

# **IMAGES AND IMPACTS OF PARENTHOOD**

Explaining fertility and family size  
in contemporary Australia

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## **ABSTRACT**

This thesis was written against the backdrop of Australia's low fertility rate to investigate perceptions at the individual level, and within the social context, of influences on fertility and family size. The thesis aligns itself with cultural, ideational and institutional theories of fertility change. It seeks to augment contemporary debate and policy, which centre around work-family compatibility and the financial costs of children, by also investigating the influence of individuals' expectations and experiences of conception, pregnancy, birth and early parenthood. For several decades the geographical, medical and sociological literature has shown these reproductive events to heavily impact on the physical and mental well-being of parents in developed societies, but it is only recently that some demographers have suggested that they warrant renewed investigation in low fertility research. These aspects are all the more salient as postmodern values associated with concern about personal well-being have risen to prominence and have become associated with the transition to below-replacement fertility.

The primary research in the thesis comprises 62 in-depth interviews with parents from across metropolitan South Australia, and a small survey of 45 individuals intending to start a family within two years. The thesis intentionally includes the views of men and of parents with larger families. Analysis of 1996 Census data establishes fertility patterns at the macro level as a basis for exploring the qualitative data.

The thesis findings contribute new knowledge by showing that in South Australia cultural and family influences shape images of family life and family size despite the rhetoric of modern reproductive "choice". They also demonstrate how lower fertility can result from individuals with postmodern preferences finding their experiences of parenthood clashing with their preferences for autonomy, rationality, personal achievement and quality of life. The thesis argues that such experiences can diffuse socially to negatively influence the images and anticipated impacts of parenthood, and hence the fertility desires, of others. In identifying gender differences in the impacts, the thesis concludes that low fertility theory and policy must diversify to better reflect the concerns of women as mothers, and to consider the embodied and social aspects of reproductive behaviour.

## **DECLARATION**

This thesis is my original work as a PhD scholar in the Department of Geographical & Environmental Studies and the Department of Gender Studies & Labour Studies at The University of Adelaide between February 2002 and January 2006.

The work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text.

I give consent to this copy of my thesis, when deposited in the University Library, being available for loan and photocopying.

.....  
Lareen A Newman

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## **ABBREVIATIONS AND ACRONYMS**

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
ART	Assisted reproductive technology
ASCO	Australian Standard Classification of Occupations
ASCR	Australian Standard Classification of Religions
DFaCS	Department of Family and Community Services
DHS	Department of Human Services (South Australia)
LARC	Long-acting reversible contraception
TFR	Total fertility rate
WHO	World Health Organisation

# Chapter 1

## Introduction

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With generally higher education and higher employment status than their mothers, how do women in [developed] countries feel about the demands of day-to-day childrearing?... The shock most women experience after the birth of their first child... the demands on one's time... the sense of personal responsibility... the increasing pressure to invest in the social and educational activities of children, may well play a significant role in discouraging additional births

(Presser 2001:180-181).

### 1.0 INTRODUCTION

Against the background of Australia's currently low fertility rate, this thesis is a study of ways in which individuals' and couples' expectations about, and personal experiences of, childbearing and childrearing influence their family size desires, their natural fertility and their parity progression. The thesis argues that investigation of such issues at the individual level can help provide a deeper understanding of influences on fertility rates and patterns at the regional and national level.

In many areas of the developed world where fertility has declined to below-replacement level governments are seeking ways to at least stabilise, if not raise, fertility rates. This action is being stimulated by the changes to population structures which are associated with low fertility, which many perceive will have negative impacts in the future in both social and economic terms. Since Australian governments became concerned about low fertility rates, as late as in the 1990s, government policy and the wider public debate has focussed primarily on work-family compatibility issues and on financial restrictions as limits to people starting a family, or having additional children. However, a reading of the geographical, sociological and medical literature from the past five decades suggests that other issues, particularly those relating to women's experiences as mothers, may also be influential. Such issues include the negative impacts of the embodied and social experiences of conception, pregnancy, birth and



early parenthood, as well as the daily difficulties that some mothers experience with various aspects of childrearing. The potential for these experiences to contribute to lowered fertility were noted to some extent in earlier demographic research but the thesis argues that they have received little in-depth investigation recently and are overlooked in contemporary policy debate. The thesis also seeks to provide a balance to the more general focus of fertility research on women and on those having smaller families or remaining childless, by including alongside these groups the views and experiences of men and of parents with larger families, so that similarities and differences in family size thinking and behaviour can be explored.

Whilst considering the influence on fertility of financial limitations and work-family compatibility issues, the particular focus of this thesis is an investigation of ways in which expectations about, and experiences of, the processes of bearing and raising children might impact on fertility and family size desires through the impact that these processes can have on parental health and well-being. Such an investigation is particularly relevant in contemporary low fertility research because, in developed societies like Australia, social change associated with the development of postmodern preferences has brought increased concern about individual health, well-being and quality of life, and such concerns have been associated with the transition to below-replacement fertility levels.

Section one of this chapter sets out the aims and objectives of the thesis, while section two considers previous research into influences on Australian fertility and family size so as to identify the gaps which the thesis seeks to address. The third section explains why the thesis investigates parenthood as a life course event, and section four defines the key terms of parenthood and parenting. The final section provides an overview of the thesis chapters.

## **1.1 AIMS AND OBJECTIVES OF THE THESIS**

The overall goal of the thesis is to broaden and deepen the understanding of Australia's current below-replacement fertility rate through research at the individual level and through research into aspects of reproductive behaviour which have generally been inadequately covered. The thesis seeks to answer four broad questions:

- A. In what ways is fertility and family size influenced by individual women's and men's personal experiences of childbearing and childrearing (ie of conception, pregnancy, birth and early parenthood)?

- B. In what ways is fertility and family size influenced by individual women's and men's beliefs and expectations about the likely personal impacts of future childbearing and childrearing?
- C. Can recent patterns in family size and fertility in South Australia be related to inter-group differences in beliefs, expectations and experiences of childbearing and childrearing?
- D. What implications do the findings have for future fertility trends, for government policy and for future research?

The specific objectives of the thesis are as follows:

- Objective 1: To identify recent *patterns* in fertility and family size for selected socio-economic areas of metropolitan Adelaide and to compare these with the state and national patterns to provide a picture of contemporary fertility behaviour.
- Objective 2: To investigate how individuals within different socio-economic areas explain *how they came to have their current family size*.
- Objective 3: To establish *what factors* individuals perceive as influencing their past, current and future family size, and what they believe contributes to any "fertility gaps".
- Objective 4: To explore the influence on fertility and family size outcomes of *anticipated experiences* of childbearing and childrearing, how these shape original desires to start a family, and how these desires may be *re-shaped by the experiences* of bearing and raising one or more children.
- Objective 5: To consider explanations of the *relative importance* of childbearing and child-rearing experiences against other key constraints commonly noted in the literature, such as financial costs, preferences for paid/unpaid work, and childcare issues, as well as other influences spontaneously arising in interviews.
- Objective 6: To consider the implications of the findings for demographic theory, government policy and future fertility trends in Australia.

In seeking to answer the main research questions the thesis combines regional level quantitative analysis (provided in Chapter 5) with individual and couple level qualitative analysis (provided in Chapters 6 to 11). The area selected for the research was metropolitan Adelaide, the capital city of the state of South Australia. This area is particularly suitable for a low fertility study since until recently it has had a significantly lower fertility rate than the other States and Territories of Australia (Hugo 1983a). Currently South Australia has the third lowest fertility rate in the nation and the median age of mothers is the third highest, at 30.6 years (Australian Bureau of Statistics (ABS) 2004a:16). Furthermore, in 2002 the total fertility rate (TFR) of the capital city of Adelaide was also third lowest, at 1.62, with only Canberra and Melbourne having lower TFRs, of 1.55 and 1.58 respectively (Hugo 2004:29).

## **1.2 PREVIOUS RESEARCH ON FERTILITY AND FAMILY SIZE IN AUSTRALIA**

In order to understand the contribution of the thesis it is useful to consider the content and methodology of other research into Australian fertility and family sizes since the national fertility rate fell below replacement level in the 1970s. Within Australian demography a tradition of micro-level research came to the fore between the early 1970s and mid-1980s, particularly in conjunction with the work of the Australian Family Formation Project at The Australian National University (see Table 1.1). Alongside this, some researchers in psychology and sociology who were conducting in-depth research on Australian family life also made some comments on influences on family size (eg Callan 1985; Richards 1978). However, in stark contrast with this, and perhaps reflecting disciplinary trends or personal research interests, Tables 1.1 and 1.2 show that much of the empirical research investigating influences on fertility and family size in Australia over the last twenty years has:

- focussed more on analysing *macro trends* in fertility and related variables than on investigating individual expectations and experiences of becoming and being a parent;
- focussed more on *quantitative* than on qualitative methods and data sources;
- focussed more on *economics* than on socio-psychological perspectives;
- focussed more on the world of *paid work and public achievement* than on the world of home, relationships and private reproduction;
- paid little attention to *gender differences* and rarely included men;
- and been “*disembodied*” in rarely considering the emotional and physical processes of bearing and raising a child, despite this being raised in earlier demographic research.

**Table 1.1****Overview of research on fertility and family size in Australia, 1971 to 1989**

Source: compiled by the author

<b>Date</b>	<b>Author</b>	<b>Focus</b>	<b>Method/Data Type</b>
1971	Demography Department, Australian National University	Australian Family Formation Project (AFFP) and Melbourne Family Survey (MFS). First survey in Australia on family size & family planning (Borrie 1975).	Personal interviews of 2,650 married women under age 60 – produced various papers as below.
1971	Spencer	Fertility trends.	Quantitative analysis.
1973	Di Iulio (in Borrie 1975)	Patterns and differentials in fertility by workforce participation.	Analysis of 1954 and 1961 Census data.
1973	Ware	Attitudes to acceptable and ideal family sizes.	Qualitative data from MFS interviews.
1975	Di Iulio	National fertility trends and differentials.	Analysis of Census data to 1966.
1975	Young	Planned/expected/actual family size by age/religion/birthplace.	Quantitative and qualitative data from MFS.
1976	Campbell	Influences on family size in Sydney.	Qualitative data as part of the AFFP.
1976	Cosford et al	Influences on family size in Canberra.	Qualitative data as part of the AFFP.
1976	Packer, Caldwell & Caldwell	Influences on family size for Greek women in Melbourne.	Qualitative data as part of the AFFP.
1977	Caldwell et al	Australian Family Formation Project, Melbourne survey.	Qualitative and quantitative: interviews with women incl. attitudes to family size, motherhood, etc
1977	Young	Life cycle of the family.	Quantitative and qualitative data from MFS.
1978	Richards	Sociology of attitudes to family, raised some reasons for different family size.	Qualitative data from personal interviews.
1979	Baxter	Family intentions of women with one child in Armidale.	Qualitative data from personal interviews.
1981	Bracher	Patterns and determinants of fertility in Melbourne.	Quantitative and qualitative data.
1983	Hugo (1983b)	Trends and differentials by socio-economic status.	Analysis of 1981 Census data.
1987	Bracher	Australian Family Project (AFP).	National survey; pre-coded interviews with women, self-completed survey for men, on eg decision-making re first birth.
1988	Miller	Economic models of fertility behaviour.	Analysis of quantitative variables.
1989	Rowland	Fertility differentials by education/marital status.	Analysis of 1981 Census data.
1989	Santow	Employment and family in women's lives.	Analysis of mixed methods data from the AFFP.

**Table 1.2**  
**Overview of research on fertility and family size in Australia, 1990 to 2005**

Source: compiled by the author

<b>Date</b>	<b>Author</b>	<b>Focus</b>	<b>Method/Data Type</b>
1990	Daly	Fertility differentials (eg workforce participation, marital status).	Quantitative data.
1990	McNicoll	Fertility trends of Australian-born and overseas families.	Comparison of quantitative data.
1990	Young	Women's work and family.	Analysis of trends.
1991	Bracher & Santow	Fertility desires and outcomes, 1966-1986.	Quantitative data; hypotheses of reasons.
1993	ABS	National survey of families.	Quantitative analysis.
1997	Jain & McDonald	Fertility by birth cohort components and differentials.	Census and other quantitative data.
1998	Abbasi-Shavazi	Fertility trends of immigrant and Australian-born women 1977-91.	Analysis of Census data.
1998	McDonald	Analysis of cohort and total fertility.	Data from 1996 Census and ANU Life course survey.
1999	Meyer	Progression to third child.	Quantitative data from national phone survey.
1999	Santow & Bracher	Reasons for changing values and family size for southern Europeans.	Qualitative and quantitative data from earlier studies.
2000	Birrell	Differentials by education/income.	1986/96 Census data.
2001	Kippen	Fertility trends 1991-1998.	Analysis of fertility rates.
2002	Gray	Men's fertility trends.	Analysis of quantitative data.
2004	Kippen	Parity progression ratios.	Analysis of quantitative data.
2004	Merlo	Antecedent conditions for motherhood.	Qualitative – telephone interviews and focus groups.
2004	Weston, Qu, Parker & Alexander	National survey of issues affecting fertility decision-making.	Structured telephone survey, some qualitative input.
2005	Kippen, Gray & Evans; Gray et al	Parity progression based on sex of previous children.	Quantitative analysis; some qualitative planned.
In progress	Carmichael & Whittaker	Influences on family formation in eastern Australia.	In-depth interviews with representative sample.

Exceptions to these foci have been research projects on childlessness which adopted a qualitative approach at the individual and couple level in order to provide a more in-depth understanding of the causes of childlessness, as shown in Table 1.3. A few other recent studies do include an in-depth qualitative component (eg Merlo 2004; Weston et al 2004) but they have not specifically followed up on issues raised which pertain to the processes of childbearing. They have also not explored in-depth interviews with men or parents of larger families, aspects which this thesis will argue in Chapter 4 are important for providing additional insights to the general focus of researching women and those having smaller families or remaining childless.

**Table 1.3**  
**Overview of research on childlessness in Australia, 1993 to 2005**

Source: compiled by the author

<b>Date</b>	<b>Author</b>	<b>Topic</b>	<b>Method/Data Type</b>
1993	Marshall	Influence of parenthood ideology on childlessness.	In-depth interviews of 10 couples; 190 questionnaires.
1998	Rowland	Childlessness trends crossnationally.	Quantitative trends.
2000	Merlo & Rowland	Prevalence of childlessness.	Analysis of quantitative trends.
2001	Weston & Qu	Reasons for childlessness.	Qualitative national survey.
2002	Beit	Reasons for childlessness, women in Queensland.	Personal interviews.
2005	Cannold	Reasons for childlessness, women in Australia and the USA.	In-depth interviews.

### 1.3 INVESTIGATING PARENTHOOD AS A LIFE COURSE EVENT

In seeking to investigate the influence on fertility of the sequential processes of reproduction from conception to early parenthood it is appropriate for the thesis to adopt a life course approach. This also enables consideration of how the fertility-related thinking and behaviour of individuals and couples develops and may change over the life course with the personal or vicarious experience of parenthood. This approach follows in the tradition of sociological and psychological research which considers how parenthood as a stage and goal in the life course sits alongside education, work, and other aspects within an individual's overall life course orientation (which will be discussed in more detail in Chapters 3, 6 and 11). This is a departure from the standard life course approach in demography which focusses more on how fertility is affected by the *timing of events* in the life course, since it considers how the *experience* of the life course event of parenthood can shape thinking about children and parenting.

The thesis therefore investigates how thinking and behaviour related to fertility and family size may be the outcome of a combination of an individual's and couple's earlier childhood experiences, subsequent life course experiences, and reactions to the current and future social, physical and economic environment. It will draw on social and psychological theories pertaining to social learning, social construction, fertility behaviour and parenthood. In considering life course orientations, the thesis seeks to balance the contemporary debate which focusses largely on how fertility may be lowered by individuals' *preferences for education and work* by also considering how fertility may be affected by *preferences for avoiding parenthood* because of negative physical and socio-psychological impacts which individuals come to

associate with childbearing and childrearing through their direct or vicarious experience. The thesis will demonstrate in Chapters 7 to 11 why explanations of fertility should give greater consideration to expectations and experiences of these physical and socio-psychological aspects of childbearing and childrearing. This applies both to the transition to having the first child (ie to family formation), as well as to the transition to having subsequent children (ie to family extension). Throughout the thesis the term “fertility decision-making” is replaced by “fertility thinking and behaviour” to allow for conception and family size to be both planned and unplanned, rather than always a conscious decision.

#### **1.4 DEFINING PARENTHOOD AND PARENTING**

For the purposes of the thesis the term “parenthood” is used to define the stage in the life course when children are borne and raised. As such, the thesis talks of “the transition to parenthood” as the movement from a pre-parenthood stage where individuals have no newborn to care for, to the stage in which they give birth to a newborn child and begin to care for it. The term “parenting” is used to represent the everyday behaviour and tasks involved in raising and caring for children.

In investigating the influences of parenthood expectations and experiences the thesis is based on the premise that parenting is a social construction rather than an innate behaviour (and this is discussed further in Chapter 3). This means that while the specific reproductive processes of conception, pregnancy, birth and early newborn care are chiefly biological processes, the way that they progress are influenced by the particular social and technological context in which they occur and by the social constructions of what these processes are seen to mean and entail. As such, the ways that people “do parenthood” can be seen as open to reconstruction. In this way it is possible (at least theoretically) for social and technological influences on childbearing and childrearing to be either in line with, or out of touch with, other developments or changes in society.

#### **1.5 OVERVIEW OF THE THESIS**

The thesis is organised into twelve chapters. After this Introduction, Chapter 2 commences by locating Australian fertility trends in a global context and then discussing Australian fertility differentials in time and space. Chapter 2 also discusses demographic trends related to

changing fertility. Chapter 3 then explores theoretical explanations for these fertility trends and differentials, and explains why the thesis aligns itself with cultural, ideational and institutional theories of fertility change. This chapter also explores in more detail the argument that, within the demographic debate on low fertility, influences related to the private and embodied aspects of reproduction (ie the processes of conception, pregnancy, birth and the first 12 to 24 months of parenthood) have remained a sub-narrative. Chapter 3 also explains in more detail why the thesis adopts a social constructionist view of parenting, and discusses a socio-psychological framework which allows the thesis to investigate influences on fertility from expectations and impacts of parenthood on an individual's physical, mental, social, material and financial well-being. The framework also highlights social learning and social diffusion as mechanisms for individuals to build images of the processes of childbearing and childrearing and to acquire parenting skills and knowledge.

Chapter 4 details the methodology of the thesis and explains why the research aligns itself with feminist standpoint epistemology and uses a predominantly qualitative approach to investigate influences on fertility at the individual level and within the social context. Chapter 4 also details the research design, the selection of areas from which interviewees were recruited, and the conduct of both parent interviews and a preconception survey. In order to better understand the social contexts in which data collection occurred, Chapter 5 provides information on the geographical, historical and social background of the study areas, along with demographic and social details of the people from whom data was collected. This chapter also provides quantitative analysis of fertility patterns for metropolitan Adelaide and South Australia from the 1996 Census to provide a backdrop for the qualitative data analysed later in Chapters 6 to 11.

Chapter 6 commences the analysis of the qualitative data. It explores how images of family life and of family size influence individual fertility-related thinking and family size preferences. It also explores influences on fertility from the wider social context and from individual personality and coping style. The subsequent three chapters (7 to 9) then explore the embodied and social experiences of conception, pregnancy, birth and early parenthood and consider how these may reshape earlier family size desires or may impact on natural fertility. Chapter 10 then explores how fertility and family size are influenced by perceived financial limitations and work-related issues.



In preparation for the final chapter, Chapter 11 begins by summarising the relative and cumulative impacts on family size of the experiences of parenthood discussed in Chapters 7 to 10. This contributes to the development of a new concept called The Baby Stage as a distinct part of the life course event of parenthood. The chapter demonstrates that reflections on impacts of this Stage influence the likelihood and timing of parents having additional children, while images of this stage can influence the fertility thinking and behaviour of those as yet without children. Chapter 11 also argues, however, that such influences must be considered in light of the background influences discussed in Chapter 6, and it discusses desire-size groupings which can inform policy and research by further illuminating the quantitative fertility patterns identified in Chapter 5.

Chapter 12 concludes the thesis by arguing that, based on the research findings, contemporary social conditions not only make it difficult for Australians to *combine* work and family but also make it difficult for many to *bear and raise children* in a way which does not negatively impact on their health, well-being and quality of life. With this in mind, the chapter makes suggestions for policy input and further research.

## **1.6 CONCLUSION**

This introductory chapter has explained that the focus of this thesis is to explore ways in which expectations and experiences of parenthood influence fertility and family size desires in contemporary Australia. The thesis will progress by describing fertility trends and patterns, exploring theoretical explanations for these, explaining why research at the individual level is required to better understand such trends and patterns, and why qualitative research is most appropriate for this. The thesis will then provide five chapters which explore these influences at the individual level in more detail, based on qualitative input from parent interviews and a survey of men and women expecting to start a family within two years. The dominant theme throughout the thesis is that, for increasing proportions of Australians, images and impacts of parenthood under contemporary conditions clash with postmodern preferences, and that the experience of such a mismatch adversely affects Australian fertility rates.

## Chapter 2

# The demographic context of low fertility in Australia

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Since 1976, Australian fertility has been below replacement level, which will eventually result in the population decreasing. With such significant implications for the size and structure of the population, low fertility lies at the heart of many current economic, environmental and social issues

(ABS 2002a:12).

### 2.0 INTRODUCTION

To place the thesis research within the wider context this chapter outlines the demographic background to Australia's contemporary low fertility rates. Firstly, it locates Australia within the wider context of fertility change in developed countries and then provides an outline of historical trends in Australian fertility rates and family sizes. The third section discusses demographic variables associated with fertility differentials. Finally, the fourth section considers some contemporary perspectives on the significance of low fertility in Australia. The next chapter will then consider theoretical explanations for such patterns and trends and explore the gaps in knowledge which the thesis seeks to fill. A more detailed analysis of fertility trends and differentials in the study area is provided in Chapter 5.

### 2.1 THE WIDER CONTEXT

To understand Australia's currently low fertility it is useful to begin by considering the wider context of fertility change in developed countries. From around 1870, the fertility of married women and the average size of completed families began to decline in most Western and Northern European countries, and in English-speaking countries of overseas European settlement such as Australia (Ruzicka & Caldwell 1977:1). A further unpredicted and unprecedented major decline in fertility in countries containing almost four-fifths of the world's population then occurred between the late 1950s and late 1970s (Caldwell 2001:93).

Immediately prior to this, many developed countries experienced either stable fertility levels or a post-war Baby Boom (Caldwell 2001:93). Therefore, whereas in 1950-55 world fertility rates were around 5.0 children per woman, by 2000-2005 they were almost half this rate at 2.65, and for 2000-2005 fertility was estimated to be below replacement level in 65 countries or areas of the world, with 66 per cent in more developed regions (UN 2005:6). This included Australia. In 15 of these countries (mostly in Southern and Eastern Europe) fertility levels were even as low as 1.3 children per woman, a level unprecedented in human history (UN 2005:9) and by 2001 some were even in the “very low” range of 1.0 to 1.3 children per woman, including Hong Kong, Germany, Italy and Japan (Caldwell, Caldwell and McDonald 2002).

While global population continues to increase due to a young age distribution overall, Lesthaege and Surkyn (2004:1) note that the demographic momentum of reduced fertility laid the foundations in the 1970-2000 period for the end of global population expansion. The United Nations (2005:v) reports that almost all population growth is now occurring in the less developed regions, while the population of the more developed regions as a whole is now changing only minimally. While the fertility of developed countries currently averages 1.56 births per woman, there have been some increases in fertility (albeit small) in Belgium, France, Germany, the Netherlands and the US (UN 2005:viii) and the fertility of developed countries is projected to slowly increase to 1.84 by 2045-2050 (UN 2005:vii-viii).). However, the UN forecasts that over the next 50 years Japan and virtually all European countries will experience a general decrease in population and a higher ratio of non-working persons to working population (UN Secretariat 2000:1). Such changes are expected to result in Europe’s share of world population being halved over a century, from 12 per cent in 2000 to 6 per cent in 2100, and Africa’s being almost doubled, from 13 to 25 per cent (UN 2005:1). Contemporary analysis and projections suggest that Australia is likely to experience changes similar to Europe (ABS 2002a; Birrell 2000; McDonald & Kippen 1999; Withers 1999; Young 1998).

A comparison of national fertility rates in 2001 showed that although Australia’s TFR (1.75) was under replacement level (ABS 2002a:31), it was nevertheless higher than that of many other major developed countries. Indeed, fertility was only higher in Norway and France (TFR 1.8), Ireland (1.9), New Zealand (2.0), and the United States (2.1) (Caldwell et al 2002:2). Table 2.1 shows that to some extent such rates reflect the momentum from past trends, and this is discussed in Chapter 6 in relation to historic family influences on individual fertility.

**Table 2.1****Selected world comparison of number of babies born per woman, 1950 to 2005**

Source: ABS (2002a:13); world data from UN (2005:6)

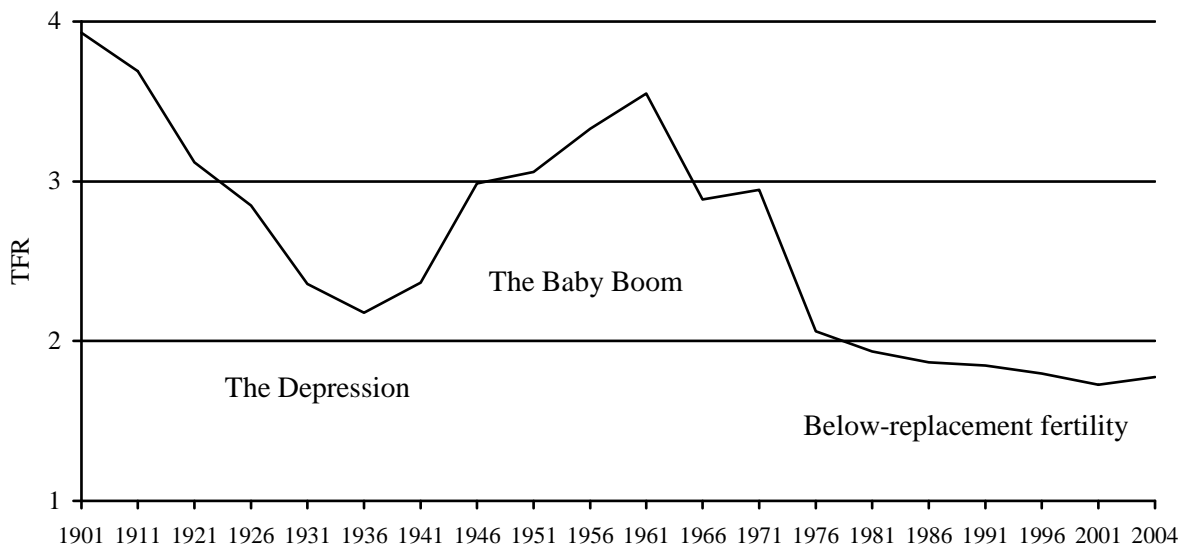
	1950-55	1975-80	2000-2005
World	5.00	n.a.	2.65
New Zealand	3.69	2.18	1.97
United States	3.45	1.79	1.93
<b>Australia</b>	<b>3.18</b>	<b>2.09</b>	<b>1.75</b>
United Kingdom	2.18	1.72	1.61
Japan	2.75	1.81	1.33
Germany	2.16	1.52	1.29
Greece	2.29	2.32	1.24
Italy	2.32	1.89	1.20
Hong Kong (SAR of China)	4.44	2.32	1.17

**2.2 TRENDS IN AUSTRALIAN FERTILITY****2.2.1 Historical trends in the fertility rate**

Australia's current period of lower fertility is not the first since European settlement of the continent in the eighteenth century, but it is the first period with rates below replacement level. Marital fertility began to decline in Australia from the 1860s to 1880s, mirroring the trends in Northern and Western Europe (as already noted in the previous section) (Day 1965; Ruzicka & Caldwell 1977). Although the TFR was still around 4.0 by 1901, this represented a decline of more than one third over the previous thirty years (Hugo 2001:174). Figure 2.1 shows that the TFR thereafter fell to be close to replacement level at 2.17 in 1933 in the midst of the Great Depression, then rose to a peak of 3.55 in 1961 at the height of the Baby Boom; it then fell again to dip below replacement level for the first time in the mid 1970s, and hovered around 1.8 to 1.9 during much of the 1980s and 1990s (ABS 2002b).

