weeks? Do you often get to do this?

(if no) Can you remember the last time this happened?

Have you had an evening out without either your partner or _____(child's name) in the last 2 weeks?

(If no) Can you remember the last time you did this?

E. YOUR FRIENDS

Moving away from your family now, I'd like to ask you a bit about your friends.

Even though you may not get to see them very often, do you have one or two good friends who you get on with particularly well?

How often do you see them?

When you do get to see them, are they able to give you any help with the house or with looking after _____(child's name)?
What kinds of things do they do for you?

What about your neighbours: how do you get on with them?

Do you feel you have enough close friends or would you like more?

Do you ever feel lonely or alone?

IF NOT IN FULL-TIME EMPLOYMENT

Do you have friends whom you can get to see during the day?

(if yes) How often would you have someone drop in on you or you call in and see someone?

Are these friends able to help you out with anything like housework, looking after _____(child's name), shopping, cooking, decorating etc?

IF WORKING OUTSIDE THE HOME

What about the people at work: how do you get on with them?

TO ALL

Among your family and friends, how many people do you know that you can talk to really frankly and openly about almost anything?

Would you like to have more or less people like this or is it about right?

How many people in your life do you feel are dependent on you, either financially or emotionally?

How do you feel about this?

13. CHILDCARE ARRANGEMENTS

Now I'd like to ask you some things about looking after _____(child's name).

a. Could you tell me about the last 24 hours before I came (if interview taking place on a Mon. ask about Fri.) in terms of _____(child's name) routine saying who did what and whether this was typical or not. (check list: dressing, washing, feeding, changing, playing, putting to bed, if child goes to minder - taking and collecting)

b. Can you tell me about last weekend?

c. Does _____(child's name) sleep through most nights?

d. What happens when s/he wakes up?
Who gets up?

e. You said that last night s/he went to bed at ____pm. Who usually decides what time s/he goes to bed?

f. Does anyone else apart from you and your partner ever look after _____(child's name)?

g. On what sort of occasions?

h. Do you feel that you get enough help in looking after her/him or do wish you could have more?

FOR THOSE WHO USE CHILDMINDERS

j. Could you tell me about your child minding arrangements?

k. Are you happy with these arrangements?

FOR THOSE WITH OTHER CHILD CARE ARRANGEMENTS

1. Are you satisfied with your child care arrangements?

14. RELATIONSHIP WITH CHILD

Now I'd like to ask you some questions about looking after your child...

a. What do you like about looking after _____(child's name)?

b. What don't you like about looking after _____(child's name)?

c. Are you planning to have any more children?

d. (if yes) Could you tell me a little more about that eg. why you'd like more children, how many etc.?

e. (if no) Could you tell me why you don't want more children at the moment?

f. How do you feel your life has changed since _____(child's name) was born? (stress that can mention positive and negative things)

15. CONTROL OVER LIFE/DEMANDS etc

a. Do you feel in control of your daily life?

b. Do you feel that you can decide what you do every day?

c. Do you feel that too many demands are placed on you and that you don't have time to do them all?

d. Do you wish you had more time to yourself?

e. Do you feel that family life is too emotionally demanding?

f. Do you think much about the future?

g. Why is that?

IF DOES THINK ABOUT THE FUTURE

h. How do you see your future? (positively, negatively, changes etc.)

Thank you very much for taking part in this interview. Is there anything you would like to mention or ask about the interview?

INTERVIEW SCHEDULE II

NAME OF RESPONDENT :

DATE OF INTERVIEW :

TIME OF INTERVIEW :

WHO WAS PRESENT :

INTERVIEW GUIDELINES : 2

I'd like to ask you some questions about your health and general situation since our last interview (state when this was).

A. ABOUT THE RESPONDENT

1. Thinking back over the past 4 months, can you tell me some of the good things that have happened?

2. And can you tell me about some of the bad things?

3. How have you felt health-wise in the last 4 months?

4. Why?

5. Can you remember any health problems that you've had in the last 4 months, however minor?
(IF YES, GO TO QUESTION 6.
IF NO, GO TO QUESTION 7.)

6. Did you take any action for these symptoms eg. take some form of medicine, go to bed early, go to doctors'/nurse, ask a friend or relative for advice etc.

7. In the past 4 months have you
   (a) taken any form of medicine?
   (b) gone to bed early or during the day because you felt tired or unwell? (if yes) Why? When?
   (c) gone to the doctors'/nurse of behalf of yourself?
   (d) asked a friend or relative for advice?

