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THE EFFECT OF FAMILY-CENTERED VERSUS WIFE-CENTERED
OBSTETRICAL CARE UPON FAMILY LIFE

DISSERTATION

Presented in Partial Fulfillment of the Requirements for
the Degree Doctor of Philosophy in the Graduate
School of The Ohio State University

by

Joseph R. Steiner, B.S., M.S.W.

The Ohio State University
1972

Approved by

Marian Currall
Advisor
School of Social Work
ACKNOWLEDGMENTS

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VITA

April 23, 1938. . . .  Born - Sterling, Ohio

1962. . . . . . . . . . B.S., Bluffton College, Bluffton, Ohio

1964. . . . . . . . . M.S.W., University of Michigan, Ann Arbor, Michigan

1964-1967 . . . . Staff Social Worker, Brook Lane Psychiatric Center, Hagerstown, Maryland

1965-1967 . . . . Director of Social Work, Cedar Ridge Children's Home, Williamsport, Maryland

1967-1969 . . . . Instructor in Social Work, Bluffton College, Bluffton, Ohio

1968-1970 . . . . Consultant and In-Service Training Director, Comprehensive Community Mental Health Center, Lima, Ohio

FIELDS OF STUDY

Major Field: Social Work


Studies in Human and Social Functioning. Professor Ronald Bounous


Minor Fields: Sociology, Adult Education, and Educational Philosophy
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INTRODUCTION

The effect that family-centered versus wife-centered obstetrics has upon family life following the birth of the first child and the hospitalization of the mother and child was the focus for this longitudinal study. The concept "family-centered obstetrics" refers to the obstetrical preparation of expectant couples who choose, with their obstetrician, to jointly involve themselves in a series of childbirth training classes designed to prepare them for joint participation during labor and delivery. "Wife-centered obstetrics," which represents the norm in this society, refers to the care of expectant couples in which the spouses did not jointly involve themselves in a series of childbirth preparation classes and did not plan to be together during parturition.

More specifically, this study utilized a comparative survey (quasi-experimental) design for the purpose of testing hypotheses regarding the effect that family-centered versus wife-centered obstetrical care had upon family life. The measures of family life included observed and self-reported indicators. The observed indicators were the quality, efficiency, and congruency of marital interaction, and the self-reported indicators were spouses'
attitudes regarding marital adjustment, self concept, concept of ideal self, concept of spouse, and concept of ideal spouse.

When the research project began, two hospitals in the Columbus area permitted both family and wife-centered obstetrical care. Nursing supervisors from these institutions assisted in the selection of obstetricians for the study, based upon the fact that these physicians gave couples the option to utilize family-centered or wife-centered obstetrical care. These obstetricians in turn assisted in obtaining the research sample by asking all expectant mothers, who met the qualifications of the study, about their willingness to participate along with their husbands in this research project.

The study sample was made up of thirty-eight couples, of which nineteen utilized family-centered and nineteen utilized wife-centered obstetrical care. Eight other couples participated in a pilot study prior to the time that persons comprising the actual study were seen. The first data-collection interview took place early in the third trimester of pregnancy prior to the time some couples entered childbirth preparation classes. These interviews took place at the hospital where the couple planned to deliver. The second data-collection interview took place in the couples' homes approximately two weeks following the mother and child's discharge from the hospital.
Justification for the study grew out of the belief that knowledge resulting from it could be useful in efforts to facilitate primary prevention of family disintegration. Most people marry and have children, and few would deny that the birth of the first child may influence changes in marital interaction as much as any event in the life of a marriage. It is known that pregnancy and the birth of the first child represent a period of developmental stress, sometimes referred to as a crisis, in the life of a family. Likewise, the realization that much personal and social dysfunction is a product of stress is generally accepted. Thus, being able to favorably influence marital interaction patterns associated with parturition appears to be one avenue to greater family-life effectiveness and to fewer social and psychiatric problems associated with pathogenic marital interaction.

Previous studies have associated different styles of obstetrical care, some of which are family-centered, with various physiological and psychological variables experienced by the wife and mother. Also, during the past decade, significant strides have been made to associate observed family interaction patterns with such labeled problems as "marital," "acting out," and "under-achievement" and to various types of neuroses and psychoses. Family-related attitudes experienced by husbands, however, and joint interaction patterns that characterize a couple have
not been systematically studied in relation to styles of obstetrical care. It was not known how family-centered versus wife-centered obstetrical care affected marital interaction patterns. How does joint preparation of spouses for childbirth and involvement of husbands in labor and delivery affect changes in spouses' joint behavior patterns following the birth of the child? How does the style of obstetrical care influence one's attitudes regarding factors in family life?

The findings of this study reveal that family-centered obstetrical care versus wife-centered care does have a favorable influence upon the quality, efficiency, and congruency of spouses' marital interaction patterns. However, hypotheses based upon favorable changes in self-reported familial attitudes being associated with family-centered obstetrical care were not supported.

Persons within the profession of social work, like those performing other remedial and rehabilitative services for the family, have not made adequate efforts to prevent family disintegration by developing opportunities for the enhancement of family life. Enriching family life may encompass a wide range of maturational and regenerative events of which childbearing is one. Hopefully, the knowledge that resulted from this study will be helpful to expectant couples, family life educators, family service
hospital policy makers, obstetricians, and others who are
devoted to preventing family disintegration by enhancing
family life.
CHAPTER I

REVIEW OF THE LITERATURE AND BACKGROUND FOR THE STUDY

**Historical Development and Description:**

*Family-Centered Obstetrics*

During the past decade, interest in the psychoprophylactic method of childbirth preparation and delivery has been growing rapidly in the United States. In 1951, a variation of the currently used method was established in the Soviet Union as the official method of preparation for and conduct of childbirth. Fernand Lamaze, a French obstetrician, visited the Soviet Union that year and observed the use and results of the psychoprophylactic method. He adopted a variation of this method in his obstetrical practice in Paris. An American patient of his, Mrs. Marjorie Karmel, wrote *Thank You, Dr. Lamaze: A Mother's Experience in Painless Childbirth* in 1959, and this book has since had wide circulation in the United States.

The husband's participation during labor and delivery, as described by Karmel, was secondary to that of a Lamaze instructor who helped the expectant mother breathe, focus her attention, and relax correctly. The husband's role was one of passive support. Training the husband to take a
more active role, actually replacing the Lamaze instructor during labor and delivery, is an American variation of the psychoprophylactic or Lamaze method. A 1965 book by Bradley, *Husband Coached Childbirth*, further popularized the notion that husbands should have the opportunity to play an active, supporting role during their wives' labor and delivery.

In 1960, Karmel and another advocate, Mrs. Elizabeth Bing, helped found the American Society for Psychoprophylaxis in Obstetrics. Today, this organization is known as ASPO, and it has local chapters in most of the large metropolitan areas in this country. A main function of these local chapters is to promote the Lamaze method and to prepare couples for active participation during labor and delivery. (See Tanzer, Chapter IV, for a detailed description and historical development of the Lamaze natural childbirth method.)

The Columbus Association of Childbirth Education (CACE) traces its beginning to the mid-fifties when a group of young couples began discussing Dick-Reed's book, *Childbirth Without Fear*. In 1957 this group hired a childbirth education instructor and classes for expectant couples were held four times per year. Overcoming the fear that is generated by ignorance was a primary goal of this group, but according to several of the physicians who participated in this study many of the couples who took these classes
were not adequately prepared to successfully participate together in labor and delivery. Less than one hundred couples attended these classes the first ten years they were offered.

In 1968 CACE identified itself with ASPO and began teaching the Lamaze method. Couples were seemingly better prepared to participate meaningfully together during labor and delivery. Their enthusiasm was contagious and the number of expectant couples who associated themselves with CACE grew rapidly. In fact, over four hundred couples completed this series of classes between 1968 and 1972.

Physicians, likewise, noticed a change in the preparation that couples had. The physicians in this study report that husbands are now much better prepared to actively participate in labor and delivery and to support the efforts of their wives and the medical team. The incidence of husbands fainting, criticizing, or actively interfering with medical care has dropped significantly. The physicians in this study, reportedly, do not permit husbands to be in the delivery room if they have not participated in the childbirth preparation classes.

The Columbus findings regarding husbands being in delivery seem to correspond with Bradley's (1962) report that trained husbands who participate are less likely to be critical and initiate malpractice suits than those who experienced wife-centered obstetrics. Bradley, likewise,
found that trained husbands do not get sick, faint, or "get in the way."

Family-centered obstetrics is identified by the joint preparation for and the plan to participate in labor and delivery. The joint preparation of spouses for childbirth typically involves, (1) attending six or more classes during the last two months of pregnancy; (2) doing a series of exercises designed to strengthen the wife's body for labor and delivery; (3) viewing a film of another couple jointly preparing for and actively experiencing together the birth of their child; (4) reading and discussing books related to childbearing and to the spouses' active participation in it; and (5) jointly practicing daily to perfect methods of relaxation, muscle control, and breathing rhythms designed to focus attention and control stress associated with labor and delivery.

During labor, a husband typically assists his wife in various ways: (1) he times contractions for the purpose of helping her predict when the next one will begin and how long it will last; (2) he encourages his wife to take a "cleansing breath" as each contraction begins (this also signals her to start a previously practiced breathing routine designed to increase the oxygen supply, focus her attention, and control stress associated with labor); and (3) he helps her rest and relax between contractions.
In summation, a husband is expected to use his formal preparation and personal intuition to provide comfort and support so that his wife can devote all of her energy to giving birth. This typically also includes personalized services (e.g., adjusting a bed or pillow, rubbing sore back muscles, or cooling his wife's forehead with a damp cloth) that may or may not be available if the husband is not there. Having the husband present and active in assisting also provides the personal support that comes from jointly experiencing the hard work associated with labor.

During delivery, a husband typically stands or sits at the head of the delivery table. This enables him to talk with his wife during the birth process, e.g., helping her predict the length of the final contractions. He may also assist by helping his wife sit up and lean forward as she pushes to expel the baby. Finally, both spouses can share the birth of the child and the child's first reaction to birth. During delivery, like labor, the husband is available to provide personalized services and support to his wife that usually can not be duplicated by hospital personnel.

When expectant mothers utilizing family-centered obstetrics do take anesthetics, they are generally given an anesthetic which permits them to be awake and aware. All of the physicians in this study indicated that if a general anesthetic is given, in which the expectant mother is put
to sleep, husbands are not permitted to be in the delivery room. Some of the physicians in the study do not permit husbands in the delivery room if any complication is anticipated, while other physicians treated each such anticipated complication on an individualized basis. For example, some husbands participated in the delivery room even though they and the physician knew the baby was going to have a breech birth.

Characteristics of Family Interaction Patterns and the Central Role the Marital Relationship Plays

The major consideration in this section is the nature of family interaction patterns and the central role the marital relationship plays in the development of these patterns. Haley (1962) outlined some of the basic characteristics of family interaction patterns when he indicated that: (1) family members deal differently with each other than they do with others; (2) family life is made up of millions of responses which tend to fall into patterns; (3) family patterns tend to persist and they tend to influence members' expectations of others outside the family; and (4) a child is not a passive recipient but an active co-creator of family interaction patterns. Riskin (1970) revealed that repetitive, formal patterns of interaction influence the products of interaction (i.e., the spouses' behavior) more than verbal content associated with marital interaction. In other words, the patterns of interaction
spouses utilize in relating to each other is more important than what is said, although the patterns of interaction may be derived in part from what is said.

Other assumptions that this research design was based upon include the following: (1) that the marital relationship constitutes a system, and that the behavioral characteristics of spouses are patterned; (2) that these patterns tend to be consistent over time, and that a few minutes of a couple's overt interaction will contain their basic interaction style; and (3) that their interaction style can be used to yield meaningful information about a couple.

Findings in family communication studies support these assumptions. Pitternger, Hackett, and Danehy (1960) found that a family's communication characteristics are revealed in the first five minutes of an interview. Drechsler and Shapiro's (1961) findings suggest that family communication during the family interview is not random but is governed by patterns. And Lennare, Beaulieu, and Embrey (1965) found that families find it difficult to alter communication patterns for long.

The marital relationship is the axis around which other family relationships are formed and maintained, and a successful marital relationship tends to produce successful parenting and family life (Satir, 1967). In working with schizophrenics, Bowen observed, for example:
the striking observation that when the parents were emotionally close, more invested in each other than in the patient, the patient improved. When either parent became more emotionally invested in the patient than in the other parent, the patient immediately and automatically regressed. When the parents were emotionally close, they could do no wrong in their "management" of the patient. The patient responded well to firmness, permissiveness, punishment, "talking it out," or any other management approach. When the parents were "emotionally divorced," any and all "management approaches" were equally unsuccessful (1960:370).

In summation, it is assumed that the family interaction patterns, be they enhancing or degrading, that develop prior to and during the childbearing years will have a major impact upon the total nature and history of family life. The marital interaction patterns are the axis around which other patterns develop, but each family member can be instrumental in creating or changing family interaction patterns. These patterns are important in that the behavior of family members results in large part from them.

Personal Adjustment, Marital Relationship, and Concepts of Self, Ideal Self, Spouse, and Ideal Spouse

This set of findings is based in part upon a conceptual scheme which was developed by Bills, Vance, and McLean (1951). Existence of psychological organization implies that the person has a "self concept" (i.e., that the individual has information relative to his present self organization) and that he has a "concept of ideal self" (i.e., that the individual has a view of himself as he wishes to
be). Personal maladjustment may be defined as "... any discrepancy between the concept of self and the concept of ideal self" (Bills, et al., 1951:257).

Working to have a more congruent relationship between one's self concept and one's concept of ideal self, thus represents working toward personal adjustment. Bills (1953) found that low self acceptance tended to be associated with high emotionality. This measure of personal adjustment also reflected itself in marital relationships. When Luckey (1961) compared persons who were satisfied in marriage with those who were not, she found that the satisfied persons had self concepts which were more congruent with their concepts of ideal self.

Bills, Vance, and McLean define self concept further by saying:

the concept of self may be further defined as the traits and values which the individual has accepted as definitions of himself. Values are derived from traits, a trait being an adjective to describe a person. A value is a trait which the individual considers valuable (1951:257).

The "concept of spouse" is defined as the traits and values a person has accepted as definitions of his (her) spouse. The "concept of ideal spouse" is the view of spouse as he (she) wishes a spouse to be. An "attitude" is an evaluation. Thus, a more congruent concept of spouse and concept of ideal spouse signifies a more positive attitude toward or evaluation of one's spouse. Attitudes
toward one's spouse become more negative as the concept of spouse and ideal spouse become more discrepant (less congruent).

A person's satisfaction in marriage is also revealed by the congruence between his concept of ideal self and his concept of spouse. Typically, a marriage becomes less satisfying as a person's concept of ideal self and concept of spouse become more discrepant. In other words, perceiving your spouse as you aspire to be is assumed to be more satisfying than perceiving your spouse as you do not want to be. Luckey (1960B and 1961) supports this theoretical proposition with her empirical finding that marital satisfaction is equated with a congruence of perceptions between the concept of ideal self and concept of spouse.

In summation, enhancement of the personal and social organization associated with a marriage relationship implies both spouses' increasingly congruent attitudes regarding (1) concept of self and ideal self, (2) concept of spouse and ideal spouse, and (3) concept of ideal self and spouse. It was assumed that there is a close association between a couple's marital interaction patterns, their evaluation of their marital relationship, and their attitudes toward their own concepts of self, ideal self, spouse, and ideal spouse.
Selecting Indicators of Family Life

The indicators of family life, i.e., of observed marital interaction and self-reported attitudes associated with family life, utilized in this study were selected because of their value in previous research studies and because of their potential value in differentiating the effects that family-centered versus wife-centered obstetrics may have. The quality of available instruments, in terms of validity, reliability, and sensitivity to measure these variables was also a key factor in the selection process. Furthermore, the process of selection involved an extensive review of the literature and personal conversations and correspondence with persons currently active in family research.

The "Marital Interaction Index," which measures the quality, efficiency and congruency of spouses' joint behavior patterns, was selected because of its ability to measure styles of marital interaction not directly associated with the content contained within the index. It is more difficult to falsify one's responses than are self-reported attitude scales since research subjects do not know which behavioral variables are being measured. It is thus considered to be the most revealing instrument in this research project. Scoring it involves a low-inference procedure which facilitates high inter-rater and intra-rater reliability (Riskin, 1970, 1971).
The quality of marital interaction and the technique for measuring the positive and negative quality of speeches was selected from Riskin's (1963, 1964, 1970) research in developing a reliable and valid family interaction scale. Scoring involves determining whether a speech is positive, neutral, negative, or non-scoreable.

Positive speeches versus negative speeches refers to the amount of friendliness versus attacking that occurs between spouses as they verbally interact. A speech consists of all vocal sounds one spouse makes until the other spouse makes a sound. Typical positive speeches include one or more of the following characteristics: (1) direct praise or encouragement; (2) direct comment about the speaker's positive feeling for the other; (3) suggestions or opinions given in a supportive tone of voice; (4) generous answers to questions given in a warm tone of voice; (5) an invitation for the other to participate; (6) evaluative comments in response to the other person said in a warm, enthusiastic tone of voice; and (7) friendly laughter.

Typical negative speeches include one or more of the following characteristics: (1) direct attacks on the other person; (2) complaints about the actions of the other person; (3) questioning the motives of the spouse; (4) sarcastic remarks, (5) attacking suggestions made by the other person in a vicious tone of voice, or with disdain.
or contempt; (6) displays of impatience or exasperation; (7) exclamatory remarks which conventionally imply disapproval; and (8) defensive responses. (See Riskin and Faunce, Family Interaction Scoring Manual, for more elaborate explanations and examples of positive and negative speeches.)

Neutral speeches consist of those speeches that have neither a friendly or attacking quality or when the tone of voice contradicts the quality of the verbal message. Speeches are scored non-scorable when their quality cannot be determined.