According to estimates from the ABS, from the mid- to late 1990s the TFR was between 1.75 and 1.80, while in the early years of the twenty-first century it fluctuated between 1.729 and 1.759 (ABS 2005a). The most recent estimate, for 2004, shows a slight increase to 1.774 (ABS 2005a). Although the recent plateauing and slight increase may reflect the end of delayed childbearing and the depression of the TFR by the "tempo effect" (explained later in section 2.2.4), the ABS (2004a) believes it will be followed by a downward trend in the number of births and TFRs. On the other hand, by comparing ABS data with the National Perinatal Data

**Figure 2.1**  
**Total fertility rate, Australia, 1901 to 2004**  
 Source: ABS (2004a, 2005a, 2005b)



collection, McDonald (2005a) suggests that Australian fertility has probably been higher than ABS statistics suggest and may well never have fallen below 1.78. McDonald (2005a) also believes that recent policy changes and increasing public discussion of delayed childbearing are likely to maintain Australia's TFR at least at 1.8 for the next ten years. Nevertheless, Hugo (in Legge 2005) believes that "the Australian fertility rate is at a critical stage. It could go in any number of directions. Which direction will be strongly influenced by policy".

### 2.2.2 Trends in family size

There is general agreement that the two main demographic factors influencing low fertility are a delay in the start of childbearing when women are in their 20s, followed by smaller families once childbearing starts (McDonald 2001a). The result has been almost universal in developed countries, with the proportion of fourth- and higher-order births declining between the early 1960s and mid-1990s, and the proportion of first- and second-order births increasing (Frejka & Ross 2001:224). Despite fluctuating fertility rates suggesting otherwise, smaller families (of two or three children) were the norm for much of the twentieth century in Australia, Britain and the USA (Borrie 1975:49; Busfield & Paddon 1977:9; Kirk 1955). Falling mortality levels and rising life expectancy are seen as significant motivators for the use of more efficient birth control which led to this "small family system" emerging in Australia as early as the 1880s

and being firmly established by the 1930s (Borrie 1975:44, 49). Indeed, by the mid-1960s, 50 per cent of Australian wives had two or three children (Borrie 1975:86), and by the 1996 Census 65 per cent of women had had two or three (McDonald 1998:6). Table 2.2 provides an indication of changes in the *minimum* number of children being born (since according to Borrie (1975) neither births from wives' previous marriages nor ex-nuptial births were counted, although the latter accounted for only around 5 per cent of births prior to the early 1960s, according to Hugo 2001:17).

**Table 2.2**

**“Average issue” of Australian wives aged 45-49, 1881 to 1973, and women, 1996**

Source: Borrie (1975:46, Table II.4), except for 1996 data from McDonald (1998)

NOTE:

This table is included on page 15 of the print copy of the thesis held in the University of Adelaide Library.

Although the range of family size in Australia has progressively narrowed to families of one, two and three children, there was a temporary increase in the proportions having third, fourth and fifth children in the 1940s and 1950s during the Baby Boom (Spencer 1971:251). This is reflected in Table 2.2 in the data between 1954 and 1973. The proportion of women bearing three or more children significantly affects the TFR and McDonald (1998, 2000b) argues that Australia's TFR has not yet fallen into the “very low” range because of the fertility behaviour of such women. At the 1996 Census 40 per cent of Australian women aged 45-49 had had three or more children (McDonald 1998:6) but it is estimated that Australia's TFR would fall to 1.4 if those who currently have more than two children stopped at two (McDonald 1998:8).

**2.2.3 Levels of childlessness**

Along with decreasing proportions of women having larger families, the proportion having no children has also changed. In 1996, when the average completed family size for women aged 45-49 was 2.48 (McDonald 1998), 11 per cent of women this age had had no children (ABS 2002c). McDonald (1998) believes that childlessness levels are not as significant in contemporary differences in national fertility rates as the proportion of women having three or more children. Indeed, although the ABS (2002c) estimates that lifetime childlessness was around 30 per cent for women in their childbearing years during the Depression, Table 2.2

shows that the average number of children born to each woman was no less than three between 1921 and 1942. Relatively high rates of childlessness are not completely new in Australia and levels of childlessness have generally been between 15 and 25 per cent (Rowland 1998). The analysis of average family sizes from 1870 onwards may obscure relatively high proportions of both childless couples and one-child families in earlier times (Anderson M. 1998). However, childlessness rates are important because, as they rise, they require a greater compensation by those who do have children if fertility rates overall are to stabilise or rise.

The trend for future cohorts is assumed to indicate a continual reduction in completed family size, with around a fifth to over a quarter of today's young women expected to never have children, either due to choice or due to reduced fecundity as childbearing is increasingly delayed to later ages (ABS 1999, 2002c; McDonald 1998). Others may remain childless "by circumstance" if they are unable to find a partner, or find a partner who does not want children (Cannold 2005). However a national survey in 2004, of those aged 20 to 39, showed that only a relatively small proportion of men and women intended to remain childless, with this situation being nominated by less than three per cent of married respondents, five to seven per cent of unmarried, and eight to eleven per cent of unmarried respondents in their thirties (Weston et al 2004:60). A better understanding of what contributes to differential parity outcomes at the individual level could therefore enhance the understanding of potential future fertility scenarios and help inform more effective government policy to stabilise or raise fertility rates.

#### **2.2.4 Delayed childbearing to later ages**

Along with increasing levels of childlessness, postponed first births have been the other major contributor to Australia's TFR declining between 1991 and 2000 (Kippen 2004). The age of first-time mothers has risen continually over past decades, with the median age at 27.6 years by 2003 (Australian Institute of Health & Welfare (AIHW) 2005:14). The shifting of childbearing into later age groups is shown in the proportion of women giving birth over age 35, which has risen from 11.8 per cent in 1993 to 18.8 per cent in 2003 (AIHW 2004:12, 2005:13). Furthermore, of *first-time* mothers in 2003, 11.8 per cent were aged 35 or older, compared with 6.6 per cent in 1994 (AIHW 2005:14). The proportion of women giving birth at age 40 or older (3.2 per cent) is not far different from the proportion giving birth aged 19 or younger (4.6 per cent) (AIHW 2005:13). However, while older-age fertility has increased it

has not yet made up for falls in fertility at younger ages (Kippen 2003). Gray (2002) notes that data for fathers shows a similar trend and each cohort of Australian men is also progressing to parenthood at a slower rate than previous cohorts. Although intended childlessness is not common (as noted in the previous section), fertility rates may be considerably influenced by certain groups continuing to delay parenthood. Indeed, in one Australian study four-fifths of childless women aged 19 to 44 said they were prepared to delay childbearing until they were 35, while a third were prepared to delay until age 40 or older (Beit 2002). The extent to which such delays may be encouraged by misplaced confidence about the success of assisted reproductive technologies will be discussed further in Chapter 7.

The delay of childbearing to later ages contributes to contemporary fertility rates appearing lower than completed family sizes. For example, when the TFR was 1.83 in 1996 (ABS 2002b), the completed family size for 45-49 year old women was 2.48 (McDonald 1998). Although the completed cohort fertility rate (CCFR) for all cohorts has been declining since 1932, no cohort has yet experienced a CCFR below replacement level (Kippen 2004). Bongaarts (2001a:261) points out that “concern over the undesirable demographic implications of prolonged very low fertility in post-transitional societies may be overstated” because the TFR is subject to a distortion known as “the tempo effect” when reproductive behaviour is changing rapidly, so that TFRs can be below the true level while childbearing is being delayed and until such changes settle down. Australia’s TFR of around 1.7 could therefore rise again if a peak of delayed childbearing is reached, and if those women who have delayed childbearing until later ages eventually start families and have at least two children. For this reason, several authors note that below-replacement fertility rates in Australia could be only a temporary phenomenon (Barnes 2001; Caldwell et al 2002; McDonald & Kippen 1999). However, data analysis suggests that Australia is experiencing overall fertility decline rather than just a delay (de Vaus 2002; Kippen 2004; McDonald 1998).

### **2.2.5 Ideal family sizes**

Both academic research and a national poll show that despite low fertility rates and delayed childbearing, ideal family sizes in Australia remain above replacement level and few people believe that having no children or only one child is ideal (Colebatch 2004; Weston et al 2004). In the late 1980s there remained a strong preference for a minimum of two children, with



desire closer to three than two (Bracher & Santow 1991). In 2004 amongst those aged 20-39 the average ideal family size was 2.5 children for women and 2.4 for men, and 46 per cent of women and 53 per cent of men preferred a two-child family, while 26 per cent of women and 21 per cent of men preferred three (Weston et al 2004:48-49). Furthermore, 30 per cent of Australians see three children as an ideal family size (Colebatch 2004), while 30 per cent of parents in their early thirties, and around 20 per cent in their late thirties, who already have two children are inclined to have a third child (Weston et al 2004:53).

The strong preference clustering on two or three children which generally continues in many developed countries, including Europe and Australia, is however not matched by fertility rates and the shortfall is seen as a “fertility gap” requiring explanation (Bongaarts 2001a; Heiland, Prskawetz & Sanderson 2005; McDonald 1998; van de Kaa 1998; van Peer 2000). There is therefore a pressing need to investigate pathways to childlessness and impediments to higher ideal or desired family sizes being reached. In recent years several studies have explored reasons for childlessness in Australia through both quantitative and qualitative data (eg Beit 2002; Merlo 2004; Merlo & Rowland 2000; Weston & Qu 2001; Weston et al 2004). However, little in-depth qualitative research has been conducted recently in Australia on influences on family size differentials or individual’s perceptions of limitations to parity progression beyond the first child, particularly as they relate to the embodied and social experiences of childbearing and childrearing. The thesis addresses this gap.

### **2.3 FERTILITY DIFFERENTIALS AND DEMOGRAPHIC VARIABLES**

This section provides some demographic explanation for the trends and patterns described in the previous section as a basis from which to explore differentials at the individual level in later chapters. Despite fertility decline at the national level, fertility change has not occurred simultaneously across the whole population, and the origins and pace of fertility decline have varied among social, economic and religious groups, and were more marked originally in urban areas (Borrie 1975:49). The variables influencing difference are seen as symptomatic of underlying differences in motives, aims, norms, values and attitudes (Andorka 1980; Clifford 1971). Theories about how these aspects influence fertility change will be discussed in the next chapter. The limitations of space mean that only the main variables contributing to temporal and spatial difference are considered in this chapter.

### 2.3.1 Marital status and partnerships

Compared with marriage, cohabitation is associated with lower intentions of having children, and contemporary childbearing in Australia still depends largely on the formation and continuation of “live-in” partnerships and, particularly, marriage (Weston et al 2004). At the 1996 Census fertility was highest in every socio-economic group for women who were wives in registered marriages (McDonald 1998:11). This relationship is further highlighted by an American study which found that 95 per cent of well-educated women intending to have children wanted to marry, but only 38 per cent of those intending childlessness wanted to marry (Toomey 1978:129). Due to this relationship, important demographic contributors to changing fertility since World War II have been changes in the age at marriage and in the proportions marrying, which are also associated with changes in the age of first childbearing (Hugo 2001). Indeed, Borrie (1975:64) notes that the post-war *Baby Boom* was in fact more a dramatic and rapid *Marriage Revolution*, with women marrying earlier and in greater proportions. This contributed to larger numbers of babies being born as the increased concentration of fertility among younger women overlapped with that of older cohorts that were still having children (UN 1977:13-14). By the end of the 1960s Australian men and women were having their first child younger, with the fertility of women aged over 30 halving between the 1910s and late 1960s, but women were also ceasing childbearing earlier because they were having smaller families (Spencer 1971).

However, the introduction of the oral contraceptive pill in Australia in 1961, and the related changes in attitudes towards sexual relations, weakened the relationship between sexual activity and pregnancy (Ruzicka & Caldwell 1982:227). This was also linked to a reversal of the younger age at marriage, rising rates of divorce and de facto partnering, and to increasing numbers of women spending longer in education and paid work before starting a family (Hugo 2001). Such changes contributed to the declining fertility rate from 1971, as identified earlier in Figure 2.1. Social change was also associated with an increasing acceptability of ex-nuptial births, which represented over a quarter of all births in Australia by 1998 (Hugo 2001:177) and almost a third by 2002 (ABS 2004a:31). Birrell (2000) also believes that ex-nuptial births are probably an additional reason why Australia’s TFR has not dropped to the very low rates experienced in Southern Europe.

### 2.3.2 Education level

The changing status and roles of women are seen as major structural forces in fertility change in both developed and developing countries (Coleman 2000a; Hirschman 2001; Knodel & van de Walle 1979). Indeed, Australia's fertility decline since the early 1960s has been associated with changes in the social role of women, including larger numbers of women pursuing education than had previously been the case (Hugo 2001). Educational attainment, or literacy, has been found to be the strongest inverse correlate of fertility at the macro-level and one of the strongest predictors of family size at the individual level (Blake & del Pinal 1980; Bongaarts 2003; Kravdal 2001; van de Walle 1991). A longer time spent in education is seen to influence the timing of first union and, therefore of parenthood, both for women (Billari & Philipov 2004) and men (Ravanera & Rajulton 2004), reducing the time available to be "at risk" of pregnancy. This helps explain why in Australia over the past four decades lower fertility has generally been associated with higher levels of education, with the average issue thirty years ago for university-educated wives aged 35-39 at the 1966 Census being 2.7 children, compared with 3.4 for those with no education (Borrie 1975:57). Indeed, McDonald (2002a:4) notes that "more highly educated women are more likely not to have a first child", but if they do they tend to "have the first child at a much later age than women with lower levels of education".

The potential impact of higher education on fertility becomes more salient when one considers the substantial increase in the proportion of Australian women with higher education qualifications, from 10 per cent in 1990 to 25 per cent in 2000, compared with an increase of half this for men, from 13 to 20 per cent (ABS 2002d). Rising higher education rates also influence levels of childlessness since women *with* a university education in 1996 were twice as likely to be childless as those without (20 per cent and 9 per cent respectively) (ABS 1999). More females than males also stay on at senior secondary and tertiary levels of education (ABS 2002d). It is unclear how the timing and pace of future fertility might be affected by the increasing availability of external, part-time and mature-age higher education opportunities for women. While the number of students enrolled in higher education rose by 31 per cent between 1990 and 1996, the greatest rate of growth, of 61 per cent, was for females studying externally (ABS 1998:326). Large take-up rates by women who have already commenced or completed their childbearing might in future undermine the traditional link between higher

education and delayed or lowered fertility. Such developments have policy implications in terms of the financial costs of higher education for individuals. They also highlight a need to investigate the conditions of part-time students who are often unable to access the concessions made available to full-time students (eg travel concessions, tax-free scholarships).

Bongaarts (2003:322) notes that the relationship between education and fertility varies among countries and is not always linear or monotonic. In some settings fertility has even increased with higher levels of education (van de Walle 1991:463). One study suggests that the relationship between education and fertility reflects the dominant gender role/family system, with the strongest negative relationship existing in countries with the most traditional family systems, but with the relationship weakening as one moves along the continuum towards more gender-equal family systems (Blossfeld 1995). This may explain why in Japan higher education continues to be linked to lower fertility through the processes of later and less marriage in a system where childbearing is still strongly associated with marriage and traditional family systems (Raymo 2003). Conversely, in Norway the relationship has weakened in recent years and is least obvious in municipalities with a relatively good supply of day care (Kravdal 2001). While higher education in Norway is still associated with a later progression to the first child and a higher level of childlessness, nevertheless, beyond parity one education has only a modest impact on Norwegian progression ratios (Kravdal 2001:212).

Two recent analyses of surveys in Europe have found that higher education is not linked to lower family size desires but to reduced likelihood of achieving those fertility desires (Heiland, Prskawetz & Sanderson 2005; van Peer 2000). Bearing this in mind, it is interesting to note McDonald's (2002a:4) point that "there is more to low fertility than simply a shift in the education distribution of the population... the other half [of the change] relates to changes of behaviours within education classes". Heiland et al (2005) suggest that the more-educated may face different hurdles in achieving their desired family size when compared with the less-educated. Chapter 3 (section 3.5.3) investigates potential relationships between education level and various expectations and experiences related to childbearing and childrearing processes that might contribute to lower fertility outcomes in groups with higher levels of education, or who have spent a greater time in gaining education.

### 2.3.3 Religious affiliation and denomination

Historically, variation in family size by religious denomination was common in Australia and was long dominated by the difference between Catholics and non-Catholics (Borrie 1975; Day 1965). Indeed, the most rapid fertility decline between 1911 and 1966 occurred among non-Catholics (Borrie 1975:53). However, Australian fertility differentials according to denomination have been progressively reduced over recent years to be no longer significant at the aggregate level (Hugo 2004:24). While this may suggest that religious influences on fertility have become less significant, it is interesting to note that Australian women with No Religion recorded the highest levels of childlessness at the 1996 Census (ABS 1999). In this respect it is important to note Lesthaeghe's finding (1977), based on one hundred years of data analysis for Belgium, that secularism is the strongest predictor of fertility decline. Furthermore, a national Australian survey in 1997 on progression to the third child found that women who were Catholic and had an unplanned first birth were 1.6 times more likely than others to have progressed from parity two to three, or higher (Meyer 1999). A clustering of variables indicating "traditional values" were associated with these women having three or more children, including younger age at first birth, not having been in an "other" de facto relationship, closer birth intervals and lower educational attainment (Meyer 1999:33-35).

The intersection of religion with education is also interesting, particularly since until the mid-1970s religion and education were the two major cultural divisions in Australia with respect to views on, and attitudes towards, family size (Ruzicka & Caldwell 1982:220). Wives born in 1921-26, for example, who had university qualifications had an average of 2.76 children by the 1966 Census, women with only primary or secondary education had 2.89, while women with no education had 3.52 (Ruzicka & Caldwell 1982:219). However, those university-educated wives who were Roman Catholic had 3.4 children (Ruzicka & Caldwell 1982:219). This relationship is further illustrated by a study of American college women where over half of those who intended to have no children had no religious affiliation, compared with only 10 per cent of those who did intend to have children (Toomey 1978:99). Although this data is now somewhat dated, those with higher education would still be expected to be more likely to have no religion because education is "an instrument with which society combats traditional beliefs" (Lesthaeghe 1977:189). Indeed, a recent Australian national survey recorded a 50 per cent higher proportion of respondents with No Religion in its sample where the level of

university qualifications was double that of the general population of the same age (Weston et al 2004:28-29). Despite the suggestion that differentials in fertility are no longer significant between Christian denominations, Chapter 5 will show that with finer level analysis of 1996 Census data, which disaggregates contemporary religion data for Christian denominations and cross-tabulates it by educational attainment, the affiliation of university-educated women with certain denominations appears to counter the traditional association between higher education and lower fertility.

### **2.3.4 Ethnic status and country of birth**

Ruzicka and Caldwell (1977:9) point out that the first evidence of fertility transition in Australia in the 1870s primarily resulted from the British colonial population acting out a social change which had begun to influence them before arriving in Australia, which then influenced the native-born cultural minority. Indeed, the overseas born as a whole have tended to show slightly lower fertility than the Australian-born population (Abbasi-Shavazi 1998; Borrie 1975; Ruzicka & Caldwell 1982). Combined with their geographic distribution, this fertility difference may also contribute to urban-rural fertility differences, considering that 82 percent of the overseas born reside in major urban areas compared with only 60 per cent of the Australian-born, while the proportion is even higher for Asian immigrants, 95 per cent of whom remain in urban areas (ABS 2005c). However, the fertility of Indigenous Australians has generally been higher than that of the non-Indigenous population (ABS 2001). In 2002, for example, when the non-Indigenous TFR was 1.8, the Indigenous rate was 2.2 (Hugo 2004:21). The younger age of Indigenous mothers is one factor contributing to this difference, with the average age being 24.8 years compared with 29.5 for non-Indigenous mothers (AIHW 2005:17). The greater concentration of Indigenous Australians outside of major metropolitan areas also contributes somewhat to the higher fertility levels of certain non-metropolitan populations, such as in northern and western Australia (Hugo 2001).

Differences in fertility associated with the wider cultural environment in migrants' countries of origin are also influential. Evidence from the 1911 and 1921 Australian Censuses, for example, suggests that the first to begin limiting family size were women born in England and Wales, most of whom were of the Church of England, Methodist or Presbyterian Churches (Ruzicka & Caldwell 1982:214). In contrast, Roman Catholic women who had come mainly

from Ireland, and Lutheran women from Germany, limited their family sizes somewhat later (ibid). Women born in English-speaking countries have traditionally shown family size trends more similar to Australian-born women, while German-born wives born between 1926 and 1931, for example, had the smallest family size and largest proportion of childless or single-child families (Ruzicka & Caldwell 1982:221). In contrast, older age-groups arriving from Greece, Italy, Malta and the Netherlands just after World War II had considerably larger completed family sizes than Australian-born women, but amongst the younger age groups only Maltese and Dutch women had higher fertility (Borrie 1975:50).

The contribution of immigrant women to the birth rate is sometimes related more to a heavier concentration in childbearing age groups rather than a propensity to have larger completed families per se (Borrie 1975:106). Differences may also result from cultural differences in attitudes to premarital and ex-nuptial pregnancy (Ruzicka & Caldwell 1982). Fertility variation by birthplace has not been significant recently when other characteristics are controlled for, except among Islamic Lebanese women whose religious beliefs, high levels of marriage, and low levels of education and workforce participation may maintain higher fertility (Abbasi-Shavazi 1998:36). It is not clear what impact on Australia's fertility rate might result from government encouragement to attract skilled migrants, considering that higher education and higher occupation levels are more often linked to lower fertility.

### **2.3.5 Workforce participation, occupation, income and life course orientation**

Along with the education-related changes to fertility rates noted earlier, changes in women's workforce participation rates over the twentieth century have also been influential. The 1880s marked the beginning in Australia of increased provision of secondary education for girls and access to the nation's three universities (Alexander 2001). This was coupled with increasing opportunities for professional careers, particularly in nursing, and increased job opportunities in new areas such as shops, offices and factories (Alexander 2001). This contributed to a dramatic increase in the level of women's involvement in paid work outside the home between 1911 and 1947, which has continued as a general upward trend, particularly amongst women of childbearing age (Hugo 2001). Indeed, women's workforce participation rate rose from 36 per cent in 1966 to 55 per cent in 2002 (Pocock 2003:19).

Women in the paid workforce have generally always had lower fertility than women not in the workforce, even when the same age-group is considered. The fertility of wives aged 35-39 at the 1966 Census, for example, was lowest for those in full-time “career occupations” (professional, administrative and clerical), who had an average of 2.5 children, compared with wives not in the labour force, who had 3.1 children (Borrie 1975:56, 357). At the 1996 Census, higher fertility in younger age groups was related to not being employed, while in older age groups the relationship was complicated by partnership status, as shown in Table 2.3.

**Table 2.3**

**Mean number of children born, women with children at home, Australia, 1996**

Source: Birrell (2000:40, Table 7)

NOTE:  
This table is included on page 25  
of the print copy of the thesis held in  
the University of Adelaide Library.

Fertility also differs by occupational status, and with this, by income. In the past, husband’s occupational status was measured and at the 1911 Census, for example, the average number of children was lowest for women with husbands in professional or commercial occupations, and highest where husbands had rural occupations, followed by those with husbands in industrial and transport occupations (Borrie 1975:56). However, by the 1966 Census the wives of husbands in professional occupations had higher fertility than those in intermediate groups (Borrie 1975:56), producing the classic U- or J-shaped curves of fertility by men’s socio-occupational group (Ekert-Jaffe et al 2002:481). This relationship has not always been consistent and reflects changes in the work-family status of women, with women at the 1981 Census on the lowest household incomes having fewer children than those better off (although partly because women at that time were expected to leave paid work when they married, leaving male income the more prominent determinant of the capacity to provide) (Birrell 2000). For younger cohorts, however, higher levels of income are associated with lower fertility across all age groups, and the relationship is becoming more accentuated so that future generations will be increasingly raised by households on the lowest incomes (Birrell 2000; McDonald 1998).



When women's own occupation status is considered, women in higher status occupations generally have fewer children. For example, women aged 35-39 at the 1996 Census who were in professional occupations had an average of 1.60 children, while those in clerical occupations had 1.90 and those in trades occupations had 2.01 (McDonald 1998:10). While women "not in the workforce" were excluded from these data, fertility for women overall was negatively associated with occupational status and was lowest for women in the group "managers, administrators and professionals" who were not wives, who had an average of 1.01 children (McDonald 1998:10). The idea that "the career woman is where the popular concept of childlessness resides" (Macken 2005:68) is therefore based on a combination of the variables discussed above which are associated with lower fertility, including higher education, greater workforce participation, higher occupational status, higher income and higher likelihood of having no religious affiliation. This combination of variables which are linked to lower fertility has been noted in recent research in Italy and Australia (Livi Bacci et al 2003; Wheeler 2001). It is also repeated in surveys covering Europe, the USA and Brazil, which show that fertility differs according to what can be called "life course orientation", with fertility lower for women who have a stronger work orientation, more modern or egalitarian views on women's roles, and higher levels of independence, as opposed to seeing a woman's role as predominantly mother and wife (Hakim 2000, 2001; Rosen & Simmons 1971; Scanzoni 1978; Toomey 1978). However, section 2.3.2 already noted that lower fertility is more likely to occur in groups or societies which maintain traditional family systems, while the relationship weakens as more gender-equal family systems develop.

### **2.3.6 Socio-economic status and urban-rural differences**

Many of the fertility differentials discussed so far also cluster together in the variable "socio-economic status". Indeed, Westoff, Potter and Sagi (1963:237) believe that this occurs because many of the variables "presumably reflect subcultural normative systems delineated by religious, educational, occupational, residential, and other dimensions". Although an analysis based on 12 studies in Europe and the USA found no universally valid relationship between socio-economic status and family size (Andorka 1980), recent data for Australia indicates a strong inverse relationship between fertility and an area's level of advantage/disadvantage, which is seen to reflect different population profiles, age and ethnic mix, as well as different levels of social and economic disadvantage (de Vaus 2002; Hugo 2004). These differences

will be explored further in relation to fertility in metropolitan Adelaide in Chapter 5 to provide background data for the qualitative component of the research.

Another major fertility difference at the aggregate level is that between urban and rural areas. This difference has long persisted in Australia and the origin and pace of fertility decline were more marked initially in urban than rural areas (Borrie 1975:49). For example, in 1911 the average completed family size for Australian women aged 45-49 ranged from 4.6 in metropolitan areas to 5.8 in “extra-metropolitan” areas. These trends continue today in South Australia, which has the widest fertility difference between capital city and rest of state of all the states, with TFRs of 1.62 and 2.05 respectively in 2002 (Hugo 2004:29).

#### **2.4 LOW FERTILITY AS A PROBLEM WORTH INVESTIGATING**

Aside from investigating low fertility as a demographic phenomenon is the possibility of investigating it as a social or economic “problem”. Scheurich (1997) questions the acceptance of any “social problem” as an empirical given or natural occurrence, and indeed currently in Australia there is a variety of opinion as to whether population increase or decrease is desirable and, consequently, whether below-replacement fertility is in fact a “problem” (eg Costello 2002; McDonald & Kippen 1999; Young 1998). Opinions and preferred population levels depend on the philosophy and motivations of the proposers. However, some academics argue that low fertility rates are a problem requiring investigation because of the serious diseconomies and significant social changes which are expected to result from the impact on age structures, on the working population, and on social welfare systems (Livi Bacci 2004; Macken 2005; Withers 1999). Fong’s 2004 qualitative analysis of the social consequences for individuals and families of China’s one child policy further support this concern. Whilst immigration could make up the shortfalls caused by lower fertility in Australia, it is thought that both society and the economy would have difficulty assimilating the large numbers of immigrants needed, and migrants could become scarce because many other developed countries also expect declining populations (McDonald 2005b; UN Secretariat 2000).