8. Ask about friends and family : have they been seeing them on as regular basis as previously etc.

9. Have you and your partner been out without _____(child's name) in the last 4 months? (If yes) When? Have many times?

10. Have you been out without either your partner or _____(child's name) in the last 4 months?

B. ABOUT THE RESPONDENT'S CHILD

1. How do you think the last 4 months have been in general for _____(child's name)?

2. Why?

3. How has her/his health been in the last 4 months - good, fairly good, or not good?

4. Why?

5. Has _____(child's name) had any health problems that you have noticed in the last 4 months, however minor?
(IF YES, GO TO QUESTION 6.
IF NO, GO TO QUESTION 8.)

6. (if yes) Did you take any action for those problems eg. give some form of medicine, put to bed, take to doctor/nurse, mention to health visitor, ask a friend or relative for advice?

7. (if taken child to doctor/nurse) Did you ask the doctor/nurse anything about your own health?

8. (if no to question 5.) In the last 4 months have you
   (a) given _____(child's name) any type of medicine?
   (b) put him/her to bed?
   (c) gone to doctors' or nurse or asked health visitor about any problem?
   (d) asked a friend or relative for advice?

9. (if taken child to doctor/nurse) Did you ask the doctor/nurse anything about your own health?

9a. Child sleeping through? Coming into your bed?

TO ALL

10. Has anyone apart from you or your partner looked after _____(child's name in the last 4 months, even for a short while?

11. (if yes) When? Why?

C. ABOUT THE RESPONDENT'S PARTNER

1. How do you think the last 4 months have been in general for your partner?

2. Why?

3. How do you think her/his health been in the last 4 months?

4. Why?

5. Do you know if your partner has had any health problems in the last 4 months?

6. (if yes) Do you know if s/he took any action for these symptoms eg. took some form of medicine, went to bed early or during the day because unfeeling unwell, went to doctors'/nurse, or asked a friend or relative for advice?

7. Do you think that your physical health differs in any way from that of your partners'?

8. Why? In what ways does it differ or is it the same?

9. How about your mental health - do you think that differs in any way from your partners'?

10. Why? In what ways does it differ or is it the same?

D. MORE ABOUT THE RESPONDENT

1. Tell me about yesterday's routine from when you got up to when you went to bed...

2. Has anything in your daily life changed at all that you have not already mentioned since our last interview? eg. joined mother and toddler group, new responsibilities at work, been on holiday, made a new friend

3. Do you think that our last interview and filling in the health diary made you

think more or in a different way about your own and/or your child's health?

E. Attitude to health services

a. Do you feel that your local health services are good, fairly good, or not good?

b. Could you tell me why?

c. How do you feel about the way the health services have treated you since _____(child's name) was born?

F. MORE BACKGROUND INFORMATION

I'd like to finish by asking some more general background questions that I didn't have time to ask you in our last interview.

1. TRANSPORT

(a) When you go out, how do you travel - on foot, bus, tube or car.

b) Do you have access to a car?

(c) What do you think of public transport in this area?

2. Housework

I'd like to ask you some questions about how you organise your domestic life...

(a) Who does most of the shopping?

(b) Who does most of the cooking?

(c) Who does most of the laundry?

(d) Who does most of the cleaning?

(e) (if have garden) Who takes care of the garden?

(f) (if have car) Who's responsibility is the care and maintenance of the car?

TO WOMEN ONLY

How much would you say your husband/partner helps with the housework and looking after _____(child's name)?

Would you like him to do more or less than he does now?

TO MEN ONLY

How much would you say that the housework and caring for _____(child's name) is shared between you and your wife/partner?

Is this how you like it to be or do you think it should be different?

3. Educational Background

(a) How old were you when you left full-time education?

(b) Since then, have you undertaken any further training of any kind?

(c) Do you have any educational, professional or other qualifications?

4. Income

I would like to ask you about your income and benefits you receive or may be entitled to.

(a) Could you tell me which of these income groups you come into - including benefits and allowances? (show card)

(b) Are you receiving any state benefits?

(c) (if yes) Which ones? (show card)

(d) Ask to respondent's with working partner
Do you know how much your partner earns or receives in benefits?

e) How much of the household income is your earnings or benefit?