The rates of positive and negative speeches revealed a capacity to differentiate between "multiproblem families," "constricted families," "families with official child-labeled problems," "questionable families," and "normal families." Multiproblem families tended to be low on positive speeches and consistently high on negative speeches; constricted families tended to be medium to low on positive speeches and medium to high on negative speeches; families with official child-labeled problems had a striking absence of both positive and negative speeches; questionable families tended to be high on positive speeches and medium to high on negative speeches; and normal families tended to be medium to high on positive speeches and low on negative speeches. An informal observation in Riskin's study also disclosed the importance of laughter as a family
diagnostic aid. Normal families had considerably more laughter than did the other families being studied (Riskin and Faunce, 1970:522).

It was thus assumed that a couples' quality of marital interaction became more favorable as the number of positive speeches increased, the number of negative speeches decreased, and the amount of laughter increased.

The efficiency of marital interaction variables (i.e., explicit information exchanged, choice fulfillment, and percentage of silence during decision making) and methods for measuring these behavioral variables were adopted from studies conducted during the last decade by Ferreira and his associates. These efficiency variables, likewise, revealed a capacity to differentiate between "normal" and "abnormal" families.

Explicit information exchanged refers to how often spouses clearly stated what they wanted, preferred, or liked, or on the contrary, did not want, prefer, or like while completing the "Marital Interaction Index." Choice fulfillment is a measure of how closely spouses' individual likes and dislikes correspond with their joint likes and dislikes. Percentage of silence refers to the amount of time spent in silence during decision-making or problem-solving interaction.

According to Ferreira and his associates, normal families displayed higher rates of explicit information

The congruency of marital interaction has not been systematically studied. Luckey (1960, 1961, and 1964) has studied congruency of spouses as it reveals itself on self-reported scales such as the "Interpersonal Check List." Congruency of observed marital interaction, however, measures a different phenomenon than perceptual congruency associated with self-reported attitude scales. Due to this basic difference and the limited work in this area, congruency rates of observed marital interaction appear to be a basic unexplored area of marital interaction.

Of particular interest in this research is the change in husband-wife congruency associated with positive speeches, negative speeches, units of laughter, explicit information exchanged, choice fulfillment, and amount of talking time. Spontaneous agreement of likes and dislikes is included as a measure of congruency. Ferreira (1965) found that spontaneous agreement (i.e., one measure of congruency) is more prevalent in normal than in abnormal families.
In this study, it is assumed that higher rates of congruency in observed marital interaction patterns are more favorable than lower rates of congruency.

The self-reported attitudes (i.e., marital adjustment, self concept, and concept of ideal self, spouse and ideal spouse) were included in this study for the following reasons. One, when couples volunteer to take part in research of family life, it seems reasonable for them to be given the opportunity to openly reveal their impressions. (One shortcoming of this, of course, is that they can consciously or unconsciously distort their perceptions in an attempt to "please" the researcher or to make themselves "look good" in the study.) Two, how persons perceive factors in their own family life is important because of the influence a person's perceptions have on his actions and feelings. Luckey reveals this importance with her belief that

The effects of social perceptions as these enter into interpersonal relationships have been a fruitful area of speculation and investigation. The bulk of theory and interpretation of research findings indicate that interpersonal behavior is closely related to, if not dependent upon, the way in which individuals perceive themselves, others, and the situation of the moment (1960b:153).

And three, the self-reported variables selected for study in this research project have a large number of accompanying studies which can be utilized to further refine knowledge associated with the effects of family-
centered versus wife-centered obstetrics upon family life. The two instruments utilized to measure these self-reported attitudes are both regarded highly for their validity and reliability. Locke and Wallace's "Short Marital-Adjustment Scale" was constructed by using the most significant items taken from the best previous tests of marital adjustment. Also, according to the authors, this test "...clearly differentiates between persons who are well adjusted and those who are maladjusted in marriage (Locke and Wallace, 1957: 255. Also see Sociological Measurement: An Inventory of Scales and Indices, and Family Measurement Abstracts for references to this scale). Bills' "Index of Adjustment and Values" (IAV) is "...one of the better self evaluation instruments" (Robinson and Shaver, 1969:94). Wylie, in The Self Concept (a comprehensive review of the literature on self concept), indicated that there is more information available about the IAV's norms, reliability, and validity than any other measure of self concept she reviewed. The original IAV contained forty-nine traits that were used to measure self concept, self acceptance, and concept of ideal self. Eastman (1958) and others have since eliminated the middle self measurement, self acceptance, but were able to determine this by determining the discrepancy between self concept and concept of ideal self. This study, likewise, will utilize self concept and concept of ideal self, and these same
traits will be used to determine concept of spouse and ideal spouse scores. Numerical values from these four concepts and congruency rates associated with them have previously been utilized to measure such things as "emotionality," "personal adjustment," "marital happiness," and "level of aspiration" (Bills, et al., 1951; Eastman, 1958; and Bills, 1953a, 1953b, and 1954).

In summation, the quality, efficiency, and congruency of observed marital interaction were thought to be good focal points to evaluate family life, as well as the self-reported attitudes of marital adjustment, self concept, and concept of ideal self, spouse, and ideal spouse. Each of these family-life indicators has been investigated in previous research studies, and has been associated with the behavior of family members. The instruments facilitate a longitudinal evaluation of family life since they can be readministered from time to time. It was not known how the expectations associated with becoming parents would affect the results of readministering these instruments.

**Transition to Parenthood as a Crisis or Stressful Transition**

These findings center upon how having children influences family life. As pregnancy progresses, drawing closer to termination, the expectant child becomes more influential in shaping or influencing the marital interaction of his parents. The act of childbirth represents both the termina-
tion of certain joint behavior patterns and the start of new ones. Going through the process of having a child, especially the first one, is one period in the life of a family when expectations for and patterns of interaction change rapidly. Stress typically accompanies this rapid change.

Bibring (1959, 1961) regarded pregnancy as a period of crisis in which a temporary personality disturbance peculiar to pregnancy takes place. For example, she indicates that expectant mothers typically experience enhanced narcissism early in pregnancy which is followed by degrees of object-libidinal striving associated with the fetus and sexual mate.

Caplan (1957) views pregnancy as a period in which persons experience an increased susceptibility to crisis. This is reportedly manifested by increasing introversion, passivity, and dependency during the middle trimester, which reaches a peak at thirty to thirty-five weeks and does not disappear until a few weeks after delivery.

Findings associated with mental illnesses seem to confirm the fact that pregnancy represents a crisis. Kline (1955) found that approximately eight percent of the women who become psychotic do so in relation to pregnancy. Boyd (1942) concluded that up to 21.6 percent of all female psychosis is related to childbearing. Jarrki-Zadeh and his associates revealed, "In comparison to dreams of non-
pregnant women, the dreams of pregnant women reveal a remarkably high incidence of trauma and less adaptive ego functioning" (1969:801).

Gorden and Gorden (1959) found that thirty percent of the women delivering normal babies showed some degree of emotional upset following delivery. Jarrki-Zadeh add to this knowledge by stating:

The fact that 80 percent of these serious reactions occur the first 30 days post partum has raised doubts in the minds of some that these reactions merely represent the stress of pregnancy falling on a predisposing personality (1969:797).

They, like Bibring and Caplan, take the position that the social and psychological pathology associated with pregnancy cannot be adequately explained by the assumption that the dysfunction simply results from added stress being placed on a person already predisposed to mental illness. Rather, the expectations and the patterns of dependency and support associated with obstetrical care may play some role in precipitating personal and social dysfunction. Grimm summarizes the literature well with her statement:

Regardless of their theoretical framework, virtually all those who have studied emotional reaction in pregnancy agree on two issues--mainly, that all women have both positive and negative attitudes toward their pregnancy and that all women experience an increase in anxiety and tension during this time. In many women existing conflicts appear to be exacerbated, and even those women who are emotionally mature and motivated for pregnancy show some anxiety about the unknown (1967:3).
It has also been found that expectant fathers, as a part of a marital interaction system, tend to experience positive and negative reactions to their wives' pregnancy and that an increase in tension and anxiety often accompanies this period. Likewise, existing conflicts in a husband's identity may be exacerbated by his wife's pregnancy and his pending fatherhood.

Wainwright (1966), in "Fatherhood as a Precipitant of Mental Illness" confirms that expectant fathers feel stress associated with their status transition and that this can exacerbate existing conflicts. He goes on to indicate that mental illnesses precipitated by fatherhood are much more common than the literature reveals, and that, although much is documented about post partum reactions in women, little is known about psychopathological reactions to fatherhood.

Deutsch substantiates a father's close association with his wife's pregnancy and his pending fatherhood by saying:

The Brahmanic myth of the father's rebirth of his son, the idea frequently expressed in folklore that the grandfather's spirit reappears in the grandson, is doubtless deeply rooted in man's psychic life. Psychoanalysis casts light on this very ancient theme by the discovery that becoming a father is for man--just as becoming a mother is for a woman--the fulfillment of old infantile longings, and that the child is not only a revival of himself but also a reconciliation with his unresolved past. Fatherhood gives him a feeling of triumph, now he can
transform the old unconscious identification of the little boy with his father into a real and permanent one (1945: 174-175).

Trethowan and Conlon, in a study which investigated the health of 327 husbands during their wives' pregnancies by comparing them with 221 married men whose wives were not pregnant, report:

Assessment of the results shows that a significantly greater number of expectant fathers were affected by a variety of symptoms than were the controls. In particular, they were found to suffer significantly more often from loss of appetite, toothache, and nausea or vomiting. It is concluded from this survey that possibly about one in nine (11 percent) of all expectant fathers may have some symptoms of psychogenic origin in relation to their wives' pregnancies. Symptoms tend to occur at any time from about the third month of pregnancy onward. Whereas the basic cause of the syndrome is anxiety, the relationship of the symptoms to this event is not always perceived by the sufferer (1965: 65).

Much has also been written about how the transition to parenthood represents a crisis. This transition focuses upon the stress that accompanies the entry of the child into the home as well as the stress associated with child-bearing. Meyerowitz (1963) indicated that the crisis of the first child is a significant transition point in the maturation of the marital relationship. Blood states:

As soon as the first baby arrives, life at home changes so sharply that this is properly called a crisis, especially for the mother. These changes are not necessarily resented but they are more drastic than any turning point in life, not excluding the marriage (1969: 438).
LeMasters (1957), who describes a crisis as any sharp or distinctive change in which old patterns are inadequate, found that 83 percent of his middle-class sample had an extensive or severe crisis adjusting to their first child. Dyer's (1963) study revealed that with the first child, 53 percent of the couples experienced "severe crisis," 38 percent "moderate crisis," and 9 percent "slight crisis." Hobbs contradicts other authors somewhat by minimizing the crisis aspects of the transition to parenthood. He does, however, recognize this period as a stressful transition when he states,

It would be more accurate to view the addition of the first child to a marriage as a period of transition which is somewhat stressful than to conceptualize beginning parenthood as a crisis experience for the majority of new parents (1968:417).

In summation, the systematic nature of marital interaction is revealed in the husband-wife similarity regarding their experiences during the transition to parenthood. Both experience personal and joint stress associated with this status transition, along with its accompanying fears, ambivalences, and hopes. Both experience changes in relating to each other. Marital interaction patterns change and this may be accompanied by changes in spouses' attitudes, feelings, and behavior in regard to family life.
Factors in Crisis Resolution

This set of findings reveals how the crisis or stress associated with the transition to parenthood can represent a threat or an opportunity for the marital partners. This crisis, like other crises, can be viewed as a turning point—as a point of no return.

If the "crisis" is handled advantageously, it is assumed the result for the individual is some kind of maturation or development. If the stress engendered by the "crisis" is not well coped with, it is assumed that the old psychological conflicts may be evoked or new conflicts may arise and a state of poorer mental health may be the result. Further, it is assumed that persons undergoing the "crisis" are amenable to influence when skilled intervention techniques of relatively brief duration are applied (Rappaport, Rhone, 1963: 68. See Caplan, 1960; Lindeman, Tyhurst, Erikson, Bibring, and Janis for supporting validation of these assumptions regarding crises).

Even though the birth of the first child is a normal development in the life of a family, it represents a point of no return with elements attached to it that are novel for the individuals experiencing them. Rappaport indicates:

This is especially true in our society where rites de passage are limited, where anticipatory socialization for new roles tends to be minimal, and where the prescriptions for behavior expected in new roles may be highly variable (1963: 69).

Goodrich and Bloomer (1963) state that the first pregnancy represents a puzzling or ambiguous situation and that the style of coping a couple uses a relevance in
future puzzling or ambiguous situations. Bibring (1959) found that during pregnancy unresolved problems have a tendency to reappear as partial or inadequate adjutivate solutions from the past appear to loosen. Thus, they may turn into family problems or they may stimulate the person or couple to a new phase of maturation.

In summation, it is assumed that the way a couple confronts the transition to parenthood will affect outcome both in terms of marital interaction changes and changes associated with attitudes one has of self, spouse, and marriage in general. It is further assumed that a couple's amenability to influence during this period will magnify the value or harm that differing styles of obstetrical care have upon family life. And finally, a learning process is assumed to take place in which the attitudes and patterns of joint participation that are employed to overcome this crisis may be used in future situations where a couple experiences stress or crisis.

**Children and Feelings of Satisfaction in Marriage**

This set of findings opposes the myth that children tend to improve feelings of satisfaction in marriage. Feldman (1969) found that marital satisfaction was lower for couples with one or more children than for couples with no children. He also found that "...the advent of the first child was a critical period, parents who had infants only
had more arguments than parents in any other stage of the family life cycle" (cited from Hobbs, 1965:367).

Pineo (1961) found that the third to twentieth years of marriage, during the primary childbearing years, was generally characterized by "disenchantment," less confiding, kissing, reciprocal settlement of disagreement, and more individual loneliness than earlier and later years of marriage. Feldman and Rogoff's (1968) study revealed that with the birth of the first child approximately 43 percent of both sexes decreased in satisfaction, about 39 percent remained the same, and approximately 18 percent increased in satisfaction, showing a statistically significant overall decrease in marital satisfaction following this time. Luckey and Bain concluded:

It may be inferred that while satisfied couples found their marriage enhanced by the companionship of each other, couples who found little in the way of companionship relied on their children primarily for satisfaction (1970:43).

In summation, Americans, who typically place a great deal of emphasis upon companionship, have generally not experienced increased marital satisfaction as a result of having children. The role that the American style of obstetrical preparation and care has played in this has not been adequately investigated.
Self Selection for Different Styles of Obstetrical Care

Findings regarding the self-selection process that influence some couples to select family-centered obstetrics and others to select wife-centered obstetrics are not consistent. Davis and Morrone (1962) found that there was significant difference between a group of women who attended a childbirth preparation class and those who did not. Reportedly, the former were older, better educated, from a higher occupational group, and had fewer expressed fears of pregnancy. Tanser (1967) indicated that she found no significant difference between those who chose natural childbirth and those who did not.

The physicians who provided subjects for this study disagreed on factors associated with women who selected family-centered versus wife-centered obstetrics. Some thought that years of schooling, intelligence, socio-economic class, or being a nurse were significant factors in causing women to be more interested in family-centered obstetrics, but one or more of the other participating physicians discounted each of these factors as being important.

It is thus assumed that in different locations, even within one city, different variables have a more significant association with couples who choose family-centered versus wife-centered obstetrical care.
Patterns of Support During Childbearing with Family-Centered Versus Wife-Centered Obstetrical Care

The final set of findings has to do with patterns of support and system boundaries of family-centered versus wife-centered obstetrical care. In other words, how does the style of obstetrical care encourage or discourage patterns of companionship and intimate sharing between a husband and wife? How do obstetrical procedures encourage or discourage isolation, separation, and the avoidance of meaningful participation in an important family venture?

Family-centered obstetrical care emphasizes a couple as the unit of attention during preparation for and participation in labor and delivery. Childbearing is viewed more in terms of a shared marital activity, with physical, emotional and social aspects, involving both the husband and wife, and eventually, the child. Wife-centered obstetrics emphasizes the wife and expectant child as the unit of attention during the childbearing period. Pregnancy is viewed primarily in terms of its physiological processes and how they alter both the mother and fetus.

Mead and Newton (1967), in their anthropological studies, clearly reveal some differences between family-centered and wife-centered preparation for labor and delivery that are found throughout the world. In summarizing a variety of studies they reveal:
Many primitive societies very directly stress the father's role during childbearing. The father feels personally responsible for the growth of the fetus because of the common belief that what the father does during pregnancy, as well as what the mother does, affects the health and development of the fetus. Food and activity restrictions involve not only the mother but the father also. The Hugao of the Philippines do not permit the husband to cut or kill anything during the wife's pregnancy. Relatives must even cut wood for him, which he then carries home. The Pacific Ocean Easter Islander father gets a real sense of participation in birth by having his wife recline against him during labor and delivery (1967:190).

Many cultures have adopted childbearing customs for expectant parents which emphasize the mutual nature of this family venture. Mead and Newton report further that:

The Ila husband and wife avoid the flesh of a hartebeest, since the young of this animal are born blind and they fear the human infant will be born blind if hartebeest flesh is eaten by the parents.... Among the Lepcha, both parents have a ceremonial cleansing in the fifth month of pregnancy. The custom of cauvade occurs in many parts of the world. Essentially it involves a period of activity, restriction and "regulation" for the father as well as the mother for a time after birth (1967:190).

It is thought, by persons who have studied childbearing customs in many cultures, that active roles for expectant fathers in preparation for parenthood help him to eventually be a better father and husband. Mead and Newton take the position that there is real survival value in childbearing customs which emphasize the active role of fathers. "It may help identify with the mother and baby" (1967:190).

In American middle-class culture, however, where wife-centered obstetrics represents the norm,
...the American man is often actively discouraged from aiding his wife directly at the time of parturition, seldom being permitted in the delivery room and being restricted in the times he may visit with his wife in the post-delivery hospital phase. During this period, too, he may be permitted to see his baby for a few minutes behind nursery glass, but touching his baby is taboo in most hospitals (Mead and Newton, 1967:191).

In other words, husbands are cast into a passive role with limited involvement during their wives' labor, delivery, and recovery.

Mead and Newton further report that in America more emphasis is placed on the wedding ceremony (i.e., name changing and changes in tax status, residence, and financial liability) rather than the later phases of fatherhood, and that this "...suitably expresses the American concept that the father's role is particularly concerned with monetary support" (1967:190). This tendency to separate men from the intimacies of parenthood or fatherhood may be further reflected in family therapy. Therapists report that it is not unusual for a father to feel that parenting is his wife's job more than his and that "...if the child acted disturbed, his wife was the one who should be seen" (Satir, 1967:4).