Despite interest in academic circles about the causes and implications of low fertility in developed countries over the last thirty years, policy action on low fertility has been slow (McDonald 2005b). Indeed, in Australia “the most significant aspect of the present period of

low fertility [has been] the near-silence on the subject from governments and the public alike” (Caldwell, Caldwell & McDonald 2002:10). Only in the last few years of the twentieth century did low fertility rise to prominence as an issue in the political and public arena. Print media articles ranged from the explanatory, through those suggesting women should return to their “breeding duties”, to those defending a couple’s choice to remain childless (eg Evans 2002; Hurrell 2001, 2002; Kemp & Williams 2002; Maiden 2001; Steketee 2001; Williams N. 2001). Both the Australian Federal Government and the Opposition have reacted in a mixed way to issues of low fertility, population ageing, support for families and family values, and assistance for working parents (eg Anderson J. 2002; Howard 2002a; Ruddock 2002; Swan 2002). Whilst the Federal Treasurer at one point commented that raising fertility is not the answer to population ageing, and higher fertility would undermine living standards in the short-term by reducing GDP per capita (Costello 2002), departmental discussion papers, ministerial comments, and fertility-related tax initiatives and maternity payments reflect academic concern that low fertility is problematic due to its potential future social and economic impact (Barnes 2001; Howard 2002b; Human Rights & Equal Opportunity Commission 2002; Ruddock 2002; Vanstone 2002). A stabilised or higher fertility rate, combined with some increased immigration, is therefore seen as the preferred option for Australia (eg Beazley 1999; Howard 2002b; Kippen & McDonald 2004; McDonald & Kippen 1999; Vanstone 2002; Withers 1999).

Policymakers and researchers could therefore benefit from a deeper understanding of mechanisms which lead individuals to be childless, to delay first births, and to have smaller families, while others continue to bear three or more children. While Ruzicka (1976) believes that higher fertility will persist in certain sub-populations, such as those where tradition and religion favour larger numbers of children, he suggests that such groups may be becoming increasingly rare. It is therefore important, as Kippen (2004) points out, to identify ways to facilitate the transition to the first birth, and then from the first to the second birth. As Ruzicka and Caldwell (1982:214) noted, however, “the cross-classification of statistical data can only point out differential patterns... [it] does not explain why some groups want larger families or why some are more successful than others (or more concerned) with avoiding unwanted births”. This is an additional aspect which the thesis will investigate for contemporary Australia.

## 2.5 CONCLUSION

This chapter has provided a demographic overview of Australian fertility trends and patterns. It showed that changes in Australian fertility rates over the twentieth century mirrored those of many other developed nations, and that while Australia's current fertility rate is in the "low" range it is nevertheless higher than that of many others. The chapter noted that the main demographic influences on falling fertility rates have been an overall delay in childbearing to later ages, combined with smaller completed family sizes. Demographic variables associated with such changes were highlighted as the increased education and workforce participation of women, changes to marriage and partnership rates, and other cultural variables including ethnic status, religious affiliation and socio-economic status. Many of the variables discussed cluster together by socio-economic status and life course orientation towards work and/or family, and the trend in recent cohorts has been towards an inverse linear relationship between fertility and socio-economic status. Since both academics and politicians see low fertility as undesirable in the longer term due to the likely effects in economic and social terms, an important concept which was noted in contemporary debate was that of a "fertility gap" existing between ideal family size, which remains at or above two children, and achieved family size which appears to be lower, since possibilities for stabilising or raising fertility rates are seen to lie in addressing the obstacles contributing to such gaps. The next chapter considers theoretical explanations for low fertility, delayed childbearing, fertility gaps and differential fertility rates, and considers how they might relate to differences in expectations and experiences of becoming and being a parent.

## Chapter 3

# Theoretical explanations of fertility differences

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Nearly all demographers still wrongly focus their thinking and analysis on fertility, rather than on becoming a parent

(Hobcraft 2004:81).

### 3.0 INTRODUCTION

Chapter 2 provided an overview of historical trends and contemporary patterns in Australian fertility. Building upon this, Chapter 3 now considers how these are explained by different theoretical approaches. It is important to note that seventy years of research have identified a “complex and shifting matrix of factors” linked to low and below-replacement fertility (Chesnais 1992:212). However, their relative influence in particular situations is still not yet understood and remains controversial (Bongaarts 2001b; Hirschmann 2001). At the beginning of the twenty-first century researchers are therefore still seeking to better understand the determinants and consequences of fertility behaviour (Eberstadt 2001; Presser 1997).

Since there exists a boundless multitude of variables influencing fertility behaviour, and consequently many hypotheses and theories (Mackensen 1980:253), it is useful to adopt van de Kaa’s terminology (1996:389) of the various approaches being:

a series of ‘sub-narratives’ from different disciplinary perspectives and orientations ... [of which] different parts... have been highlighted at different times depending on policy interests, improvements in technical skills, availability of data, changes in societal settings, and the degree of satisfaction with the dominant sub-narratives of the day.

The first three sections of this chapter consider explanations of fertility at the broad level, within economic theories and cultural/ideational theories. This prepares the way for the fourth section to consider the particular sub-narratives within demography which pertain to the embodied and social experiences of childbearing and childrearing, including consideration of why these aspects have generally been overlooked in research and debate in Australia, and a

review of developments in sociology, geography, medicine and psychology which suggests that they merit renewed investigation. Finally, section five explains a socio-psychological framework which later chapters use to explore the potential positive and negative impacts of such experiences of parenting on individual fertility and family size desires.

### **3.1 PARADIGMS OF THINKING AND BEHAVIOUR**

There are two dominant paradigms of explanation for fertility change in Western nations; one group of theories is economic-based, and the second relates to cultural and ideational change (Lesthaege & Willems 1999). However, at the level of universal human behaviour an explanation that underpins both paradigms lies in Maslow's theory of motivation and personality, which states that once the basic requirements for existence are satisfied individuals will seek to satisfy more existential and expressive needs (Lesthaege & Surkyn 2004:6). Notestein (1945:40, 1953:16) believed that the fertility decline of the late nineteenth century resulted less from innovation in birth control methods than it did from *a change in motives* that led to birth control being more consciously adopted as a way of adjusting to new forces. Indeed, some argue that relatively effective contraceptive methods had been known for centuries (Anderson M. 1998; Carlsson 1966). Caldwell (1997, 2001) therefore sees fertility change as resulting more from changes in attitudes about the types of contraception available and the virtues of reproducing, and about family size and population growth, which alongside demographic pressure (and sometimes also organised assistance) provide both the ability, the permission and the motivation for fertility change. Since this thesis focusses on impacts of parenting experience, it is important to emphasise that key changes which have repeatedly been shown to correlate positively with lowered fertility, both temporally and spatially, are changing attitudes towards women's roles not only as workers but also as mothers, which have resulted from women's increased levels of educational achievement and workforce participation (Bongaarts 2001b; Coleman 2000a; Hirschman 2001; Mason & Smith 2001).

### **3.2 ECONOMIC THEORIES**

Micro-economic and Human Capital theories see fertility behaviour as related to the impact of having children on current expenditure and capital investment. One approach sees individuals acting as consumers, where the motivation to have children is based on rational decisions about the costs and benefits of having each child (eg Becker 1960, 1976; Easterlin 1975). The

resultant net “utility” is seen to vary according to the parents’ educational attainment levels, and particularly to that of the mother. With regard to fertility change in relation to women’s higher education levels or employment, the opportunity costs and foregone earnings related to time out of the workforce to bear and raise a child are seen as influential (eg Gronau 1973; Davies, Joshi & Peronaci 2000). In particular, the “price” of a woman’s time is seen to increase as her education level or social status and wages rise, so that time allocated to raising children is time substituted for earning money (Ekert-Jaffe et al 2002). Women with higher levels of education therefore have greater “investments in education” which “stand to suffer a substantial financial penalty should they have children” (Birrell 2000:33), hence their tendency towards lower fertility. On this theoretical basis, policies which aim to stabilise or raise fertility levels seek to minimise the financial effects of mothers taking time out of the workforce, and to maximise the opportunities for mothers to use their educational investment. They include offering paid parental leave, government family assistance payments and childcare subsidies, improved availability and access to childcare, and mechanisms to facilitate mothers’ return to paid work after maternity leave.

It is also believed that the wider socio-economic climate can encourage individuals to limit family size in times of perceived insecurity and increased job competitiveness, whilst encouraging larger families in times of prosperity, optimism and employment security (Chesnais 1992:192). This explanation is seen to account for the marriage boom in the prosperous years after World War II, and for contemporary young Australians delaying parenthood in the more recent unfavourable conditions of the “new economy” (McDonald 2002a). It is also supported by research which shows that men with limited employment opportunities are reluctant to take on partnership and parenting responsibilities, while women may be reluctant to accept them as partners (Birrell, Rapson & Hourigan 2004). Young Australians are also delaying parenthood in order to first achieve economic security and home ownership, as well as relationship security (Merlo 2004; Weston et al 2004).

Another aspect of economic theory is the “quantity-quality tradeoff” (eg Becker & Lewis 1973; De Tray 1973; Schulz 1973). This explains decreasing family size as a strategy used by parents to provide what they see as better economic and social opportunities for the children they do have, with attempts to keep the number of children in line with the family’s financial outlook (Aries 1980; Kirk 1955). Chesnais (1992) cites writers in the late nineteenth century who believed that family size was reduced by people who aspired in this way to social

advancement for themselves and their children. Such changes were also influenced by a historically situated change in the parent-child relationship (where the focus increasingly shifted to the child - as described by Aries 1973) and in the family's internal economic structure, both of which were highlighted in the Wealth Flows Theory of fertility decline developed by Caldwell (1982). An additional aspect of this, which links with the effects of education on fertility, is the desire of parents to provide an education, or what they see as a *better* education, for their children, coupled with the belief that the ability to pay for this is only attainable by having fewer children to provide for (Caldwell 1982:192). At the same time, other desires may compete with having children, and empirical research (Easterlin & Crimmins 1991) finds that while family continues to be important in people's lives, the desire to be financially very well-off and professionally successful in business has increased since the 1970s.

With Australian women in higher status socio-economic groups generally having lower fertility (as explained in Chapter 2), it is important to note that family size intentions are thought to be influenced not only by absolute income, but also by the individual's perception of *relative* economic deprivation. Having smaller families is thought to enable individuals to achieve a standard of living through their own income which is perceived as relatively consistent with that experienced in adolescence and as provided by their parents (Easterlin 1968, 1987). Empirical research confirms that *perceived* and not *actual* income needs are most likely to affect family size (Cartwright 1976). While lower income groups perceive their income needs relative to the husband's wage, higher income groups perceive their income needs relative to their desired standard of living (Hattery 2001).

However, in terms of providing a suitable model for demographic behaviour Bergman (1995) suggests that economic theories are "preposterous" because they do not take account of institutional influences and constraints. Others point out that perceived economic needs (or aspirations) may be influenced by pre-existing cultural, social and institutional features which provide the environment within which people react to political and economic forces (Kertzner 1995; McNicoll 1980; von Rosenstiel, Oppitz & Stengel 1980). Furthermore, economic theory does not explain which factors at the group and individual level influence whether or not economic considerations are considered important influences on fertility in the first place. Pocock (2003:17) believes that it is necessary to include a different economic perspective, "the economy of care", where the guiding principles contradict the assumptions of "rational man"



who maximises his private utility, and where decisions are seen to be made on motivations of love, reciprocity and relationships where “gain” derives from obligations and responsibilities that cannot be measured in dollars, or individually.

The need to incorporate these other aspects were recognised in Easterlin, Pollak and Wachter’s (1980:117) expansion of economic explanation to incorporate the notion that family size could also be influenced by an “interplay of tastes, technology and the budget constraints”. There is therefore basic agreement among demographers that fertility decline is based on individual calculations that lower fertility makes sense, not solely on economic terms but also for social and psychological reasons, and that it results from a multitude of *individual* decisions made within a framework of economic *and* social-structural factors (Bulatao 2001, my emphasis). Later chapters of the thesis will consider both socio-psychological and economic influences and Chapter 11 will attempt to make some assessment of their relative influence on the fertility of individuals.

### **3.3 CULTURAL AND IDEATIONAL THEORIES**

Whilst some theories give more weight to the influence of economics, others give more weight to impacts on fertility from *cultural* and *ideational* change. In an analysis of theoretical explanations of fertility difference, Mason (1997:450, emphasis added) concludes that “models of fertility [change]... need to be ideational in that they must recognise that changing *perceptions* ultimately drive fertility change”. In relation to Maslow’s theory which was mentioned earlier, Lesthaege & Surkyn (2004:2) suggest that the Second Demographic Transition, to below replacement fertility levels, has been particularly stimulated by a change in thinking, with increased consideration of the *impact of having children on the adult’s lifestyle and ability to achieve self-realisation*. It is to expectations and experiences in this realm that this thesis directs its main attention.

#### **3.3.1 Contemporary lifestyles and postmodern values**

Although such consideration of the impact of children on adults’ lifestyles is associated predominantly with more recent fertility change, it was also associated with earlier periods of declining and low fertility in the papers contributing to Demographic Transition Theory in the 1930s and 1940s. Landry (1934:41), for example, believed that fertility fell where children

were perceived to negatively affect the parents' social life, social aspirations and freedom, while Davis (1937:303) suggested that fertility declined as children were seen increasingly as "an inconvenience in every sphere of activity — a hindrance to travel, parties, unencumbered living quarters, etc". Such concerns were seen to stem from the "growing individualism" and a "shift in social goals from those directed toward the survival of the group to those directed toward the welfare and development of the individual" (Notestein 1945:40-41). Also implicated were the pursuit of marriage as a means of "private satisfaction" independent of its social function [of producing children], along with the rising acceptability of childlessness (Davis 1937:297). Fertility decline was also seen to be related to other changes to a more "rational" style of life which included the questioning of existing institutions, desire for social reform, increasing secularity, the rise of science, and the increasing desire for rationality and control over life and the future (Landry 1934:40, 162).

Chapter 2 has already highlighted the increased educational and work opportunities for women, starting in the 1880s, which were associated with fertility decline. However, fertility decline no doubt also reflected other changes in women's lifestyle brought about by First-wave Feminism, which were incompatible with wifehood and motherhood. Along with winning of the vote, better education and work opportunities contributed to the rise of the 1920's and 1930's equivalent of today's childless career women, called "New Women", who were well-educated, young, career-minded girls earning an independent living, and styling themselves on spirited-heroine Hollywood actresses such as Katherine Hepburn and Greta Garbo, and looking forward to a bright, care-free future without marriage (Alexander 2001; Friedan 1965). The Baby Boom can also be seen as related to another change in women's lifestyle images, because Alexander (2001:136) points out that when the birth rate began to fall and fears of foreign invasion increased in the late 1930s, the identity of "Housewife/Mother" returned to favour. Indeed, the "era of familism" which came to dominate between the 1940s and 1970s (McDonald 1995) can be seen as related to women rejecting the "New Woman" lifestyle and restyling themselves from the late 1940s on actresses such as Marilyn Monroe and Debbie Reynolds as "fluffy and feminine [and] gaily content in a world of bedroom and kitchen, sex, babies and home" (Friedan 1965:32, 47).

Such changes in thinking and lifestyle are commonly associated with a change from what Lesthaeghe (1977) calls "traditional" to "postmodern" value orientations. McDonald (2000a; 2002b) names this Postmaterialist Values Theory. These values, according to several authors

(Bachrach 2001; Inglehart 1977, 1997; Knodel & van de Walle 1979; Lesthaege 1977, 1980, 1998), include, in summary:

- the questioning of meta-narratives and traditional authority, and diminishing acceptability of institutional regulation of family life, linked to an increasing desire for self-determination of lifestyle and personal relationships; along with
- increased toleration and support for diversity (such as a less traditional outlook towards marriage and family) — which reflects rising “secularism”;
- a focus on the higher-order needs of self-fulfilment, personal freedom, quality of life and well-being — which reflects rising “individualism”;
- an increasing desire for “higher quality” children (if any) and a desire for upward social and economic mobility — which reflects rising “consumerism”; and
- a better knowledge of fertility control.

According to Lesthaege (1977), the likelihood of an individual or group adopting postmodern values is increased by education. In particular, education is thought to make people more receptive to new ideas (Andorka 1980), more likely to adopt new attitudes and lifestyles (Cosford et al 1976), less fatalistic about life, and therefore more likely to plan in all aspects of life (van de Walle 1991). Education also encourages the questioning of social norms (Marshall 1993) and permits the “decoding of symbols that maintain social distinctiveness” (Lesthaege & Surkyn 1988:6). Such changes in turn affect reproductive attitudes and behaviour, and norms and preferences about family size (Kravdal 2001; van de Walle 1991). This helps explain why rising levels of women’s educational participation and achievement were identified in Chapter 2 as key factors in fertility change. Postmodern values particularly encourage fertility decline if they include rejection of institutions which promote childbearing, if children are seen to reduce individual freedom, and if work and leisure are seen as alternative paths to self-fulfilment (Bachrach 2001). While the socialisation of children is the mechanism through which traditional gender systems are maintained (Coltrane & Adams 1997; McNicoll 2001), the socialisation of succeeding cohorts in different social and economic environments is seen as the process which facilitates ideational and fertility change (Lesthaege 1983).

### 3.3.2 Institutional theories

Theories of ideational and cultural change suggest that the mechanisms whereby such changes in thinking influence fertility behaviour are closely related to changes in the systems of society which give meaning to life (van de Kaa 1996), in other words to changes in institutions such as the family, religion and government. Furthermore, these institutions, or “clusters of behavioural rules”, are seen as mainly responsible for the “regional flavour” of fertility differences (van de Kaa 1996:426). Therefore, fertility is seen to be higher in societies or groups where education, religious doctrines, moral codes, laws, community customs, marriage habits, and family organisation are focussed toward maintaining high fertility (Notestein 1945:39). Continuing the theme that women’s education and workforce participation rates impact on fertility by changing their opportunities and ideas about family, some institutional theories see fertility being reduced when women experience conflict or incongruity between values and ideas related to their roles in different spheres of life (Hobcraft 2000; McDonald 2002a; Tsuya 2000). McDonald (2000b:11, emphasis added) sees this resulting particularly when “institutions which deal with women *as individuals* are more advanced in terms of gender equity than institutions which deal with women *as mothers* or members of families”.

Gender Equity Theory addresses these underlying issues of power relations (eg Caldwell et al 2002; McDonald 2000a, 2000b, 2002a). It contends that despite increased opportunities and gender equality in education and work outside the home, women are still limited in their ability to work and rise on the employment ladder because they still undertake the majority of childcare and housework inside the home, as dictated by the tradition of the breadwinner model of the family (McDonald 2000b). This notion was raised almost sixty years ago by Davis (1937:303) who noted that fertility might be adversely affected by the unequal impact of children on the mothers’ career path, her “professional proficiency”, and her time and household labour. The breadwinner model is discussed further in section 3.7, which considers how the associated social construction and social conditions of privatised motherhood contribute to women’s difficulties with childbearing and childrearing because they clash with postmodern values.

Based on the potential role of education in encouraging ideational change and the adoption of postmodern values, this thesis hypothesises that more highly educated women will be more likely to avoid having a first or subsequent child if they find their experiences of childbearing

and childrearing being out of line with their postmodern preferences, such as for autonomy, rationality, control, self-actualisation, and the maximisation of well-being. Chapter 2 (section 2.2.5) has already noted that ideal family sizes in Australia are higher than current fertility rates, and the dominant theme in contemporary debate is that conflict between women's roles as mother and worker contribute to this perceived "fertility gap" (Birrell 2000; Bongaarts 2001b; McDonald 1998, 2000b; Pocock 2003; Rindfuss & Brewster 1996). Solutions to low fertility are therefore seen to lie particularly in work-family policies which encourage the increased participation of fathers in domestic work and childcare, and which allow for or encourage monetary and workplace change such as improved parental leave provisions and payments, better childcare provision and payments, and work arrangements which facilitate daily and longer-term movement between home and workplace (Caldwell et al 2002; Gallus 2002; Heiland, Prskawetz & Sanderson 2005; House of Representatives Standing Committee on Family and Human Services 2005; McDonald 2001b, 2001c; McIntosh 1998; Olah 1999; Rindfuss & Brewster 1996; Rindfuss, Guzzo & Morgan 2003). However, policies offering work-focussed change and modest financial contributions have had either limited or unreliable effects on the birth rate (Demeny 1986, 2000; McNicoll 2001), and empirical evidence on the link remains inconclusive (Gauthier 1996; Manne 2001). The next section will discuss other theoretical narratives which suggest that fertility rates may be lowered because women are also concerned about the impact of the processes of childbearing and childrearing on their personal health and well-being. The thesis agrees with Hochschild (2003) who points out that "to look at the system of work is to look at half the problem [because] the other half occurs at home". However, the thesis will also argue that there is more to "home" than just the gender division of unpaid work.

### **3.4 WHEN POSTMODERN VALUES MEET PARENTHOOD**

#### **3.4.1 Demographic literature on the impact of parenting**

Alongside the impacts of children on adult lifestyles and aspirations discussed in section 3.3.1, over the last 100 years some have suggested that fertility desires are negatively impacted by personal experiences of the processes of conception, pregnancy, birth and early parenthood. However, this has not been a major narrative in demography. Already a century ago a

government inquiry in the state of New South Wales suggested, for example, that declining fertility might be linked to an increasing:

unwillingness to submit to the *strain and worry* of children... a desire to avoid *the actual physical discomfort* of gestation, parturition and lactation (Legislative Council of New South Wales, 1904, cited in Borrie 1975:176, emphasis added).

The potential impact on fertility of such embodied experiences were also noted by Landry (1934:41, 75), who believed that fertility could fall in situations where women simply found motherhood itself “repugnant” or where the bearing and raising of children negatively impacted on the mother’s health. Later research identified such impacts in more detail (eg Bulatao 1980, 1981; Callan 1985; Cartwright 1976; Peel 1972; Young 1977). In particular, two interview-based studies with parents (Young 1977 in Australia, and Cartwright 1976 in Britain), found that for women the psychological, physical and social impact of childbearing and childrearing limited family size more than the financial costs. For example, while 44 per cent of the 1,500 British mothers in Cartwright’s study wanted fewer children than originally planned due to financial costs, 66 per cent gave childbearing and childrearing as major disincentives, and of these almost half cited fear or dislike of being pregnant or giving birth (Cartwright 1976:25). Negative influences on fertility levels due to parents having difficulty coping with childrearing, or finding it harder than they expected, were also noted by others in Australia and the USA (eg Richards 1978; Westoff, Potter & Sagi 1963:193-5). The “value of children” approach, developed by Bulatao (1980:99) to investigate influences on lower fertility for parents in the USA, the Philippines and Thailand, also discovered a list of social and psychological disadvantages alongside the financial costs, including health and pregnancy worries, problems with discipline and other childrearing issues, and increases in the amount of emotional strain associated with parenting. Indeed, Bulatao (1981:22) concluded that “an analysis of the family lifecycle and the impact on parents of the experience of having children might lead to a more systematic theory of value change in family formation”.

While the above aspects refer directly to the physical and emotional impacts of parenting which might encourage people to downgrade family size desires, others have suggested that fertility decline in Western societies has been linked to what Caldwell (1982:201) terms an overall “collapse of the domestic society” in the modern era. Several eminent demographers (Caldwell & Ruzicka 1978; Davis 1955; Landry 1934) have argued that changing social conditions lead not only the economic costs, but also the physical and socio-psychological

costs, of parenting to be more acutely felt as parenting moves from a responsibility of previous extended and mixed-generation households more directly onto the independent individual or couple, with women's increasing workforce participation isolating mothers at home and reducing communal child care support. Such isolation and loss of support has further intensified as social networks have increasingly relocated to the workplace (Leblanc 1999; Pocock 2001).

In order to justify investigating such aspects of parenthood in the current thesis, it is useful to consider why the physical and socio-psychological impacts of parenting have not featured more prominently in more recent Australian fertility research and policy. One possibility is that since parenthood is often portrayed as simple and relatively effortless by those who are not involved (Engel 1998), and women at home with children are often perceived to either be "doing nothing" or at least not a serious job anyway (Crittenden 2001; Leblanc 1999; Nedelsky 1999; Parsons 2000; Rich 1976), the physical, psychological and social costs of motherhood are assumed to be minimal or, even if major, not an important influence on fertility. This stands in stark contrast to the reality for many parents, in particular for working mothers for whom "on-the-job stress [ie in paid work] is nothing compared to the second shift at home" (Maushart 2001:113).

The relegation of the physical, psychological and social costs of motherhood to a "sub-narrative" in demography suggest that demographers have followed the emphasis of Second-wave Feminism, which Pocock (2003:8) and Macken (2005:44) believe has focussed on achieving women's advancement in the public sphere and improving the lot of women in the traditional "world of men", but has had little effect on the household, personal and institutional front for *women with children*. At the discipline level, the omission of a distinctly feminist or gender perspective until only recently is particularly surprising in fertility research considering that most fertility research has been conducted *on women*, and changes in the education and employment *of women* have long been seen as major influences on fertility change. According to Greenhalgh (1996), a lack of specifically feminist inquiry in demographic fertility research resulted from politically-oriented funding support and the ideology and characteristics of those "doing demography" which curtailed radical perspectives emerging in the 1970s. Therefore, by the mid-1990s demography was still "lodged somewhere between a prefeminist stage and a 'demography of women'" (Greenhalgh 1996:23) and by 2000 had still focussed relatively little on gender issues (Presser & Sen 2000). Discussions and policies directed at declining fertility

and ageing populations had therefore paid little attention to women's unpaid work (Mackinnon & Bryson 2000).

McDonald (2002b) touches on influences on fertility arising from individuals acting cautiously to avoid the risk of negative "unknowns", including the potentially negative impact that children might have on relationships, or the difficulties of coping with raising a child. Nevertheless, these aspects are not given prominence. Therefore, whilst it can be argued that "among higher educated women, those with *low* psychological *benefit* thresholds for children are very likely not to have any children at all" (McDonald 2002a:16), this thesis will argue that some also perceive *high* psychological *and physical costs* which make them risk averse to having a first child or additional children. Furthermore, there is minimal research that considers how men's fertility thinking and behaviour may be shaped by their expectations or experiences of everyday *fatherhood* (Weston & Parker 2002). The idea that these private aspects of reproductive behaviour might be worthy of serious demographic research has re-emerged recently (eg Hobcraft 2000; Presser 2001), and Livi Bacci (2004:208) suggests that these "psychological costs, including worries, the possible consequences for the woman's health, a reduced social life and so on" must be factored into any cost-benefit analysis of parenthood since the "net sum of these non-economic factors is one of the elements that influence fertility". Chapters 6 to 11 of the thesis explore these at the individual level.

### **3.4.2 Government policy and the impact of parenting**

Since Chapter 12 of the thesis will reflect on the implications of the research for government policy it is also useful to note that, in line with academic interests, policy and discussion papers have also rarely considered the psychological and physical costs of parenting, except as they relate to paid work or the division of household labour. They have focussed instead on the economic-related policies as outlined in section 3.2. For example, while the South Australian Government's Population Policy developed in 2004 contains twelve strategies aimed at stabilising or raising fertility rates, eleven focus on childcare and work issues and the only strategy addressing home-based issues is the provision of a one-off maternity nurse visit for new mothers (Department of Human Services 2003; Government of South Australia 2004). Similarly, Barnes (2001) considers the effect of motherhood on a mother's self esteem, but this is in relation to being *out* of the workplace, and not also to being *in* the home.



This thesis will therefore argue that for demographers and politicians to overlook the wealth of issues pertaining directly to private experiences of motherhood is to ignore what, according to Macken (2005:53), had become *the* women's issue by the end of the 1990s. The focus of contemporary demographic research in fertility therefore requires widening because although:

the question for feminists since the 1970s [has been] "How do I deal with the world out there?", the very real question for mothers in the post-feminist era is "How do I deal with the world in here?" (Redden 2000:xii, xvi).