None
less than a quarter
between a quarter and a half
more than a half
don't know

(f) Could you tell me how money is handled in your household (explain)?

(g) To women who get a fixed amount for housekeeping
Do you feel this is enough?

(h) In general, who pays for the following items of expenditure?

mother/ partner/ both/ state benefit/ other/ NA

Food

Bank/mortgage

Household bills
eg. gas, electricity

Household expenses
(incidental)

Children's clothing

Your clothing

Holidays/luxuries

Childcare/minder

Insurance policies

Other major outgoings

(i) Do you worry about money?

FINALLY

(a) Is there anything else you'd like to tell me about the last _____ weeks/months that you might have forgotten?

(b) Is there anything that you'd like to ask me?

INTERVIEW SCHEDULE III

NAME OF RESPONDENT :

DATE OF INTERVIEW :

TIME OF INTERVIEW :

WHO WAS PRESENT :

INTERVIEW GUIDELINES : 3

I'd like to ask you some questions about your health and general situation since our last interview (state when this was).

A. ABOUT THE RESPONDENT

1. Thinking back over the past 4 months, can you tell me some of the good things that have happened?

2. And can you tell me about some of the bad things?

3. How have you felt health-wise in the last 4 months?

4. Why?

5. Can you remember any health problems that you've had in the last 4 months, however minor?
(IF YES, GO TO QUESTION 6.
IF NO, GO TO QUESTION 7.)

6. (If yes) Did you take any action for these symptoms eg. take some form of medicine, go to bed early, go to doctors'/nurse, ask a friend or relative for advice etc.

7. (if no to question 5.) In the past 4 months have you
   (a) taken any form of medicine?
   (b) gone to bed early or during the day because you felt tired or unwell? (if yes) Why? When?
   (c) gone to the doctors'/nurse of behalf of yourself?
   (d) asked a friend or relative for advice?

8. Ask about friends and family : have they been seeing them on as regular basis as previously etc.

9. Have you and your partner been out without _____(child's name) in the last 4 months? (If yes) When? Have many times?

10. Have you been out without either your partner or _____(child's name) in the last 4 months?

B. ABOUT THE RESPONDENT'S CHILD

1. How do you think the last 4 months have been in general for _____(child's name)?

2. Why?

3. How has her/his health been in the last 4 months - good, fairly good, or not good?

4. Why?

5. Has _____(child's name) had any health problems that you have noticed in the last 4 months, however minor?
(IF YES, GO TO QUESTION 6.
IF NO, GO TO QUESTION 8.)

6. Did you take any action for those problems eg. give some form of medicine, put to bed, take to doctor/nurse, mention to health visitor, ask a friend or relative for advice?

7. (if taken child to doctor/nurse) Did you ask the doctor/nurse anything about your own health?

8. In the last 4 months have you
   (a) given _____(child's name) any type of medicine?
   (b) put him/her to bed?
   (c) gone to doctors' or nurse or asked health visitor about any problem?
   (d) asked a friend or relative for advice?

9. (if taken child to doctor/nurse) Did you ask the doctor/nurse anything about your own health?

9a. Child sleeping through? Coming into your bed?

TO ALL

10. Has anyone apart from you or your partner looked after _____(child's name in the last 4 months, even for a short while?

11. (if yes) When? Why?

C. ABOUT THE RESPONDENT'S PARTNER

1. How do you think the last 4 months have been in general for your partner?

2. Why?

3. How do you think her/his health been in the last 4 months?

4. Why?

5. Do you know if your partner has had any health problems in the last 4 months?

6. (if yes) Do you know if s/he took any action for these symptoms eg. took some form of medicine, went to bed early or during the day because unfeeling unwell, went to doctors'/nurse, or asked a friend or relative for advice?

D. MORE ABOUT THE RESPONDENT

1. Has anything in your daily life changed at all that you have not already mentioned since our last interview? eg. joined mother and toddler group, new responsibilities at work, been on holiday, made a new friend

   (a) Is there anything else you'd like to tell me about the last _____ weeks/months that you might have forgotten?

   (b) Is there anything that you'd like to ask me?

E. Motherhood/Fatherhood

I'd like to ask you some more things about being a mother/father.

(a) Can you tell me something surrounding the events of becoming pregnant with _____(child's name)?

- How long have you been with partner?
- Why decided to have child then
  conscious decision or "mistake"

To Mother's only

(b) Can you tell me something about the experience of being pregnant with _____(child's name) and the actual birth

To Partner's only

Can you tell me something about _____(partner's name)'s pregnancy with _____(child's name) and about actual birth? (Were you there?)