Family-centered obstetrics increases the patterns of support, strengthening the system boundaries, between husbands and wives as they actively prepare together and participate in the birth of their child. The obstetrical services and the relationship with the physician and the
hospital personnel tend to be experienced together by the couple. This is sometimes viewed as the successful completion of the joint act that began at the time of conception. Tanzer (1967:341-349) substantiates these claims with the verbatim responses of women who have experienced different styles of obstetrical care.

Wife-centered obstetrics emphasizes the dependency patterns an expectant mother has with her physician, the hospital personnel, and obstetrical services in general, possibly damaging system boundaries she has with her husband. The husband tends to be excluded from these dependency patterns, and he may or may not feel excluded by his wife as these patterns become more intense.

To the extent that a husband wants to be knowledgeable about, or involved in obstetrical care he has to enter a relationship that, by design, has excluded him. This is in some ways similar to psychiatric care in which a therapist refuses to see a spouse, and the person in treatment is the only source of information the spouse has about the progress of the "therapeutic relationship." In other words, a husband is cast in a passive, non-active role, and generally treated as if he had no role in childbearing.

Many men are seemingly repulsed by this, reacting to it by avoidance and withdrawal while making such statements as "that's what I'm paying the doctor for." Being cast in
this passive role may cause other husbands to feel they are no longer as important to their wives, and that their babies, which are overtly or covertly associated with obstetrical care, are their wives' but not their own major concern.

A husband's reaction to obstetrical care also affects his wife's reaction. Bradley (1965) found that having husbands actively involved in labor and delivery significantly reduced the rates of post-partum psychosis wives experienced. Kline (1955), in his study of post-partum psychoses, reports that resentment toward the husband is frequently associated with this psychiatric reaction, and that one of the most frequently expressed sources of resentment (of the wife toward her husband) is passivity on the part of the husband.

Tanzer's (1967) study further substantiates the belief that a husband's participation or lack of it during parturation influences a wife's reaction. She found that when a husband is jointly involved (natural childbirth) a wife tends to see him as "...a strong figure, to be praised explicitly, and whose presence and contribution were almost a necessity" (1967:341). She goes on to say that husbands who were not involved during labor and delivery were "...seen with substantial uniformity as an impotent or weak figure, one who is in the way, or one who needs to be worried about and taken care of" (1967:349).
Karmel, who opposes the American style of wife-centered obstetrics, uses stronger language in her claim:

Most American hospitals torture new mothers. They go on the theory that the hospital is there for nursing staff and doctors, not the patients. The mother is kept waiting half an hour while her history is recorded and certain assurances given that her bills will be paid. She is then stripped of her possessions, everything but her wedding ring, and hurried into a too-short, ugly hospital robe... psychologically she is reduced to a nonentity, a person expected to react like a helpless baby, completely submissive. Treated in this way, how can she be expected to participate fully in the birth process? All she wants is to be rendered unconscious of the terrors and encoraching discomforts. Insult is added to injury when she is put into bed with bars like a crib (1959:138-139).

Many of these degrading routines change rapidly when husbands are permitted to accompany their wives and actively participate in parturition. In a sense, he serves as an advocate for his wife to help ensure that more emphasis is placed on the meaning of the experience to her.

Grimm (1967) acknowledged that focusing upon physiological processes during pregnancy has helped to reduce maternal and infant mortality. She clearly claims, however, that current practices and attitudes associated with wife-centered obstetrics contribute to a rise in psychological tension. Richardson and Guttmacker, in the forward of their book *Childbearing: Its Social and Psychological Aspects*, make the claim that:
The behavior of women and those who assist them in childbirth becomes patterned and regulated into customs and practices. Cross-cultural comparisons of customs and practices show that within Western industrial societies obstetrical services that are often thought of as planned and rational contain many forms of behavior which are habitual, traditional and so assumed as to preclude their evaluation (1967:IX).

This research, by design, questions whether the systematic exclusion of husbands from many of the more intimate events during childbearing is rational.

This study, however, does not assume that all men want or should be involved in obstetrical care. Rather, this should be an option that couples can freely and openly explore with their obstetricians without the overt or covert threat that for many, currently, accompanies such an exploration. For example, one physician contacted prior to the time this study began openly acknowledged he would not admit patients who preferred family-centered obstetrics. Also, several expectant mothers who were in the research sample indicated they were turned down by an obstetrician when he learned they were interested in having their husbands actively involved. Likewise, physicians on the staff of a local hospital recently voted to continue the policy of not allowing individual obstetricians to have the discretion to permit selected husbands to be in the delivery room with their wives. This permits them to hide behind the shield "It's against hospital policy" when.
couples attempt to explore the possibility of joint participation with them.

Many husbands have no interest in joint participation with their wives during parturition. Engle (1963) found that in Evansville, Indiana, where husbands are reportedly encouraged to participate in the childbearing process 54.9 percent of 267 fathers studied indicated they did not feel husbands belonged in the delivery room. Bradley found that:

Both obstetricians who forced the participation of husbands and hospitals which exclude him from the delivery room have more anxious, frightened mothers who plead for medication and require more forceps deliveries than if they had received no prenatal instruction at all (1962:172).

Forced participation and exclusion from participation are considered to be equally unacceptable. Free and open discussion with each expectant couple about their interest and about alternatives, regarding style of obstetrical care, would appear to be an ideal custom.

In summation, it seems reasonable to assume that if one spouse, in order to receive services, has to become increasingly dependent upon a person or service that excludes the other spouse, marital interaction patterns will be shaped differently than if both spouses are intimately involved with the outside person or service. This seems especially true when (1) both spouses would prefer to be jointly included with the outside person or service,
and (2) when the event precipitating the need for outside services is as important to both spouses as bearing children.

Summary of Findings that Served as a Background for the Study

The review of the literature reveals that a marital relationship, like a nuclear family, is characterized by a process and style. This process and style has a profound influence upon the spouses' and eventually the children's attitudes and behavior. This relationship, although partially shaped by children, is the axis around which other family relationships evolve and develop. Enhancing its quality is thought to have a direct positive influence upon the nature and history of a family's life.

In America, the marital relationship has generally not prospered following the transition to parenthood. This status transition frequently represents a crisis in which unresolved conflicts may be evolved within spouses, and spouses' potential susceptibility to a variety of pathological reactions is increased. But with this increased susceptibility to personal or marital disintegration, is also an increased susceptibility to personal and marital maturation and growth. This maturation may be facilitated with minimal intervention at the right time. The extent of this potential growth to a marriage relationship is not fully known. Also, it is not known how contrasting styles
of obstetrical care help or hinder spouses as they attempt to confront, evade, or cope with this transition crisis.

In contemporary American culture childbirth is generally cloaked in privacy and seeing birth is usually considered appropriate only for medical personnel. Childbearing is generally treated as an illness. Husbands, or other family members, are generally expected to adhere to an imposed "quarantine" that may physically, psychologically and socially separate them from their wives and babies. Is our most popular style of obstetrical care (i.e., wife-centered obstetrics) rational or is it the result of habitual traditional patterns that are so assumed as to preclude their evaluation? Whether our respect for this "quarantine pattern" during obstetrical care distracts from the marital relationship following the childbearing process needs to be studied in more detail.
CHAPTER II
MAJOR QUESTIONS, ASSUMPTIONS AND HYPOTHESES

The time boundaries of this longitudinal study emphasized changes that took place in family life between early in the third trimester of pregnancy and several weeks after the mother and child were discharged from the hospital. The study was designed to help clarify how family-centered versus wife-centered obstetrics affects family life. That is, how does family-centered versus wife-centered obstetrical care affect observed marital interaction patterns (i.e., joint behavior patterns of spouses) and self-reported attitudes persons have about their marital adjustment, self concept and concept of ideal self, spouse, and ideal spouse. The specific questions that were studied include the following:

I. How did family-centered versus wife-centered obstetrical care affect observed marital interaction variables?

A. How did the style of obstetrical care affect the quality of marital interaction?

1. the couples' rates of positive (friendly speeches?

2. the couples' rates of negative (attacking) speeches?

3. the couples' units of laughter?
B. How did the style of obstetrical care affect the efficiency of marital interaction?

1. the couples' units of explicit information exchanged?
2. the couples' amount of choice fulfillment?
3. the couples' percentage of silence during decision making?

C. How did the style of obstetrical care affect the congruency of marital interaction?

1. spouses' spontaneous agreement rates?
2. spouses' congruency rates of positive speeches?
3. spouses' congruency rates of negative speeches?
4. spouses' congruency rates of units of laughter?
5. spouses' congruency rates of explicit information exchanged?
6. spouses' congruency rates of choice fulfillment?
7. spouses' congruency rates of total talking time?

II. How did the style of obstetrical care affect self-reported attitudes that were generally assumed to be associated with or influenced by one's family life?

A. How did it affect self-reported attitudes of one's marital adjustment?

B. How did it affect self-reported attitudes of one's self concept and concept of ideal self?
C. How did it affect self-reported attitudes of one's concept of spouse and ideal spouse?

D. How did it affect congruency ratings associated with these self-reported attitudes?
   1. self concept and concept of ideal self?
   2. concept of spouse and concept of ideal spouse?
   3. concept of ideal self and concept of spouse?

It was assumed that there is a close association between observed patterns of marital interaction and self-reported attitudes associated with family life. It was beyond the scope of this study, however, to systematically evaluate how observed marital interaction variables complement or contradict self-reported attitudes associated with family life. (Using this data to help refine knowledge regarding the association of observed marital interaction and self-reported attitudes will be the focus of a later study.)

It was further assumed that (1) the sample selected for the investigation reflected many of the characteristics of the population from which it was drawn; (2) the groups that were compared were independent of each other in that responses of persons in one group in no way affected the responses of persons in the other group; (3) there are changes in family life which accompany the birth of a child, and that these changes are generally more significant with the first child; (4) that dissimilar styles of
obstetrical care generally have dissimilar influences upon changes in family life associated with childbearing; and (5) changes in family life are assumed to be "favorable" or "unfavorable." This distinction was dependent upon how the indicators of family life were previously associated with normal or abnormal families. That is, change in a direction that characterized abnormal families was assumed to be "unfavorable," while change in a direction that characterized normal families was assumed to be "favorable."

It was hypothesized for testing that couples who have utilized family-centered versus wife-centered obstetrics would experience more favorable change, which included less unfavorable change, regarding their:

• $H_1$ quality of marital interaction;
• $H_2$ efficiency of marital interaction;
• $H_3$ congruency of marital interaction;
• $H_4$ marital adjustment;
• $H_5$ self concepts;
• $H_6$ concepts of spouse;
• $H_7$ congruency between self concept and concept of ideal spouse;
• $H_8$ congruency between concept of spouse and ideal spouse;
• $H_9$ congruency between concept of ideal self and spouse.
CHAPTER III
RESEARCH METHODS AND DESIGN

Testing hypotheses related to the effect of family-centered versus wife-centered obstetrical has upon family life was the purpose of this longitudinal study and its comparative survey design. A pilot study consisting of eight couples was completed prior to collecting data for the actual study. Its main purpose was to refine the procedures for systematically seeing couples at the hospital where they planned to deliver. Some refinement of the situations and choices in the "Marital Interaction Index" also resulted from this preliminary study.

The study sample consisted of thirty-eight couples, of which nineteen utilized family-centered obstetrics and nineteen utilized wife-centered obstetrics. All of the couples were seen early in the third trimester of pregnancy, and again, several weeks after the mother and child were discharged from the hospital. The first interview took place at the hospital where the expectant mother planned to deliver, and the second interview generally took place in the couples' home. Two couples preferred to be seen at the hospital for the second interview due to the
fact that members of their extended families were temporarily staying with them.

**Sampling Frame and Procedures**

All couples selected to participate in this study were required to meet the following criteria: that they (1) be primipara (i.e., expecting their first child); (2) have established their own household; (3) plan to deliver at Mt. Carmel or St. Ann's Hospital as a private patient; (4) plan to deliver in December, 1971, or January, February, or March, 1972; and (5) have not taken part in previous classes preparing them for joint participation during labor and delivery. These criteria limit the ability to generalize the findings of this study to all expectant couples, but it was necessary to control for demographic and socio-economic variables which were not studied in this project.

The sampling frame grew out of an informal study of the community, in which it was revealed that only two hospitals, Mt. Carmel and St. Ann's, permitted obstetricians to decide whether husbands could be in labor and delivery. (Since this study began, several other local hospitals have adopted the practice of allowing the physician to decide with his patients what a husband's involvement in labor and delivery can be.)

An obstetrical nursing supervisor from each hospital participated in the selection of obstetricians for this study. The basis for this selection was whether a physician
permitted couples to utilize family-centered or wife-centered obstetrical care. In other words, all of the physicians selected to participate in this study revealed by their practice that they provide both family-centered and wife-centered obstetrical care.

Twelve physicians were invited to participate in the study. Of these, two physicians preferred not to become involved. Also, two of the ten physicians who did have interest in supporting the study did not have family-centered and wife-centered obstetrical patients who met the criteria of the study. Eight obstetricians thus supported this study by asking expectant mothers, with whom they were working, whether they and their husbands were willing to volunteer for the study. Four of these physicians deliver most of their patients at Mt. Carmel Hospital. The remaining four deliver all of their family-centered obstetrical patients at St. Ann's Hospital, but a significant number of their wife-centered obstetrical patients are delivered at other local hospitals.

The obstetrician or his office nurse asked each patient expecting her first child during December, 1971, or January, February, or March, 1972, her willingness to take part with her husband in a voluntary study on childbirth and family life. Those who agreed to participate filled out a questionnaire (see Appendix A) entitled "Questionnaire for Expectant Mothers." This was used to obtain basic
demographic and socio-economic data and information which was helpful in determining their interest in family-centered versus wife-centered obstetrical care.

Every two weeks during September, October, and November these questionnaires were collected from each physician and scored according to the criteria for selection. Couples from each physician who qualified were then grouped into one of two categories: one, couples who expected to utilize family-centered obstetrics, and two, couples who expected to utilize wife-centered obstetrical care. There was thus a group of couples selecting family-centered and wife-centered obstetrical care for each of the eight physicians in the study.

All of the couples making up the smaller of the two groupings for each physicians were selected and the same number of couples from the larger group were selected at random. For example, one physician supplied four couples planning to use wife-centered care and six couples planning to use family-centered care. Each of those planning to use wife-centered care were selected, and four of the six couples planning to use family-centered care were chosen at random for inclusion in the sample. This procedure was designed to insure that each physician had approximately the same number of patients in each of the two groups being studied. It is assumed, however, that these two groups are independent of each other in that the responses of
persons in one group would not affect the responses of those in the other group.

As anticipated, there was some shifting of those expecting to be in one of the two groups. Five couples who originally indicated their preference for family-centered obstetrics ended up selecting wife-centered obstetrics. Generally, this was because they failed to carry through on the necessary preparation. That is, the obstetricians in the study require couples to attend preparation classes in order to experience childbirth together. Also, five couples who originally expressed no interest in family-centered obstetrics ended up selecting it. This generally occurred as a result of their becoming aware that family-centered obstetrics was available, and perhaps, by having it promoted by an acquaintance or friend.

Procedures and Instruments Utilized to Collect Data

The first data collection took place at the physicians' offices when subjects voluntarily filled out the "Questionnaire for Expectant Mothers," which was also used to select the sample. Those expectant mothers selected for the study were then contacted by phone to schedule a joint interview with her and her husband at the hospital where they planned to deliver. This apparently eliminated much resistance associated with participation in research projects. Many of the research subjects expressed
gratitude for being able to visit the hospital, prior to delivery, where they planned to have their baby. Two husbands refused to participate after their wives had voluntarily filled out the "Questionnaires for Expectant Mothers."

The three instruments utilized to collect data correspond closely with the major research questions and hypotheses outlined in Chapter Three. The "Marital Interaction Index" (see Appendix B) is a lengthened version of a low inference scale developed by Ferreira and his associates. Ferreira and Winter (1965) indicated that the content of the situations and choices used in this index have little importance. Ferreira (1971) stated that the seven situations he developed (see Appendix B, one through seven) are sufficient in-and-of themselves to evaluate marital interaction. He recommended, however, that several more situations and choices specifically focused upon the population being studied also be developed (see Appendix B, eight through twelve).

Riskin's method of "microanalysis" was adapted to the "Marital Interaction Index" to measure the quality of marital interaction (i.e., the relationship). Positive speeches, negative speeches, and units of laughter were used as indicators of the quality of marital interaction. This index also measured the efficiency of marital interaction, based upon explicit information exchanged, choice
fulfillment, and the percentage of time spent in silence during decision making. Further, it measured the congruency of marital interaction, based upon the spouses' rates of spontaneous agreement, positive speeches, negative speeches, units of laughter, explicit information exchanged, choice fulfillment, and total talking time.

The "Short Marital Adjustment Index" (see Appendix C), developed and refined by Locke and Wallace, is a self-report scale designed to measure attitudes one has toward his (her) marital adjustment.

Bills' "Inventory of Adjustment and Values" formed the basis of the second self-report attitude scale (see Appendix D). The original IAV contained forty-nine traits to independently measure self concept, self acceptance, and concept of ideal self. Eastman (1958) found that self acceptance could also be measured by determining the discrepancy between self concept and concept of ideal self, and that this reduced the time the index takes to administer by one-third. In this study, likewise, the second self-rating, i.e., self acceptance, persons originally made on each trait was excluded, and the discrepancy between self concept and concept of ideal self was assumed to be a good measure of self acceptance.

Thus, forty-nine traits from the IAV were chosen to measure self concept and concept of ideal self, and these same traits were selected to measure concept of spouse and
concept of ideal spouse. The following congruency ratings were also obtained from the IAV's scores: self concept--concept of ideal self, concept of spouse--concept of ideal spouse, and concept of ideal self--concept of spouse.

The IAV, like the "Short Marital Adjustment Index," provided a systematic way to deal with what a subject says about himself and his spouse. When used as a classification of direct, surface statements that a subject makes about himself and his spouse, both of these instruments may be considered valid expressions of the way a person chooses to present himself and his view of his spouse. It was not known how persons would choose to present themselves in a research study that focuses upon childbirth and family life.