### **3.5 POTENTIAL MECHANISMS OF INFLUENCE**

Based on the discussion so far, the thesis argues a need to investigate in more depth earlier suggestions that fertility can be negatively influenced by negative physical, psychological and social impacts of childbearing and childrearing as they clash with women's (and also men's) needs as individuals in a society influenced by postmodern values. This argument is strengthened by considering the non-demographic literature on motherhood. This shows that in the realms of sociology, psychology, geography and medicine the socio-psychological and physical impacts of motherhood have attracted attention for over four decades. Indeed, in 1970 Handel (1970:99) observed that a relatively new line of sociological inquiry had emerged to investigate "the socially structured strains in becoming a parent, particularly in the middle class, and particularly for women". Such research explored the difficulties which many mothers in Britain, the USA and Australia were having with their lived experiences of motherhood (eg Rich 1976; Lazarre 1976; Dally 1982; Wearing 1984; Dyck 1990; Oakley 1992). Friedan's research (1965) shows that these experiences were not completely new, with the "problem of the trapped American housewife" and her difficulties adjusting to, and coping with, domestic life having been widespread from as early as the 1940s.

It is timely to consider how such experiences might impact on fertility because women continue to experience difficulties with motherhood in the home. Growing numbers of Japanese women, for example, are finding motherhood "tedious, exhausting or exasperating" due to the "tyranny of children, the monotony of routine or the debilitation of being constantly alone with a child" (Jolivet 1997:1,14). Similarly, some American mothers feel "demoralized by the pressure to become the ultimate self-sacrificing mom" (Semans & Winter 2001:12). Indeed, many writers suggest that high levels of anxiety, depression, confusion, contradiction and uncertainty among mothers are evidence of a "Crisis in Motherhood" which is underway in

Australia, the USA, Britain and Japan (DiQuinzio 1999; Fox 1998; Jolivet 1997; Leblanc 1999; Maushart 1997; Miller-McLemore 1999; Mosse 1997; Pocock 2003; Probert 2002; Wolf 2001). It is therefore pertinent to consider whether this might impact on the desire for children.

### **3.5.1 The transition to parenthood as a potential “culture shock” experience**

Quantitative and qualitative research suggests that difficulties with motherhood and fatherhood for many in Australia, Britain, Japan and the USA stem from unexpected and often major changes to their lives, minds and bodies which come particularly with first-time experiences of childbearing and childrearing (eg Boyce & Condon 2000; Department of Family & Community Services (DFaCS) 2004a; Kitzinger 1994; Leblanc 1999; Nickel & Koecher 1987; Redden 2000; Wolf 2001). Consideration of the impact of such lifestyle changes is precisely what Lesthaeghe & Surkyn (2004) associate with fertility decline, hence the thesis’ intention to investigate this potential relationship in-depth.

A significant proportion of parents are in fact “overwhelmed by the chaos of infancy” (Nedelsky 1999:313) and many first-time mothers in middle-class Australia expect motherhood to be difficult, but rarely as difficult as they experience it (Leblanc 1999). Based on their recent study, Fisher and Rowe (2004:1) highlight a wide variety of impacts:

The birth of an infant demands dramatic adaptation of women. In becoming a mother a woman has to relinquish, at least temporarily, her autonomy, personal liberty, occupational identity, capacity to generate an income, and social and leisure activities in service of infant care. The adaptation to new required roles, major responsibilities, generational shift, multiplication of the unpaid workload, and, for some, harm to bodily integrity through unexpected adverse reproductive events, places demands on individual psychological resources and existing relationships.

Redden (2000) suggests that for many Australian women this transition is similar to entering an unknown territory with little preparation for what to expect or how to cope. To this extent the adjustment to parenthood, at least the first time, can be likened to experiencing “culture shock” if parents have low levels of skills, knowledge and confidence to cope with everyday parenting. Culture Shock Theory focusses on the psychological consequences of exposure to novel, unfamiliar cultural environments (Furnham & Bochner 1986:3-4), and one can argue that this is the situation in which new parents find themselves if they have little prior experience of bearing or raising children. Incorporating the notion of “culture shock” into

fertility research enables consideration of a mechanism by which parenting experiences may influence fertility.

It takes only a small leap of the imagination to see the relevance for fertility research of “culture shock” research on how individuals and families react to their migration to new environments. Both migration and the transition to parenthood include consideration of desires and expectations, personal coping resources and social support in adjusting to new experiences. Otherwise known as “culture stress”, culture shock leads to problems when it is related to changes in values and lifestyles that moving from one culture to another usually entails, and to a lack of social supports in the new setting (Furnham & Bochner 1986:200). Being lacking or deficient in the social skills of the new society, the individual is exposed to:

a sudden shift in contingencies that customarily reinforce social behaviour; to a lack of knowledge or uncertainty about mutual expectations; to rigid personalities unable to accept change, to value differences leading to negative evaluations of the new culture; to status loss; to the noxious effects assumed to be inherent in change per se to difficulties with diet; to the lack of social support systems in the new culture; and to other factors that make life in the new society, particularly the interpersonal side of it, uncertain, unpredictable and generally unpleasant (Furnham & Bochner 1986:6).

The wider social changes associated with women’s higher education and workforce participation, which were shown to influence fertility in Chapter 2, can therefore be seen to not only have reduced the support networks for childrearing, but to have also increased the likelihood of individuals experiencing culture shock as they become parents if they are now less prepared for parenthood than in other times or in other groups which offer more frequent daily and life-time contact with children and other parents. Indeed, increased social interest in the condition of children early in the twentieth century had already changed motherhood “from an intuitive endeavour learned informally through observation, into a professionally controlled, explicitly taught activity” (Sanson & Wise 2001:42).

### **3.5.2 Measuring the impact of parenthood as a life event**

The life event of becoming a parent through the processes of childbearing and childrearing holds the potential to cause modern individuals to experience culture shock because:

distress may be associated with *changing* from one situation to another... Every person's behaviour tends to settle into an optimal pattern that minimises the energy and resources expended to meet daily needs. Habits are easy, efficient solutions to everyday problems. Big changes in a person's life... disrupt habits and force the person to use mental and physical energy to adapt (Mirovsky & Ross 1989: 92).

The theme of stress resulting from such behavioural adjustment runs through the psychological literature on life event impacts. Reiss (1981) discusses Holmes and Rahe's life events research from the late 1960s which showed that representative samples from the same subculture or social class agree quite precisely on their stress-scaling of life events. Reiss (1981:177) believed this reflected a "shared conception of the stressful potential of a wide variety of events" such that "an event is stressful by virtue of a common social construction that it will produce a substantial change or alteration in the life patterns of an average family". The thesis will argue in later chapters that, in this way, expectations and experiences of contemporary parenthood are leading to parenthood being constructed as a stressful event, which has negative impacts on fertility desires. It is unclear whether parenthood has always been a stressful experience but parents in the past accepted the stresses as part of life, or whether parenthood has become more stressful in recent decades. The increased social interest in the condition of children, as mentioned earlier in section 3.5.1, may well have contributed to an increase in the number or range of parental stresses, although the following section will argue that increased stress may also have resulted from changes in expectations, lifestyle preferences, and skills related to parenthood. The sociological literature cited earlier shows that many contemporary women in developed countries experience motherhood as a stressful event, yet no research has been found which applies the Holmes and Rahe "Life Events Scale" (1967) or similar measures of stress in demographic fertility research. This scale will be used in Chapter 11 to quantify the potential cumulative effects of parenthood experiences described in Chapters 7 to 10.

### **3.5.3 Parenthood impacts and lowered fertility**

Continuing the theme of fertility decline being linked to women's education, workforce participation and delayed childbearing, the sociological and psychological literature shows that factors which correlate with increased likelihood of mothering difficulties are also those which correlate with lower fertility. For example, decreased satisfaction and increased difficulty with mothering are associated with higher education levels (Maushart 1997), professional employment (Hays 1996), and preferences for being in control, being

independent and being achievement-oriented, because these cause motherhood to be seen as a threat rather than a challenge (Dimitrovsky 2000). Women who enjoy their work or professional life also have a more difficult transition to motherhood than those committed to motherhood (McMahon 1995). Furthermore, the risk of experiencing postnatal depression can be higher for mothers having a first child over age 34 or living in urban areas (Astbury et al 1995; Chaudron et al 2001). Considering that major life changes can disrupt habitual behaviours and routines (as discussed in the previous paragraph), expectations and experiences of parenthood could have a greater influence on lowering fertility for those who delay parenthood if this delay means they have had a longer time to develop habitual behaviours and routines which do not include caring for dependents, so that the transition to parenthood requires a greater level of adjustment. Hence the aim of the thesis to explore how fertility may relate as much to “pushes from parenthood” as to “pulls from education and paid work”.

### **3.6 A SOCIO-PSYCHOLOGICAL FRAMEWORK FOR THE THESIS**

This review of the literature demonstrates that explanations of fertility change based on consideration of the impact of childbearing and everyday childrearing have remained “sub-narratives” in demography, even though research in other disciplines suggests that they merit further investigation in the extent to which they might influence fertility by conflicting with individuals’ ability or willingness to become or be parents under contemporary conditions. In seeking to renew investigation along these lines the thesis adopts a life course perspective to consider how fertility-related thinking and behaviour may be shaped by experiences in childhood and later life (as per Beets, Liefbroer & Gierveld 1999; Gerson 1985; von der Lippe 2004). Considering Haaga’s (2001) call to demographers to seek “mediating cognitive factors” which lie between aspirations and fertility behaviour, the thesis adopts de Bruijn’s (1999) Integrated Model of Fertility which is based in developmental psychology in order to consider how fertility may be affected by individuals’ thoughts about, and reactions to, experiences of childbearing and childrearing. De Bruijn’s framework is appealing because of its basis in general principles of human behaviour. It can be applied to a consideration of expectations and experiences of becoming and being a parent because it includes theories of social learning and emotional reaction, the role of mental agency in interpreting anticipated and experienced events, and the biological dimension of reproduction.

Although de Bruijn does not consider the potential impact on fertility of anticipated or actual childbearing and childrearing experiences, his discussion of social learning cites five psychological studies which show that “people shun or fail activities that they believe exceed their coping abilities, but confidently undertake and perform those activities which they believe they can manage” (de Bruijn 1999:105). This aspect of his framework is used in the current thesis to consider how people’s fertility and family size may be related to the extent to which they are confident or anxious about bearing and rearing children. Furthermore, de Bruijn’s application of social learning theory to fertility behaviour also considers the way in which *cognitive schemes* (otherwise known as “mental schemes”, “knowledge structures” or “inner frames of reference”) shape how people learn and structure the information available to make fertility-related decisions (de Bruijn 1999:82). This second aspect is also important for the argument of the current thesis because it enables consideration of how, through a process of assimilation, people take information from the physical, social and intrapersonal environment and match it to their existing cognitive frame of reference, which the current thesis will call their “image of parenthood”. De Bruijn (ibid) notes that such schemes filter incoming information, while a mechanism of accommodation adjusts, expands or differentiates the existing cognitive organisation accordingly. Furthermore, de Bruijn’s framework allows for anticipation of future outcomes and aspirations to be motivators influencing learning and current decision-making processes (de Bruijn 1999:96), and for the timing, pace, and number of children to be influenced partly by physiological processes that are not, or not entirely, influenced by intended action (de Bruijn 1999:167).

De Bruijn’s framework therefore allows the current thesis to consider both the impact of *anticipated* experiences and the impact of *actual* experiences of childbearing and childrearing, particularly since it sees that:

people interpret events and experiences and organise the information derived from them into beliefs about what leads to what. Future events cannot serve as determinants of behaviour, but people can convert future consequences into current motivators by representing foreseeable outcomes symbolically (De Bruijn 1999:96).

The mental schemes which people build can also pertain to “life careers” or life goals in specific “careers” such as family or work, and can change with new information inputs, shifting perceptions, and cumulative life experiences (de Bruijn 1999:174). Furthermore, since “life events are likely to reformulate a person’s salient set of information about restrictions,

options, responsibilities, tasks, efficacy and motivation for behaviour” (de Bruijn 1999:142), this framework allows for experiences of the life event of parenthood to reshape “images of parenthood” and family size preferences. We can use these aspects of the framework to consider how the images of parenthood constructed by individuals, groups or societies might affect the extent to which they believe it is desirable or possible to have children, and the extent to which they expect or experience difficulties.

### **3.6.1 Linking in with social construction theory**

De Bruijn’s discussion of mental schemes at the individual level enables the thesis to draw on the social constructionist perspective as it relates to parenthood. Social constructionism is a theoretical standpoint that implies understandings of the world as historically and culturally situated as a result of relationships between, and interchanges among, people (Gergen 1999). It is related to Giddens’ Structuration Theory in that it sees human behaviour as not only structured by the social world in which humans live (social structure), but which they in turn structure (human agency) (Giddens 1997:6). Social constructions are collections of ideas held at the cultural level which are socially transmitted and which may be shared between different members of societies so that they take on the nature of internalised personal beliefs or ideas (McGurk & Kolar 1997:38). The “social construction of reality” is seen as a key source of the structure of the social environment and of the structure of knowledge on which people’s fertility behaviour depends (de Bruijn 1999:169).

Although the influence on fertility decline of changing cultural belief systems and social institutions have been studied in demography, Graham (2000) identifies a need for social theory to be more widely incorporated into demography and population geography. Greenhalgh (1996) suggests that the demographic imagination has been limited by a resistance to certain theoretical constructs because they are more difficult to operationalise, measure and analyse as variables, and that this explains why few have considered reproduction as a social construction. In seeking to better understand low fertility this means that “we cannot only focus on the event of the birth of a child [as it feeds into demographic data] without also examining how the mother and all others involved talk about the child, or the pregnancy or the birth” (Underhill-Sen 2001:454).

Rather than seeing parenting as an instinctive or purely biological behaviour, the current thesis is based on the premise that childbearing and childrearing are predominantly socially constructed and socially learned (as per Arendell 1997; Hanigsberg & Ruddick 1999; Hrdy 1999; Kitzinger 1997; Rich 1976; Small 1998; Tarkka 2003). This is because:

children's care and needs need to be made sense of ... Human parenting is not only or even predominantly the outcome of biological imperatives or genetic imprinting. *Parenting activities are not "natural" behaviours* derived from the capacity to reproduce. How children are cared for, reared and socialised into group life are social processes... *parenting entails various behaviours, skills and objectives learned through participation in the social community*. Even the capacities to nurture and empathise with others, although intrinsic to being human, are developed through learning ... [As such] the activities and objectives of parenting, beyond those of basic survival, can vary in relation to the respective social context and historical moment. Cultural meanings about parenting and parenthood are based on tradition, practice and ideology (Arendell 1997:3-4, emphasis added).

Since the thesis is also conducted from a geographical perspective, it also seeks to investigate "how the relations between social structure and human agency fall out [differently] from place to place" (Livingstone 1992:357); in other words whether the different ways in which people think about parenting and "do" parenting in different groups or different places could contribute to differential fertility thinking and family size outcomes. This is particularly relevant to fertility research and will be discussed later in relation to differential fertility levels between different socio-economic areas. Cross-national studies confirm cultural differences in how people conceive of parenting, as well as how they actually parent (Bornstein et al 1998). Seeing parenting as a social construction links in with demographic theories addressing cultural, institutional and feminist aspects of fertility change. Social constructions or images of parenting can be seen as a melting pot for the influences on fertility of institutions, personal beliefs, culture, values and attitudes pertaining to parenthood. Indeed, Casterline (1999) appears to argue for demographers to adopt a social constructionist approach when he calls for a move beyond viewing culture as an internalised set of constraints imposed on individuals, towards adopting the sociological and anthropological view of individuals as active participants in the construction and maintenance of culture.

### **3.6.2 Mechanisms of influence to apply to fertility thinking**

Earlier sections have explained how de Bruijn's framework sees personal "mental schemes" (which can also be seen as individual "constructions" or "images") developing from daily



interactions within the cultural/social environment(s) in which people live or to which they have access. In preparing to discuss how expectations and experiences of parenthood may impact on fertility thinking it is important to outline the four main sources of information input (or learning processes) with regard to any task. Following de Bruin (1999:171-2), these are:

1. **Personal mastery experiences:** a person's reflection on his or her personal history of performance and behaviour and related consequences;
2. **Observational (or vicarious) learning:** the observation of models, and the evaluation of their behaviour, consequences in the particular situation, and the abilities of the models involved to perform adequately;
3. **Social messages** (written or verbal communication): explicit messages conveyed by people in the social context or via communication channels such as radio, television, print media, etc;
4. **Emotional arousal:** feelings of contentment, fear, love, shame, etc that are experienced with particular events, behaviours or situations, can develop into emotional associations with broader classes of events, behaviours or situations.

Since de Bruijn does not directly consider experiences of parenthood as an input in his framework, it is necessary to explain that for the purposes of the current thesis *personal mastery experiences* would include previous experience in caring for babies and children, while *observational learning* would include the observation of others' experiences of bearing and raising children in friendship groups, family, and the media, for example. *Social messages* would be statements, beliefs or implied messages transmitted through social networks and the media which send positive or negative messages about experiences of childbearing and childrearing, while *emotional arousal* or feelings such as love and fear which come to be associated with particular events could include both positive and negative expectations or experiences of conception, pregnancy, birth and everyday parenting. De Bruijn (1999:172) notes that personal experience and observational learning are the strongest of the four influencing mechanisms.

The processes of influence in de Bruijn's framework are summarised in Figure 3.1. Outcomes which can impact on desires for children (or additional children) include not only considerations of material well-being, but also considerations of physical well-being (including pleasurable inner states) and psychological well-being with respect to the self and relationships with others (self-esteem, creativity, affiliation, social status, power). To this extent the framework allows for consideration of how the social, physical and psychological impacts of contemporary childbearing and childrearing might clash with the postmodern values listed in section 3.3.1. Furthermore, his adoption of the concept of "problem space" in relation to the concept of choice allows for individual behaviour to be seen as the outcome of narrow and subjective representations of reality which can include situations characterised by complete ignorance, selective or incomplete understandings, or where behaviour follows norms and is motivated by the "normalcy" of these standards (de Bruijn 1999:177).

De Bruijn's inclusion of social learning as an input to fertility thinking and behaviour means that social interaction and social diffusion mechanisms are implicit in his framework. Indeed, researchers have increasingly focussed on these as mechanisms of influence on fertility in recent years (see eg Bernardi 2003; Bernardi, von der Lippe & Keim 2005; Bongaarts & Watkins 1996; Buehler & Fratzak 2005; Casterline 2001; Marten 2002). The analysis chapters which follow will consider how, through mechanisms of social diffusion, individual experiences of parenting may act as an information input to the fertility thinking of others.

The concepts of social learning and self-efficacy can also link the culture shock theory and parental stress research discussed in earlier sections into de Bruijn's framework. This enables the thesis to consider the potential influence on fertility-related behaviour of the expectations of certain kinds of parenthood experiences, the skills which individuals bring to parenthood, and the potential influence of stressful experiences of parenthood on personal well-being. The thesis hypothesises, therefore, that such expectations and experiences contribute to a social construction of parenting which has a major influence on the desire to start a family, or the desire to have a larger family. It also allows consideration of the extent to which differential fertility outcomes result from different reactions to parenthood and from different individual coping abilities and levels of social support.

**Figure 3.1 Simplified version of de Bruijn's Integrated Model of Fertility**

Source: Based on de Bruijn (1999:163)

NOTE:  
This figure is included on page 52  
of the print copy of the thesis held in  
the University of Adelaide Library.

### 3.7 THE SOCIAL CONSTRUCTION OF PRIVATISED MOTHERHOOD

Section 3.3.2 noted how institutional theories of fertility change which incorporate gender equity issues see fertility lowered particularly when women with postmodern values come into contact with the social construction of privatised motherhood. Since later chapters of the thesis will consider how fertility is affected by this potential mismatch between postmodern values and the social construction and related social conditions of parenthood, it is necessary to briefly consider this social construction in more detail.

It is widely accepted that in Western industrial societies there exists a traditional “breadwinner” model of the family which includes a particular social and historical construction of motherhood which provides an image of, and role prescription for, what mothers should do and should be (Abbey & O’Reilly 1998; Diem 1998; Elvin-Nowak & Thomsson 2001; Hays 1996; Jolivet 1997; Pocock 2003; Probert 2002). The “breadwinner model” emerged from around the 1880s as the public and private spheres of production and reproduction were reorganised during the Industrial Revolution, and it was reinforced by an “era of familism” between the 1940s and 1970s (McDonald 1995; Probert 2002). Although temporary and radical alterations occurred at times, such as during the two World Wars, most women reverted to full domesticity when the men returned (Summers 1975). Various known as the “cultural idealisation of motherhood” (Cooley 1999), the “patriarchal institution of motherhood (Miller-McLamore 1999), or “the ideology of domesticity” (Williams J. 2000), this social construction requires that mothers be devoted to family and housework (reproductive work) while their husbands undertake paid work (productive work), that mothers be accessible and close to their children, not focus on any other career, expend large amounts of physical, moral, mental and emotional energy, and exhibit professional-level skills to ensure the “proper” development of their children as individuals and good citizens (Elvin-Nowak & Thomsson 2001; Summers 1975; Wearing 1984).

This ideology is taken to an extreme level in what Hays (1996) identifies as the phenomenon of “intensive parenting”, whereby mothers in developed countries (and particularly those in professional employment) go to extreme efforts to provide for their children’s every physical, mental, social and economic need. The thesis will argue in later chapters that such social constructions of motherhood impact on fertility by also contributing to parental stress and the associated “Crisis in Motherhood” identified in Chapter 3. However, several authors point out

that such a crisis relates not only to gender equity in the home, but also to the impact of motherhood on health and well-being, and that it is not an inherent part of motherhood but more a reflection of the social constructions and associated social conditions under which women are expected to bear and raise children (Cannold 2005; Maushart 1997; Rich 1976).

Since under this ideology of motherhood the “good” mother is *self*-less and *self*-sacrificing, always nurturing and giving to others (Baker 2001; Cooley 1999; Roberts 1999; Sanger 1999), this construction stands to cause conflict in a society dominated by postmodern values where the focus shifts to increased nurturance of the *self*. Indeed, Morgan and King (2000) theorise that this historical trend towards the privatisation of motherhood, and the attitudinal shift towards the unacceptability of carers other than the mother, clashes with women’s needs as individuals and hence can potentially affect fertility levels. To multiply difficulties, parenting has become more difficult over the twentieth century (Alexander 2001; Grose 1992; Sanson & Wise 2001), and there has been increased pressure to provide not only for children’s physical and moral development but also for their social, intellectual and cognitive development and self-esteem (Jamrozik & Sweeney 1996; Richardson 1993). At the same time, there has been a continuing decline in the recognition and value attributed to children and parenting, at least in America and Australia, and children are being perceived in an increasingly negative light (Belsky & Kelly 1994; Kolar & Soriano 2000).

Despite the existence of this social construction, many Australian women, like their American and French counterparts, had *personally* questioned the major discrepancy which they experienced between the romantic expectations of fulfilling marriage and family life, and the loneliness, overwork and boredom of housework and motherhood (de Beauvoir 1949; Friedan 1965; Summers 1975). By the 1970s the feminist movement was *publicly* questioning these negative impacts but focussed on equality in paid work, while essential changes on the household, personal and institutional front were overlooked or resisted (Pocock 2003). The developments contributed to women’s rising participation rates in education and paid work, as discussed in Chapter 2. They also contributed to the dominance of the breadwinner model of household arrangements giving way in contemporary Australia to diversity and complexity (de Vaus 1997; Probert & Murphy 2001). Changing priorities are reflected in data which shows that 80 per cent of young married women saw motherhood as their most important role in 1971, but only 30 per cent believed this in 1991 (McDonald 1995:33-36). Nevertheless, an institutional and generational “lag” exists because the “traditional” construction of

motherhood continues to dominate the views of men and older Australians, while the views of younger women are usually less traditional (de Vaus 1997; Newspoll 2001). The promising aspect for fertility futures is that, if particular social contexts and social constructions contribute to childbearing and childrearing difficulties which negatively affect fertility, then research and policy might deconstruct and reconstruct them in ways more favourable to individual well-being and fertility rates.

### **3.8 CONCLUSION**

This chapter has reviewed the major theoretical narratives which seek to explain fertility differences in time and space. It has shown that both economic theory and cultural theories explain different aspects of change contributing to increasing levels of childlessness and smaller families. However, the chapter highlighted the importance of the development of post-modern values for the transition to below-replacement level fertility rates. The chapter also highlighted how contemporary fertility research and debate has relegated to a sub-narrative the potential impact on fertility thinking and behaviour of anticipated and actual experiences of childbearing and childrearing, particularly for women, and particularly as they clash with post-modern values and changing cultural expectations about lifestyle, health and well-being. The chapter argued that earlier developments in demography as a discipline contributed to these particularly feminist and gendered perspectives being overlooked both in research and policy, despite their prominence within other literatures. The thesis therefore seeks to provide some deeper explanation of quantitative fertility patterns in Australia by delving into the lives of individual men and women to discover their perceptions of influences on their fertility and family size, and in particular the relative influence of the physical, psychological and social impacts of parenthood, as well as potential mechanisms of influence. The next chapter outlines the methodology on which the thesis proceeds.

## Chapter 4

# Methodology of the research

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The increasing use of mixed methods in fertility research... provide[s] the opportunity to situate studies within a wider framework, linking constructions of reproduction to different levels of social organisation, and exploring the intersections between the “local” and the “global”

(Sporton 1996:25).

### 4.0 INTRODUCTION

This chapter sets out the rationale for the research methodology. The first section explains the epistemological standpoint of the thesis, while the second section explains why the thesis foregrounds research at the individual level and why qualitative methods were most appropriate for this. The third section explains the research design and the fourth section then details the quantitative data sources and methods used. The fifth section explains ethical considerations; section six explains the conduct of parent interviews; and section seven details a small survey of men and women intending to start a family in the near future.

### 4.1 EPISTEMOLOGICAL STANDPOINT

Since the thesis seeks to understand potential influences on fertility of experiences of childbearing and childrearing, and in particular the perceived impacts on women as mothers, the thesis takes a feminist perspective because this allows for greater consideration of the emotional aspects of lived experience and is more sensitive to women’s experiences (Henwood & Pigeon 1993; Punch 1998). These aspects are generally excluded in the traditional standardised, structured approach. In particular, the thesis draws on perspectives from feminist geographies which, according to Johnston, Gregory, Pratt and Watts (2000:259, emphasis added):

- are committed to situating knowledge *within the context of people's lives* and see interpretations as context-bound and partial, rather than detached and universal;
- trace the interconnections between all aspects of *daily life*, across the subdisciplinary boundaries of economic, political and cultural geography;
- focus on making “women visible” by considering *women's experiences* and perceptions, which often *differ from men's*; and
- are *critical of women's oppression* in society and of the various ways that this is reproduced in theory [this thesis considers women's oppression particularly as *mothers*].

The thesis is written within the wider tradition of Cultural Geography, in that it looks at the “commonsense subjectivities of people... [and] seeks to devote the kind of quizzical attention usually reserved for the distant... to advanced capitalist societies like Australia” (Anderson K. 1999:1). Based on the explanations in Chapter 3, it seeks to uncover “people's constructions of the world and the socio-spatial articulation” (Anderson K. 1999:13) as they influence fertility thinking and behaviour. The study also aligns itself with the more naturalistic or interpretative paradigm because this approach assumes that “not everything that is important can be measured with precision” (Rubin & Rubin 1995). The study approach was to seek reality as represented through the eyes of participants and to understand the *meaning* of experience and behaviour *in context* and in its full *complexity* (Ezzy 2002; Henwood & Pidgeon 1993). The interpretive approach offers the potential to gain important insights into fertility thinking and behaviour because, as Schuetz (1962:49) explains (emphasis added):

By a series of commonsense constructs [people] have pre-selected and pre-interpreted this world which they experience as the reality of their daily lives [and] it is these *thought objects of theirs which determine their behaviour* by motivating it. The thought objects constructed by the social scientist in order to grasp social reality have to be founded upon the thought objects constructed by the commonsense thinking of men [sic] living their daily life within their social world.