To All

Birthweight of baby (if not asked before)

(c) Now you've been a mother (father for X years) how do you feel you've changed/developed as a parent in that time?

(d) What kind of mother/father would you describe yourself as?
(if in paid employment - relationship between parenthood and paid employment)

(e) In what ways do you think that as a parent you are different or similar to your parents?

(f) Do you think your relationship with _____(partner's name) has changed since had _____(child's name)?

(g) What do you want for your child?

(h) How do you see your child in 5 / 10 / 15/ 20 years time?

APPENDIX E

LIST OF FAMILIES

All of these names are fictional. This list of pseudonyms is intended to help the reader to follow the quotations. The pseudonyms do not necessarily reflect the parents' ethnic origin, and some biographical details have been slightly altered to protect confidentiality. The ages of the children and employment status of parents are as given in the first interview. Where women are full-time mothers their last occupation is given.

1. **Dawn and Nigel ABBOT, John (19 months).**

   Dawn is a full-time mother (former holiday camp worker), Nigel works full-time (shiftwork) as a snooker hall steward. Both are white, UK.

2. **Louise and Tony BEVIN, Sarah (14 months).**

   Louise is a full-time mother (former bank clerk), Tony is an electrician for the local council. Both are white, UK.

3. **Diane and Simon CARTWRIGHT, Nicole (2 years).**

   Diane is a full-time mother (former cosmetics consultant), Simon is a builder (foreman). Both are of Greek Cypriot origin.

4. **Ruth DOBBS and Paul EDWARDS, Mark (18 months).**

   Ruth works full-time (shiftwork) as a croupier in a casino, Paul works four days a week as a warehouseman/driver. Both are white, UK.

5. **Lesley and David FISHER, Hazel (22 months).**

   Lesley is a full-time mother (former wages clerk), David is a self-employed builder/decorator. David is of Greek Cypriot origin, Lesley is white, UK.

6. **Alison GRANGE and Joe HARRIS, Judith (13 months).**

Alison is a full-time mother (former cleaner), Joe is a self-employed bricklayer. Both are white, UK.

7. **Rosemary and Robin INGRAM, Elizabeth (14 months).**

Rosemary is a full-time mother (former shop assistant), Robin is an airport baggage handler. Robin is of Turkish Cypriot origin, Rosemary is white, UK.

8. **Deborah JESSOP and Tim KING, Jenny (19 months).**

Deborah works part-time as a play leader in a nursery, Tim is a telephone engineer. Tim is white, UK. Deborah is white, Canadian.

9. **Joanne and Ben LAND, Stephen (12 months).**

Joanne is a full-time mother (former secretary), Ben is a car mechanic. Both are white, UK.

10. **Patricia MORGAN and Ed NEWTON, Benjamin (18 months).**

Patricia is a full-time mother (former typist), Ed is unemployed and has temporary work as a barman. Both are white, UK.

11. **Suzanne and Daniel OLIVER, Lee (23 months).**

Suzanne is a full-time mother (former typist), Daniel works as a decorator for the local council. Both are white, UK.

12. **Helen PRICE and Sam ROBERTS, Annie (17 months).**

Helen works part-time as a nursery assistant, Sam is a builder. Both are Afro-Caribbean.

13. **Jill and Peter SMITH, Katy (16 months).**

Jill works full-time from her home as a childminder, Peter is a carpenter. Peter is Irish, Jill is white, UK.

14. **Julie and Matthew THOMAS, Christine (17 months).**

Julie works full-time as a computer operator in a bank, Matthew is a carpenter. Both are white, UK.

15. **Jane VERNON and Andrew WICKS, Mandy (16 months).**

Jane works part-time as day care officer for people with disabilities, Andrew works part-time as a long-distance lorry driver. Both are white, UK.