Beyond these four instruments, a "Wives" and "Husbands" questionnaire (see Appendix E and F) was utilized during the second interview to find out more about the couples' experiences during the childbearing process and to gather data on possible intervening variables. Furthermore, each of the spouses were asked to verbally respond to a series of open-ended questions regarding the hospital experiences associated with childbearing (see Appendix G). These responses were recorded for further evaluation.

The first data-collection interview, which consisted of a standardized series of assignments, took place early in the third trimester of pregnancy. Some attempt was made
to place the couple at ease by informing them about the nature of the research and its general purpose. For example, they were told there were no right and wrong answers. Also, emphasis was placed upon the importance of learning more about how having children affects normal, healthy families. Participants were not informed that a comparison of family-centered versus wife-centered obstetrics was being made. Persons were also invited to ask questions throughout the interview, if they did not understand some assignment.

Following this, written permission was obtained to tape record portions of the interviews and spouses were seated in such a way as to insure privacy while filling out the "Short Marital Adjustment Index." Many persons joked about this but seemed relieved to know their spouses would not see how they responded to this questionnaire. It was emphasized that they should fill this out as they felt then, recognizing that they might feel differently at a later date.

Persons were then asked to privately fill out the "Marital Interaction Index." This consisted of selecting three choices one liked most and three choices one liked least or not at all for each of twelve situations. Instructions emphasized that this questionnaire contained a number of choices, which although they may be improbable
in real life, should be filled out as if they were in fact real choices.

After these were collected, spouses were asked to fill out the same questionnaire as a couple. Selecting the three choices most preferred and least preferred as a "couple" was the assignment. In other words, the choices they selected were to apply to the two of them. The couple was asked to come to decisions as they would if they were home. They were then informed the tester would leave the room and that they should open the door when they had completed the questionnaire. A tape recorder was turned on as the tester left the room.

The "Index of Adjustment and Values" was the last structured assignment of the first data-collection interview. Spouses were again asked to fill this out privately and as they felt at the moment, recognizing that they might fill it out differently at another time. The interview generally ended with informal questions and comments and occasional jokes about the need to know how to get to the hospital rapidly or about the new status couples would soon have as parents. Arrangements were made for the tester to phone the couple near their expected date of delivery to schedule the second interview.

The second interview was much as the first although special improvisations associated with having the interviews in homes had to be made. Interviews typically began with
the couple showing the tester the baby, which was usually sleeping. If a baby cried, one parent usually held him (her) as the spouses conversed and filled out the questionnaires.

The first questionnaires filled out in this interview were the "Wives" and "Husbands" questionnaires, designed to disclose information about objective experiences during childbearing and possible intervening variables. This was followed by a more subjective verbal account of experiences and feelings associated with childbearing, which was tape recorded for more systematic analysis. Besides more informal comments, the questions outlined in Appendix G were covered.

The last part of this interview consisted of filling out for a second time the "Short Marital Adjustment Index," the "Marital Interaction Index," and the "Index of Adjustment and Values." Directions remained the same. For the last part of the "Marital Interaction Index" couples moved, or had the tester move, to another room so that they would be interacting privately as they jointly filled out the questionnaire. This decision-making interaction was again tape recorded. In concluding this interview, couples were informed of the tester's interest in doing a two or three year follow-up study in order to expand what can be learned by the longitudinal nature of the study.
Assumptions of Data and Procedures for Scoring

The scores for data in this research were assumed to be nonparametric in nature. That is, most of the data is assumed to be of nominal or ordinal quality, and it is not known whether the population is normally distributed. Nonparametric statistical tests (i.e., median, Fisher Exact Probability, Chi Square, and Mann-Whitney U Tests) were thus used to determine the rate and direction of change differences between the family-centered and wife-centered obstetrical groups, and to determine the likelihood that these differences resulted from chance.

The probability rate of .05 was utilized to determine the statistical significance of findings. A two-tailed test of statistical significance was used to descriptively compare the two groups since no significant differences were anticipated prior to the entry of some couples into childbirth preparation classes (i.e., family-centered obstetrical care). A one-tailed analysis of statistical significance was used to test the hypotheses. It was assumed that important trends in the findings may be discovered which will be valuable to the reader even when they fail to reach the .05 level of statistical significance.

Positive speeches, negative speeches, and the units of laughter were used to score the quality of marital interaction. The method of "microanalysis," popularized by Riskin, was utilized to score the quality of marital
interaction speeches. This analysis was done "blindly," i.e., by an interpreter who knew nothing about the couple except that they were in the study. This involved use of the tape to transcribe, evaluate, and score the first sixty speeches (i.e., the first sixty verbal or vocal sounds that one spouse makes until the other spouse makes a sound). A second block of sixty speeches were scored as the couple began discussing the seventh situation posed in the "Marital Interaction Index."

Each one of these blocks of sixty speeches represented from three to five minutes of interaction. Thus, six to ten minutes of marital interaction was microanalyzed. Riskin's (1964) work reveals that four to five minutes of microanalysis contains enough information on which to do meaningful analysis. All speeches were scored as positive, neutral, negative, or nonscorable.

The amount of laughter that occurs during the micro-analysis was scored in units. One laughter unit or unit of laughter consisted of laughter that occurred from the time it became audible on the tape to the time it was inaudible.

Whether the quality of marital interaction was significantly more favorable in the family-centered versus the wife-centered group was determined by whether at least two of the three indicators making up the quality of marital interaction showed a statistically significant favorable
change, or less unfavorable change, between the first and second data collection. That is, did the rate of positive speeches increase more (or decrease less), the rate of negative speeches decrease more (or increase less), and the units of laughter increase more (or decrease less) in the family-centered versus the wife-centered group?

The efficiency of marital interaction was obtained by:

one, matching what was heard on the tape with what was written on the private "Marital Interaction Index"; two, listening to the tape; and three, tallying what was written on the private marital interaction questionnaire with what was written on the joint questionnaire.

The units of explicit information exchanged were obtained by listening to the tape and registering each time a spouse explicitly or clearly stated that he (she) wanted, preferred, or liked, or on the contrary, did not want, prefer, or like a listed choice. What was heard on the tape was then compared with what appeared in writing on the private "Marital Interaction Index." One explicit informational unit was scored whenever what was heard corresponded in fact with the choice, positive or negative, that appeared in writing on the spouse's private "Marital Interaction Index." The rate of explicit information exchanged was a couple's rate derived from the sum of the two spouses' rates.
A couple's choice fulfillment was determined by tabulating the sum of choices, positive and negative, that appeared on either of the two private questionnaires and were also found on the joint questionnaire. The possible range in score was from zero, or no choice fulfillment, to 144, which represented the highest possible rate of choice fulfillment.

The amount of silence that occurs as the couples fill out the joint "Marital Interaction Index" was determined by using a stop watch, while listening to the tape, to determine the percentage of decision time in which neither spouse is talking. "Microanalysis" of six minutes of each taped interaction was scored to determine the percentage of time a couple was silent and the percentage of time the husband and the wife spoke. This six-minute measurement began as couples started discussing the second situation on the "Marital Interaction Index."

Whether the efficiency of marital interaction was significantly more favorable in the family-centered versus the wife-centered group was determined by whether at least two of the three indicators making up the efficiency of marital interaction showed a statistically significant favorable change. That is, did explicit information exchanged and choice fulfillment increase more and did the percentage of silence decrease more in the family-centered versus the wife-centered obstetrics group?
The congruency rates of marital interaction, likewise, were scored by tabulating the written results of the private and joint "Marital Interaction Index" and/or by identifying what was heard on the tape with what appeared in writing on the questionnaire.

Spontaneous agreement was a congruency rating that was scored by summing the number of matched choices, positive and negative, that occurred between a husband and wife's private questionnaires. In other words, a couple's rate of spontaneous agreement reveals how much they intuitively agreed and disagreed prior to the time they openly discussed their likes and dislikes. This congruency rating was different than the following congruency ratings in that the larger the numerical figure became, the more congruency this represented. The possible range in scores was from 0, in which no choices selected by the spouses matched, to 72, in which all the choices selected by each spouse matched the other.

The spouses' congruency rates of positive speeches was scored by determining the difference between a husband's and wife's number of positive speeches during the "micro-analysis." The possible range of scores was from 60, if one spouse had all positive speeches and the other spouse's speeches were all negative, neutral or non-scorable, to 0, if both spouses had the same number of positive speeches.
The spouses' congruency rates of laughter units was scored by determining the difference between a husband's and wife's units of laughter during the "microanalysis."

Spouses' congruency rates of explicit information exchanged was determined by differentiating the explicit informational units a husband had with those his wife had. The range of possible scores was from 72, for the least congruency to 0, for the most congruency. The congruency rate was obtained by determining the difference between the husband's and wife's units of explicit information exchanged.

The spouses' congruency rates of choice fulfillment, sometimes referred to as "win rates," were scored in a three step process: one, tabulating the number of choices, positive and negative that appeared on a husband's private questionnaire and the joint questionnaire; two, likewise, tabulating the number of choices, positive and negative, that appeared on a wife's private questionnaire and the joint questionnaire; and, three, the difference between these two rates, which represented the congruency rates of choice fulfillment, was calculated. The possible range of scores was from 72, in which the joint questionnaire matched the choices of one spouse completely and contained none of the other spouse's choices, to 0, in which the same number of choices that appeared on each spouse's private questionnaire also appeared on the joint questionnaire.
Spouses' congruency rates of total talking time were obtained with a stop watch from the "Marital Interaction Index" taped discussion. It was calculated by analyzing six minutes of interaction to see the times that each spouse was making vocal sounds, verbal or non-verbal. The difference between the percentage of time the husband and wife spoke represented this congruency rate.

The indicators of marital interaction congruency in this study, like those representing the quality and efficiency of marital interaction were not equal, and thus were not considered additive. In order for marital interaction congruency, therefore, to have had more favorable change in the family-centered versus the wife-centered group, four of the seven indicators of marital interaction congruency had to show a statistically significant favorable change in the hypothesized direction. That is, spouses' congruency rates of spontaneous agreement, positive speeches, negative speeches, units of laughter, explicit information exchanged, choice fulfillment, and total talking time had to become more congruent (or less divergent) in the family-centered versus the wife-centered obstetrical group.

The score for the self-reported attitudes of marital adjustment was obtained from the Locke-Wallace "Short Marital Adjustment Index." Appendix C reveals the numerical weighting that each response had. The possible range of scores was from 2, which represented a "very unhappy"
evaluation of one's marital adjustment, to 158, which represented a "very happy" evaluation of one's marital adjustment. The spouses' scores were combined to represent marital adjustment for a couple. These scores, however, were assumed to represent the sum of two individual's attitudes rather than some joint evaluation made by the two spouses.

The self-reported attitudes of one's self concept, concept of ideal self, spouse, and ideal spouse were obtained by summing the column totals in Bills' "Inventory of Adjustment and Values" (IAV). The different congruency scores (i.e., self concept--concept of ideal self, concept of spouse--concept of ideal spouse, and concept of ideal self--concept of spouse) were determined by calculating the difference between the appropriate column totals.

Possible Intervening Variables

There were many possible intervening variables that could have altered the validity of the project's findings. There was only one, however, for which the research design has controlled. It was assumed that the obstetricians could be significant intervening variables if different ones had most or all of their patients in one of the two groups being compared. Procedures were thus adopted in the selection of the sample to insure that physicians had a similar number of patients in both the family-centered and wife-centered group.
Other variables were identified and studied to investigate the probable influence they had on the findings. In developing the research design, however, control was not provided for them. These variables are classified into one of four categories: characteristics of individuals, characteristics of couples, characteristics of spouses' joint behavior patterns and familial attitudes early in the third trimester of pregnancy, and factors associated with parturition, hospitalization, and the post-hospital recovery period.

Characteristics of individuals that were compared between the family-centered and wife-centered group include the following: age, years of schooling, occupational roles of spouses, marital history of spouses and their parents, and religious identification. Characteristics of couples, likewise, were compared. These include the length of marriage, family income for 1971, anticipated family income decrease for 1972, and planned versus unplanned pregnancies.

The group that selected family-centered obstetrics was compared in terms of spouses' joint behavior patterns and familial attitudes with the group who later selected wife-centered obstetrics, early in the third trimester of pregnancy. The observed quality, efficiency, and congruency of marital interaction were compared, as were the self-reported attitudes associated with marital adjustment, self concept, and concepts of ideal self, spouse, and
ideal spouse. In other words, these variables were studied to see if the two groups appeared to come from the same, or a basically different, population prior to the entry of some into childbirth preparation classes.

And finally, the two groups were compared in terms of factors related to parturition, hospitalization and the post-hospital recovery period. These factors included, spouses being together during labor and/or delivery, mothers being awake during delivery, mothers using medication during parturition, couples using rooming-in when they had the option, persons experiencing complications associated with childbirth, couples having help in the home following the mother and child's discharge from the hospital, and the method's method of feeding the baby, breast or bottle.

One variable that could not be controlled for or precisely evaluated was the effect of physicians knowing which patients were receiving family-centered versus wife-centered obstetrical care. It was not thought, however, that their awareness of this favorably influenced variables associated with family-centered obstetrical care. Six of the eight doctors supplying couples for the study reportedly "do not push" family-centered obstetrical care but rather "simply make it available to those who request it." One physician, who had only two couples in the study, is known as a doctor "who encourages" spouses to experience
childbearing together. The other physician, who had six couples in the study, encourages women who display "abnormal fears or confusion" about childbearing to take the childbirth preparation classes. He indicated, "This gives them a chance to talk with others and to overcome some of their fears." This physician reportedly does not encourage or discourage prepared husbands to participate in delivery.
CHAPTER IV

FINDINGS

General Description of Family-Centered and Wife-Centered Obstetrical Groups

The family-centered and wife-centered obstetrical groups were compared in terms of a number of variables. This was done to determine whether certain types of individuals or couples were more inclined to select one style of obstetrical care versus the other or whether both groups came from essentially the same population. This comparison was also made to identify factors that might intervene in the effects different styles of obstetrical care have on family life. In comparing the two groups, special emphasis was placed upon the characteristics of individuals, couples, spouses' behavior patterns and attitudes at the beginning of the third trimester of pregnancy, and factors associated with labor, delivery, and recovery.

Many of the comparisons of the family-centered versus the wife-centered obstetrical groups are presented in tabular form. Nineteen couples, or thirty-eight persons, comprised the number representing the family-centered group and nineteen couples, or thirty-eight persons, comprised the number in the wife-centered group. The general charac-
teristics of the two groups were assumed to be similar prior to the time the family-centered group members began childbirth preparation classes. A two-tailed test of statistical significance was used to reveal the probability of differences between the two groups.

Characteristics of Individuals

Age and years of schooling differences of persons in the two groups were not consistent. "Years of Schooling" refers to years of formal training. Husbands in both groups had a similar age distribution but wives selecting family-centered care tended to be older than those selecting wife-centered care. Husbands and wives selecting family-centered care had significantly more years of schooling than did those selecting wife-centered care.

Table 1. Spouses' Ages and Years of Schooling: Median Years, U Test Scores, and Levels of Significance

<table>
<thead>
<tr>
<th></th>
<th>Family-Centered</th>
<th>Wife-Centered</th>
<th>Mann-Whitney U</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husbands</td>
<td>25 years</td>
<td>24 years</td>
<td>159.0</td>
<td>.53</td>
</tr>
<tr>
<td>Wives</td>
<td>24 years</td>
<td>23 years</td>
<td>119.5</td>
<td>.07</td>
</tr>
<tr>
<td><strong>Years of Schooling</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husbands</td>
<td>16 years</td>
<td>14 years</td>
<td>99.0</td>
<td>.01*</td>
</tr>
<tr>
<td>Wives</td>
<td>16 years</td>
<td>13 years</td>
<td>54.5</td>
<td>.0002*</td>
</tr>
</tbody>
</table>

*Statistical significance occurs at the .05 level.
The spouses' occupational roles in the two groups were not, according to the Fisher Exact Probability Test, significantly different. "Wives Employed" refers to whether the wives were working outside of the home prior to childbearing. "Wives: Nurses" refers to whether an expectant mother was trained as a nurse. None of the husbands in the study were nurses. "Husbands' Positions" refers to the occupational position that husbands had or were training for at the time of the first data collection. "White collar" refers to professional, administrative, and sales positions, and "Blue collar" refers to positions requiring manual labor and skills.

Table 2. Occupational Roles of Spouses

<table>
<thead>
<tr>
<th></th>
<th>Family-Centered</th>
<th>Wife-Centered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wives Employed</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>15</td>
<td>14</td>
</tr>
<tr>
<td>No</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>Wives: Nurses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>No</td>
<td>13</td>
<td>17</td>
</tr>
<tr>
<td><strong>Husbands' Positions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White collar</td>
<td>14</td>
<td>12</td>
</tr>
<tr>
<td>Blue collar</td>
<td>5</td>
<td>7</td>
</tr>
</tbody>
</table>
Table 3. The Marital History of Spouses and Their Parents

<table>
<thead>
<tr>
<th></th>
<th>Family-Centered</th>
<th>Wife-Centered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First Marriage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husbands</td>
<td>19</td>
<td>19</td>
</tr>
<tr>
<td>Wives</td>
<td>19</td>
<td>17</td>
</tr>
<tr>
<td><strong>Parents Divorced</strong></td>
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<td></td>
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<td>Husbands</td>
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<td>2</td>
</tr>
<tr>
<td>Wives</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

The study sample was made up primarily of persons who identified themselves as Protestant or Catholic. Thirteen husbands and twelve wives in the family-centered group and twelve husbands and wives in the wife-centered group identified themselves as Protestant. Four husbands and six wives in the family-centered group and six husbands and seven wives in the wife-centered group referred to themselves as Catholic. There was one husband in the family-centered group who identified himself as Jewish, and a husband and wife who did not identify themselves with any organized religion. Also, one husband in the wife-centered group did not identify himself with any organized religion. The difference in religious identification between the two groups was not considered to be important.

**Characteristics of Couples**

The length of marriage for those couples selecting wife-centered care is significantly shorter than for those
groups was not considered to be important.