Van Peer (2000) also points out that an important tool for causal analysis is a multi-level approach where micro-data are integrated with economic, cultural and population-related indicators. In light of the benefits outlined, the current research therefore adopts a multi-level and mixed methods approach to data collection in the expectation that it will better address what is seen as the need to:



- investigate low fertility at the *local level* to determine variation across and within across settings (Fricke 1997), particularly since the same fertility levels may result from very different society-specific pathways (van Peer 2000);
- consider changes in, and determinants of, the *number* of children people are having (McDonald 2000a); and
- *ask people directly* about their actual family and work preferences, since at this stage these are unknown or simply assumed from actual behaviour (Hakim 2001; Manne 2001; Probert & Murphy 2001).

#### 4.1.1 Including men in fertility research

As well as focussing on *women's* issues, feminist research can also consider gender difference. Much demographic fertility research in developed countries ignores men's views and fertility preferences, particularly where in-depth research is conducted at the micro level. This is despite the fact that at least six studies show husbands and wives report different views and desires for children (Thomson 1983). While men's preferences for the *number* of children has been investigated (eg Morgan S.P. 1985; Stash 1996; Thomson, McDonald & Bumpass 1990), there is little research which specifically asks Australian fathers what influences their family size, or how this might relate to their experiences of parenting. Although some researchers have intended to include fathers alongside mothers, limited time and resources often preclude their eventual involvement and data is reported only for mothers (eg Meyer 1999). Alternatively, where fathers are involved they are not interviewed to the same depth as mothers (eg Baxter 1979). However, to broaden the understanding of influences on fertility, researchers highlight the need to include fathers (Goldscheider & Kaufman 1996; Meyer 1999). Otherwise, as Fried and Udry (1979:274) point out, researchers "cannot be sure that they have not left out half of what they need to know". Including fathers in the current research was also expected to allow gender comparisons of perceptions, experiences and reactions which could inform more effective fertility policy.

#### 4.2 INVESTIGATING AT THE INDIVIDUAL LEVEL

Since despite many decades of work, "debates in the journals are hot with conflicting claims on every issue" about low fertility, Hirschman (1994:221) suggests the use of grounded theory as perhaps the most effective strategy to help identify micro-level motivations behind fertility

behaviour, on which higher level structural explanations can be founded. Investigation at the individual level is helpful because:

Whereas demographic outcomes (such as fertility) as well as major determinants are situated at the *social level*, the processes that link outcomes and determinants are located at the *individual level*... The acknowledgement that individual behaviour itself is the outcome of underlying processes pushes analysis back to... the *intra-individual level*. The elements that pertain to this analytical level include internal processes of thought, attention, representation, motivation and emotion, which shape the personal considerations of individual decision-making. Besides these cognitive processes, this intra-individual level also includes physiological processes involved in fertility and fecundity (de Bruijn 1999: 162).

Furthermore, the individual-level approach can avoid the trap whereby, according to Chesnais (1992), most empirical studies either omit cultural variables such as norms, traditions and family structure, which in turn ignores history and social structure, or only incorporate them in opposition to economic and socio-economic variables. Larson (1997) has criticised Australian demographers for overly focussing on aggregate data in investigating fertility change and has suggested this more holistic approach which considers local social context.

The need to incorporate qualitative methods to gain a better understanding of the causes of fertility change has been noted in recent years (Hakim 2001; Knodel 1997; Obermeyer 1997; van Peer 2000), particularly since:

Quantitative indicators are inevitably distant from fertility decision-making. Qualitative data focussed on the subjective, interpretive and contextual meanings the actors themselves attribute to change allow us to see people in the process of social change... Women [and men?] are aware of the changes around them, are conscious and deliberate actors in the fertility transition (Simmons 1996:266).

In conducting research into individual lives, qualitative methods have much to offer and can be equally as effective as the “good” science which is traditionally equated only with quantitative methods (Daly, Kellehear & Gliksman 1997:15-19). Although some believe that “demography without numbers is social waffle” (Coleman 2000b:357), demographers have found the incorporation of qualitative and individual-level research useful (Axinn, Fricke & Thornton 1991; Caldwell, Hill & Hull 1988; Simmons 1996; Sporton 1999; Winchester 1999). In some cases, qualitative research can lead to almost the opposite conclusions from those drawn from numbers or large-scale surveys alone (eg Knodel 1997). When compared with quantitative research, investigation based on personal contact often shows that issues are more complex and

contradictory because it enables exploration of *why* people do things, what people might *prefer*, and the *effects* of social situations (Pocock 2001, 2003; Probert & Murphy 2001).

Recent Australian research examining the effectiveness of telephone interviews which specifically asked women about having children also concluded that qualitative research methods, in particular in-depth interviews, would yield more valid responses than standardised questionnaires because they are more similar to the situations in which women normally talk about children (May 2002). This thesis therefore follows in the tradition of in-depth qualitative fertility research within demography and sociology both in Australia and overseas (eg Westoff, Potter & Sagi 1963; Ware 1973; Young 1975; Caldwell et al 1976; Campbell 1976; Busfield & Paddon 1977; Richards 1978; Bulatao 1980; Caldwell 1982; Santow 1989; Santow & Bracher 1999). However, the thesis also adopts the view of several writers that qualitative and quantitative data should be used to complement each other (Jayaratne 1993; Obermeyer 1997; Punch 1998). Therefore, whilst this thesis explores qualitative *explanations* of fertility, it seeks to link this with the quantitative *patterns* which will be discussed in Chapter 5.

### **4.3 RESEARCH DESIGN**

#### **4.3.1 Structure of the research design**

For reasons outlined so far, the research was initially designed to encompass three levels of investigation to combine quantitative and qualitative research methods:

##### **i) Level One**

Analysis of 1996 Census data (the latest census collecting “number of issue per woman”, or number of children ever born) for metropolitan Adelaide to establish macro patterns in family size and to compare this with some known fertility-related variables as detailed in Chapter 2.

##### **ii) Level Two**

A survey of between 100 and 200 parents in metropolitan Adelaide using a semi-structured questionnaire to seek quantitative and qualitative data, triangulating the insights gained with

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the findings from the quantitative analysis (Level 1) and in-depth parent interviews (Level 3).

### **iii) Level Three**

In-depth interviews conducted with a sub-sample of 30 mothers from the level two survey, and separate interviews with the fathers of their children, using an unstructured interview; and focus groups to explore themes in different socio-economic areas.

The final research design differed somewhat from this plan. While the quantitative and qualitative aspects were maintained, the idea of focus groups was abandoned after considering the inhibiting effects that the researcher had previously observed in parenting groups during discussions of parenting experiences. This inhibition was attributed to the politics of “the mommy wars” identified by Hays (1996), where “working” mothers or those in egalitarian relationships would tend to not discuss their experiences if the discussion became dominated by “at-home” mothers or those in traditional relationships, or vice-versa. For this reason, individual in-depth interviews were chosen as the preferred method of data collection so that individual feelings and perceptions could be explored uninhibited by the presence of others, including spouses or partners.

Whilst the Level One research was maintained, as the research design evolved it was also felt that conducting the Level Three interviews before the Level Two larger-scale survey would provide a better understanding of influences on fertility and family size from a more grounded perspective. Reversing this order was expected to allow the quantitative survey questions to draw on the themes raised in the qualitative study. Rubin and Rubin (1995:73) suggest that theoretical saturation is reached when the researcher is confident that further interviews are providing little new information. In the thesis research this stage was only approached when 62 in-depth interviews had been conducted, covering 39 families across four socio-economic areas. It was felt that by this stage the interviews provided sufficient quality and quantity of data to explore potential meanings behind statistical patterns of fertility without the need to conduct the larger Level Two survey. Furthermore, a sample in this size range has been demonstrated by others conducting qualitative research in the social sciences as sufficient to allow exploration of ideas and influences, and at the same time meet time and funding constraints (see eg Bernardi 2003; Busfield & Paddon 1977; Campbell 1976; Marten 2002; Pocock, et al 2001; Richards 1985; Wearing 1984).

### **4.3.2 Including parents and non-parents**

Another change to the research design was the inclusion of a survey of non-parents. Originally the study excluded people without children, since several other studies on childlessness had already been conducted or were underway in Australia (as detailed in Chapter 1). However, just after the Research Proposal was completed, an opportunity arose to conduct a survey of people attending “Preconception Seminars” who were actively considering whether or not to start a family in the near future, and so were a special group of non-parents which might otherwise be difficult to recruit. This survey is termed the preconception survey. The research design, data collection methods and analytical process for the census analysis, parent interviews and preconception survey are outlined separately below. These three different aspects of the research are referred to collectively throughout the thesis as the Adelaide Fertility and Family Size Study (AFFSS).

## **4.4 THE 1996 CENSUS DATA**

Metropolitan Adelaide is characterised by a “striking spatial pattern of socio-economic status” with a southeast-northwest divide strongly in evidence, and a strong relationship between status, levels of education and occupation (Hugo 2004:47-50). Since differences by socio-economic variables have long been a feature of Australian fertility, as explained in Chapter 2, areas selected for quantitative analysis and parent recruitment were aligned along this divide to provide socio-economic diversity.

Chapter 5 contains analysis of 1996 Census data to provide the quantitative picture for the study area of metropolitan Adelaide, against which the qualitative research was undertaken. Census data was received in electronic tabulations at census district level and was processed in Microsoft Excel spreadsheets. The tabulations by socio-economic status drew on a suburb-census district concordance list compiled by Faulkner (2005) for her spatio-temporal analysis of fertility rates in Adelaide. Tailor-made groupings of census district data were compiled for the current thesis to reflect suburbs groupings within specific socio-economic areas. Area selection was based on the ABS Social Atlas of Adelaide (ABS 2002e) and personal knowledge of the areas, and areas were known to be relatively homogenous in terms of education level, income, rates of unemployment, occupation groups, house prices and extent

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of home ownership (see details in Chapter 5). Maps for Adelaide showing the SEIFA index of relative socio-economic disadvantage and advantage/disadvantage (Hugo 2004:46-47) confirmed that the selected areas represented a cross-section from highest to lowest status.

In order to compare how fertility rates might be affected by slight differences in characteristics in the highest and lowest status areas, two areas were chosen for each of these for the quantitative analysis, giving a total of six areas. Areas Lowest A and Lowest B both contained Adelaide's highest proportions of low income households, people without qualifications, elementary workers, the unemployed, and single parent households. While area Lowest A had a greater concentration of people/suburbs with these characteristics, area Lowest B was chosen for parent recruitment for travel-time purposes. Similarly, both areas Highest A and Highest B contained Adelaide's highest proportions of high income households, people with university qualifications, people in "professional/managerial/administrative" occupations, and low unemployment. Area Highest A was an inner city area with a high concentration of those described as "DINKS", defined by ABS (2002e) as couple-only families with both partners in paid employment of at least 25 hours per week, the younger partner aged under 40, and high incomes. For this reason area Highest B was selected for parent recruitment. Areas remain unnamed to protect the confidentiality of interviewees, whose occupations and family situations are often described in some detail.

Once the areas had been chosen, census data at census district level for "number of issue" was aggregated to represent the clusters of suburbs. Various tabulations were produced and are presented in Chapter 5. Originally it was intended to also sample rural families, particularly since rural fertility rates are generally higher than urban rates (Hugo 2004:29). However, funding and time limitations precluded this.

#### **4.5 ETHICAL CONSIDERATIONS**

An Ethics Application to cover the method and instruments for the qualitative component of the research was submitted to, and approved by, the University of Adelaide Human Ethics Committee (see Appendix 1). Although there was no intention to ask questions which could be considered controversial (eg on abortion experiences or use of IVF), the ethics clearance was sought since there was a possibility that such issues could emerge spontaneously from the

interviewees and survey respondents. To ensure informed consent, free of coercion and without pressure to participate, the purpose of the research was explained to potential participants at the time of recruitment. It was made clear that there was no obligation to take part and that any individual could decline to participate, decline to answer questions, terminate an interview at any time, and withdraw interview notes/questionnaires up until the time that the data had been analysed. All participants were provided with an information sheet about the study, including contact details of the researcher and supervisors (see Appendix 2). Consent forms were not used for the preconception survey as consent was seen to be expressed in the taking of a form. For the interviews, consent forms were read through and signed before the interview, and permission was sought for interviews to be taped (see Appendix 3). No interviewees declined the tape-recording, although one mother did ask for the tape to be switched off while she made a particular comment about the attitudes of self-employed business owners to paid maternity leave. No interviews were terminated prematurely, and in fact they often ran longer than agreed because interviewees often became more interested in the topic than they had anticipated and were keen to share their experiences. This has been found by other researchers interviewing about women's experiences (Caldwell & Ware 1973; Finch 1993; Oakley 1992). When completing the consent form, all interviewees were offered the chance to be sent research results at a later date. Several of those who initially said they were not interested in receiving results found the interview extremely interesting and subsequently requested results.

## **4.6 THE PARENT INTERVIEWS**

### **4.6.1 Timing and length of the study**

The thesis was conducted in part-time candidature for the first two years and full-time for the subsequent two years. Interviewing was therefore spread over 12 months, commencing with piloting in February 2003 and being finalised in March 2004. Interviewing was interspersed with preliminary analysis and writing, and the drafting of a report on the preconception survey.

### **4.6.2 The four socio-economic areas for parent recruitment**

Section 4.4 has already explained the selection of six areas for quantitative analysis of census data. Three of these areas were originally selected for parent recruitment to represent low,

middle and high socio-economic status, to enable within-region and across-region comparisons of influences on fertility and family size. However, as interviews progressed through the middle-status area it was felt that the interviewees actually represented an upper-middle status area, with many of the women being university-qualified while their male partners had lower-level qualifications but were in technical or managerial positions. Consequently, this area was renamed as the “upper-middle” status area, and a fourth area was added to represent a “lower-middle” status group, where the women in particular were more often working in clerical/service occupations and had only secondary level qualifications.

### 4.6.3 Selecting parent interviewees

Families usually resident in Adelaide were sought for in-depth interview from the four chosen areas. Temporary residents and visitors were excluded. Potential interviewees were selected using “purposeful sampling”, whereby the study did *not* aim to select a representative sample but to gain deeper insight by interviewing a limited group of information-rich people, an acceptable method for qualitative research (Punch 1998:193). With no access to State Birth Registration data, selecting a random sample of parents with at least one young child would have been difficult and, given the study objectives, a purposive sample was deemed more appropriate.

Family size and age of youngest child were the two main selection criteria. Firstly, a range of family sizes was sought, with approximately equal numbers of parents having each of one, two, three, and four or more children. Although this means that the group of interviewed parents is over-representative of those with larger families when compared with the general population, nevertheless it does enable consideration of influences on below- and above-replacement fertility at the individual level. The thesis argues that including larger families is particularly important since, as explained in Chapter 2 (section 2.2.2) the existence of women who have borne three or more children plays a significant role in keeping Australia’s fertility from falling into the “very low” range. Furthermore, earlier research which did not limit family size suggests that responses from parents of larger families provide valuable insights into influences on fertility, particularly when they can be compared with influences on those with smaller families (eg Busfield & Paddon 1977; Campbell 1976; Cartwright 1976; Land 1969). Table 4.1 shows the family size characteristics of the selected families.



**Table 4.1****Number of children ever born in study families**<sup>\*1</sup>

Source: Adelaide Fertility and Family Size Study, Adelaide 2003-04

	AFFSS study areas by socio-economic status					40-44 year old women, 1996 Census	
	Highest	Upper-middle	Lower-middle	Lowest	Total	Adelaide <sup>*2</sup>	Australia <sup>*3</sup>
Parity range	1 to 5	1 to 5	1 to 7	1 to 7	1 to 7	-	-
Mothers							
1 child	27% (3)	27% (3)	14% (1)	40% (4)	28% (11)	12.7%	11.3%
2 children	36% (4)	27% (3)	29% (2)	10% (1)	26% (10)	42.9%	38.4%
3 children	9% (1)	18% (2)	29% (2)	30% (3)	21% (8)	21.0%	24.6%
4+ children	27% (3)	27% (3)	29% (2)	20% (2)	26% (10)	9.4%	13.2%
Fathers <sup>*4</sup>							
1 child	27% (3)	27% (3)	29% (2)	25% (2)	27% (10)	na	na
2 children	36% (4)	27% (3)	14% (1)	38% (3)	30% (11)	na	na
3 children	9% (1)	18% (2)	29% (2)	25% (2)	19% (7)	na	na
4+ children	27% (3)	27% (3)	29% (2)	13% (1)	24% (9)	na	na

\*1 This was not necessarily within the “family” which was interviewed; several fathers had children from previous relationships now living elsewhere. The family size counted in this study was the number of children of the interviewed mother. Note also that two women had babies who died aged under 3 months which are also not counted here - they had not impacted on family size thinking.

\*2 Compiled by the author from the latest census data available (1996) – see Chapter 5.

\*3 From McDonald (1998).

\*4 Number of children ever born was unknown for the ex-partners of 2 women so these are excluded from the four family size rows at the bottom of the table, hence only 37 fathers compared with 39 mothers.

The inclusion of people with children from previous relationships, blended families, and single parents with children living elsewhere, blurred the parity lines somewhat but this is explained where it affects the data. In light of statistical and anecdotal evidence that the average age of both first-time mothers is generally still rising, and with almost 19 per cent of women giving birth aged 35 years or over in 2003 (AIHW 2005:13), the study set no age limits and therefore included some women who had had a first or subsequent child over the age of 40.

The second criterion was that the youngest or only child be aged one to six years at the time of the interview so that fertility and family size were likely to be current or recent considerations. The lower age limit was set so as not to interrupt people with a new baby, and to allow time for adjustment and reflection on the experiences with the most recent child. A decision was also made to interview mothers and fathers from the same couple where possible to enable the investigation of couple dynamics. Single parents were intentionally included since they

represent 19 per cent of South Australian mothers and 3 per cent of fathers (ABS 2004a). In some cases the previous partner or current “boyfriend/girlfriend” was also interviewed to provide a second viewpoint. No attempt was made to recruit interviewees with particular ethnic backgrounds, although people from backgrounds which were visually or audibly different during recruitment were targeted for inclusion (eg from Asia or Indigenous Australia) to maximise variation. No attempts were made to recruit same-sex couples, since at present they represent less than 0.5 per cent of all couples in Australia (Birrell & Rapson 2002:61). However, their inclusion in a future in-depth study might provide interesting insights into equity in the division of paid and unpaid work, and any related influences on fertility.

#### 4.6.4 Contacting interviewees

A variety of methods was used to recruit interviewees, as shown in Table 4.2. Since “in cultural studies it is common to start with a personal acquaintance who is a member of the group being studied” (Rubin & Rubin 1995:68), pilot interviews were conducted with the researcher’s husband and four friends who fitted the selection criteria (two mothers and two fathers, including one father and one mother who grew up in lower status areas). Some further recruits were recommended by these people. Approximately one quarter of new interviewees resulted from snowballing, and 75 per cent of the fathers were recruited this way. Personal referrals maximised the ability to select for variation in characteristics and family size, which was more difficult to achieve with public recruitment. In some instances, personal recommendation was crucial to success. For example, one mother commented that:

I know [friend] is particular about that sort of thing [giving out personal information] and if she did it [the interview] and says it’s OK, then it’s OK.

Another quarter of interviewees were recruited during visits to new non-connected public groups, such as parenting groups, kindergartens and playgroups, and this included three fathers. The best approach was found to be mingling with parents in a group, or while waiting to collect children, to explain the study and carefully gauge the interest level. Other recruitment resulted from general conversations about how the study was progressing, with people offering to contact others they thought might take part who fitted the selection criteria. Fewer interviewees were recruited in the lower-middle status area since it quickly became apparent that themes raised overlapped with those from the upper-middle status area.

**Table 4.2****Recruitment methods for parent interviewees**

Source: Adelaide Fertility and Family Size Study, Adelaide 2003-04

	Lowest status		Lower-middle status		Upper-middle status		Highest status area		Number (Per cent)	
	Mothers	Fathers	Mothers	Fathers	Mothers	Fathers	Mothers	Fathers	Mothers	Fathers
Personal acquaintance of researcher	0	0	0	0	4	2	1	0	5 (13%)	2 (8%)
Via acquaintance of researcher	0	0	1	0	3	0	0	0	4 (11%)	0 (0%)
Public recruitment	6	2	0	0	1	0	6	1	13 (34%)	3 (13%)
Snowballing from earlier interview	2	0	6	0	3	1	3	0	14 (37%)	1 (3%)
Father via mother	-	5	-	4	-	4	-	5	0 (0%)	18 (75%)
Mother via father	1	-	0	-	0	-	1	-	2 (5%)	0 (0%)
Total	9	7	7	4	11	7	11	6	24 (100%)	38 (100%)

**4.6.5 Refusals to participate**

In line with the ethical considerations, no coercion or pressure was used in recruitment. Potential participants were asked if they were interested in taking part in a study “to find out what sorts of things influence parents in the number of children that they have now, or are likely to have in future”. It was explained that although an official “interview” was being sought, in reality this was more like an everyday conversation. Absolute confidentiality was also assured in line with the Ethics Application, and it was explained that pseudonyms would be used for any publications. If there was hesitancy, it was made clear that there was no obligation to take part and participants were free to decline to participate. This was also emphasised to those who offered to contact others through snowballing.

In two cases mothers were reluctant to go forward to interview. Having made an appointment and received a demographic questionnaire, one mother from the upper-middle status area contacted the researcher with concerns about providing personal details on the questionnaire. This was despite her husband’s encouragement that such questions were standard for such research. After much reassurance about confidentiality, and reiteration that any question could

be left blank, the mother agreed to the interview because she was interested in the issues; she eventually provided three hours of discussion. A second mother of a very large family in the lower-middle status area was contacted via a mutual acquaintance and agreed at first to an interview. However, despite similar reassurances as given to the first mother, this second mother subsequently withdrew her appointment saying that her husband would not like her talking about their family issues.

In order to represent diversity, a concerted effort was made to recruit full-time working mothers with three or more children in the higher status areas, particularly since these women go against the higher status/lower fertility trend. On three occasions attempts were made to contact such parents via a private school, a private kindergarten and a public playgroup using notices, the school newsletter, and flyers in parent pigeonholes. However, none of these formal approaches were successful. Informal recruitment was therefore attempted with five families via mutual acquaintances; two were “too busy” to participate, while two female GPs declined because they felt the questionnaire and interview were too personal, considering that they were somewhat known to the researcher. A fifth woman, a senior medical specialist with five children, had just moved interstate. Two other women who offered to help with recruitment said few mothers at their legal practices had large families, and those that did worked only part-time. However, the lack of such women in the study is not seen as a major failing, since some of the interviewed parents discussed their previous experiences of combining larger families and paid work, even though they had reduced their hours or were “home full-time” by the time of their interview. Other parents were able to offer observations of friends or colleagues in this position.

#### **4.6.6 Encouraging fathers to participate**

Despite using no pressure to recruit, a concerted effort was made to encourage fathers’ participation for the reasons outlined in section 4.1.1. Since mothers were generally more accessible and were more likely to recommend other mothers, fathers were generally recruited by negotiation with the mother at the end of her interview (75 per cent). However, in some cases this seemed to lead to gate-keeping, with mothers saying their partner “would not be interested”. Sometimes this appeared to be a way of protecting fathers who worked long hours, or in two cases a way of denying the father an interview due to the mother’s resentment about

the father's lack of support for childrearing and domestic work. Ten male partners were not interviewed because the mother or the father said they were "too busy", "too private" or "not interested", and all but one of these fathers was from the two higher status areas. These issues surfaced much less in the lower status areas, where only six of the 16 fathers were not interviewed. Recruitment tactics were therefore changed to ask fathers to recommend other fathers but this only resulted in recruiting one "full-time stay-home" father. Three other fathers were recruited directly when collecting their children from kindergarten.

Fathers were more likely to accept an interview if it could be one hour or less. Fathers' interviews were generally shorter anyway if most of the demographic information had been collected and checked at the mother's interview. Another successful tactic was offering fathers the option of a telephone interview at home or at work. Originally it was felt that face-to-face interviews were best to investigate personal issues and to build rapport. However, by the time the telephone option was offered to attract more fathers, 40 face-to-face interviews had been conducted and a comparison on the quality and type of data obtained showed that neither were compromised. Telephone interviewees made comments with a similar level of frankness and intimacy as in the face-to-face situation, and some may particularly have chosen a phone interview because it felt *more* comfortable. Another reason to extend the use of phone interviewing was to minimise the need for the researcher to drive long distances to conduct interviews at night.

#### **4.6.7 Conducting the in-depth interviews**

Interviews were offered at any time convenient to the interviewee, including early mornings, evenings and weekends, and were conducted in a place convenient to the interviewee. In most cases this was in the interviewee's lounge or dining room, although several fathers were interviewed in a private office at their workplace. In order to minimise influences from others, interviewees were asked to arrange for other adults to be absent during the interview, and in only three cases was a grandmother or father nearby minding the child(ren). In no cases were partners interviewed together. Although most mothers arranged their interview when children were being cared for elsewhere, in 14 (37 per cent) of the mother-interviews a baby or toddler(s) were playing, watching television nearby, or were elsewhere in the house. Three of the lower status mothers asked to be interviewed at their playgroup session when their pre-

school children could be kept occupied, but this did not prevent them from discussing intimate aspects of birth or “accidental” conception.

Interviews took on average 1½ hours, although some ran up to three hours for women who had had difficult or particularly complicated experiences. By comparison, some father interviews were one hour or less, partly because the mother had provided much of the family information already, but partly because some fathers discussed topics in less depth than the mothers. The need to obtain sufficient depth of explanation was balanced with the time and energy constraints of the interviewees. In some cases a commitment to limit the interview time was essential to successful recruitment, particularly for higher status fathers who were difficult to recruit anyway.

All interviews were conducted by the researcher and all tapes were also all transcribed by the researcher. This maximised the ability to be immersed in the data and to think about analysis immediately (Dunn 2000:74; Minichiello et al 1995:100). Furthermore, genuine insights into demographic events come from this direct and continuing contact between one main investigator and the people being investigated (Caldwell 1988:469). Transcriptions were usually made the same day. However, on one occasion a tape recorder malfunction led to a transcript being constructed immediately after the interview from hand-written interview notes and recollection. Nevertheless, this experience led to the trial of hand-written notes (with taped back-up) for the next interview to see whether a shorter, selective transcription offered any benefits. A preliminary analysis of all data collected to that point led to the decision that verbatim transcription allowed more accurate recall and interpretation. The next interview was therefore fully transcribed and full verbatim transcripts were used for all subsequent interviews. The second exception occurred after two successfully transcribed phone interviews, when it was discovered that most of the third interview had not been recorded due to a technical problem with the phone. Since the transcription was commenced the morning after this late-night interview, most of this transcript was constructed from recall alone.

#### **4.6.8 The interview schedule**

The interview schedule is supplied as Appendix 4. Since interviews gain depth and reality from being directed by the interviewee to matters that are of interest and importance to them

and based on their lived experiences (Punch 1998; Rubin & Rubin 1995), the best approach was to begin interviews with questions phrased in an open way (Rubin & Rubin 1995:46). The content and structure were designed to put the interviewee at ease and encourage a “natural” conversation. Interviews took on a life history approach as interviewees tended to reflect on their paths to first-time and subsequent parenthood, and possible future influences on their family size. Discussion followed the issues raised by the interviewees themselves, in a more grounded approach, but a semi-structured approach allowed other questions to be informed by the theoretical background of the thesis. While the semi-structured approach reduces between-case comparability, it does provide a more valid explanation of an individual’s perception of reality (Minichiello et al 1995). It also helps identify the forces influencing fertility as well as “giving a hint as to the nature of current change and what may be immediately ahead of us” (Caldwell et al 1976:vii). In reality, the interview schedule therefore came to act more as a checklist rather than a rigidly followed line of questioning for every interviewee. This allowed the exploration of other interesting influences on family size which arose spontaneously, such as potential adoption, “accidental” pregnancy, and IVF use. However, the themes of childbearing and everyday parenting experiences, financial costs and work-family issues were probed for everyone.