APPENDIX F

ADVANTAGES AND DISADVANTAGES OF HEALTH DIARIES

The main advantages of health diaries are that:

i) compared with retrospective interviews they show wider disparities between the experience of symptoms and medical attendance;

ii) they can place 'minor' health events in the context within which they occur and thereby illuminate and extend both other qualitative and quantitative methods.

a) Recording incidence

It is known that retrospective interviews tend to under-report 'minor' everyday events, which may only be remembered for one or two days (Roghmann and Haggerty 1972); the health diary is ideally suited to this purpose. Much wider disparities between the experience of symptoms and medical attendance have been found using the prospective health diary as opposed to the retrospective interview. A health diary study of women registered with a south London practice showed that only one in 37 symptom episodes was treated by a doctor (Banks et al 1975) and a similar, though smaller, diary study (Freer 1980b) found that only one in 40 symptoms was likely to be treated medically. However using retrospective interviews Horder and Horder (1954) and White et al (1961) estimated that for every symptom for which medical help was sought there were three to four symptoms that were not taken to the medical profession. Using data from the San José Health Survey, Mooney (1962) found estimates of the occurrence of illness based on a one-day recall period were four times greater than those based on a calendar-month recall.

In her survey of 19 studies, which have used health diaries, Verbrugge (1980) argues that diaries excel in recording incidence rather than prevalence; they are well suited to collect information about health events experienced during the diary period but not for information about chronic conditions of low impact. They also show higher counts

of diffuse symptoms for which people do not know the underlying medical condition and which do not result in restricted activity or medical attention.

b) **Recording health service utilisation and home treatment**

The health diary has also been found to have a much higher validity for reporting utilisation of health services compared with the interview (Roghmann and Haggerty 1972), although Verbrugge (1980) argues they are as good but not better than the interview for such information. She hypothesises that the diaries are superior to interviews for information about minor health actions such as home treatments, and this method was used by both Freer (1980b) and Morrell and Wale (1976) in their studies on self-care.

c) **A more comprehensive picture**

Another advantage of the health diary is that it can place 'minor' health events in the context in which they occur such as the health of the rest of the family, other events, time and so on. It allows for a more comprehensive and holistic view of individual health and provides an automatic time series study. If the diary is carefully designed, it can collect data on structural influences as well as recording symptoms, and in this way provide a richness of material that more fully reflects the individual's 'lived experience'.

On the qualitative side, diary data have been incorporated within observational methods. Zimmerman and Wieder (1977) for example describe the diary-interview method that is useful when observers wish to understand the experiences of those occupying 'diffuse roles' in which activities are pursued alone, and which therefore cannot be easily studied by the participant observer. In this case, Zimmerman and Wieder were attempting to study housewives who spend most of their day with their children or by themselves, and whose interaction with the adult participant observer would obscure the very processes they were trying to explore. Zimmerman and Wieder therefore asked their respondents to keep a diary about aspects of their lives. The diary then became the basis for intensive interviewing, with the resulting diary-interview compensating for the limitations of participant observation.

Time-budgets and diaries have also been widely used in survey design. Cullen (1979) for example uses a 24-hour retrospective diary with respondents, which attempts to capture 'the what, when and where of everyday life' (1979:118). When coupled with interviews, Cullen argues, diaries can be used to pinpoint the structures, which individuals perceive as constraining their everyday lives.

Roghmann and Haggerty (1972) too provide cogent arguments for using diaries in survey research on health and illness. They show how the health diary provides data ideally suited to analysis of individual health, because the 'individual' and the 'day' can be used as units of analysis together with the units more commonly used such as 'population' and time periods longer than a day. The diary data facilitate analysis within, as well as between, families or households and 'within person' (over time) and between person. Diary data thus permit an easy aggregation of events over time to compute new variables describing person and family characteristics (Roghmann and Haggerty 1972:157).

Roghmann and Haggerty (1972) argue that by linking the diary information to the initial interview and the follow up interview for the analysis at the level of the person and the family can lead to a unique file of survey data that has a very large spread of measures, ranging from social background characteristics over attitudes, perceptions and knowledge to measures of health and illness behaviour. Such a file, they argue, will permit the test of various conceptual models specifying the relationship between attitudes, perceptions and actual behaviour; the causal structures between background factors and dependent variables can be identified.

Disadvantages of health diaries

The main disadvantages, which seem to prevent health diary use, concern:

i) respondent cooperation;

ii) conditioning effects; and

iii) data analysis.

i) **Respondent cooperation**

Past health diary studies indicate that when approached to keep diaries, between 86 and 98 percent of respondents agree (Verbrugge 1980). Drop-out rates are low and in 19 diary studies the completion rate varied between 88 and 100 percent. According to Verbrugge (1980), agreement to keep the diary and study completion rates do not seem related to the length of time respondents are asked to maintain the diary (cf. Cartwright [1983] who argues the same for self-completion questionnaires). This may be because in most of the studies reviewed by Verbrugge, respondents only filled in the diary on days when they had symptoms, and in her own study where respondents were asked to fill in the diaries every day they were paid for doing so.