Characteristics of Couples

The length of marriage for those couples selecting wife-centered care is significantly shorter than for those selecting family-centered care. In general, being married longer before the birth of the first child also appears to be closely associated with spouses who are older and have more years of schooling.

Table 4. Length of Marriage: Level of Significance

<table>
<thead>
<tr>
<th></th>
<th>Family-Centered</th>
<th>Wife-Centered</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than three years</td>
<td>7</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Three years or more</td>
<td>12</td>
<td>5</td>
<td>0.05</td>
</tr>
</tbody>
</table>

Couples with high and low incomes for 1971 existed in both groups, and amount of income was not significantly different in the two groups.

Table 5. Family Income for 1971

<table>
<thead>
<tr>
<th></th>
<th>Family-Centered</th>
<th>Wife-Centered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $8,000</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>$8,000 to $11,999</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>$12,000 to $15,999</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>$16,000 to $19,999</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>$20,000 and over</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
The change in employment status for wives was the major cause of the anticipated family-income decrease for 1972.

Table 6. Anticipated Family Income Decrease for 1972

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Family-Centered</th>
<th>Wife-Centered</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Under $3,000</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>$3,000 to $5,999</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>$6,000 to $8,999</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>$9,000 and over</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

The difference between the two groups regarding anticipated income decrease was not significantly different although there was some tendency for the family-centered group members to anticipate more of an income decrease for 1972 than the wife-centered group members.

Twelve couples in both groups indicated that they had planned versus unplanned pregnancies so this was not considered to be a factor in selecting a style of obstetrical care.

Characteristics of Spouses' Joint Behavior Patterns and Attitudes at the Beginning of the Third Trimester of Pregnancy

The joint behavior patterns of spouses (i.e., the marital interaction patterns) and their self-reported attitudes used to evaluate change associated with a style
of obstetrical care revealed that, in general, there were no significant differences between the two groups at the beginning of the third trimester of pregnancy. Statistical significance was again determined by a two-tailed test since it was assumed that the two groups were similar at this time.

There was no significant difference between the two obstetrical groups, early in the third trimester of pregnancy, regarding the observed quality, efficiency, or congruency of marital interaction. Table 7 reveals a non-significant tendency for couples who selected wife-centered care to use more positive speeches (i.e., friendly speeches)

Table 7. Quality of Marital Interaction: Median and U Test Scores and Levels of Significance

<table>
<thead>
<tr>
<th></th>
<th>Family-Centered</th>
<th>Wife-Centered</th>
<th>Mann-Whitney U</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive Speeches</td>
<td>11</td>
<td>17</td>
<td>138.0</td>
<td>.21</td>
</tr>
<tr>
<td>Negative Speeches</td>
<td>5</td>
<td>5</td>
<td>151.0</td>
<td>.39</td>
</tr>
<tr>
<td>Units of Laughter</td>
<td>13</td>
<td>12</td>
<td>177.5</td>
<td>.93</td>
</tr>
</tbody>
</table>

than couples who choose family-centered care. The distinction in scores of negative speeches (i.e., attacking speeches) and units of laughter is less apparent and would appear to be due more to chance than to differences between the two groups.
The indicators of marital interaction efficiency, likewise, failed to reveal a statistically significant difference between the two groups. Explicit information refers to the behavioral characteristic of stating likes and dislikes clearly. Choice fulfillment refers to how well spouses' individual likes and dislikes correspond with their joint likes and dislikes. Median and U Test scores reveal that the persons who selected one of the two obstetrical styles being studied were similar regarding these indicators of interactional efficiency.

Table 8. Efficiency of Marital Interaction: Median and U Test Scores and Levels of Significance

<table>
<thead>
<tr>
<th></th>
<th>Family-Centered</th>
<th>Wife-Centered</th>
<th>Mann-Whitney</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explicit Information</td>
<td>100</td>
<td>102</td>
<td>180.0</td>
<td>.99</td>
</tr>
<tr>
<td>Choice Fulfillment</td>
<td>97</td>
<td>97</td>
<td>171.0</td>
<td>.78</td>
</tr>
<tr>
<td>Percentage of Silence</td>
<td>24</td>
<td>23</td>
<td>160.5</td>
<td>.56</td>
</tr>
</tbody>
</table>

The congruency of marital interaction, likewise, failed to reveal significant differences between the two groups. Spontaneous agreement refers to the intuitive agreement between likes and dislikes spouses have prior to discussing or comparing them.
Table 9. Congruency of Marital Interaction: Median and U Test Scores and Levels of Significance

<table>
<thead>
<tr>
<th></th>
<th>Family-Centered</th>
<th>Wife-Centered</th>
<th>Mann-Whitney U</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spontaneous Agreement</td>
<td>32</td>
<td>33</td>
<td>143.5</td>
<td>.28</td>
</tr>
<tr>
<td>Positive Speeches</td>
<td>2</td>
<td>2</td>
<td>157.0</td>
<td>.49</td>
</tr>
<tr>
<td>Negative Speeches</td>
<td>1</td>
<td>1</td>
<td>152.5</td>
<td>.40</td>
</tr>
<tr>
<td>Units of Laughter</td>
<td>3</td>
<td>4</td>
<td>174.0</td>
<td>.85</td>
</tr>
<tr>
<td>Explicit Information</td>
<td>7</td>
<td>3</td>
<td>125.0</td>
<td>.10</td>
</tr>
<tr>
<td>Choice Fulfillment</td>
<td>4</td>
<td>4</td>
<td>167.5</td>
<td>.70</td>
</tr>
<tr>
<td>Spouses' Talking Time</td>
<td>10</td>
<td>7</td>
<td>145.0</td>
<td>.30</td>
</tr>
</tbody>
</table>

The behavioral trends, between the two groups, in the spouses' marital interaction congruency are not consistent or significantly different.

The self-reported attitudes associated with family life, like the observed behavioral indicators, seemed to reveal that those couples selecting family-centered versus wife-centered obstetrical care came from the same population.

Table 10 discloses that husbands who selected wife-centered care tended to evaluate their marital adjustment more favorably than did those who chose family-centered care. This distinction, however, is not considered to be
significant. "Combined Scores" refers to the summed scores for each husband and wife.

Table 10. Self-Reported Attitudes of Marital Adjustment: Median and U Test Scores and Levels of Significance

<table>
<thead>
<tr>
<th></th>
<th>Family-Centered</th>
<th>Wife-Centered</th>
<th>Mann-Whitney</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Husbands</td>
<td>115</td>
<td>122</td>
<td>117.5</td>
<td>.07</td>
</tr>
<tr>
<td>Wives</td>
<td>123</td>
<td>127</td>
<td>146.5</td>
<td>.32</td>
</tr>
<tr>
<td>Combined Scores</td>
<td>235</td>
<td>253</td>
<td>126.0</td>
<td>.11</td>
</tr>
</tbody>
</table>

The self-reported findings of the "Index of Adjustment and Values" also failed to reveal a significant difference between the two groups. No important trends are revealed in Table 11, and it appears that any differences between the family and wife-centered groups are due to chance.

There is some tendency for persons selecting family-centered care to have more congruent self-reported attitudes than those selecting wife-centered care. This tendency, revealed in Table 12, is not uniform. When each congruency rating is examined separately, only the wives' concept of self and ideal self congruency is significantly greater in the family-centered versus the wife-centered group.
<table>
<thead>
<tr>
<th>Concept</th>
<th>Family Centered</th>
<th>Wife-Centered</th>
<th>Mann-Whitney</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Concept of Self</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husbands</td>
<td>183</td>
<td>187</td>
<td>162.5</td>
<td>.60</td>
</tr>
<tr>
<td>Wives</td>
<td>184</td>
<td>176</td>
<td>121.5</td>
<td>.08</td>
</tr>
<tr>
<td>Combined Scores</td>
<td>376</td>
<td>365</td>
<td>141.5</td>
<td>.25</td>
</tr>
<tr>
<td><strong>Concept of Ideal Self</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husbands</td>
<td>220</td>
<td>227</td>
<td>132.0</td>
<td>.16</td>
</tr>
<tr>
<td>Wives</td>
<td>226</td>
<td>226</td>
<td>173.0</td>
<td>.83</td>
</tr>
<tr>
<td>Combined Scores</td>
<td>449</td>
<td>446</td>
<td>172.5</td>
<td>.82</td>
</tr>
<tr>
<td><strong>Concept of Spouse</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husbands</td>
<td>197</td>
<td>207</td>
<td>142.0</td>
<td>.26</td>
</tr>
<tr>
<td>Wives</td>
<td>205</td>
<td>202</td>
<td>150.5</td>
<td>.38</td>
</tr>
<tr>
<td>Combined Scores</td>
<td>405</td>
<td>409</td>
<td>173.5</td>
<td>.84</td>
</tr>
<tr>
<td><strong>Concept of Ideal Spouse</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husbands</td>
<td>216</td>
<td>223</td>
<td>139.5</td>
<td>.23</td>
</tr>
<tr>
<td>Wives</td>
<td>226</td>
<td>226</td>
<td>172.5</td>
<td>.82</td>
</tr>
<tr>
<td>Combined Scores</td>
<td>448</td>
<td>446</td>
<td>180.0</td>
<td>.99</td>
</tr>
</tbody>
</table>
Table 12. Congruency of Self-Reported Attitudes, Concept of Self and Ideal Self, Spouse and Ideal Spouse, and Ideal Self and Spouse: Median and U Test Scores and Levels of Significance

<table>
<thead>
<tr>
<th></th>
<th>Family-</th>
<th>Wife-</th>
<th>Mann-Whitney</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Concept of Ideal Self</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husbands</td>
<td>32</td>
<td>36</td>
<td>178.0</td>
<td>.94</td>
</tr>
<tr>
<td>Wives</td>
<td>36</td>
<td>50</td>
<td>106.5</td>
<td>.03</td>
</tr>
<tr>
<td>Combined Scores</td>
<td>68</td>
<td>86</td>
<td>127.0</td>
<td>.12</td>
</tr>
<tr>
<td>Concept of Spouse and Ideal Spouse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husbands</td>
<td>24</td>
<td>16</td>
<td>164.0</td>
<td>.63</td>
</tr>
<tr>
<td>Wives</td>
<td>17</td>
<td>22</td>
<td>169.5</td>
<td>.75</td>
</tr>
<tr>
<td>Combined Scores</td>
<td>37</td>
<td>39</td>
<td>171.5</td>
<td>.79</td>
</tr>
<tr>
<td>Concept of Ideal Self and Spouse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husbands</td>
<td>18</td>
<td>22</td>
<td>177.5</td>
<td>.93</td>
</tr>
<tr>
<td>Wives</td>
<td>16</td>
<td>22</td>
<td>137.5</td>
<td>.20</td>
</tr>
<tr>
<td>Combined Scores</td>
<td>38</td>
<td>39</td>
<td>151.5</td>
<td>.40</td>
</tr>
</tbody>
</table>

Characteristics of Factors Associated with Childbearing

Factors associated with labor, delivery, hospitalization, and the post-hospital recovery period reveal some similarities and some significant differences between the family and wife-centered groups. A two-tailed test of statistical significance was used even though some of the
factors studied were assumed to be more closely associated with one of the two styles of obstetrical care.

All husbands were permitted to be with their wives most of the time when they were in the labor room at the hospital. Seventeen husbands in the family-centered group and fifteen husbands in the wife-centered group were with their wives most of the time in labor. The others indicated they were with their wives in labor half the time or less. The Fisher Exact Probability Test reveals this difference lacks significance at the .66 level.

The Fisher Exact Probability Test was also utilized to obtain the levels of significance revealed in Table 13. "Together in Delivery" refers to whether the spouses were together during the birth of their child. Being together in delivery was an expectation of persons in family-centered care but not being together during this time did not disqualify a couple from this group. A physician committed himself to the plan for spouses to be together during delivery when he signed a permission form for them to participate in childbirth preparation classes. A couple committed themselves to being together in delivery by attending classes designed to prepare them for joint participation during labor and delivery. In other words, all of the husbands selecting family-centered care planned to be with their wives at the time of delivery. Unforeseen circumstances, however, prevented three of the couples from
Table 13. Factors in Parturition, Hospitalization, and the Post-Hospital Recovery Period: Levels of Significance

<table>
<thead>
<tr>
<th>Family-Centered</th>
<th>Wife-Centered</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Together in Delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>16</td>
<td>3</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>16</td>
</tr>
<tr>
<td>Mothers Awake</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>17</td>
<td>14</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Medication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>16</td>
<td>19</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Analgesics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>No</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Anesthetics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>14</td>
<td>18</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Rooming In</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>No</td>
<td>13</td>
<td>19</td>
</tr>
<tr>
<td>Complications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>No</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>Help in Home</td>
<td></td>
<td></td>
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<tr>
<td>Yes</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>No</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Method of Feeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast</td>
<td>11</td>
<td>5</td>
</tr>
<tr>
<td>Bottle</td>
<td>8</td>
<td>14</td>
</tr>
</tbody>
</table>

*Indicates statistically significant differences between the two groups.
being together at this time. One husband left the hospital to obtain their "Lamaze Labor and Delivery Guide," thinking he had plenty of time before his wife delivered, and thus missed the delivery. Two other husbands in the family-centered group were not permitted in the delivery room as a result of complications: a Caesarean section and a stillbirth.

The husbands in the wife-centered group did not attend childbirth preparation classes and they did not plan to be with their wives in the delivery room. Three, however, accepted unexpected invitations from the physician in charge to view the birth of their baby. The difference between the two groups, regarding their being together during delivery, was statistically significant.

"Mothers Awake" refers to whether the expectant mother was awake during the delivery of her child. The difference in proportions of mothers awake between the two groups was not significant. This finding is a surprise since it was assumed that a higher proportion of women in the wife-centered group would prefer to be put to sleep during the delivery of their first child.

Medication is a general term that refers to the use of analgesics and/or anesthetics during parturition. There was less tendency for expectant mothers using family-centered obstetrics to use medication in general as well as fewer analgesics and anesthetics. This finding, how-
ever, reveals that this distinction between the two groups is not significant.

Only one of the two hospitals in the study provided "rooming in," which refers to the provision for the baby to be in the mother's room when she, or the father, make this request. Rooming in enables the mother, like the father, to hold, feed, and possibly bathe the baby prior to the time he (she) is taken home. If the mother or the parents prefer to be alone, the baby is returned to the nursery. This distinction between the two groups is considered to be significant.

Complications refers to difficulties, of which the parents were aware, that occurred during or following the birth process. The number of complications, reported in Table 13, refers to the number of persons who experienced difficulties. Six complications occurred in the family-centered group. These included: (1) two spinal headaches following delivery, one lasting ten days and the other lasting fourteen days; (2) a still birth; (3) a Caesarean section; (4) a hemotoma (i.e., a blood mass) on a baby's head; and (5) a breech birth.

Five persons in the wife-centered group experienced complications. These included: (1) a Caesarean section; (2) an infection that required a mother to be hospitalized two additional days; (3) a kidney problem following delivery that caused a mother to be hospitalized three extra
days; (4) an infection which necessitated a baby's transfer to a children's hospital where he stayed for several days; and (5) a partial cleft palate in a newborn child which, at a later time, will require corrective surgery. No attempt was made to evaluate the difference in severity or quality of the complications experienced by persons in the two groups.

"Help in Home" refers to someone outside the immediate nuclear family temporarily moving into the home, or specifically coming to the house on a scheduled basis, to help with household tasks following the mother and child's discharge from the hospital. No differences were apparent between the two groups.

Mothers in the family-centered group were more inclined to breast feed their babies than were mothers in the wife-centered group. This distinction between groups, however, was not significant.

In summation, the persons in the family-centered and wife-centered obstetrical groups appear to come from a similar population. Only five of nearly sixty variables studied to compare the two groups revealed statistically significant differences between them. These included years of schooling, length of marriage, wives' self-reported concept of self and ideal self congruency, being together in delivery, and having rooming in. The last two differentiating variables were expected in that they were an extension of the expectations of those who utilized
family-centered care. In other words, those who planned to be together during the delivery, and took the preparation classes for this, were in fact together during delivery more than those who had not so planned (i.e., the wife-centered group). Also, persons in the family-centered group preferred rooming in more consistently than did those in the wife-centered group. This finding may be more significant than Table 13 indicates. Many of the thirteen couples in the family-centered group who did not have the rooming-in option volunteered the information that they would have liked to have their babies with them more while at the hospital. A typical response by husbands in the family-centered group was, "It did not seem right that we could hold our baby in the delivery room and then had to wait three days until we went home to hold him again."

The Effect of Family-Centered Versus Wife-Centered Obstetrical Care

The research hypotheses emphasized the capacity of family-centered versus wife-centered obstetrical care to favorably change observed joint behavior patterns (i.e., marital interaction patterns) of spouses and spouses' self-reported attitudes associated with family life.
Statistical Support for Accepting or Rejecting Hypotheses

Hypothesis one refers to changes in the observed quality of marital interaction. Two of the three indicators of marital interaction quality (i.e., positive speeches, negative speeches, and units of laughter) had to show a statistically significant change in the family-centered versus the wife-centered group for the hypothesis to be accepted. In other words, the rates of positive speeches and units of laughter had to increase and the rates of negative speeches had to decrease in the family-centered versus the wife-centered obstetrical group. A one-tailed test of statistical significance was used since the hypothesis is directional.

Table 14. Changes in Marital Interaction Quality: Median and U Test Scores and Levels of Significance

<table>
<thead>
<tr>
<th></th>
<th>Family Centered</th>
<th>Wife-Centered</th>
<th>Mann-Whitney U</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive Speeches</td>
<td>6</td>
<td>1</td>
<td>104.0</td>
<td>.01</td>
</tr>
<tr>
<td>Negative Speeches</td>
<td>-2</td>
<td>0</td>
<td>111.5</td>
<td>.02</td>
</tr>
<tr>
<td>Units of Laughter</td>
<td>-2</td>
<td>2</td>
<td>154.0</td>
<td>.44*</td>
</tr>
</tbody>
</table>

*A two-tailed test of significance is used when findings are not in the hypothesized direction.*
Hypothesis one is accepted. Positive speeches and negative speeches did reveal significant change in the hypothesized direction. The trend regarding units of laughter was a surprise in that these changes were not in the hypothesized direction.