Several improvements were made after the early interviews to the order, length and number of questions. Some questions on role conflict were removed as they did not elicit sufficiently specific responses about influences on family size. A question was also added at the end to ask interviewees to summarise what they saw as the main influence(s) on their family size. Questions in the schedule and questionnaire were developed based on the researcher’s previous experience and training at university and during employment at the Australian Bureau of Statistics, on guidance from the research design literature (eg Bradburn & Sudman 1991; Cannell, Miller & Oksenberg 1981; Clark & Schober 1992), and also on other questionnaires used for mothering, parenthood or fertility research (eg Bulatao 1980; Hattery 2001; Hays 1996; World Fertility Surveys). Questions on other issues were added where they had frequently been raised as influential during general discussions at birth and parenting groups in which the researcher is involved as a parent. Questions were worded in language likely to be used by parents and potential parents, as recommended by Bradburn and Sudman (1991).

#### 4.6.8.1 *Attitude questions*

Towards the end of the interview some structured statements about family-related attitudes, beliefs and preferences were included. The aim was to test suggestions that these aspects are linked to, and help explain, family size (as per Hakim 2000, 2001). The idea of improving cross-sectional fertility analysis by dividing respondents into three or four preference groups according to their responses to survey questions was suggested by Easterlin, Pollak and Wachter (1980:104) and this method has been employed in investigations of the social construction of parenting (Hattery 2001), women's work-family preferences (Gerson 1997) and parents' gender roles (Belsky & Kelly 1994). The questions for the current study were selected from those used by De Vaus (1997), Evans and Kelly (1999), Newspoll (2001), Hakim (2000, 2001, pers comm.), and van Nimwegen et al (2002:34). However, it was felt that some questions were highly leading and likely to encourage agreement with traditional beliefs (as outlined in Chapter 3, section 3.7). Despite their use in large-scale national surveys, the validity of such statements has also been called into question (eg by May 2002; Probert & Murphy 2001). As such, Hattery's questions were also included since they reflect both traditional and modern beliefs about parenting and childcare (Hattery 2001).

Writers on methodology recommend that interviewing should be seen as a dynamic and flexible process (Rubin & Rubin 1995:42) and that questions which the interview process reveals to be unimportant or problematic should be dropped (Dunn 2000:55). During the AFFSS interviews, many of the attitude and preference statements were indeed found to be leading or proved difficult for parents to provide a closed answer to. Some parents commented that questions were "stupid" or "old-fashioned", or felt they could be answered in either a general or a personal way, but not both. Replies could often not "fit into the box" and many respondents qualified their responses, thereby making response categorisation difficult. Hakim's three key questions for categorising mothers' work-home preferences in large national surveys (Hakim 2000, 2001, pers comm), which have been used in some Australian national research, including the Department of Family and Community Services' HILDA (Household, Income & Labour Dynamics in Australia) study, proved particularly difficult to answer for single mothers, mothers on short-term maternity leave, those doing considerable amounts of unpaid volunteer work, and those whose work-home preferences changed with the age of their children. For example, single mothers often replied that they were the "main breadwinner" as they were the sole income earner. This placed some in the "work-centred"



category even though they were only working because they needed the income and their preference was to have a partner providing the family income and to be “home-centred” in a traditional arrangement. Quantitative analysis of the “preference type” and other responses by family size was therefore not conducted and it was felt that the in-depth analysis of interviews provided a better picture of the more complex realities of influences on fertility and family size outcomes.

#### **4.6.9 The demographic questionnaire**

Demographic and family history details were collected on a questionnaire. This was originally completed by the researcher at the start of the interview, but after the first six interviews a self-enumerated version, handed out at the time of recruitment, was developed to save approximately half an hour of interview time. This new approach also enabled both partners to provide details, eg on their work history, or children from other relationships. At the beginning of the interview the researcher then checked the form for missing data, or for data needing elaboration, and used it to gain an idea of the person’s background and family circumstances. The questionnaire is provided as Appendix 5.

#### **4.6.10 Establishing rapport and being an “insider”**

The choice of a research question is often predicated on aspects such as the researcher’s worldview, their life experiences, their age, ethnic background, gender and class (Minichiello et al 1995:179). In social research being an “insider” has as many benefits and limitations as being an “outsider” and “a feminist researcher doing research on women shares the powerless position of those she researches” (Oakley 1992:16). One can also say the same of a parent researching on parenthood. In the present study, in most cases before the interview the interviewees were aware that the researcher was, amongst other things, a mother of three young children (aged 2, 4½ and 6½ when interviewing started). Interviewees had either seen the researcher with her youngest daughter when recruiting in public, or had heard comments which implied this, such as “I know as parents *we’re* all pressed for time ...”. However, the researcher’s own family size, views and experiences were not known to the interviewees before the interview. The exceptions to this were the initial interviews with friends. In many instances the researcher’s personal situation did not surface during the interview, although a

few interviewees did enquire at the end as to her family size and how she was combining her time being a researcher with her role as a mother.

The fact that in this particular study the researcher was an “insider” as a parent of young children made it easy to establish rapport and to encourage interviewees to be open about discussing their experiences of parenthood. It also facilitated the accommodation of certain needs. One woman, for example, was interviewed as she followed her toddler round the garden to keep the child occupied; part of another interview occurred as the mother prepared lunch for her baby. One major benefit of being an “insider” in such instances was that of being used to holding conversations and working at the same time as caring for, or being interrupted by, young children. Being an insider also offered benefits when approaching kindergartens and playgroups, in being able to perhaps gauge more quickly when would be suitable times and ways to recruit parents. Several interviewees also commented that people who do not have children have little idea of what parenting is like and that it would be too much effort to explain everything to them. However, parents were still asked to elucidate issues from their standpoint to ensure a correct interpretation of any implied or non-specific answers. The researcher was also able to avoid the negative influence that being a parent herself might have on the interview by being conscious of the potential influence.

The researcher was conscious during the study of putting to others questions that she had asked, or was currently asking, of herself, and that this could potentially bias the conduct and analysis of interviews. Hence she was keen to ask others to elucidate their experiences. Since her third (and youngest child) was between ages 2 and 3 when interviews were conducted, she was at a similar stage to many interviewees in reflecting on influences on fertility and family size and wondering whether or not (around the age of 39) she and her husband wanted a fourth child or were ready to say their childbearing days were over. Also, at the time interviewing commenced, the researcher’s only sibling was, at the age of 36 and living in Sydney, wondering whether or not to start a family or to follow her (older) partner’s preference to remain childless. Her very different background, set of concerns and experiences made the researcher conscious during interview and analysis to double-check for broadness in the themes selected.

#### 4.6.11 Getting at “the truth”

What was said during interviews was generally taken at face value. However, since an interpretive approach was being taken, body language, tone of voice and initial reactions were also taken into consideration to gauge the *meaning* of what was said. The fact that the same researcher conducted, transcribed and interpreted all 62 interviews minimised between-interviewer bias and maximised the inclusion of non-written cues during transcription and their consideration in interpreting transcripts. Several interviewees made a point of commenting that the interview was conducted in a way which made them feel comfortable:

RESEARCHER: Are there any other comments you want to make or questions?  
 SARAH: Oh, you did the interview very well (laughs).  
 RESEARCHER: Oh thank you! It’s really hard to know.  
 SARAH: I found it very relaxing, it was good.  
 RESEARCHER: It’s more of a chat really isn’t it. I hope that’s how it comes across?  
 SARAH: Yeah, it was good.

Caldwell et al (1973:50) recommend that questions on experiences of feelings, no matter how intimate, cause little trouble as long as the interview schedule is organised so that a good rapport is established before such matters are broached. Some of the AFFSS interviewees felt comfortable enough to reveal very intimate details, for example one mother commented:

I don’t know how personal you want me to get ...but *before* when we were trying to get pregnant, when you have sex that’s all you’re thinking about, getting pregnant. Whereas now we know it’s not going to happen (laughs) you know, so it’s fantastic!! (laughs). Do you know what I mean!

The desire to reveal “the truth” as they saw it occurred as much with participants unrelated to the interviewer as it did during the pilot interviews with friends, and perhaps more so if people felt comfortable talking to a complete stranger. For example, one father said that:

I tried to be *as honest as I could* with the answers because I don’t think there’s any point coming across as the ideal father, because that isn’t going to help your survey... I love going home at the end of the day [and seeing the children], but within half an hour I’m glad I was at work today (emphasis added).

During the interview with another father, whose only child had been conceived through IVF, humour was used to build rapport over the phone and help the father feel comfortable discussing the subject of IVF and, as he put it, “going in those little rooms and things... to do

it, especially on cue”. This father seemed to have felt quite comfortable with the way the interview was conducted, with the conversation closing as follows:

- RESEARCHER: ... I’m really trying to get as many dads as I can because dads are normally not really talked to in depth about this sort of stuff [influences on family size] and they do have a slightly different perspective. How did you find the interview?
- ADAM: Oh, I’d do it again.
- RESEARCHER: Well, recommend it to all your friends!
- ADAM: I will! This lovely lady rings you, answer the questions! It’s not hard.

On some occasions the interview offered an opportunity for participants to discuss issues that they seemed to have not previously discussed. Although no-one became severely distressed, one mother had tears well up in her eyes as she recounted the difficulties of coping with first-time motherhood, and one father became angry during his phone interview about how he felt fathers were treated during the separation and divorce process. Another mother became animated with anger against her husband for his lack of support and, as her interview progressed, there was an air of guilt about divulging “secret information” and painting the partner in a negative light, but mixed with the desire to tell someone about this:

So when I came home, and *this is very personal, this is something I haven’t even discussed with him [husband]*, he really hurt me because he honestly didn’t think it was his child. He knew how adamant I was that I didn’t want children, and he thought my reaction was because I was pregnant with another man. How stupid is that! (emphasis added)

#### 4.6.12 Analysing the interview data

Following Ezzy (2002), this study did not use a “pure” grounded theory approach because data gathering was not un-influenced by pre-conceived theories. Rather, the analysis was an “ongoing simultaneous process of deduction and induction, of theory building, testing and rebuilding” where pre-existing theory helped orient the line of inquiry but did not constrain what was noticed (Ezzy 2002:10,12). An interpretive approach was used for analysis, since the interviews were designed to understand influences on fertility and family size from the individual’s viewpoint. Indeed, it is *perceptions* of life events, more than the events themselves, which shape actions and reactions (Kerr 1994: 13-14). In order to delve into these perceptions, two specific approaches were used. Firstly, thematic analysis was used because general issues of interest were known prior to analysis, but unanticipated issues could also be uncovered since the specific nature of categories and themes was not predetermined (Ezzy

2002:88). Potential codes and themes arose initially both during the interviews and during transcription, where coding categories were added to the transcript in bold type as ideas were generated whilst re-experiencing the live-voice tape. Further ideas were generated through ongoing readings of the literature so that analysis and theory-building became an interactive process. Ideas about the research questions and emerging themes were recorded in a notebook, while another notebook recorded reflective notes on methodological issues and fieldwork experiences. Informal discussion about the study's progress with people who were not involved in interviews (eg friends, neighbours, parents waiting to collect children at school), along with ongoing informal observation of discussions in the playground, at parent support group meetings, and in the media, also provided a sounding board to test emerging theories.

Preliminary analysis of the first ten interviews using QSR NUD\*IST generated over 200 codes, which expanded further after subsequent interviews. With such a richness of data, only new themes of major difference were added. Further categories were analysed in-depth with NUD\*IST on a selective basis as writing progressed, focussing on influences on numbers of children and parity progression. This analysis forms the basis for some of the interview-based tables which are intended to provide some indication of the extent of the phenomenon in question. However, they should not be seen as providing reliable statistical estimates of incidence, since selection of interviewees was not based on random sampling.

The second analytical approach was in the hermeneutic tradition, where interviews were interpreted for holistic meaning (Ezzy 2002), rather than being dismembered into coding categories to establish patterns. A strictly qualitative or ethnographic summary with direct quotations is therefore sometimes used (as outlined by D.L. Morgan 1988 and used in Pocock 2001). Interview excerpts in the thesis were selected to be representative in their meaning about particular key issues and to convey the deeper meaning of what was said or implied. Furthermore, one of the research objectives was to gauge the relativity of various influences on fertility and family size in individual cases. Since it was sometimes felt that using QSR NUD\*IST alone de-contextualised the data too much, whole transcripts were carefully re-read and interpreted in order to provide some indication of the relative and cumulative influences on family size from that interviewee's perspective. Following Caldwell (1976:vi), the qualitative data is presented in discussion of the main threads as well as by "letting those interviewed speak as much as possible in their own voices" by way of interview excerpts.

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## 4.7 THE PRECONCEPTION SURVEY

### 4.7.1 Background to the survey

An opportunity arose to conduct a smaller self-enumerated survey to gauge perceptions of influences on family size of people considering starting a family within 12 to 24 months when Preconception Seminars for the public were organised by Adelaide Community Healthcare Alliance (ACHA) as part of their marketing strategy.<sup>1</sup> These commenced in 2001 and ran until October 2002. The seminars were publicly advertised through the local press and attendance cost \$30 per couple for two three-hour evening sessions. They were not restricted to the holders of private health insurance. Information presented comprised an obstetrician discussing conception and infertility issues; a naturopath discussing health for conception and pregnancy; speakers on postnatal depression, miscarriage and stillbirth; a new parent couple with their young baby; the hospital finance officer outlining the costs of private maternity care; and the researcher of this study discussing the financial costs of having children.

### 4.7.2 Timing and length of the survey

The data collection stage was determined by the frequency of the seminars. Forms were distributed from the May 2002 seminars until the last seminar in October 2002, at which time a change in ACHA management led to “strategic decisions” to retrench staff and cease the seminars. This was despite positive feedback from attendees and despite the apparent marketing success of the seminars (90 per cent of attendees completing evaluation forms said they would choose an ACHA hospital for their maternity care).

### 4.7.3 Selecting respondents and conducting the survey

At the end of each seminar the researcher outlined the Fertility and Family Size study and invited attendees to participate by taking home a questionnaire, information sheet and pre-paid return envelope. Forms were completed by 42 per cent (see Table 4.3), compared with 54 per

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<sup>1</sup> ACHA is a private health care service organisation and the key provider of private hospital services for much of metropolitan Adelaide. In 2000-01 it owned the state’s newest and largest private hospitals respectively which provided, among other services, the two largest private maternity facilities for Adelaide.

**Table 4.3****Attendance and response rates from the Preconception Seminars**

Source: Adelaide Fertility and Family Size Study, Adelaide 2003-04

Date of seminar	Attended	Forms taken	Forms returned
May 2002	38	28	13
August 2002	35	35	22
October 2002	35	16	10
Total	108	79	45

cent who completed on-the-spot evaluation forms for the organisers. Of those taking AFFSS forms home, 57 per cent were returned in the reply-paid envelopes (45 forms). Although all forms were returned after the 11 September 2001 terrorist attack, and the October 2002 seminar was held only weeks after the Bali Bombing terrorist attack, world peace or politics were rarely mentioned as an impact on fertility and family size by these respondents.

**4.7.4 The survey questionnaire**

The survey questionnaire is provided as Appendix 6. The form collected demographic data and attitudinal data on family formation, family size and parenting, thoughts about work and parenting, and the usefulness of the seminars. Selection and wording of survey questions was made on a similar basis to that for the Interview Schedule (see section 4.6.8). The survey was designed to be completed in approximately 45 minutes by individuals who had never had a baby. Where couples were involved, each partner completed their own form.

**4.7.5 Analysing the survey data**

Survey forms were coded on receipt and personal identifying information was removed. Numerical and coded data were loaded by the researcher into SPSS to produce descriptive statistics and cross-tabulations. Written comments provided some qualitative data.

**4.8 CONCLUSION**

Against the background of Australia's low fertility rate (as discussed in Chapter 2) and in conjunction with the themes raised by the review of the literature (as discussed in Chapter 3), this chapter has explained the epistemological standpoint of the study and has argued that a "mixed methods" approach is the most appropriate to explore how macro-level fertility

patterns, which will be detailed in Chapter 5, are influenced by individual thinking and behaviour in relation to parenthood experiences, which will be detailed in Chapters 6 to 11. This chapter has emphasised how the study places a particular emphasis on understanding the views of both men and women from their own perspective and within their social context, as well as understanding differential impacts on those with smaller and large families. The views of some people intending to start a family will also be used to contribute to the discussion. Despite the intention to analyse family size outcomes by work-family preferences, as per Hakim's Preference Theory, the empirical research found that many parents were unable to answer the requisite questions for this to be calculated, and this is discussed further in Chapter 9. The next chapter provides information on the background of the study area of metropolitan Adelaide, and on the socio-economic environment and characteristics of interviewees and survey respondents who provided the qualitative data.



## **CHAPTER 5**

# **The study area and the study participants**

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The cultural process by which people construct their understanding of the world is inherently a geographical concern. In the course of generating new meanings and decoding existing ones, people construct spaces, places, landscapes, regions and environments

(Anderson K. 1999:5).

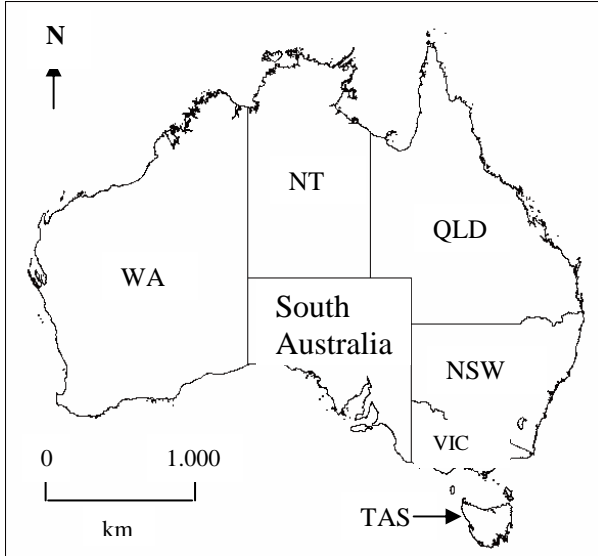
### **5.0 INTRODUCTION**

Previous chapters explain why this thesis considers social context and personal background important to fertility research. This chapter therefore provides background information about the study area and the interviewees and survey respondents. The first main section provides background information about the study area of metropolitan Adelaide, in the State of South Australia. It includes a detailed section on fertility and makes comparisons with the national trends and patterns described in Chapter 2. The second main section examines key characteristics of the interviewed parents and, where possible, makes comparisons with the wider population in order to identify how representative the non-random sample was. The third section provides a description of the four socio-economic areas selected for parent recruitment and some indication of the extent to which parents were representative of their area. Finally, the fourth section presents some characteristics of respondents in the preconception survey.

### **5.1 THE STUDY AREA**

#### **5.1.1 Geography and history**

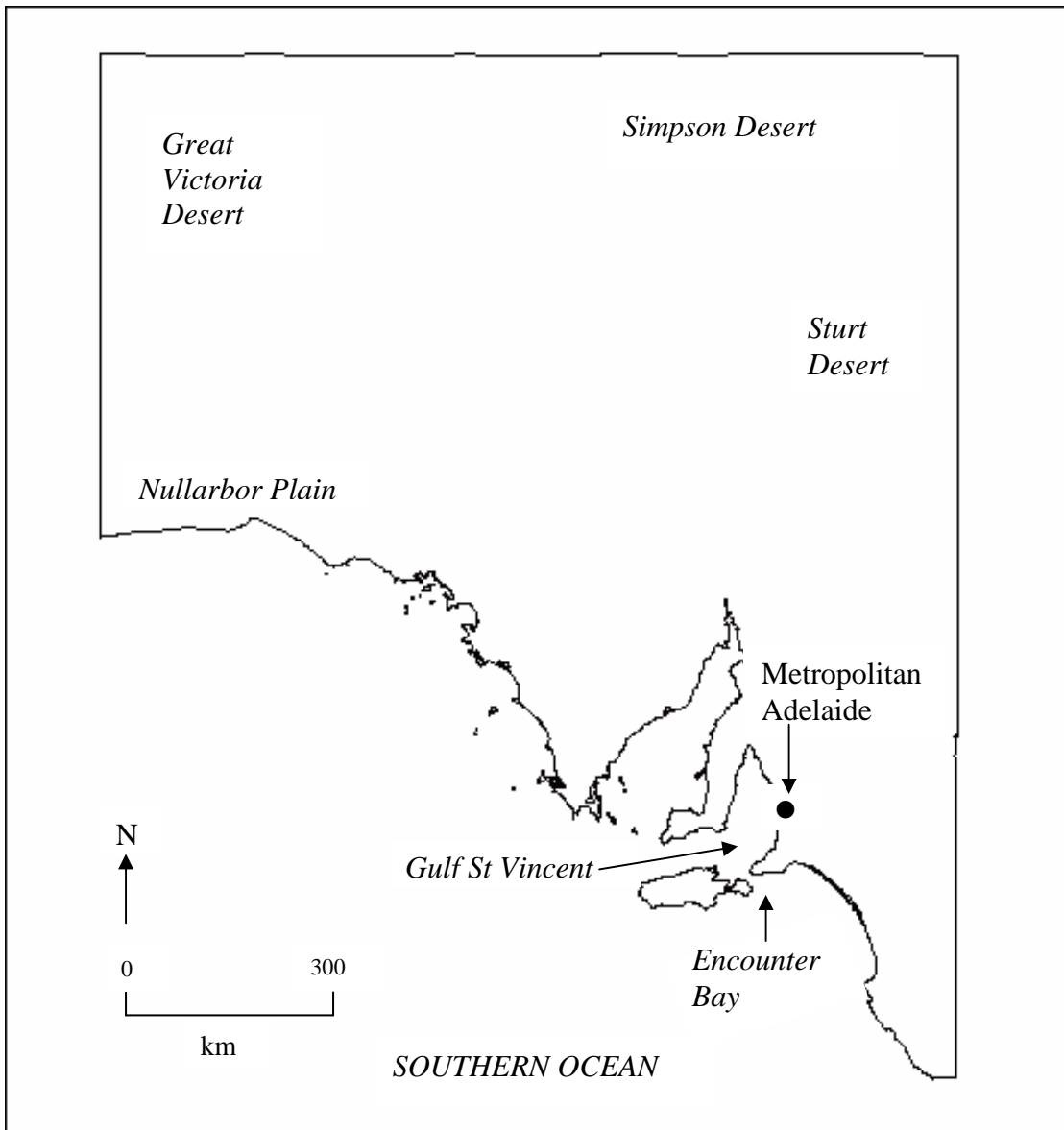
The Adelaide Fertility and Family Size Study (AFFSS) was conducted in metropolitan Adelaide, the capital city of the State of South Australia. Figure 5.1 shows the State's location



**Figure 5.1**

**Location of the study area**

Source: Compiled by the author based on University of Melbourne (2001) and Readers Digest Association (1977).



in south-central Australia, covering one-eighth the landmass of the continent (just over 985,000 kilometres) (ABS 1996a). Much of the State is covered by plains and desert, one-half the State is devoted to extensive pastoralism, and one-third has no significant economic use (ABS 1996a). The climate is Mediterranean in type and in summer mean maximum temperatures range from less than 25°C along the southern coasts to over 37°C in the far north (ABS 1996a). This accounts for most of the State's population (73 per cent) residing in metropolitan Adelaide which lies in the more hospitable area, centred on a plain facing the Southern Ocean and backed by a low range of hills. Adelaide has a higher urban concentration than Australia as a whole, for which the figure is 64 per cent (ABS 2004a).

Carbon-14 dates suggest that for at least 10,000 years before European settlement the Aboriginal people of the Kaurna tribe inhabited the area which later became metropolitan Adelaide (Ross 1984). The first recorded sighting of the South Australian coast by Europeans was in 1627, but the coast was not thoroughly explored by Europeans until 1802 (ABS 1996a). Isolated and intermittent whaling and sealing bases were then established in some areas. An 1833 report of *Two Expeditions into the Interior of Southern Australia* highlighted the potential for British settlement and further exploration focussed British interest on establishing settlement along Gulf St Vincent and Encounter Bay (ABS 1996a). In 1834 the British Government passed the South Australian Colonisation Act to enable free British settlers to take up this land (ABS 1996a). The Province was proclaimed in December 1836 and the city of Adelaide surveyed in 1837, when the first land allotments were made. By 1842 the Aboriginal population was estimated at only 700 (Ellis 1976), with many communities having been decimated by smallpox spreading west from other settled areas of the continent (Gara 1988). The Constitution Act of 1855 established a system of responsible government, at which point the State's population totalled almost 86,000 (ABS 1996a).

### **5.1.2 Economic development and population change**

Whereas the Aboriginal inhabitants had lived in "hunter-gatherer" groups, upon European settlement South Australia's economy became focussed on settled agriculture and mining (Prest 2001). This was encouraged by interstate and overseas demand for wheat, wool and minerals, particularly until the 1880s, and with manufacturing also playing a major role from the 1920s (Prest 2001:160). However, from the 1990s onward South Australia's gross state

product per capita was only 90 per cent of the national average (Prest 2001:160-161), and today represents only 6.5 per cent of Australia's GDP (ABS 2005d). Despite a growth in service industries from the 1980s and its leading role producing half of Australia's wine, South Australia is not well placed for other growth industries (ABS 2005d, 2005e; Prest 2001). However, new sectors of information technology, property services and education are being developed, and tourism is being actively promoted based on the State's natural and cultural endowments (Government of SA 2005).

South Australia's economic fortunes have fluctuated widely over time, interlinked with population growth. Indeed, population growth rates only exceeded the national rate during two periods, namely 1861 to 1881 when mining and farming were rapidly expanding, and 1947 to 1966 when manufacturing growth was coupled with a programme of European immigration (Prest 2001:353-354). For 150 years the State has subsidised immigration to meet perceived economic and social requirements (Prest 2001). The highest proportionate increases in population occurred in the post-war years until 1954, and population growth rates remained well above the national average until the mid 1960s (Prest 2001:xv). However, this was followed in the 1970s by relative decline in both economic prosperity and demographic expansion (Prest 2001:161). Despite these economic characteristics, metropolitan Adelaide offers cheaper housing than in the eastern states (with prices half those in Sydney and two-thirds those of Melbourne), and is one of the world's least expensive cities even though it offers a cosmopolitan lifestyle and one of the highest standards of living of anywhere in the world (Government of SA 2005). These aspects are currently being used by the State government to attract immigrants in greater proportions.

### **5.1.3 Immigration**

Immigration is an important component of population in the Australian context. Indeed, the overseas-born represent 21 per cent of South Australia's population (compared to 23 per cent nationally), with approximately 9 per cent born in the United Kingdom and Ireland, 16 per cent in Europe and the former USSR, and 3 per cent in East and South-East Asia; less than 2 per cent are of Aboriginal descent (ABS 2004a). More recent changes in migrant origin are reflected in distribution, with European-born migrants more likely to live outside urban areas, but over 95 per cent of Asian migrants, for example, remaining in urban areas (ABS 2004a).

Despite taking migrants predominantly from Germany, Italy, Greece and Eastern Europe after World War II, South Australia was characterised by relatively homogenous immigration until the 1970s, with only 10 per cent of the population born in non-English speaking countries and the majority coming from the UK and New Zealand (Prest 2001:354).

South Australia is situated away from the main concentration of population and economic activity centred on Sydney (1,400km away by road) and Melbourne (700km away) and which have attracted half of all Australia's immigrants (ABS 2004a). In the late 1960s South Australia's share of overseas migrants was 10 per cent (64,766 persons), but fell to 3.7 per cent by 2002 (3,316 persons) (Clarke 2003). The State's failure to attract migrants has been a concern and partly reflects the lack of a large migrant community to which new migrants can be drawn (Hugo, in Clarke 2003:70). However, from 1996, State Specific Migration Mechanisms were introduced to encourage overseas migrants to regional areas to address labour shortages. The biggest impact was in South Australia and Victoria, for which 17 per cent and 52 per cent of the 25,000 visas respectively were granted (ABS 2004a).