Kosa et al (1967) found that in a study where they repeated the administration of the health diary, health information was recorded equally conscientiously each time. However, Sudman and Lannom (1978) argue that a distinction should be made between studies where the diaries are posted back by the respondent and those where it is collected by an interviewer - the former having the higher drop-out rate.

The quality of data produced by either method depends on the effort research staff devote to motivating and recontacting the respondents (Rowley 1986). Clearly it is important to conduct an initial face-to-face interview with the respondents, not just to collect social background and health information (see below), but also to explain in detail what kind of information is wanted. Freer (1980a) states that where health diaries are used in general practice research, patients tend to record only purely medical problems, as they do not believe that doctors are interested in the psychosocial aspects of their health. Similarly they often exclude minor and transient problems, perhaps because recording these day-to-day problems might seem like excessive complaining or will be interpreted as hypochondriasis. Although these problems are not quite the same when the researcher is independent of the medical profession, they still have some validity.

One aspect of respondent cooperation, which has hardly been referred to in the literature, is that the use of health diaries is entirely dependent on the literacy of the

respondents. The diary method is clearly biased against those sections of the population who are semi-literate or illiterate. Similarly, unless the diaries are translated, they are biased against those who do not have English as a first language.

ii) **Conditioning effects**

Verbrugge (1980) suggests that two conditioning effects are of concern in diary studies, sensitisation and fatigue. Respondents may increase the number of problems they report by focusing on their health problems and increasing their awareness of pains and discomforts they take for granted. Several studies have drawn attention to this problem. Mechanic and Newton (1965) cite an example from their study where families failed to maintain family illness logs for the required 15-day period, because they said that the attentiveness the diaries required, increased family morbidity. Sudman et al (1974) suspect that for routine doctor visits respondents were sensitised and made an 'extra' visit for a check up early in the diary period. Murray (1985) therefore suggests that detailed background information should be collected during an extensive interview before the diary is begun, and the diary should not be treated as an independent source of longitudinal data on general health status.

As the diary period lengthens, respondents may tire of keeping a daily record and as a result may become less thorough in reporting health events. In her pilot study, Murray (1985) reports that the drop-out rate may have resulted from the 'fatigue' caused by the daily recording of chronic psychosocial problems, and notes that several respondents did comment on the feeling of despondency created by their daily symptom reports. In my own pilot study, the seven-day diaries yielded more complete information than the 14-day diaries. Mooney (1962) found that as time went by there was an increasing tendency to omit the reporting of minor illness.

Another factor can easily change the levels of health reporting over time, season of year. Acute illnesses are most common in the winter months and reports of symptoms, functional impairment and some health actions will be increased during this time (Verbrugge 1980:88).

iii) **Data analysis**

Health diaries generate an enormous volume of data, usually more than repeated interviews with the same number of respondents (Verbrugge 1980:92). To avoid becoming overloaded with data, Rowley (1986) suggests that item content should favour closed questions, which can easily be coded during the data analysis stage. However, in smaller studies the use of open-ended questions can yield detailed and continuous (over time) qualitative data. These data then create analytical problems for example, what is an 'episode'? How are 'symptoms' distinguished from 'conditions'? What differentiates 'acute' from 'chronic' problems?

Health diaries capture events for an individual over a specified time period. They may therefore collect only partial data for a particular episode, which begins before the diary period and/or continues after the diary period has ended. In addition, respondents who miss days during the study may produce incomplete episodes, and those who drop out of the study generate many days of missing data. These 'truncated data' (Verbrugge 1980) create problems for individual and aggregate-level analysis.

There are also certain statistical problems posed by the nature of health diary data. The time-series of data provided by the health diary for each individual cannot be adequately handled by statistical techniques for analyses of health dynamics.

APPENDIX G

HEALTH DIARY

HEALTH DIARY

As part of my study of health and illness in families, I am interested in everyday health matters. So I am asking you if you would help by filling in a diary over a week (7 days) to cover all your experiences of health and illness, however minor.