Hypothesis two refers to changes in the observed efficiency of marital interaction. Two of the three indicators of joint behavioral efficiency (i.e., explicit information exchanged, choice fulfillment, and percentage of silence) had to show a statistically significant favorable change in the family versus the wife-centered group for the hypothesis to be accepted. Thus, the rates of explicit information exchanged and choice fulfillment had to increase and the percentage of silence decreased more in the family-centered versus the wife-centered obstetrical group.

Table 15. Changes in Marital Interaction Efficiency: Median and U Test Scores and Levels of Significance

<table>
<thead>
<tr>
<th></th>
<th>Family-Centered</th>
<th>Wife-Centered</th>
<th>Mann-Whitney</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explicit Information</td>
<td>16</td>
<td>-6</td>
<td>77.0</td>
<td>.001</td>
</tr>
<tr>
<td>Choice Fulfillment</td>
<td>7</td>
<td>1</td>
<td>103.0</td>
<td>.01</td>
</tr>
<tr>
<td>Percentage of Silence</td>
<td>-8</td>
<td>4</td>
<td>49.0</td>
<td>.001</td>
</tr>
</tbody>
</table>
Hypothesis two is accepted. Table 15 reveals a distinct favorable change that the family-centered experienced. Rate changes of explicit information exchanged and choice fulfillment and changes in the percentage of time in silence all occurred in the hypothesized direction. Also, each of these changes is statistically significant.

Hypothesis three refers to changes in observed marital interaction congruency, i.e., to changes toward increased similarity of the spouses' joint behavioral patterns rather than toward increased discrepancy in these patterns. Four of the seven indicators of marital interaction congruency (i.e., spontaneous agreement, positive speeches, negative speeches, units of laughter, explicit information exchanged, choice fulfillment, and talking time) had to show a statistically significant favorable change in the family-centered versus the wife-centered group for the hypothesis to be accepted. In other words, to be favorable, the change in numerical rates of spontaneous agreement had to increase while the change in the other numerical rates of congruency had to decrease.

Hypothesis three is accepted. Four of the seven indicators of marital interaction congruency revealed significant change in the hypothesized direction. Negative speeches revealed an important trend in the hypothesized direction that failed to achieve statistical significance,
and the findings regarding positive speeches and units of laughter were not in the hypothesized direction.

Table 16. Changes in Marital Interaction Congruency: Median and U Test Scores and Levels of Significance

<table>
<thead>
<tr>
<th></th>
<th>Family-Centered</th>
<th>Wife-Centered</th>
<th>Mann-Whitney U</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spontaneous Agreement</td>
<td>2</td>
<td>-2</td>
<td>90.0</td>
<td>.004</td>
</tr>
<tr>
<td>Positive Speeches</td>
<td>1</td>
<td>0</td>
<td>157.0</td>
<td>.49*</td>
</tr>
<tr>
<td>Negative Speeches</td>
<td>0</td>
<td>0</td>
<td>132.5</td>
<td>.07</td>
</tr>
<tr>
<td>Units of Laughter</td>
<td>0</td>
<td>0</td>
<td>177.0</td>
<td>.92*</td>
</tr>
<tr>
<td>Explicit Information</td>
<td>-4</td>
<td>6</td>
<td>69.0</td>
<td>.001</td>
</tr>
<tr>
<td>Choice Fulfillment</td>
<td>-1</td>
<td>2</td>
<td>108.5</td>
<td>.02</td>
</tr>
<tr>
<td>Talking Time</td>
<td>-2</td>
<td>2</td>
<td>118.0</td>
<td>.03</td>
</tr>
</tbody>
</table>

*Findings are not in the hypothesized direction.

Hypothesis four refers to changes in self-reported attitudes of marital adjustment. The combined scores of husbands' and wives' change in attitude had to be significantly more favorable in the family-centered versus the wife-centered group for the hypothesis to be accepted.
Table 17. Changes in Self-Reported Marital Adjustment Attitudes: Median and U Test Scores and Level of Significance

<table>
<thead>
<tr>
<th></th>
<th>Family-Centered</th>
<th>Wife-Centered</th>
<th>Mann-Whitney</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Husbands</td>
<td>8</td>
<td>-1</td>
<td>95.5</td>
<td>.006</td>
</tr>
<tr>
<td>Wives</td>
<td>0</td>
<td>2</td>
<td>138.0</td>
<td>.21*</td>
</tr>
<tr>
<td>Combined Scores</td>
<td>5</td>
<td>2</td>
<td>141.0</td>
<td>.12</td>
</tr>
</tbody>
</table>

*Findings are not in the hypothesized direction.

Hypothesis four was not accepted. Husbands in the family-centered versus the wife-centered group did experience a statistically significant favorable change in the self-reported attitudes of marital adjustment. For wives, however, a less significant trend in the opposite direction occurred. The combined scores revealed a non-significant trend for persons in the family-centered group to express more favorable attitudes of marital adjustment.

Hypothesis five refers to changes in self-reported self-concept attitudes, and hypothesis six refers to changes in concept of spouse attitudes. The combined scores of husbands and wives' attitudes for each of these had to change, becoming significantly more favorable in the family-centered group, for these hypotheses to be accepted.
Table 18. Changes in Self-Reported Attitudes of Self Concept and Concept of Spouse: Median and U Test Scores and Levels of Significance

<table>
<thead>
<tr>
<th></th>
<th>Family-Centered</th>
<th>Wife-Centered</th>
<th>Mann-Whitney</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self Concept</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husbands</td>
<td>4</td>
<td>5</td>
<td>175.0</td>
<td>.44*</td>
</tr>
<tr>
<td>Wives</td>
<td>4</td>
<td>11</td>
<td>142.0</td>
<td>.26*</td>
</tr>
<tr>
<td>Combined Scores</td>
<td>7</td>
<td>14</td>
<td>160.0</td>
<td>.54*</td>
</tr>
<tr>
<td><strong>Concept of Spouse</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husbands</td>
<td>2</td>
<td>1</td>
<td>177.5</td>
<td>.93</td>
</tr>
<tr>
<td>Wives</td>
<td>1</td>
<td>2</td>
<td>141.5</td>
<td>.25*</td>
</tr>
<tr>
<td>Combined Scores</td>
<td>1</td>
<td>9</td>
<td>142.5</td>
<td>.27*</td>
</tr>
</tbody>
</table>

*Findings are not in hypothesized direction.

Hypotheses five and six were not accepted. The trends revealed in Table 18 failed to clearly differentiate the two groups. Reporting more favorable attitudes of self concept and concept of spouse did not appear to be associated with the family-centered style of obstetrical care.

Hypothesis seven refers to changes in attitude congruency between self concept and concept of ideal self; hypothesis eight refers to changes in attitude congruency between concept of spouse and ideal spouse; and hypothesis nine refers to the attitude congruency between concept of ideal self and spouse. Each of these hypotheses, dependent upon self evaluation and disclosure, were based upon the assumption that the family-centered versus the wife-
centered obstetrical group would experience significantly favorable attitude congruency change, i.e., that each of these attitudes would become more congruent in the family-centered versus the wife-centered obstetrical group.

Table 19. Changes in Congruency of Self-Reported Attitudes, Concept of Self and Ideal Self, Spouse and Ideal Spouse, and Ideal Self and Spouse: Median and U Test Scores and Levels of Significance

<table>
<thead>
<tr>
<th></th>
<th>Family-Centered</th>
<th>Wife-Centered</th>
<th>Mann-Whitney</th>
<th>Level of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self Concept</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and Concept of Ideal Self</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husbands</td>
<td>0</td>
<td>-1</td>
<td>156.0</td>
<td>.47*</td>
</tr>
<tr>
<td>Wives</td>
<td>0</td>
<td>-3</td>
<td>178.0</td>
<td>.94*</td>
</tr>
<tr>
<td>Combined Scores</td>
<td>-4</td>
<td>-2</td>
<td>175.5</td>
<td>.88</td>
</tr>
<tr>
<td><strong>Concept of Spouse and Ideal Spouse</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husbands</td>
<td>0</td>
<td>0</td>
<td>172.0</td>
<td>.80</td>
</tr>
<tr>
<td>Wives</td>
<td>1</td>
<td>-3</td>
<td>160.0</td>
<td>.55*</td>
</tr>
<tr>
<td>Combined Scores</td>
<td>3</td>
<td>-1</td>
<td>149.5</td>
<td>.36*</td>
</tr>
<tr>
<td><strong>Concept of Ideal Self and Spouse</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husbands</td>
<td>3</td>
<td>3</td>
<td>166.0</td>
<td>.67</td>
</tr>
<tr>
<td>Wives</td>
<td>3</td>
<td>-5</td>
<td>162.0</td>
<td>.59*</td>
</tr>
<tr>
<td>Combined Scores</td>
<td>4</td>
<td>-2</td>
<td>158.0</td>
<td>.51*</td>
</tr>
</tbody>
</table>

*Findings are not in hypothesized direction.
Hypotheses seven, eight, and nine are not accepted. The trends reflected in Table 19 appear to be more a result of chance than to basic differences between the family and wife-centered obstetrical groups.

In summation, there is a gross discrepancy between those findings based upon observed joint behavior patterns of spouses and those findings that were based upon spouses' self-reported attitudes of factors associated with family life. Hypotheses one, two, and three, based upon changes in observed marital interaction patterns of spouses, were accepted. Hypotheses four through nine, based upon spouses' self-reported attitude changes, were rejected.

Analysis of Possible Intervening Variables

It was difficult to precisely evaluate the influence that possible intervening variables had on the style of obstetrical care and resulting changes in family life. The non-parametric nature of the data and the relatively small sample size contribute to this difficulty. In other words, when possible intervening variables were controlled the remaining cases were frequently too few to do reliable analysis. No attempt was made to analyze the compounding effect that two or more possible intervening variables had.

The discrepancy between findings based upon observed joint behavior of spouses and their self-reported familial
attitudes became apparent with the analysis of possible confounding variables, just as it did in testing hypotheses. Meaningful patterns were found with those data based upon observed marital interaction but findings based upon self-reported attitudes appeared unrelated to likely intervening variables. This is consistent with the non-significant and non-consistent self-reported findings hypothesized to be influenced by a style of obstetrical care.

Important trends associated with the indicators of marital interaction quality, efficiency, and congruency were identified. Although many of them failed to achieve statistical significance, using the Mann-Whitney U Test, they are presented in summary form. An example of this summary form can be illustrated with the comparative findings of the study's hypotheses. Ten of the thirteen indicators of marital interaction quality, efficiency, and congruency revealed trends for family versus wife-centered obstetrical care to affect change of couples' joint behavior patterns in a favorable direction. Change in nine of these indicators (i.e., positive and negative speeches, explicit information, choice fulfillment, percentage of silence, and congruency associated with spontaneous agreement, explicit information, choice fulfillment, and spouses' talking time) was significant.

Husbands in the delivery room and rooming-in, two variables closely associated with the overt or covert
expectations of family-centered obstetrics were evaluated as possible confounding variables. The three couples utilizing wife-centered care who were unexpectedly invited to jointly view the birth of their babies were compared with the sixteen couples utilizing family-centered preparation who also jointly experienced the birth of their babies. Although the number of cases was small, the Mann-Whitney U Test clearly differentiated the two groups. All but two of the thirteen indicators of observed marital interaction revealed that couples experiencing family-centered obstetrical care tended to utilize the childbearing process better than those couples utilizing wife-centered obstetrical care even though in this situation they all viewed the birth of their babies. Only two of these differentiating trends, however, were significant—decreased rates of negative speeches and percentage of silence.

When three couples in the wife-centered group who did jointly view the birth of their child were compared with the sixteen couples in this group who did not, only four of the thirteen indicators of marital interaction revealed more favorable change for those three couples who did jointly view their babies' births. None of these were significant. In other words, these data imply that couples who are not formally or informally prepared to view their babies' births together do better when they do not, in fact, jointly view the birth of their babies.
This may or may not imply that being together in delivery is valuable even though couples have not attended childbirth preparation classes. Unresolved confounding variables are the selection process physicians used in inviting these three couples in the wife-centered group to jointly view the birth of their babies and the "shock effect" of unexpectedly being asked to jointly participate at the last moments before birth. In other words, the three couples who jointly viewed the birth of their babies did not have the opportunity to psychologically prepare for this. Two of the three husbands openly expressed feelings of unpreparedness. For example, "He asked me to come into the delivery room, so I did. But I didn't really know what to do." This data seems insufficient to adequately analyze the intervening effect of having husbands in the delivery room.

The possible confounding influence rooming-in has upon the style of obstetrical care and its effect upon family life seemed to reveal what was anticipated from the subjective comments made by research participants, i.e., rooming-in does have a favorable impact upon the spouses' marital interaction patterns that appears to increase the value of family-centered obstetrical preparation and care. Another way to interpret these findings is that when couples are prepared to participate in childbearing together, the frustration that accompanies husbands being excluded from
contact with their babies in the hospital also tends to limit the favorable changes in spouses' behavior generally associated with family-centered obstetrical care.

Twenty-four couples, twelve in each obstetrical group, who did not have the option for rooming in were compared. The rate of favorable change in the family-centered versus the wife-centered group was considerably less than in the original findings which did not control for the rooming-in variable. Eleven of the thirteen indicators used to evaluate the quality, efficiency, and congruency of marital interaction corresponded with the original hypotheses but only two (decrease in percentage of silence and increase in spontaneous agreement) were statistically significant. This decline in significance may also be partially due to the decreased number of cases. From this data, however, it appears that family-centered preparation of spouses and participation in parturition appears to be of less value when rooming in is not also an option for them. Or, in other words, the value of having couples jointly participate is blunted when the baby is, by hospital policy, excluded from meaningful interaction and contact with his (her) new parents.

Years of schooling was not considered to be a significant intervening variable, although the findings do suggest that persons with more years of schooling may experience somewhat greater benefits from family-centered obstetrical
care. When the couples in which husbands had less than sixteen years of schooling were compared, four in the family-centered group and twelve in the wife-centered group, eleven of the thirteen marital interaction variables revealed more favorable change in the family-centered group. Explicit information, choice fulfillment, percentage of silence, spontaneous agreement and explicit information congruency revealed significant change.

The results of comparing couples in which the husband had sixteen or more years of schooling were even more substantial. In this analysis, fifteen couples who utilized family-centered care were compared with seven couples who utilized wife-centered care. Twelve of the thirteen observed indicators of spouses' joint behavior disclosed change that was more favorable for couples who utilized family-centered obstetrical care. Eight of these changes in marital interaction patterns were significant--decreased negative speeches and percentage of silence, and increased positive speeches, explicit information, and choice fulfillment, and congruency associated with explicit information, choice fulfillment, and spouses' talking time.

Years of schooling for wives revealed some variations in the findings but this, likewise, was not considered to be a significant confounding variable. Couples in which the wives had less than sixteen years of schooling were compared. The Mann-Whitney U Test revealed that with the
nine couples who utilized family-centered care and the sixteen couples who utilized wife-centered care in this grouping, there was again a clear distinction between the two groups. Change was more favorable in ten of the thirteen indicators of marital interaction patterns for the family-centered group, and seven indicators revealed a significant change—decreased negative speeches and percentage of silence, and increased positive speeches, negative speech congruency, explicit information, explicit information congruency and spontaneous agreement.

When couples in which the wives had sixteen or more years of schooling (ten family-centered and three wife-centered) were compared, findings again consistently showed the positive influence of family-centered obstetrical care on the joint behavior of spouses. Thirteen of thirteen or all of the indicators of marital interaction quality, efficiency, and congruency revealed more favorable change in those couples who utilized family-centered obstetrical care. However, only three of these change rates, choice fulfillment, talking time congruency, and percentage of silence, were significant.

Length of marriage was significantly different between the two groups. To analyze the confounding effect of this upon a style of obstetrical care and resulting changes in family life, couples in each group married less than three years were first compared, nine using family-centered care
and fourteen utilizing wife-centered care. Ten of the thirteen marital interaction indicators disclosed more favorable change in those couples in the family-centered group. Favorable changes in explicit information, explicit information congruency, choice fulfillment, percentage of silence and spontaneous agreement were significant.

When those couples married three years or more were compared, ten family-centered and five wife-centered, the trends were similar but less significant. Eleven of thirteen indicators revealed more favorable change in the couples who utilized family-centered care but only changes in explicit information congruency and choice fulfillment congruency achieved statistical significance.

The one significant difference that the self-reported responses disclosed between couples in the two groups, prior to the entry of some into childbirth preparation classes, was the difference in congruency between wives' self-reported concepts of self and ideal self.

Eleven in the family-centered group and eleven in the wife-centered group had self-ideal self congruency scores for wives of less than forty-three. When these two groups were compared eleven of the thirteen marital interaction indicators revealed more favorable change for the family-centered group. Rates of positive and negative speeches and explicit information congruency and percentage of silence changed significantly.
Eight in the family-centered group and eight in the wife-centered group had self-ideal self congruency scores for wives of forty-three or over. When these two groups were compared, ten of thirteen indicators of spouses' joint behavior revealed more favorable change in the family-centered group. Explicit information, explicit information congruency, choice fulfillment, percentage of silence, and spontaneous agreement changed significantly. In other words, wives' congruency of self and ideal self scores, which were self reported, was not considered to be an important intervening variable regarding the relationship of obstetrical care styles to changes in family life.

In summation, analysis of possible intervening or confounding variables is difficult and is inconclusive when studies based on nonparametric data have small samples. The most important intervening variable in this study appears to be rooming-in, i.e., giving parents the right to spend considerable periods of time with their babies before they leave the hospital. Having rooming-in appears to accentuate the value of family-centered obstetrical care, and not having the option for rooming-in seems to frustrate couples who were prepared to experience childbearing together.

The favorable effects of having husbands in the delivery room also appear to be accentuated by having good preparation for this experience. It seems likely that some
couples can prepare for this adequately without formal classes, but less is known about the "shock effect" of unexpectedly inviting husbands into delivery at the last moments before birth.