#### **5.1.4 Fertility trends**

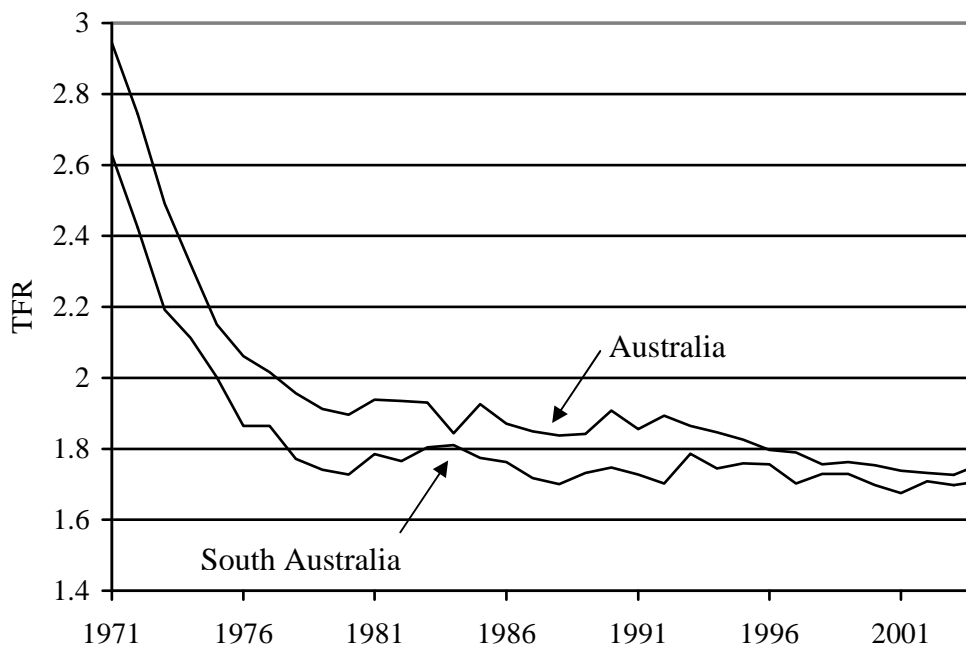
Since the focus of the thesis is on influences on fertility in metropolitan Adelaide, this section provides considerable detail on fertility trends and patterns for this city and the State of South Australia. The influences on fertility discussed in Chapters 2 and 3 are not repeated here, but since trends and patterns can vary both across and within different settings (as noted in Chapter 4, section 4.1) variations at the state level are emphasised where they deviate from the national level identified in Chapter 2.

Chapter 1 has already noted that South Australia is a suitable location to conduct research into low fertility because it has the third lowest fertility rate in the nation (ABS 2004a, 2005b). Furthermore, over much of its European history South Australia's fertility has been significantly lower than that of the other States and Territories (Hugo 1983a). Despite this lower rate, South Australia's fertility since World War II has generally followed the national trend of a sharp increase in the early post-war years, followed by a steep decline between the early 1960s and mid 1970s when fertility fell below replacement level (Hugo 2002a:29). In recent years, however, South Australia's fertility rate has not declined as steeply as the

national rate and has fluctuated only slightly either side of 1.7 (Hugo 2002a), contributing to a convergence as shown in Figure 5.2. Reasons for difference and convergence between the State and national rates are suggested in later sections in relation to education, religion and migration trends. An additional contributing factor assisting those with children may be Adelaide's housing costs. These are cheaper than in the eastern states (Government of SA 2005) where the major centres of population are located.

**Figure 5.2**  
**Total Fertility Rates, Australia and South Australia, 1971 to 2004**

Source: ABS (2000, 2004b, 2005b).



#### 5.1.4.1 Levels of childlessness

Chapter 2 noted how childlessness was one factor contributing to lower overall fertility rates. Table 5.1 shows the levels of childlessness for Adelaide women at the 1996 census. A significant difference is noticeable between the 25-29 and 30-34 year groups, and also between the 30-34 and 35-39 year groups, which reflects the trend of delayed childbearing to older ages. However, Table 5.1 shows that despite 14.4 per cent of women aged 40-44 having borne no children, the completed family size was still 2.0 children. Table 5.2 will show that this level of childlessness was balanced by 30 per cent of women this age having three or more children.

**Table 5.1****Mean number of children ever born per woman and rates of childlessness  
Adelaide Statistical Division, 1996 census**

Source: Compiled by the author from ABS 1996 Census of Population &amp; Housing, unpublished data

	Age groups				
	25-29 Born 1967-71	30-34 Born 1962-66	35-39 Born 1957-61	40-44 Born 1952-56	45+ Born 1951 or before
Mean number of children per woman	0.7	1.4	1.9	2.0	2.5
Percentage childless	58.9	31.2	18.6	14.4	10.6

*5.1.4.2 Delayed childbearing*

Delayed childbearing is the second main factor contributing to overall lower fertility rates. The national trend of delayed childbearing discussed in Chapter 2 is reflected in South Australia, with the proportion of mothers aged 35 or over in South Australia increasing almost fourfold from 4.6 per cent in 1981 (Department of Human Services (DHS) 2003:57) to 17.7 per cent in 2003 (Department of Health 2005:61). This compares with 18.8 per cent aged 35 or over nationally in 2003 (AIHW 2005:13). South Australian first-time mothers are slightly younger than the national average, at 27.1 years in 2003 (Department of Health 2005:61) compared with 27.6 years nationally (Australian Institute of Health & Welfare (AIHW) 2005:14). Nevertheless, 36.3 per cent of first-time mothers in South Australia in 2003 were aged 30 or older (Department of Health 2005:61). The influence of higher education on delayed childbearing and parity progression is discussed later in section 5.1.5.2.

**5.1.5 Patterns in fertility and family size**

The latest data on family size distribution for South Australian women with near-completed fertility is provided in Table 5.2. This shows that Adelaide mirrors the national pattern, although it had slightly higher proportions of women with zero or one child, and somewhat lower proportions with three or more children. The table also shows the continuation of urban-rural fertility differences noted in Chapter 2, with the 75 per cent of South Australian women resident in metropolitan Adelaide having 2.01 children, compared with the 2.26 children of

their rural counterparts. Metropolitan women were also more likely to be childless or to have one child, and less likely to have four or more children.

**Table 5.2**

**Distribution of number of children ever born, women aged 40-44 years<sup>\*1</sup>, 1996 census**

Source: Compiled from ABS Census of Housing & Population 1996, unpublished data, except data for Australia from McDonald (1998)

Per cent	Number of children						
	None	One	Two	Three	Four	Five or more	Mean number
Metropolitan Adelaide <sup>*2</sup>	14.4	12.7	42.9	21.0	6.6	2.4	2.01
Rest of South Australia	8.8	8.6	39.4	26.3	10.1	3.6	2.26
Australia	12.8	11.3	38.2	24.6	13.2		2.17

\*1 The age group 40-44 years is used to estimate near-completed fertility without moving into cohorts born too long ago. However, the parent interviews in Adelaide suggest age 50-54 would be a better category, particularly in an era where the decimal points of fertility change are of significance. In 2002, 3 per cent of Australian women giving birth were at or over age 40, compared with 4.9 per cent at or below age 20; 2.7 per cent of South Australian giving birth were at or over age 40 (AIHW:2004:12).

\*2 As represented by Adelaide Statistical Division.

#### *5.1.5.1 Religious affiliation and denomination*

Chapter 2 noted how fertility decline has been associated with an increase in secularisation and a decline in the influence of religion. This was reflected in a narrowing of fertility differentials between major Christian denominations, so that in South Australia more recently at the aggregate level the major differential by religion has been higher fertility among Muslim groups (Hugo 2004:24). However, Table 5.3 shows that Muslim women, along with Jewish, Buddhist and Hindu women, represented only two per cent of metropolitan Adelaide women aged 40-44 at the 1996 census, and their behaviour cannot therefore be expected to strongly influence overall patterns. Themes emerging from the AFFSS parent interviews and preconception survey in fact suggested that it would be worthwhile disaggregating fertility data by Christian denomination, as shown in Table 5.3.

Table 5.3 shows that in 1996, Adelaide women in New Protestant religious groups had the highest fertility, with an average 2.43 children. Catholicism's earlier dominance of Australian higher fertility (as discussed in Chapter 2) has never been as prominent in South Australia, where the religious profile reflects the historical sources of immigrants. Indeed, along with Catholics and Anglicans as the dominant groups, the State has always had a strong over-



**Table 5.3**

**Mean number of children ever born and religion, women aged 40-44 years<sup>\*1</sup>,  
Adelaide Statistical Division, 1996 census**

Source: Compiled from ABS 1996 Census of Population & Housing, unpublished data

	Number of women	Percentage women	Mean number children
New Protestant <sup>*2</sup>	1,023	2.6	2.43
Other Christian (28, 29) <sup>*3</sup>	191	0.5	2.33
Buddhist/Hindu/Muslim/Jewish (1,3, 4, 5)	802	2.1	2.21
Baptist/Methodist/Presbyterian etc <sup>*4</sup>	2,480	6.4	2.11
Orthodox (221, 223)	1,115	2.9	2.10
Catholic (207)	8,925	23.1	2.08
Lutheran (217)	1,367	3.5	2.05
Uniting Church (2331)	4,781	12.4	2.01
Anglican (2011)	6,753	17.5	2.00
Other Religions (6) <sup>*5</sup>	189	0.5	1.97
Not stated/inadequately described	3,317	8.6	1.93
No Religion (7) <sup>*6</sup>	7,719	20.0	1.85
Total	38,662	100.0	2.01

- 1 Excludes 1,219 women giving no number of children (of whom 16% Catholic, 11% No Religion, 8% Anglican, 6% Uniting, 46% not stated). Slightly undercounts since numbers above 6 were taken as 6 for calculations
- 2 Includes eg Brethren, Jehovah's Witnesses, Latter Day Saints, Pentecostal . The division into "New Protestant" and "Old Protestant" groups follows Southworth (2005:83) who identifies "historic" churches (Church of England/Anglican and Catholic), "Old Protestant" churches (eg Baptists, Methodists), and "New Protestant" churches (eg Seventh Day Adventists, Jehovah's Witness). This division is considered important since comparison of census data for 1947, 1991, 1996 and 2001 (Bouma 1997, 2002) shows that mainstream Christian groups (apart from Catholics) are declining in the proportion of population which they represent, while many small religious groups are flourishing.
- 3 "Other Christian" includes eg Christadelphians, Religious Society of Friends (Quakers), Christian Science; "Other Protestant" includes Aboriginal Evangelical Missions, Born Again Christian, Congregational and Wesleyan Methodist.
- 4 Includes Baptist, Methodist, Reformed, Presbyterian, Salvation Army.
- 5 "Other Religions" include for example Australian Aboriginal Traditional Religions, Baha'i, Chinese and Japanese Religions, Nature Religions, Sikhism and Church of Scientology.
- 6 Includes No Religion, Agnosticism, Atheism, Humanism and Rationalism

representation of Non-conformist groups (Hugo 1990). Hugo (2004:6-7) believes that one possible explanation for the State TFR generally having been lower than the national rate is its lower proportion of population being Roman Catholic (see Table 5.20 in section 5.3.7).

Table 5.3 also shows that in Adelaide the differentials between those With and Without a religion are important, with women with No Religion having the lowest fertility with an average of 1.85 children. This has important implications for fertility trends, considering that

the proportion of Australians with No Religion rose from under 1 per cent over the period 1901 to 1966, to 7 per cent in 1971 (ABS 2001, 2005d), and up to 17 per cent in 1996 (Bouma 1997). However, the implications for fertility of a slight fall between 1996 and 2001, to 15.5 per cent with No Religion (Bouma 2002), are as yet unclear.

In considering the contribution of parity differences to overall fertility rates it is also interesting to consider the distribution of number of children by religious group. Table 5.4 shows that the small group of Other Christian women, who have an average of 2.33 children, demonstrate the point made in Chapter 2 that the proportions of women having three or more children make an important contribution to fertility rates, and that higher rates of childlessness (of 19 per cent in this group) do not necessarily lead to below replacement level fertility levels if they are countered by large proportions of women at or above parity three (47 per cent in this group). Furthermore, it is also interesting to note that while Adelaide women with No

**Table 5.4**  
**Distribution of number of children ever born and religion, women aged 40-44 years<sup>\*1</sup>, Adelaide Statistical Division, 1996 census**

Source: Compiled from ABS 1996 Census of Population & Housing, unpublished data. Religious groups are as per the Australian Standard Classification of Religious Groups (ASCRG) (ABS 1996b)

Per cent	Number of children						Mean number children
	None	One	Two	Three	Four or more	Total	
New Protestant <sup>*2</sup>	11.2	10.0	33.4	24.3	21.0	100.0	2.43
Other Christian (28, 29) <sup>*3</sup>	18.8	8.9	25.1	24.1	23.0	100.0	2.33
Buddhist/Hindu/Muslim/Jewish (1,3, 4, 5)	14.6	15.0	32.2	22.6	15.7	100.0	2.21
Baptist/Methodist/Presbyterian etc <sup>*4</sup>	13.8	10.8	41.1	23.2	11.1	100.0	2.11
Orthodox (221, 223)	11.1	12.0	44.0	24.2	8.6	100.0	2.10
Catholic (207)	13.3	12.1	41.6	22.9	10.0	100.0	2.08
Lutheran (217)	13.1	12.1	43.8	21.3	9.7	100.0	2.05
Uniting Church (2331)	12.8	11.7	46.8	21.5	7.2	100.0	2.01
Anglican (2011)	13.5	11.9	45.9	21.0	7.7	100.0	2.00
Other Religions (6) <sup>*5</sup>	21.2	14.3	31.2	20.6	12.7	100.0	1.97
Not stated/inadequately described	15.9	13.3	43.6	18.9	8.4	100.0	1.93
No Religion (7) <sup>*6</sup>	17.2	15.3	42.3	18.1	7.2	100.0	1.85
Total	14.3	12.7	42.9	21.1	9.1	100.0	2.01

Notes 1-6: See notes for Table 5.3.

Religion had the lowest average family size of 1.85, they did not have the highest rates of childlessness (this was 17 per cent, compared with 19 per cent for the Other Christian women), but they did have the lowest proportions with three or more children (25 per cent compared with the 47 per cent of the Other Christian women). The relationship between fertility and religion becomes more interesting still when combined with education level, and this is discussed in section 5.1.5.3, after trends according to education level alone.

#### 5.1.5.2 Education level

The relationship between education and lower fertility which was detailed in Chapters 2 and 3 is reflected in Adelaide. Table 5.5 indicates that at age 40-44 it was the fertility behaviour of Adelaide women with basic or no post-school qualifications (who represent almost two-thirds of all women) which kept overall fertility close to replacement level at 2.02. The average family size was 2.11 for these women, compared with 1.74 for those with a Bachelors degree and 1.55 for postgraduates. The table also shows a relationship between higher education level and later commencement of childbearing (as discussed earlier in section 5.1.4.2), with a 5 to 10 year age difference. Adelaide mothers with no post-school qualifications aged 15-19 had had already had 0.05 children in 1996, whereas with women with a bachelors or postgraduate qualification and this number of children were in the 20-24 age group. Similarly, those with

**Table 5.5**  
**Mean number of children ever born, education level and age, Adelaide Statistical Division, 1996 census**

Source: Compiled from ABS 1996 Census of Population & Housing, unpublished data

	Age group							Total%
	15-19	20-24	25-29	30-34	35-39	40-44	45+	
Postgraduate	0.00	0.06	0.22	0.76	1.30	1.55	1.88	4.7
Bachelor degree	0.00	0.04	0.21	0.89	1.51	1.74	2.03	10.4
Undergraduate or Associate Diploma	0.08	0.08	0.41	1.16	1.73	1.95	2.26	10.4
Skilled/basic vocational qualification	0.03	0.15	0.56	1.30	1.82	2.00	2.31	8.4
Level of attainment inadequately described	0.00	0.20	0.53	1.21	1.77	1.87	2.20	6.2
Level of attainment not stated	0.04	0.24	0.76	1.45	1.89	2.06	2.36	
No post-school qualifications	0.05	0.33	0.91	1.57	1.98	2.11	2.53	60.0
Total	0.05	0.25	0.71	1.40	1.85	2.02	2.45	100%

no post-school qualifications who had almost 1.0 children (0.9) were in the 25-29 age group while women with a bachelors degree and a similar number of children (0.89) were in the 30-34 age group. However, it is important to remember that women with university qualifications represented only 15 per cent of all women, so that the fertility behaviour of the least-educated women (60 per cent) currently dominates. This is one reason why the thesis recruited interviewees from different socio-economic areas.

#### 5.1.5.3 *Education level and religion*

Education and religion were once the major cultural divisions in Australia with respect to views on, and attitudes towards, family size (Ruzicka & Caldwell 1982:220). This section will briefly consider contemporary fertility data by these two variables together since some interesting links emerged from the qualitative component of the AFFSS. These links are explored in greater detail in Newman and Hugo (forthcoming). Table 5.6 shows that in metropolitan Adelaide at the 1996 census, within all religion groups for women aged 40-44 years, family size was lowest for those with the most education and highest for those with the least education, although the trend between extremes was not linear in all cases. Even within religion groups with above replacement family size at the aggregate level, it was the less-well educated women who had the larger families. The average 1.5 children of the postgraduates with Buddhist/Muslim/Hindu/Jewish religions, for example, was balanced by the 2.48 children of women in the same religion group with no qualifications, to give an overall average of 2.21. Table 5.6 also shows that patterns varied *within* education level. For example, whilst the average family size for those in the No Religion group was 1.85 children overall, for Postgraduates with No Religion it was 1.33 but for those with no post-school qualifications and No Religion it was 2.05. Similarly, although Postgraduates overall averaged 1.53 children, family size was as high as 1.95 for Lutheran women.

It is worthwhile focussing on the family size distribution of Adelaide women with university-level education, since they have the lowest fertility overall. Furthermore, differences in influences on fertility and on how women adjust to motherhood, according their education level, socio-economic status and social construction of motherhood, will be considered in later chapters. Table 5.7 shows that some university-educated women in Adelaide exhibited the

**Table 5.6****Mean number of children ever born, religion and education level, women aged 40-44 years, Adelaide Statistical Division, 1996 census**

Source: Compiled from ABS 1996 Census of Population &amp; Housing, unpublished data

	Post-graduate	Bachelor	Under-graduate & associate diploma	Skilled/basic vocational	No post-school	Total	No. of women
New Protestant <sup>*2</sup>	**1.94	2.12	2.42	2.34	2.51	2.43	1,023
Other Christian (28, 29) <sup>*3</sup>	*0.60	**2.20	**2.00	**2.52	2.56	2.33	191
Buddhist/Hindu/Muslim/Jewish (1,3, 4, 5)	1.50	1.72	1.96	1.61	2.48	2.21	802
Baptist/Methodist/Presbyterian etc <sup>*4</sup>	1.55	1.97	2.28	2.23	2.11	2.11	2,480
Orthodox (221, 223)	1.36	1.58	1.78	2.07	2.22	2.10	1,115
Catholic (207)	1.59	1.81	2.03	2.06	2.16	2.08	8,925
Lutheran (217)	1.95	1.82	1.96	2.14	2.08	2.05	1,367
Uniting Church (2331)	1.80	1.83	2.01	2.06	2.04	2.01	4,781
Anglican (2011)	1.69	1.92	2.00	1.98	2.03	2.00	6,753
Other Religions (6) <sup>*5</sup>	1.58	**1.83	**1.45	**1.91	2.13	1.97	189
Not stated/inadequately described	1.44	1.71	1.79	1.88	2.05	1.93	3,317
No Religion (7) <sup>*6</sup>	1.33	1.50	1.69	1.80	2.05	1.85	7,719
Total	1.53	1.74	1.95	2.01	2.11	2.01	38,662
Percentage of all women stating number of children	4.7%	10.4%	10.4%	8.5%	6.0%	60.0%	100%

Notes 1-6: See notes for Table 5.3.

\* denotes &lt; 10 women in cell; \*\* denotes &lt; 25 women in cell.

traditional positive relationship between fertility and particular religions which was identified in Chapter 2. Catholic women, for example, accounted for 28 per cent of those with four or more children. However, they also represented respectively 19 and 22 per cent of university-educated women with no child or one child. The existence of two different groups of Catholic women may relate to differences in levels of religiosity, with Westoff and Potvin (1967) finding that education in church-based institutions in the USA was associated with higher fertility than education in secular institutions. A more recent analysis of Spanish Fertility Surveys (Adsera 2005) also showed that fertility was significantly higher among practising Catholics than non-practising Catholics.

**Table 5.7****Number of children ever born and religion of university educated<sup>1</sup> women aged 40-44 years, Adelaide Statistical Division, 1996 census**

Source: Compiled from ABS 1996 Census of Population &amp; Housing, unpublished data

Percent	Number of children				
	None n=1,388	One n=852	Two n=2,277	Three n=981	Four or more n=338
No Religion	35.8	35.2	27.6	24.0	13.9
Catholic	18.8	21.6	19.8	20.0	28.1
Anglican	13.0	10.6	15.5	17.4	18.9
Old Protestant	16.7	15.1	19.9	23.3	24.3
New Protestant/Other Protestant/Other Christian	3.9	3.9	3.6	4.2	5.6
Buddhist/ Hindu/ Muslim/Jewish/Other Religions	3.0	5.5	4.0	3.1	3.0
Inadequately described	9.0	8.1	9.7	8.1	6.2
Total	100.0	100.0	100.0	100.0	100.0

1 Bachelors and postgraduate qualifications

For explanation of which denominations are included in which grouping see Table 5.3.

The combined fertility-lowering effects of having a university education *and* No Religion is also highlighted by the family size distribution in Table 5.7, where Adelaide women with these characteristics represented two and a half times as many women in the group with no child or one child as they did in the group with four or more children. It will be interesting to see whether these differences remain when these women reach the 50-54 year age group in the next census which collects “number of issue” data (in 2006), by which time some of those with zero and one child may have progressed to higher parities. It will also be interesting to see what the patterns are for women moving through the lower age groups.

#### 5.1.5.4 Ethnic status

Chapter 2 discussed fertility differences by ethnic status at the national level, and section 5.1.5.1 has already noted how the historical sources of migrants to South Australia influenced its ethnic composition, which in turn influenced fertility differentials through their associated religious and cultural background. Chapter 2 (section 2.3.4) also noted how post-war fertility for Indigenous women has been higher than that for non-Indigenous women. In South Australia at the 1996 census, Indigenous women aged 40-44 had had an average of 2.9 children compared with 2.1 for non-Indigenous women (Hugo 2004:21). However, this

difference is likely to have minimal effects on the State TFR, considering that only 2 per cent of South Australians are of Aboriginal descent.

#### 5.1.5.5 Socio-economic status

Chapter 2 noted how many of the variables influencing fertility clustered together in the variable of socio-economic status, and that in recent Australian cohorts there has been a strong inverse relationship between fertility and socio-economic status. Table 5.8 shows that metropolitan Adelaide reflects this national pattern across all age groups. Women aged 40-44 living, for example, in status area Highest B had an average of 1.7 children, compared with an average of 2.3 children for the same-aged women in status area Lowest A. Table 5.8 also indicates the later start to childbearing associated with better educated (higher status) women, with women in status area Lowest A with 1.28 children being in the 25-29 age group, while those in status area Highest B with 1.30 children were in the group ten years older.

**Table 5.8**  
**Mean number of children ever born to women in selected socio-economic areas<sup>1</sup>,**  
**Adelaide Statistical Division, 1996 census**

Source: Compiled from ABS 1996 Census of Population & Housing, unpublished data

Area by socio-economic status	Age group						
	15-19	20-24	25-29	30-34	35-39	40-44	45+
Lowest A	0.13	0.65	1.28	1.87	2.20	2.30	2.92
Lowest B	0.07	0.42	1.07	1.72	2.12	2.20	2.60
Lower-Middle	0.03	0.18	0.72	1.58	2.02	2.05	2.36
Upper-Middle	0.01	0.06	0.40	1.29	1.80	1.98	2.33
Highest A	0.02	0.09	0.29	1.03	1.63	1.84	2.15
Highest B	0.03	0.06	0.22	0.83	1.30	1.71	2.13
Adelaide average	0.05	0.25	0.71	1.41	1.86	2.01	2.45

<sup>1</sup> The delineation and selection of areas is detailed in Chapter 4.

Despite these differences, Table 5.9 shows that at age 40-44 all areas had women who ranged from having had no children to those who had five or more. Nevertheless, as with the distribution by religion, it is the relative proportions of women at different parities which influence overall fertility rates for areas. For example, status area Lowest A had 50 per cent more women with three or more children than did status area Highest B (37.4 per cent and 24.2 per cent of women respectively). Similarly, the proportion with no children was over three times higher in the highest status areas (for example, 26 per cent in status area Highest B

compared with 7.5 per cent in status area Lowest B), although it could be argued that some recuperation could occur by the time the women in area Highest B reach age 50-54 at the 2006 census. The lower status areas also had higher percentages of women with two or more children (around 80 per cent compared with 65 per cent in the higher status areas). Patterns were similar for the 35-39 year olds although this is not presented here in a table.

**Table 5.9**

**Distribution of number of children ever born to women aged 40-44 years in selected socio-economic areas, Adelaide Statistical Division, 1996 census**

Source: Compiled from ABS Census of Housing & Population 1996, unpublished data, except data for Australia which is from McDonald (1998)

Socio-economic status area	Percentage						Mean number children
	No children	One child	Two children	Three children	Four children	Five or more children	
Lowest A	9.7	11.0	41.9	23.2	8.4	5.8	2.30
Lowest B	7.5	10.9	48.4	23.8	6.9	2.6	2.20
Lower- Middle	9.0	13.0	50.0	21.5	5.7	0.9	2.05
Upper-Middle	16.3	9.0	46.2	20.8	5.2	2.3	1.98
Highest A	17.1	12.5	45.6	20.1	3.9	0.8	1.84
Highest B	26.3	14.7	34.6	16.2	6.7	1.3	1.67
Adelaide SD	14.4	12.7	42.9	21.0	6.6	2.4	2.01
Rest of State	8.8	8.6	39.4	26.3	10.1	3.6	2.26
Australia total	12.8	11.3	38.2	24.6	13.2		n.a

Research by Faulkner (2005) shows that in metropolitan Adelaide from the 1976 to 1996 census fertility has consistently reflected this socio-economic pattern, with fertility being lower in the inner suburbs and rising with distance from the city centre, and with contrasts becoming sharper over time. Intra-urban migration is seen to play a role in shaping these differentials, with those starting families being more likely to move to cheaper low-density housing in the outer suburbs (which are also generally lower socio-economic areas), while singles and couples concentrate in inner suburban higher density housing (with their generally higher socio-economic status). However, these trends undoubtedly also reflect lifestyle preferences between different socio-economic groups, since it is difficult to imagine, for example, well-educated professional couples moving to lower status outer suburbs when they start a family, although they may well move from area Highest B, leaving it with its higher proportion of childless women (which may be linked to its higher prevalence of units and inner-city style living), to go to area Highest A, thereby contributing to its higher fertility (which may be associated with a greater prevalence of family homes on larger blocks).



### **5.1.6 Population decline and ageing**

Along with decreasing levels of immigration, at least until very recently, and declining fertility, South Australia has experienced net population loss to interstate and overseas, and particularly those of working age and with higher skills and higher incomes (Government of SA 2004). However, since higher education is often linked to lower fertility rates, this selective loss may mean that groups prone to higher fertility remain more strongly represented in South Australia (Hugo 2004:9). This may partly explain the increasing convergence of the national fertility rate with that of South Australia, as noted in section 5.1.4.

Along with the net loss of younger people there has been a rise in the percentage of the population aged 65 or older, giving South Australia the nation's highest proportion aged over 65 by 2003 (14.9 per cent, compared with 12.8 per cent nationally) (ABS 2004a). Generally high living standards are reflected in South Australia also having the nation's highest median age at death, and a life expectancy (for 2001-03) of 77.7 years for males and 82.7 years for females (ABS 2004a). These factors, combined with a fertility rate which is not rising, has led to population growth which has been the lowest of the mainland states over much of the last decade (Hugo 2004:1). Indeed, for 2002-03 it was only 0.6 per cent, compared with other states ranging from 0.8 per cent (New South Wales) up to 2.3 per cent (Queensland) (ABS 2004a). South Australia's population had reached 1 million in 1966, and by 2004 was estimated to be 1.53 million, or just under 8 per cent of the national total (ABS 1996a, 2005e). However, predictions are that the proportion aged 65 and over will keep rising, and population size will begin to decline in the third decade of this century (Hugo 2002b:2).