It is very important that both parents fill in a separate diary each for the same week, so that I have information about the same period of time for each of them. Please could you fill in the information for each day under the following headings:

A. About you

1. What kind of day has it been for you? (Please ✓ appropriate box.)

2. How has your health been over the last 24 hours? (Please ✓ appropriate box.)

3. Can you note down an particular things that you may have felt on each day, eg. tiredness, headache, but also any <u>good feelings.</u> I am interested in any good or bad feelings, however minor they might seem to you. If you can, try and say what you think caused the feeling, eg. lack of sleep caused tiredness, or maybe you felt good because your child behaved well or did something for the first time, or perhaps something went well at work.

4. Where it applies, please could you write down anything you did about any health problems you had (however minor), eg. talked to doctor or nurse, took some form of medicine (please say what kind), talked to friend or relative about the problem etc.

5. Please could you write down the main things you did during the day, eg. went to work, housework, shopping, played with child, visited a friend, watched TV, etc. I have divided up the space provided into morning, afternoon and evening. Please write down as many things as you can beside each part of the day.

6. Please write down if anything happened that made you feel good/happy or if anything bothered or upset you - it may be to do with your child, your job, your partner, a friend, etc.

B. About Your Child

These questions apply to the times when you were with your child, as you may not have been with her/him all day.

1. What kind of day do you think it has been overall for your child? (Please ✓ appropriate box.)

2. How do you think your child's health has been over the last 24 hours? (Please ✓ appropriate box.)

3. Could you please note down any health problems that you may have noticed in your child.

4. Please could you write down anything that you did about your child's health problem, eg. went to doctor or nurse, gave some form of medicine (please say what kind), put child to bed, asked friend or relative for advice.

There are 2 sheets for each day. Please try to fill in the diary as fully as possible, even if you don't think the things you are writing seem important. If you need more space, please use the back of the sheets.

I know that filling in these diaries takes time, but the reason for asking you to do them is that they give the kind of information which is difficult to get just by talking to you. They are very valuable to me, and I appreciate your help very much.

If you have any problems with the diary or would like to ask me something about it, please phone me and I'll be happy to talk about it.

Day :

About You

1. What kind of day has it been for you?
(Please ✓ the box that describes your feelings best.)

A very good day	☐
A good day	☐
An average day	☐
A poor day	☐
A very poor day	☐

2. How has your health been over the last 24 hours?
(Please ✓ the box that describes your feelings best.)

Very good	☐
Good	☐
Average	☐
Poor	☐
Very poor	☐

3. Details of any particular feelings (good and bad) or health problems you may have had today. Please also note down what you think caused the feeling/problem.

4. Did you do anything about any health problems you noticed?

5. Things you did during the day:

   Morning:

   Afternoon:

   Evening:

6. Did anything happen today which made you feel good/happy or was there anything that bothered or upset you? Please write down here (go to over the page if necessary.

Day :

About Your Child

1. What kind of day do you think it was for your child?
(Please ✓ the box which describes your feelings best.)

A very good day	☐
A good day	☐
An average day	☐
A poor day	☐
A very poor day	☐

2. How do you think your child's health has been over the last 24 hours?
(Please ✓ the box which describes your feelings best.)

Very good	☐
Good	☐
Average	☐
Poor	☐
Very poor	☐

3. Details of any health problems you may have noticed in your child.

4. Did you do anything about the problems you noticed in your child?

APPENDIX H

Letter to Parents

Dear

I am a research student at the Thomas Coram Research Unit, which is part of the University of London, and I am writing to you about a research project that I am doing. It is concerned with the health of parents of young children and their use of health services. Your health visitor has given me your names as people who may be interested and willing to take part in the project.

I am interested in your personal experiences of having and caring for a child and how this may affect your health. In the past there has been a lot of research into the health and welfare of children, but not so much into how parents feel. It is important to look at the impact of children on parents' health so that this can be taken into account by the people running the health services.

I should like to stress that my research is completely independent of the health services. I have no connection with the health centre, other than having been given your names and address as suitable parents for my project.

If possible, I should like to come and interview both of you in your home and to explain more fully about the project. All the information you give me will be treated in the strictest confidence. In other words, nothing you tell me will be passed on to your health visitor or anyone else, and your names will not of course be used in any report or publication on the research.

If, however, you decide you do not wish to take part, please let me know at the above address. If I have not heard from you by then, I will ring or call round to arrange a convenient time to come and talk to you.

Thank you very much for your help and I look forward to meeting you.

Yours sincerely,

Naomi Fulop

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