Years of schooling of husbands and wives, length of marriage, and wives' self-reported congruency of concept of self and ideal self were not considered to be significant intervening variables.
CHAPTER V
CONCLUSIONS

Summary and Possible Explanations for the Conflicting Findings

The major purpose of this longitudinal comparative study was to describe, explain, and evaluate the effect of family-centered versus wife-centered obstetrical care upon family life. The research sample was systematically selected based upon (1) the hospitals in the community whose administration policy permitted physicians to decide what a husband’s role during labor and delivery could be; (2) the physicians utilizing these hospitals who permitted couples to decide if they preferred family or wife-centered obstetrical care; and (3) the couples, who were patients of these physicians, who upon request volunteered to participate in a study on childbirth and family life.

Since the sample was not randomly selected but chosen, based upon criteria of the study, the results cannot necessarily be generalized to other populations. Within the sample and instrumental limits, however, this study has indicated there is a significant and positive association between family-centered versus wife-centered obstetrical care and improvements in the observed quality, efficiency,
and congruency of marital interaction, i.e., improvement in the joint behavior patterns of spouses that can be observed as they interact.

As hypothesized, couples who utilized family-centered versus wife-centered obstetrical care experienced significantly more favorable change regarding the quality, efficiency, and congruency of their interaction patterns. Between early in the third trimester of pregnancy and several weeks following delivery, their rates of positive speeches, explicit information, and choice fulfillment increased significantly, their rates of negative speeches, and percentage of silence decreased significantly more, and the congruency rates of spontaneous agreement, explicit information exchanged, choice fulfillment, and spouses' talking time increased significantly more than in the wife-centered group. Rooming-in and husbands being in the delivery room appear to be variables that had an intervening role in differentiating the joint behavior patterns of those couples in the two obstetrical groups.

The self-reported familial attitudes that were selected to measure change in family life associated with a style of obstetrical care revealed no significant change differences between the two groups.

The method utilized to evaluate change in self-reported indicators of family life used the subjective orientation of respondents to perceive and reveal their attitudes at two
points in time. This involved spouses perceiving and presenting attitudes of marital adjustment and concepts of self, ideal self, spouse, and ideal spouse on two occasions, and then tabulating the change that took place in these reported attitudes over time.

Several factors are assumed to provide the explanation for the discrepancy between changes in the observed and the self-reported indicators of family life. First of all, self-reported data are susceptible to willful as well as unwillful distortion. By the second interview, it was assumed that normative pressures tended to influence participants in both groups to "answer correctly" or to answer as they assumed the researcher wanted them to. This desire to "look good" may have been unusually strong because of (1) the societal expectations that accompany childbearing; (2) the uncertainties, disruptions, pleasures, and ambivalences (i.e., the stresses) that accompany a child's entry into the home; and (3) the developing relationship the spouses had with the researcher as a result of the continuing contacts that occurred in the data collection process.

Distortion in self-reported indicators of family life corresponds with Olsen's (1969) finding that in self-reported methods of family-research data collection, persons tend to overestimate what is expected of them and underestimate what is not expected.
And secondly, a person's satisfaction (dissatisfaction) with a situation seems to arise from an "awareness" or "perception" that things are going (not going) the way one thinks they should (Hawkins and Johnson, 1969:507). The same seems to be true with the attitudes one has of his marital adjustment and concepts of self, ideal self, spouse, and ideal spouse. One tends to evaluate these indicators in reference to whether he (she) perceives them to be as they should be. In other words, part of this evaluation involves a subjective questioning of how others in one's reference group react in similar situations.

The persons in the family-centered group and those in the wife-centered group, generally, did not have couples in the other group as their primary references. Another way to say this is that couples who selected family-centered obstetrical care tended to associate with other couples who experienced similar obstetrical care. Thus, the self-reported evaluations tended to grow out of a subjective comparison with persons familiar to one rather than a somewhat distant group that experienced another style of obstetrical care. Differential results probably would have been more likely if participants were asked to evaluate how the style of obstetrical care they selected (i.e., family or wife-centered) influenced their attitudes of marital adjustment and concepts of self, ideal self, spouse, and ideal spouse.
In summation, family-centered obstetrical care did have a more favorable influence upon spouses' joint interaction patterns than did wife-centered obstetrical care. This favorable change in spouses' joint behavior, however, was not accompanied by corresponding changes in the self-reported familial attitudes of spouses. Rooming-in and husbands being in the delivery room seemed to accentuate the value of family-centered care upon changes in family life. It is not really known how these variables affect couples who utilize wife-centered obstetrical care.

Practical Implications of Findings

Childbearing is a major venture for marital partners. Expectant parents, especially fathers, are far too often overtly or covertly encouraged to avoid the responsibilities, uncertainties, and decision-making that accompanies this period. A major implication of this study seems to be that couples should be more meaningfully involved in confronting rather than avoiding the uncertainties, responsibilities, and decision-making associated with childbearing.

Early this century childbearing became more of a medical procedure and less of a joint family venture for vast numbers of people in our society. What started out as helping mothers avoid pain and complications of childbearing seemed to evolve into a policy and expectation pattern that
encouraged both spouses to avoid meaningful participation and accountability during obstetrical care. The "orders" of various medical personnel, efficiency in obstetrical procedures, and physiological processes became the first, and sometimes, the only concern.

Childbearing involves more than the entry of a healthy fetus into the world, and obstetrical care should reflect this. Obstetrical care that reflects no more than efficiency and high survival rates is no better or worse than other medical care that emphasizes concern for disease to the point that the personhood and humanness of patients is ignored. A major contribution of family-centered obstetrical care has been to reawaken the realization that the person, and his immediate family, rather than systematic degrading obstetrical rules and routines, should be the first order of concern.

This study has provided knowledge that may support those who advocate family-centered obstetrical care. In this country, spouses are generally not expected to confront obscurities and liabilities during pregnancy and parturition; they are often not helped to share their desires, hopes, fears, and concerns during this period; and they are frequently not encouraged to examine decision making alternatives, and the likely consequences, that accompany childbearing. The family-centered obstetrical care movement has done much to reverse this.
As spouses become meaningfully involved, paying for obstetrical care no longer implies they are absolving themselves of accountability and decision making. Helping spouses to be jointly involved and to exercise responsibilities during this important family venture does favorably influence their behavior patterns following the birth of their child.

Opportunities for rooming-in seems to be a logical extension of family-centered obstetrical care, and failure to provide this service appears to limit the value that family-centered preparation and participation has. Having couples participate in the delivery room may be of value to them even though they did not attend formal preparation classes for this, but the practice of surprising spouses at the last moment before delivery by inviting them to jointly view the birth of their baby seems questionable.

Whether couples select family or wife-centered obstetrical care, as defined in this study, would appear to be less important than systematically giving all couples who seek obstetrical services an active role in discussing and helping to decide if they want to do such things as (1) attend childbirth preparation classes; (2) participate in labor and/or delivery; and (3) be with the baby following delivery. Also, expectant mothers should be made aware of alternatives that exist regarding analgesics and anesthetics, and respect for their preferences should be a consideration.
in their administration. Expectant couples also deserve to know the probable consequences of other obstetrical decisions. In other words, the foremost practical application of findings from this study, and the value placed upon enhancing family life, emphasize the need to change outdated dehumanizing obstetrical care procedures. Ideally, spouses, as well as physicians and other medical personnel, would actively participate in obstetrical decisions. Inviting a husband to come with his wife for several of the pre-natal examinations is one likely avenue to begin this process.

Having spouses meaningfully involved with physicians and other personnel providing obstetrical services ideally involves teaching and learning; it involves some uncertainties, and it occasionally involves changing one's mind or one's routine procedures. It does not involve a servant-master relationship. Ritualized routines, even if efficient, in which the expectant mother or father are systematically excluded from meaningful participation should be a thing of the past.

Theoretical Implications and Suggestions for Further Research

The general emphasis by professionals upon maladjustment, illness, medicine, and treatment has contributed to the lack of attention to healthy populations in need of basic services. This study reveals how one style of
obstetrical care improved the quality, efficiency, and congruency of marital interaction. In other words, this study helps to demonstrate how being more responsive to healthy populations who are in "risk periods" may prevent family disintegration and also enhance family life. This demonstration can be thought of as knowledge to support family advocacy, i.e., going from case to cause.

Another example of family advocacy is Klaus' et al. (1972) study entitled "Maternal Attachment: Importance of the First Post-Partum Days." Klaus and his associates reveal the importance of extended mother-child contact during the first several days after the child's birth. Reportedly, mothers who had extended contact during this time were more reluctant to leave their infants with someone else, showed greater soothing behavior, and engaged in significantly more eye to eye contact and fondling.

In this study, on family versus wife-centered obstetrical care, mothers were generally not permitted to have extended contact with their babies. Most couples did not have the rooming-in option, and if they did, they were still generally not permitted to keep the baby with them the first twenty-four hours after delivery. Many mothers in the family-centered group expressed frustration as a result of these policies. It appears that newborn babies are treated as if they are sick until they "prove" themselves to be healthy. More needs to be known about the results of
varied practices in obstetrical units upon the spouses' relationship as well as the parent-child relationship that will likely follow. What would be the effects of parents being able to determine when they could have their babies? Perhaps a more basic question is, What would be the effect upon spouses of having the baby at home or in a small neighborhood clinic? Should people have the right to medical care even if they prefer to have their baby at home or in the physician's office? The movement to have babies at home is currently stimulated by the degrading routines persons fear they will be exposed to if they enter a hospital.

It is now known how fathers being restricted from physical contact during the immediate post-partum period affects the father-child relationship. However, the reason generally given for restricting fathers contact with their infants, i.e., the likelihood of exposing the child to infection, is not considered valid by Bradley (1962). He found that hospitals which permitted parents to be with their babies had no higher rates of infection than did other hospitals. It is interesting that in this study complications associated with infections were only prevalent in the wife-centered group. How could fathers being encouraged to have extended contact with newborn infants and other simple modifications in obstetrical care routines shortly after delivery significantly affect parental behavior, marital behavior?
Couples that utilized family-centered obstetrical care did experience a favorable behavior change between early in the third trimester of pregnancy and several weeks after the entry of the babies into their homes. In other words, couples who utilized family-centered care seemed to interact better during the "honeymoon period" of having a new baby in the home.

One might assume that behavior in a "honeymoon period" is an indication of behavior which is likely to follow, but this has not been sufficiently studied empirically. How does the behavior during this "honeymoon period" tend to reflect itself later in family life? How does it influence marital interaction and how does it influence parent-child interaction? Does a father's assistance with childcaring duties, traditionally reserved for mothers, tend to enhance a marriage and persons in it or does such care by fathers tend to degrade the self esteem of young mothers?

Little is known about how the interaction of spouses during the first several weeks post-partum affects family interaction patterns in later years. And what tends to be the effect of a mother or mother-in-law moving into the home at this "honeymoon period?" Little is known about how factors during this period reflect themselves on family life in later years.

Adequate research has not been done to learn more about how couples currently select one style of obstetrical care
versus another. Is it strictly by chance, the suggestion of friends, or encouragement by physicians? Do couples selecting family-centered obstetrical care have an expectation toward marriage that seeks growth in relationships through mutually shared experiences?

Persons in the family-centered obstetrical care movement consider themselves to be advocates for family life. What are the implications for professional persons of family advocacy or of going from case to cause? How can and how should professional people serve as family advocates? Sunley (1970) feels that the major goal of family advocacy is improving the social environment of families. What does this mean for change in hospitals? What does it mean for schools, churches, recreational centers, and other social agencies? Rapaport (1970) indicates that persons in professions have been slow to lead, develop, and promote institutional and service delivery change. Asked another way, how can institutions be made more responsive to individuals and families, and what should be a professional person's role in changing institutions? Is the professional person's role primarily to the target population being served or the institution in which he (she) works?

Many persons who participated in this research project gave examples of goal displacement within a hospital's obstetrical unit. Hospitals, like obstetrical care units,
are established to achieve ends associated with a target population, and means are utilized to achieve ends. Ends and means are not the same phenomenon. Goal displacement occurs when what was once a means to an end becomes an end in itself. Thus, procedures which were once applied to help people become routines which, to be successfully completed, need patients.

The end result of such goal displacement is frequently a dehumanizing atmosphere in which the efficiency of routines is paramount. Persons become "things" to facilitate the efficient functioning of routines in an obstetrical care unit. Means take on a value that is independent of the hospital's ultimate goals.

Boulding, in discussing the discrepancy between means and ends, states:

It must never be forgotten that the ultimate thing which any society is producing is people. All other things are intermediate goals, and all organizations are intermediate organizations. No matter how rich we are or how powerful we are, if we do not produce people who can at least begin to expand the enormous potential of man, the society must be adjudged a failure (1966:213).

Having spouses prepared for active participation during hospitalization appears to reduce the evidence of goal displacement. Family-centered hospital care is more typically evaluated in terms of its meaning to the spouses, rather than just by how efficiently obstetrical routines were completed. Having patients awake and aware and actively
involved with a loved one creates the potential for open conflict with the expectation that patients are to be subservient to established routines, good or bad.

The theoretical implications of goal displacement can be generalized to other types of institutions established to serve people. What are the implications of goal displacement for schools, social agencies, churches, or governments? Boulding, in discussing goal displacement in education, said:

The educational system is particularly specialized in the production of people, and it must never lose sight of the fact that it is producing people as ends, not as means. It is producing men, not manpower; people, not biologically generated non-linear computers. If this principle is stamped firmly in the minds of those who guide and operate our educational systems, we can afford to make mistakes, we can afford to be surprised by the future, we can even afford to make some bad educational investments, because we will be protected against the ultimate mistake, which would be to make the educational system a means... serving purposes other than man himself (1966: 213).

Additional research is needed to learn more about the tendency of institutions, established to help people, to experience goal displacement. Why does the number of interviews or the length of an interview sometimes become more important than the person seeking help? Why does the classroom lecture sometimes become more important than the students in the classroom? Why does the control of a population become more important than that population?
Or, why does a routine scheduling of instrument deliveries or systematic exclusion of husbands from the delivery room become more important than the expectant mother or child?

To differentiate what the true ends of an organization or institution are, one has to closely observe the priorities in the allocation of means and the organizational processes that accompany such means (Etzioni, 1961:72). Whose ends are being served by the practices listed as examples in the preceding paragraph, the target populations or the persons supposedly providing services?

Childbirth represents a point of no return with elements attached to it that are novel for persons experiencing them. Family-centered preparation for and participation in childbearing represents a rites de passage where anticipatory socialization for new roles is a focal point. This joint anticipatory socialization for new roles (i.e., actively becoming parents) was found to be beneficial to family life, i.e., beneficial to changes in the quality, efficiency, and congruency of spouses' joint behavior. This knowledge provides insights that can be used to prevent family disruptions by creating opportunities for enhancing family life.

What are the implications of joint active participation of spouses in preparing for other expected but yet novel points of no return in family life? How might anticipatory
socialization for new roles help individuals and families maximize their growth potential during such times as (1) when they marry; (2) when their children start to school; (3) when their children leave home; (4) when their children marry; (5) when they retire; and (6) when one spouse dies?

These periods in the life of a family are typically stressful transitions, just as is the birth of the first child. Little is known about how these periods of rapid transition can be mobilized to strengthen individuals and families.

Closely associated with the joint preparation for and participation in childbearing is the role of educational programs in enhancing family life. The implications of developing preventive educational programs versus rehabilitative or treatment programs for persons and families have not been fully utilized. Programs in family life education now exist in a number of specialized areas. . .

among which are interpersonal relationships, self understanding, human growth and development, preparation for marriage and parenthood, child rearing, socialization of youth for adult roles, decision making, sexuality, management of human and maternal family resources, personal, family, and community health, family-community interaction, and the effects of change on cultural patterns ("Family Life Education Programs: Principles, Plans, and Procedures," 1968:211).

Little is known about the effectiveness of these programs in actually changing behavior of family members and/or family interaction patterns.
This study emphasized one transition period that most families experience, the birth of the first child. For some, having a child is a major crisis. It becomes a crisis when spouses' typical patterns of response to stress are not adequate to cope with the stresses of this rapid transition. Assumed characteristics of a crisis for a person include: (1) the potential for maturation and growth or less adequate social and personal functioning; and (2) increased amenability to influence when skilled intervention techniques are used. Such techniques include: (1) helping the person confront the crisis rather than evade it; (2) helping the person confront the crisis in manageable doses; (3) helping the person find the facts since dreams, fantasies, and the unknown are assumed to be worse than the known; (4) helping the person accept help, or in other words, assisting without degrading; (5) helping with everyday tasks; (6) not giving false reassurance, and (7) not blaming others.

Good childbirth preparation classes overtly or covertly incorporate many of the techniques used to help people in crisis. Persons are helped to confront rather than evade, and to confront in manageable doses. Effort is made to overcome the unknown, to make participants aware of what will happen and their role in guiding or responding to the events of labor and delivery. Husbands are taught how to help with the "everyday tasks" of childbearing.
False assurance is not given and persons are expected to take responsibility and not blame others.

What are the implications of actively responding to this crisis for other family crises which most persons do not assume will happen to them? For example, crises caused by accidents, major illnesses, loss of income, suicide, or acts of nature? More needs to be done to develop and evaluate programs based on the assumption that local people and families will experience unexpected crises.

In summation, theoretical implications, like further research, become valuable only if they directly or indirectly help persons. Hopefully, this study will serve as a stimulus to others to learn more about current practices that degrade our humanity and new practices that will enhance it. And, in the final analysis, it is hoped that what we know and what we learn will lead to appropriate action.
APPENDIX A

CHILDBIRTH AND FAMILY LIFE RESEARCH PROJECT

and

QUESTIONNAIRE FOR EXPECTANT MOTHERS
I am one of a group of physicians who is working with Mr. Joseph Steiner from Ohio State University. We are interested in finding out more about how childbirth affects family life, and we need the help of persons like yourself to complete this project. Participation will be on a voluntary basis only, and all names will remain anonymous.

You can help us complete this childbirth and family life study by filling out the attached questionnaire. Within several weeks and following the birth of your child, Mr. Steiner will contact some of you by phone to schedule a joint interview with you and your husband. Thank you for helping us complete this study, and I hope you feel gratified by knowing your participation has contributed to scientific and practical knowledge of childbirth and family life.
QUESTIONNAIRE FOR EXPECTANT MOTHERS

Name __________________________ Date ________ Date of Birth ________

Home Phone ____________________________ Home Address __________________________

Highest Year of Schooling __________________________

Is this your first marriage? Yes ( ) No ( ) Date of Marriage __________

Are you working outside the home? Yes ( ) No ( )

Occupation __________________________

In addition to myself and husband, the following number of persons are living in our home:

_______ children, ____ parents, _____ Others.

(Specify number of each using zero to specify none)

I plan to give birth at ______________________ hospital.

I expect to deliver ______________________ (state month). My religious preference is Catholic ( ) Protestant ( ) Jewish ( ) other ( ).

I would like to be aware ( ) asleep ( ) or am currently undecided ( ) about what I prefer during the birth of my baby. (check one)

I prefer to have my husband with me during labor ( ) delivery ( ) both labor and delivery ( ) am undecided ( ) or I prefer that he not be there ( ). (check one)

Most women prepare for childbirth, formally or informally. For example, they read, talk with friends, or some take a Red Cross course, Lamaze training, or a childbirth preparation course offered by a hospital.

I plan to prepare for childbirth by( please explain using the back of the page if more space is necessary)

How did you decide on the preparation you selected? (please explain using the back of the page if more space is necessary)
What non-medical person do you feel will be the most helpful to you in preparing for the birth of your child?

I plan to bottle feed ( ) or breast feed ( ) or am undecided ( ) about the matter at this time. (check one)

Husband's name ____________________________________________
Husband's Date of Birth ________________________________
Occupation _____________________________________________
Phone number at Work _____________________________________
Highest year of schooling __________________________________
Religious Preference _______________________________________

My husband is likely to be interested in which of the following:

1. Attending hospital prenatal classes with me? yes ( ) no ( ) undecided ( )
2. Attending Lamaze (natural childbirth) classes? yes ( ) no ( ) undecided ( )
3. Viewing his baby's birth? yes ( ) no ( ) undecided ( )
4. Touring the hospital prior to labor? yes ( ) no ( ) undecided ( )
5. Visiting with my physician prior to labor? yes ( ) no ( ) undecided ( )
6. Other (specify) _________________________________________

THANK YOU FOR YOUR COOPERATION
APPENDIX B

MARITAL INTERACTION INDEX, A AND B
INSTRUCTIONS FOR THE MII (A)

1. This questionnaire is to be filled out privately by husbands and wives. In other words, please do not confer with each other while answering the questions.

2. Twelve situations are posed, and each situation has ten choices. You are to mark the three choices you like best (most) with an X and the three choices you like least with an 0. Thus, each situation posed is to have four choices that are not marked.

3. Many of the situations posed, and their accompanying choices, may seem unlikely to ever occur, but they are to be filled out as if they were in fact real situations and choices in your life.

SITUATIONS POSED

1. What famous people would you most want to meet (least want to meet) if you were going to a party this weekend?

   _____ Muhammed Ali
   _____ Teddy Kennedy
   _____ Barbara Walters
   _____ Coretta King
   _____ Abbie Hoffman
   _____ Bess Myerson
   _____ Creighton Abrams
   _____ Johnny Carson
   _____ Walter Cronkite
   _____ John Galbraith

2. What foods would you most prefer (least prefer) to eat if you were going out for dinner this weekend?

   _____ perch
   _____ spagheti
   _____ pork chops
   _____ frog legs
   _____ duck
   _____ caviar
   _____ rabbit
   _____ shrimp
   _____ turkey
   _____ chef's salad
3. What two-tone colors do you prefer most (prefer least) for your next car?

- dark blue-ivory
- jade-cameo white
- bronze-ivory
- cardinal red-black
- dark green-ivory
- gold-black
- tropical lime-black
- copper-black
- rosewood-ivory
- light blue-cameo white

4. What magazines would you most like (least like) to have subscriptions for?

- Today's Health
- Argosy
- Travel
- TV Radio Mirror
- Guideposts
- Popular Science
- Look
- Esquire
- Sports
- New Republic

5. What films would you most like (least like) to see if you were going to a movie this weekend?

- Anne of a Thousand Days
- Shenandoah
- Diary of a Mad Housewife
- The Sound of Music
- War Between the Planets
- The Sterile Cuckoo
- Cold Turkey
- Blue Water, White Death
- Lawrence of Arabia
- The Guns of Navarrone
6. What countries would you most like (least like) to visit for one year?

_____ India  
_____ Greece  
_____ Brazil  
_____ Australia  
_____ Hungary

_____ Turkey  
_____ Spain  
_____ Tanzania  
_____ Congo  
_____ Russia

7. What sporting events would you most like (least like) to attend this weekend?

_____ rodeo  
_____ air show  
_____ ping pong tournament  
_____ football game  
_____ sailing races

_____ diving competition  
_____ baseball game  
_____ ski jumping demonstration  
_____ stock car races  
_____ soccer game

8. What factors are the most essential (least essential) to the care and development of a newborn baby (ages one to ten weeks)?

_____ to be held by different persons so he (she) does not depend too much on one person

_____ a mobile to watch to help focus his (her) attention

_____ to be held when he (she) cries

_____ to have his (her) own crib

_____ to start solid foods

_____ to be held at least six hours per day

_____ a daily bath

_____ a daily walk in sunshine and fresh air
8. (continued)

____ sterilized diapers
____ to bath the head before the body

9. What children's (ages two to four) toys do you think are the most appropriate (least appropriate) for your child?

____ tinker toys
____ scooter

____ toy truck
____ finger paints

____ dolls
____ sand box

____ coloring book and crayons
____ red wagon

____ swing
____ a Big Wheel

10. When you consider your friends and acquaintances or marriage in general, which of the following situations do you think cause the most problems (the least problems) between spouses?

____ prolonged visitation by the wife's friends
____ lack of common interests

____ husband's watching football on T.V.
____ lack of agreement over how often to visit in-laws

____ wife's purchase of nonessential clothes, shoes, etc.
____ unsatisfaction during sexual relations

____ husband's distribution of clothes around the house
____ sharing marital confidences with friends or relatives

____ different ideas of what constitutes a vacation
____ conflicts over if and/or when to have children
11. Which of the following books do you think could be the most helpful (least helpful) to you during the coming months?

- The Common Cold and You
- New Simplicity in Preparing Baby Formula
- The Fundamentals of Toilet Training
- What to Look for in Buying Infant's Furniture
- Sleep My Little One
- ABC's of Childhood Disease
- Accident Handbook
- Proper Care of Babies Feet
- Foods for Growing Boys and Girls
- Names for Boys and Girls

12. What babies' names do you prefer most (prefer least) for your next child?

- Christina
- Allen
- Frank
- Janice
- Sarah
- Scott
- Richard
- Victoria
- Shirley
- Luther
INSTRUCTIONS FOR THE MII (B)

1. This questionnaire is to be filled out privately by husbands and wives. In other words, please do not confer with each other while answering the questions.

2. Twelve situations are posed, and each situation has ten choices. You are to mark the three choices you like best (most) with an X and the three choices you like least with an O. Thus, each situation posed is to have four choices that are not marked.

3. Many of the situations posed, and their accompanying choices, may seem unlikely to ever occur, but they are to be filled out as if they were in fact real situations and choices in your life.

SITUATIONS POSED

1. What famous people would you most want to meet (least want to meet) if you were going to a party this weekend?

   _____ Joe Namath
   _____ John Gilligan
   _____ Madalyn Murrey O'Hare
   _____ Bobby Seales
   _____ Martha Mitchell

   _____ Golda Mier
   _____ J. Edgar Hoover
   _____ Paul Newman
   _____ Hugh Downs
   _____ Jonas Salk

2. What foods would you most prefer (least prefer) to eat if you were going out for dinner this weekend?

   _____ halibut
   _____ chicken
   _____ cheese fondue
   _____ breaded veal
   _____ clams

   _____ lobster
   _____ venison
   _____ barbecued ribs
   _____ ham
   _____ roast beef
3. What two-tone colors do you prefer most (prefer least) for your next car?

- starlight black-ivory
- light blue-black
- baja gold-ivory
- rosewood-black
- nordic silver-black
- cardinal red-ivory
- copper-black
- dark green-ivory
- bluestone gray-black
- yellow-cameo white

4. What magazines would you most like (least like) to have subscriptions for?

- Parents Magazine
- True
- Christian Living
- Life
- Saturday Review
- Redbook
- Playboy
- Popular Science
- Sports Illustrated
- True Confessions

5. What films would you most like (least like) to see if you were going to a movie this weekend?

- Ryan's Daughter
- Around the World in Eighty Days
- Tora, Tora, Tora
- The Owl and the Pussycat
- Air Port
- Woody Allen's Bananas
- The Student Nurses
- 1932--The Moonshine War
- Alice's Restaurant
- Le Mans
6. What countries would you most like (least like) to visit for one year?

- Indonesia
- Mexico
- The Phillipines
- Italy
- Czechoslovakie
- Nigeria
- Colombia
- Israel
- South Africa
- England

7. What sporting events would you most like (least like) to attend this weekend?

- wrestling
- auto thrill show
- air races
- track and field events
- billiards tournament
- horse races
- weight lifting contest
- tennis match
- basketball game
- golf tournament

8. What factors are the most essential (least essential) to the care and development of a newborn baby (ages one to ten weeks)?

- a room that is over 72°
- to be protected from school age children who may expose him (her) to childhood diseases
- to be exposed to music, movement, and bright colors
- to be rocked while feeding
- to have his (her) diapers changed promptly
- to be laid in different positions so he (she) does not just get used to one position
- to be fed on demand rather than by schedule
- to be talked to while being changed or bathed
- a pacifier
- to take vitamins daily
9. What children's (ages two to four) toys do you think are the most appropriate (least appropriate) for your child?

- beach ball
- tricycle
- bubble blower
- musical toy
- play-doh
- toy car
- football
- building blocks
- picture book
- puppet

10. When you consider your friends and acquaintances or marriage in general, which of the following situations do you think cause the most problems (least problems) between spouses?

- the husband's inappropriate behavior at parties
- questions regarding the use of money
- the wife's seeming inability to complete household tasks
- conflicts regarding relationships with in-laws
- the husband's spending too much time at work
- the wife's tendency to gossip on the telephone
- refusal to demonstrate affection except in bed
- lack of joint activities outside of the home
- conflicting philosophies of life
- differences over the discipline of children

11. Which of the following books do you think could be the most helpful (least helpful) to you during the coming months?

- Baby Feeding Made Easier
- Choose Your Calories Wisely
- Stork Facts
- Around the Clock with Your Baby
- The Simplest, Most Sanitary Way to Bottle Feed
11. (continued)

_____ How to Get the Best Baby Crib for Your Money
_____ A Bath Can Do More--Much More Than Bathe Your Baby
_____ A Handy Baby Laundry Guide
_____ Helpful Hints for Traveling with Baby
_____ Permissiveness and the Baby

12. Which babies' names do you prefer most (prefer least) for your next child?

_____ Elizabeth  ____ Eric
_____ David  ____ Barbara
_____ Linda  ____ Michael
_____ Thomas  ____ Enid
_____ Anne  ____ Jeffery
APPENDIX C

SHORT MARITAL ADJUSTMENT INDEX
SHORT MARITAL ADJUSTMENT INDEX

This form is to be filled out by both the husband and wife. Frank and sincere replies are of the highest importance and the following points are to be kept in mind while filling out this questionnaire:

(1) Be sure to answer all questions; and

(2) Do not confer with your spouse or share your answers while filling out this questionnaire. (If you prefer, you may want to discuss this together after you leave.)

1. Check the dot on the scale line below which best describes the degree of happiness, everything considered, that you associate with your marriage at the present time. The middle point, "happy," represents the degree of happiness which most people get from marriage, and the scale gradually ranges on the one side to those few who are very unhappy in marriage, and on the other, to those few who experience extreme joy in marriage.

Very Unhappy Perfectly Happy

State the approximate extent of agreement or disagreement between you and your mate on the following items. Please check one space in each row.

<table>
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<th>Always Disagree</th>
<th>Almost Disagree</th>
<th>Frequently Disagree</th>
<th>Occasionally Disagree</th>
<th>Almost Agree</th>
<th>Always Agree</th>
</tr>
</thead>
</table>

2. Handling family finances
3. Matters of recreation
4. Demonstrations of affection
5. Friends

6. Sex relations

7. Conventionality (right, good, or proper conduct)

8. Philosophy of life

9. Ways of dealing with in-laws

10. When disagreements arise, they usually result in:
    husband giving in ____; wife giving in ____; agreement by mutual give and take ____.

11. Do you and your mate engage in outside interests together? All of them ____; some of them ____; very few of them ____; none of them ____.

12. In leisure time do you generally prefer: to be "on the go" ____; to stay at home ____; Does your mate generally prefer: to be "on the go" ____; to stay at home ____?

13. Do you ever wish you had not married? Frequently ____; occasionally ____; rarely ____; never ____.

14. If you had your life to live over, do you think you would: marry the same person ____; marry a different person ____; not marry at all ____?

15. Do you confide in your mate: almost never ____; rarely ____; in most things ____; in everything.
APPENDIX D
INDEX OF ADJUSTMENT AND VALUES
INSTRUCTIONS FOR THE IAV

There is a need for each of us to know more about ourselves and our spouses but seldom do we have an opportunity to systematically look at ourselves as we are and as we would like to be. The IAV is a list of terms that to a certain degree describe people.

1. On page one (yellow page), take each term separately and apply it to yourself by completing the following sentence:

   I AM AN ________________________PERSON

Then, in Column I, decide HOW MUCH OF THE TIME this statement is like you and rate yourself on a scale from one to five according to the following key:

1. Seldom, is this like me.
2. Occasionally, this is like me.
3. About half of the time, this is like me.
4. A good deal of the time, this is like me.
5. Most of the time, this is like me.

II. Now go to Column II, using the same term, complete the following sentence:

   I WOULD LIKE TO BE AN ________________________PERSON

Again, this time in Column II, use the following scale to indicate HOW MUCH OF THE TIME you would like this trait to be characteristic of you:

1. Seldom, would I like this to be me.
2. Occasionally, I would like this to be me.
3. About half of the time, I would like this to be me.
4. A good deal of the time, I would like this to be me.
5. Most of the time, I would like this to be me.
III. On page two (green page), take each term separately and apply it to your spouse by completing the following sentence:

MY HUSBAND (WIFE) IS AN ___________ PERSON

Then in Column I, decide HOW MUCH OF THE TIME this statement is like him (her).

1. Seldom is this like him (her).
2. Occasionally this is like him (her).
3. About half of the time this is like him (her).
4. A good deal of the time this is like him (her).
5. Most of the time this is like him (her).

IV. Now go to Column II, using the same term, complete the following sentence:

I WOULD LIKE MY SPOUSE TO BE AN ___________ PERSON

Again, this time in Column II, use the following scale to indicate HOW MUCH OF THE TIME you would like this trait to be characteristic of your spouse.

1. Seldom would I like this to be him (her).
2. Occasionally I would like this to be him (her).
3. About half of the time I would like this to be him (her).
4. A good deal of the time I would like this to be him (her).
5. Most of the time I would like this to be him (her).
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<th>II.</th>
<th>Meddlesome</th>
<th>I.</th>
<th>II.</th>
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APPENDIX E

WIVES
WIVES

The following questions are designed to facilitate understanding of factors associated with the birth of the first child.

I. Child's Birth

1. Expected date of child's birth __________________

2. Physician present at delivery __________________ (name)

3. The length of my labor was __________________

4. I was awake _______, asleep _______ during delivery (check one)

5. I had _____ did not have _______ rooming in at the hospital (check one)

6. I am bottle _____, breast _____ feeding my baby. (check one)

7. Check the following words that characterized how the world seemed to you (i.e., how life seemed to you) during the birth of your child.

    truth
    goodness
    beauty
    wholeness
    connectedness
    aliveness
    uniqueness
    perfection

    inevitability
    completeness
    justice
    order
    simplicity
    richness
    effortlessness
    playfulness
    self sufficiency

II. Family Data

1. I would like to have 0, 1, 2, 3, 4, more children (encircle one).

2. Did anyone come into your home to help with the baby? Yes _____ no ______ (check one) If so, who? How long did they stay? ______

3. My parents were (1) not divorced _____ (2) divorced (check one).

4. I plan to return to work outside of the home? Yes _____ No _____ If so, approximately when

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APPENDIX F

HUSBANDS
HUSBAND

The following questions are designed to facilitate understanding of factors associated with the birth of the first child.

I. Child's Birth

1. I was with my wife during labor the following amount of time (check one).
   ______ none of the time
   ______ very little of the time
   ______ about half of the time
   ______ most of the time

2. My wife and I were together during the birth of our child. Yes ____ No ____ (check one).
   If no, where were you? ________________________________

3. Check the following words that characterized how the world seemed to you (i.e., how life seemed to you) during the birth of your child.
   ______ truth   ______ inevitability
   ______ goodness   ______ completeness
   ______ beauty   ______ justice
   ______ wholeness   ______ order
   ______ connectedness   ______ simplicity
   ______ aliveness   ______ richness
   ______ uniqueness   ______ effortlessness
   ______ perfection   ______ playfulness
   ______ self sufficiency

II. Income

1. What was your family income during 1971? (check one)
   ______ under $8000
   ______ $8000-$11,999
   ______ $12,000-$15,999
   ______ $16,000-$19,999
   ______ $20,000 or over

3. How much will your family income decrease in 1972 as a result of having a baby? (check one)
   ______ none
   ______ under $3000
   ______ $3,000-$5,999
   ______ $6,000-$8,999
   ______ $9,000 and over
III. Family Data

1. This child was planned _____ unplanned ______ (check one)

2. I would like to have 0, 1, 2, 3, 4 more children. (encircle one)

3. This is my first _____ second ______ third _____ marriage (check one).

4. My parents were (1) not divorced _____ (2) divorced _____ (check one).
APPENDIX G

GENERAL INFORMATION
GENERAL INFORMATION

Medication: Analgesics__________ Anesthetics__________

1. What was the best part of childbirth from your perspective?
   Husband

   Wife

2. What was the most difficult part associated with having the baby from your perspective?
   Husband

   Wife

3. What changes do you notice in yourself and each other as a result of having the baby?
   Husband

   Wife

4. If you could change something about the whole experience what would it be?
   Husband

   Wife

5. What did you learn about having a baby this time that you will utilize if you have another?
   Husband

   Wife
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