### **5.1.7 South Australia's Population Policy (2004)**

As noted in Chapter 2, most analysts argue that Australia should aim for a demographically stable population age structure. For South Australia this would mean increasing population to around 2 million and then stabilising it (Hugo 2002b:2). As the twenty-first century arrived, the "problems" of an ageing and declining population led the State government to release a Population Policy to boost future economic growth by maintaining the current national population share, doubling the current population growth rate, and achieving a state population of 2 million by mid-century (Government of SA 2004:1). Despite acknowledging fertility as

“the most important long-term factor” in this and that “stabilising fertility *at least* at current levels must become a high priority”, the Policy focusses on 20 migration-related strategies, and although it does contain eleven fertility-related strategies these only address work flexibility, childcare provision and a “Return to Work” scheme for parents.

The minimal incorporation of fertility-related strategies in this Policy to address the more private aspects of reproduction was already noted in Chapter 3 (section 3.4.2). In contrast to migration issues, the State government believes that fertility change will require “a more widespread and fundamental cultural shift... by men, workplaces, and the larger community” (Government of SA 2004:14). The required types of change were discussed in Chapter 3 in relation to gender equity theory and the social construction of motherhood. However, this thesis will argue that governments can do more than they currently believe to improve the private aspects of reproduction through their general philosophical outlook, and through the control and influence which they have over systems of education, maternity care, health, and family and community services. To understand the particular cultural shift that may be required in South Australia, it is important note that the dominant cultural and family values reflect those of Australia as a whole, as discussed in Chapter 3. Indeed, the main sources of South Australia’s past immigration were mainly Northern and Western Europe, and McDonald (1995) notes that these groups were largely indistinguishable in terms of having similar breadwinner-based family values.

## **5.2 THE STUDY PARENTS**

Against this wider background, this second section describes characteristics of the four selected socio-economic areas in the AFFSS from which parents were recruited for interview, and also considers how representative the interviewed parents were of their area. Descriptions of areas are based on personal observation at the time of interviews, and characteristics described in *Adelaide: A Social Atlas 2001* (ABS 2002e).

### **5.2.1 The highest status area**

**Interviewees:** *Mothers 11, fathers 6 (5 fathers too busy or “too private” to be interviewed)*

This is an old-established inner metropolitan area with some of the most prestigious suburbs of Adelaide. Located 5 to 10km (or 5 to 10 minutes drive) from the Adelaide central business

district (CBD), it lies on gently sloping land with quiet leafy streetscapes. Houses are large, even grand, and set back from the road on large blocks of land; many date from colonial times. Most gardens are well-established and well-manicured, with brush or ironwork fencing. Wide streets are lined with wide grassed verges and old-established exotic shade trees. A prevalence of newer Australian or expensive European cars (eg BMW, Audi) is noticeable.

The area has large percentages of people with high household incomes of at least \$100,000 per year, which is three or more times the average household income for Adelaide of \$31,000 (ABS 2002e). The area also has high percentages of people with university qualifications, (including postgraduate specialisation), with professional occupations, high levels of home ownership and houses in the highest price bracket. Most interviewed families in this area had these characteristics: in most couples both parents were university-educated, and over half had at least one partner with postgraduate qualifications; most had professional or managerial status. The exception was a couple who had gained Year 12 qualifications and worked their way to management in business. For this reason, and the influence of downshifting, differences in length of time in the workforce or of residency in Australia, their current or former occupation group was a better indicator of status than income or education. However, almost half the families had a household income of \$100,000 or more, and a quarter earned \$80-\$100,000. A few were home owners but most were purchasing, with repayments ranging from \$600 to \$1600 per month (from equal to double the metropolitan median: ABS 2002e). One couple were recent business migrants and were privately renting. No single parents could be recruited but several parents were in second marriages or second relationships. Most fathers had full-time paid work, but one was part-time, another was studying after retrenchment, and another had been a “full-time” father for four months while his wife worked full-time.

### **5.2.2 The upper-middle status area**

**Interviewees:** *Mothers 11, fathers 7 (4 fathers were too busy or too private for interview)*

This is a middle-outer area of Adelaide situated on undulating land, approximately 15 to 20km or (15 to 20 minutes drive) from the CBD. It is quiet and leafy with streetscapes of native vegetation. Houses are average-sized on medium blocks, often built 15 to 25 years ago. There is a variety of well-cared for and more natural-style gardens, often with no fences. Streets are narrow, often with no footpaths and lined with native vegetation.

The area is characterised by large percentages of people with household incomes 1½ to 2½ times the Adelaide average, and interviewed parents were generally in this bracket. However, parents' household incomes ranged from \$40,000 to \$200,000, with differences reflecting the combination of partners being in full-time, part-time or no paid work, as well as occupational status. The area is also characterised by large percentages of people with post-school qualifications who are often in professional, administrative or technical occupations. Indeed, just over half the families had one partner with university qualifications and just under half had one with post-school diplomas. Mothers were often more highly educated than their male partners. The area also has high levels of home ownership with houses in a medium price bracket, and one third of interviewed families owned their home and two thirds were purchasing. No single parents were interviewed but parents in two couples were in second marriages and there was one blended family. Just over half the mothers were home full-time, but half of these had previously worked part-time whilst they had young children. Another quarter were in full-time paid work (with one working full-time from home), and one-fifth were studying part-time (one at undergraduate and one at postgraduate level). All fathers were in full-time paid work, except for one who had recently commenced an apprenticeship and who had previously been a "full-time father" for 10 months.

### 5.2.3 The lower-middle status area

**Interviewees:** *Mothers 7, fathers 4 (1 father not interested, 2 ex-partners out of contact).*

Note: Fewer parents were interviewed from this area because themes and characteristics emerged as a mix of those from the lowest and upper-middle status areas.

This is another middle-outer area of Adelaide situated approximately 20 to 25 km, or 25 minutes drive, from the CBD. It is closer to large suburban shopping centres than to the CBD. The area has streetscapes of native vegetation and average-sized family homes on medium blocks with a newer appearance than homes in the higher status areas. Gardens are also generally smaller. Suburbs have the appearance of newer residential estates with a prevalence of "rooftops and roads".

This area is characterised by a large percentage of people with household incomes around the metropolitan average of just under \$40,000 per annum. However, income in interviewed families ranged from \$20-30,000 up to \$70-\$100,000. Differences were attributable to the

presence of three single parents, the number of hours or number of jobs being worked by any individual, the age of parents, and length of time partners had been in the workforce.

Other general characteristics of this area are a higher proportion of people in clerical, service or trades occupations with trade qualifications, school-only qualifications, or no qualifications. AFFSS parents had combinations of partners with such qualifications, with the highest being Year 12 or TAFE qualifications (from technical/vocational institutions). Most were working in service or trade occupations. This area also has some representation of single parent households, and three single mothers were interviewed. The area also has a high percentage of households with newer home loans and one of the highest percentage of mothers in the workforce in Adelaide. Indeed, in the AFFSS interviews almost three quarters of the mothers in this area were working, including the three single mothers who were all working part-time. Furthermore, almost three-fifths of families were purchasing their own home, while a few were owner-occupiers; two of the single mothers (just over one quarter of all families) were in public rental housing. Just over one quarter of mothers were home full-time and had not worked since their first child, while the other three quarters were in part-time work. The fathers in a relationship all worked full-time, and two fathers even worked two or three jobs (including one full-time position), raising their income substantially above the average.

#### **5.2.4 The lowest status area**

**Interviewees:** *Mothers 9, fathers 7 (10 families – 2 male ex-partners not contactable, 1 shy; 1 mother not interested)*

This is an outer area of Adelaide situated 40km, or 30 to 40 minutes drive, from the Adelaide CBD. It has both residential and light industrial zoning, with some houses directly facing industrial estates. Houses are average-sized family homes on medium-sized blocks with a variety of well-cared for and unkempt gardens, often with no fences, or with metal colorbond or older-style public housing metal fencing. Wide streets have footpaths and some areas of unoccupied open land. A prevalence of older style and smaller Australian cars was noticeable.

This area is characterised by large percentages of people with household incomes around half the Adelaide average, or solely reliant on government payments (of around \$20,000). Over half the families interviewed were solely reliant on government payments, one-third had one parent unemployed and the other full-time at home, another fifth were single mothers on

government payments alone, while in another couple both parents were unemployed and looking for work.

One-third of families in this area had a full-time working male and a full-time mother at home, while one had a full-time working male and a part-time working mother. Only one family had both parents working full-time. Income reflected work status and occupation and only those with one or both parents in work had incomes around the metropolitan average. The area is also characterised by high proportions with no qualifications, school-only qualifications or trade qualifications. AFFSS parents were less well educated than those in other areas, with almost three quarters of families having at least one parent with Year 10 qualifications or less. In another third of families both parents had TAFE qualifications.

The area also has a higher representation of single parent households and the unemployed, and higher levels of rented properties. Two single mothers were interviewed, and parents in another three families had only met recently. Relationship instability appeared common, with three fifths of families interviewed having at least one parent who had been in at least one previous relationship. Despite low income levels, three fifths of families were purchasing their own home, with repayments around the metropolitan average of \$600-800 per month (ABS 2002e). Another fifth were in private rental housing and a further fifth in public rental housing. This is one of the two lowest socio-economic areas of Adelaide. Indeed, one of the kindergartens used for recruitment was part of a State Education Department project on “Strengthening Families and Communities” for “areas of aggregated disadvantage”.

### **5.3 COMPARING THE STUDY PARENTS WITH THE WIDER POPULATION**

This section provides data on the interviewed parents and compares them with the wider population (at metropolitan, state or national level depending on data availability) in order to establish how representative they are. Although families were intentionally selected to give approximately 25 per cent with each of 1, 2, 3 and 4 children (for reasons explained in Chapter 4), differences in some other characteristics, such as work and family status, were used as partial selection criteria to provide diversity. However, such selection was not according to any preselected proportions.

### 5.3.1 Family status and marital status

In 2003 South Australia had 160,000 families with children under age 15 (7.2 per cent of the national total, in 8 per cent of the national population); of these families, 75 per cent were couples, 19 per cent single mothers and 3 per cent single fathers (ABS 2004a). The AFFSS parent group contained more couples and slightly fewer single mothers than the general population (see Table 5.10). Although no single fathers were interviewed, one father had raised a toddler alone for a year and four others gave their perspectives on the impact on their family size desires and outcomes of their earlier separation or divorce. The higher proportion of single parent families in the AFFSS lower status areas mirrors the State distribution.

**Table 5.10**  
**Family status of interviewed parents at time of interview**

Source: Adelaide Fertility and Family Size Study 2003-04, Parent Questionnaire; data for South Australia is for 2003 from ABS (2004a)

	South Australian population	Status area				
		AFFSS Total	Highest	Upper-middle	Lower-middle	Lowest
Couple* <sup>1</sup> families, children <15	75 %	34 (87 %)	100 %	100 %	57 %	80 %
Single* <sup>2</sup> mothers	19 %	5 (13 %)	0 %	0%	43 %	20 %
Single* <sup>2</sup> fathers	3 %	0 (0 %)	0 %	0%	0 %	0 %
Other	2 %	0 (0 %)	0 %	0 %	0 %	0 %
Total	100 %	39 (100 %)	100 %	100 %	100 %	100 %

1 Interview parents included as couples are those in marriages and de facto relationships, as well as those who described their relationship as “living together as boyfriend-girlfriend”.

2 Single means with no partner and “not seeing anyone”.

Table 5.11 shows that the proportion of AFFSS parents in a first marriage was similar to the state average. However, in the lower status AFFSS areas more parents were in a second or subsequent relationship than parents in other areas, but this had not necessarily contributed to the women having fewer children. Indeed, during interviews, relationship instability appeared to be a more accepted part of the wider family culture in the lower status areas. Larger family size was only related to both parents being a first marriage in the higher status areas.

**Table 5.11****Marital status of interviewed parents at time of interview**

Source: Adelaide Fertility and Family Size Study 2003-04, Parent Questionnaire; South Australian data for 2002 from ABS (2004a)

	South Australian population	AFFSS areas by status				
		Highest	Upper-middle	Lower-middle	Lowest	AFFSS Total
Both in 1 <sup>st</sup> marriage	64%	82 % (Family size 1-5)	82 % (Family size 1-5)	43 % (Family size 3-7)	30 % (Family size 1-3)	62 %
Both in 1 <sup>st</sup> de facto relationship	n.a.	0 %	0 % (0)	0 %	10 % (Family size 1)	3 %
One or both in 2 <sup>nd</sup> or subsequent relationship, or single* <sup>1</sup>	n.a.	18 % (Family size 1-2)	18 % (Family size 1-4)	57 % (Family size 1-3)	60 % (Family size 1-7)	36 %
Total	100%	100% (11)	100% (11)	100% (7)	100% (10)	100 % (39)

1 In some cases one partner had conceived a child prior to the current relationship, but conception had not necessarily occurred in an ongoing relationship. The maximum number of previous partners/spouses for one person was five, although having one previous partner was more common.

**5.3.2 Mothers' and fathers' age at first birth**

Table 5.12 shows that at their first birth AFFSS mothers were around a year older than the 2002 state average (DHS 2003:57). The most likely explanation was the AFFSS selection of parents from all status areas, which led to higher status women being over-represented. Mean age at first birth rose from around 25 years in the lower status areas, up to 31-32 years in the higher status areas, following the Adelaide pattern. Higher status AFFSS fathers were slightly older at their first birth than mothers, but in the lower status areas fathers were slightly younger. Although all parents had at least one child aged six or under, some of those with larger families or longer birth intervals also had teenagers or children in their early twenties.

**5.3.3 Education level**

Tables 5.13 and 5.14 show that the selection of similar numbers of families from each area resulted in the oversampling of the better educated. Nevertheless, the AFFSS parents represented diversity in educational attainment, with 63 per cent of mothers in the highest status area having postgraduate qualifications, and 60 per cent of mothers in the lowest status



area having left school in Year 11 or earlier (and some in Year 8). Fathers showed the same pattern but with less extreme difference. In the lower-middle status area the large proportions of parents with diplomas or certificates related to many having trade certificates.

**Table 5.12****Parents' age<sup>\*1</sup> at first birth, family size and age of children**

Source: Adelaide Fertility and Family Size Study, 2003-04, Parent Questionnaire

	AFFSS areas by status				
	Highest	Upper-middle	Lower-middle	Lowest	Total
Mothers mean age at first birth (yrs)	31.9	31.0	25.4	25.1	28.7
Fathers mean age at first birth (yrs)	32.5	30.4	25.3	24.8	28.6
Mothers median age at first birth	31	29	26	25	28
Fathers median age at first birth	32	30	23	23	28
Mothers range of age at first birth	26-40	21-42	20-34	19-36	19-41
Fathers range of age at first birth	27-41	25-41	20-35	19-32	20-41
Average number of children for mothers	2.45	2.55	3.1	2.7	2.6
Family size range (number children)	1-5	1-5	1-7	1-7	1-7
Age range of mothers' children (yrs) <sup>*2</sup>	1-11	1-19	1½-20	1-22	1-22
Age range of fathers' children (yrs)	1-11	1-19	1-20	1-25	1-25

1 This is more complicated for fathers where mothers had had one or more previous partners. The age taken is that for current father or last partner at the birth of his first child (which was not necessarily with the interviewed mother). This leads to differences when comparing the age range of fathers' children with the mothers'.

2 Current pregnancies were counted as a child for family size purposes, since in family size thinking this child was generally considered already part of the family.

**Table 5.13****Mothers' highest level of education attained or being completed**

Source: Adelaide Fertility and Family Size Study 2003-04, Parent Questionnaire; data for Australia is from Weston et al (2004:28) providing a 2001 census 1% sample of women in a similar age range to most AFFSS mothers

	Australia	AFFSS areas by status				
	Women aged 20-39	AFFSS mothers	Highest	Upper-middle	Lower-middle	Lowest
Postgraduate (Diploma, Masters, Phd)	3.5 %	23 %	63 %	18 %	0 %	0 %
Bachelor degree	16.6 %	15 %	27 %	27 %	0 %	0 %
Advanced Diploma, certificate	20.4 %	31 %	9 %	36 %	57 %	40 %
Year 12	22.1 %	10 %	0 %	18 %	14 %	0 %
Year 11 or less	27.7 %	21 %	0 %	0 %	28 %	60 %
Inad. descr./not stated	9.7 %	0 %	0 %	0 %	0 %	0 %

**Table 5.14****Fathers' highest level of education attained or being completed**

Source: Adelaide Fertility and Family Size Study 2003-04, Parent Questionnaire; data for Australia is from Weston et al (2004:28) providing a 2001 census 1% sample of men in a similar age range to most AFFSS fathers

	Australia	AFFSS areas by status				
	Men aged 20-39	AFFSS fathers total	Highest	Upper-middle	Lower-middle	Lowest
Postgraduate (Diploma, Masters, Phd)	2.9 %	15 %	45 %	9 %	0 %	0 %
Bachelor degree	12.5 %	18 %	45 %	18 %	0 %	0 %
Advanced Diploma, certificate	31.4 %	36 %	0 %	36 %	71 %	50 %
Year 12	20.0 %	8 %	9 %	9 %	14 %	0 %
Year 11 or less	24.2 %	23 %	0 %	27 %	14 %	50 %
Inad. descr./not stated	9.0 %	0 %	0 %	0 %	0 %	0 %

**5.3.4 Occupation group and occupational status**

Tables 5.15 and 5.16 show that just over half the AFFSS mothers and fathers represented higher level occupation groups and just under half represented lower level groups. Lower status mothers were more likely to be in elementary clerical/service occupations and lower

**Table 5.15****Mothers' current or most recent occupation groups\*<sup>1</sup>**

Source: Adelaide Fertility and Family Size Study 2003-04, Parent Questionnaire

Occupation group (ASCO)	AFFSS areas by socio-economic status				
	Highest	Upper-middle	Lower-middle	Lowest	AFFSS total
Groups 1 & 2: Managers, administrators and professionals	91 %	64 %	0 %	0 %	44 %
Groups 3 & 5: Associate professionals and advanced clerical/service workers	9 %	18 %	14 %	0 %	10 %
Group 6: Intermediate clerical, sales and service workers (supervisors)	0 %	18 %	43 %	40 %	23 %
Groups 8 & 9: Elementary clerical/sales/service workers and labourers	0 %	0 %	29 %	40 %	15 %
Groups 4 & 7: Tradespersons, production and transport workers	0 %	0 %	14 %	20 %	8 %

<sup>1</sup> Based on the Australian Standard Classification of Occupations (ASCO) (ABS 1997).

**Table 5.16****Fathers' current or most recent occupation groups\*<sup>1</sup>**

Source: Adelaide Fertility and Family Size Study 2003-04, Parent Questionnaire

Occupation group (ASCO)	AFFSS areas by socio-economic status				
	Highest	Upper-middle	Lower-middle	Lowest	AFFSS total
Groups 1 & 2: Managers, administrators and professionals	91 %	55 %	14 %	0 %	44 %
Groups 3 & 5: Associate professionals and advanced clerical/service workers	9 %	18 %	14 %	10 %	13 %
Group 6: Intermediate clerical, sales and service workers (supervisors)	0 %	9 %	0 %	10 %	5 %
Groups 8 & 9: Elementary clerical/sales/service workers and labourers	0 %	0 %	0 %	40 %	10 %
Groups 4 & 7: Tradespersons, production and transport workers	0 %	18 %	71 %	40 %	28 %

1 Based on the Australian Standard Classification of Occupations (ASCO) (ABS 1997).

status fathers in trades occupations. Mothers were more likely to have obtained their occupational status through education while fathers were more likely to have “worked their way up the ladder” to higher status. AFFSS families were relatively representative of employment status across the State, with parents having employment in 52 per cent of families, compared with 58 per cent of South Australian couples with children under 15 (ABS 2004a). Another 13 per cent of AFFSS families had no employed parent, compared with 20 per cent of all South Australian children under 15 having no employed parent (ABS 2004a).

### 5.3.5 Work-family arrangements

Table 5.17 shows the work-family arrangements of AFFSS families. Categories are according to Pocock (2003:41), with the addition of “single” parent and “role reversal” categories. Almost all AFFSS mothers had been in paid work before having children and 64 per cent had followed a path from “traditional” arrangements with a baby, to some paid work once their child or children reached a certain age (from under one year old for those keen to return to work, up to five years for those who preferred exclusive maternal childcare). Just over half the AFFSS mothers were in the workforce or studying at the time of interview (54 per cent), compared with 52 per cent of South Australian mothers with children aged 0 to 4 years in 2003 (ABS 2004a). The workforce participation of AFFSS mothers generally reflected their

**Table 5.17****Work-family arrangements of interviewed parents at time of interview**<sup>\*1</sup>

Source: Adelaide Fertility and Family Size Study 2003-04, Parent Questionnaire; 2001 census data is from ABS (2002e:33)

	AFFSS Total	Highest	Upper-middle	Lower-middle	Lowest	Average Family Size (Range)
<b>Traditional:</b> Father works 38-60+ hours, mother home	41 %	36 %	45 %	29 %	50 %	3.3 (1-7)
<b>Single mother:</b> full-time home	5 %	0 %	0 %	0 %	20 %	5.0 (3-7)
<b>Modified traditional:</b> Father works 38-60+ hours, mother part-time worker or student	33 %	55 % (4 mothers work 3-6 hrs per week, 2 work 20-22 hrs)	36 % (2 mothers studying, one casual, one works from home)	29 % (both mothers work 20-22 hrs per week)	10 % (works 19 hours per week)	2.0 (1-4)
<b>Single mother</b> working part-time	8 %	0 %	0 %	43 %	0 %	2.0 (1-3)
<b>Shared:</b> Father and mother both full-time workers or both part-time	8 %	0 %	9 %	0 %	20 %	2.0 (1-4)
<b>Role reversal:</b> Mother worker, father student	5 %	9 %	9 %	0 %	0 %	1.5 (1-2)
2001 Census % mothers, with dependent children, in the workforce as % of labour force	-	17-21 % in most areas	17-21 % in most areas	Over 21 % in many suburbs	14-17 % in most areas	-
Total	100 % (39)	100 % (11)	100 % (11)	100 % (7)	100 % (10)	-

<sup>1</sup> The word “work” is used as short-hand for “paid work”, but in no way implies that parents who are “at home” in domestic and childcare roles are not performing useful work. Three families in the lowest status area had at least one partner looking for work (officially counted as in the workforce).

area’s characteristics (as per ABS 2002e:33), with higher rates of participation in the lower-middle status area (which has high rates of “dwellings being purchased”), and lower rates in the lowest status area. However, work status had not necessarily been stable since having children. One-eighth of AFFSS mothers had taken up full- or part-time work since having

children but had subsequently resigned, for example due to children not settling at childcare, or a perceived lack of financial benefit.

Whilst the tables indicate the diversity of work-family arrangements in the AFFSS, the use of these groups based on behaviour does not necessarily reflect work-family preferences or future intentions. For example, four mothers in the highest status area were officially “in the workforce” but working only three to six hours a week (in private tutoring or marking university assignments) because they wanted to maintain some attachment to the workforce but still be as “traditional” a non-working mother as possible. Although AFFSS parents with “traditional” arrangements had the largest average family size, it is important to remember that larger families with full-time working mothers are under-represented in this study.

### 5.3.6 Country of birth

In terms of country of birth, AFFSS mothers were representative of all South Australian mothers giving birth in 2003 (the main year of interviews), apart from slightly under-representing Asian-born mothers (see Table 5.18). However, Table 5.19 shows that AFFSS parents were more likely to be the children of migrants than were the general population.

**Table 5.18**

**Birthplace of interviewed parents**

Source: Adelaide Fertility and Family Size Study 2003-04, Parent Questionnaire; Adelaide data from ABS (1996c); SA mother data from Department of Health (2005:11)

	Adelaide population 1996	SA mothers giving birth in 2003	AFFSS total	AFFSS mothers	AFFSS fathers
Australia	71.9 %	-	74.4 %	82.0 %	66.6 %
New Zealand	0.7 %	-	2.6 %	2.6 %	2.6 %
<i>Oceania</i>		86.5 %		84.6%	69.2 %
United Kingdom & N Ireland	10.3 %	-	10.3 %	7.7 %	13.0 %
Italy & Greece	3.5 %	-	0.0 %	0.0 %	0.0 %
Other specified Europe/former USSR	3.3 %	-	1.3 %	0.0 %	2.6 %
<i>Europe and USSR</i>	-	6.4 %	-	7.7 %	
Specified E/SE Asia	2.8 %	-	2.6 %	2.6 %	2.6 %
<i>S, NE &amp; SE Asia</i>	-	5.1 %	-		
Other	4.6 %	2.0%	5.2 %	5.2 %	5.2 %
Not stated/unknown	2.9 %	-	3.8 %	0.0 %	3.7 %

**Table 5.19****Birthplace of own parents of interviewed parents (the grandparent generation)**

Source: Adelaide Fertility and Family Size Study 2003-04, Parent Questionnaire; Adelaide data from ABS (1996c)

	Mother's parents	Father's parents	Adelaide population
Australia	60.2 %	58.9 %	71.9 %
New Zealand	2.6 %	3.8 %	0.7 %
United Kingdom & N Ireland	16.7 %	10.3 %	10.3 %
Italy & Greece	5.1 %	3.9 %	3.5 %
Other specified Europe/former USSR	5.1 %	7.7 %	3.3 %
Specified E/SE Asia	2.6 %	2.6 %	2.8 %
Other	5.1 %	5.1 %	4.6 %
Not stated/unknown	2.5 %	7.7 %	2.9 %

**5.3.7 Religion**

Tables 5.20 and 5.21 show that fewer AFFSS parents “had a religion” than the general population. However, AFFSS responses may reflect both affiliation *and* religiosity, since parents were not asked the Census question “What is this person’s religion?”, but whether they considered themselves “members of a religious group today”. The word “member” may have implied a strong commitment or regular attendance, encouraging a greater proportion to reply they had No Religion. However, even though only 38 per cent of mothers and 39 per cent of fathers identified with a religion, 66 per cent of mothers and 61 per cent of fathers said that religion or spirituality were very or somewhat important to them. The other main difference with the general population was a much lower proportion of AFFSS parents being Catholic and Anglican. This may reflect a greater disparity between affiliation and religiosity for these two groups, as found in a recent British survey (King 2004). Differences in spatial concentration may also be involved, with levels of Catholic affiliation closer to the national average in the highest status area, and the percentage Anglican closer in the lower-middle status area. Recruitment did not include any religious-based pre-schools.

This variety of data shows that in comparison with both the wider population and their socio-economic area the interviewed parents were generally representative. However, they were somewhat more likely to be in a couple relationship, to have overseas-born parents, to be better educated and to have a larger family.

**Table 5.20****Mothers' current religion**

Source: Adelaide Fertility and Family Size Study 2003-04, Parent Questionnaire; data for Australia is from Weston et al (2004:28) providing a 2001 census 1% sample of women in a similar age range to most AFFSS mothers

	Australian women aged 20-39	Adelaide women aged 40-44 in 1996* <sup>1</sup>	AFFSS Total (n=39)	Highest (n=11)	Upper-middle (n=11)	Lower-middle (n=7)	Lowest (n=10)
No religion	17 %	20 %	54 %	20 %	55 %	72 %	80 %
Catholic	27 %	23 %	8 %	27 %	0 %	0 %	0 %
Anglican	19 %	17 %	3 %	0 %	0 %	14 %	0 %
Old Protestant	19 %	22 %	18 %	27 %	36 %	0 %	0 %
Other Christian and New Protestant	(Christian unspecified)	6 %	8 %	9 %	9 %	14 %	0 %
Buddhist, Hindu, Islam, Judaism and Other Religions	6 %	3 %	3 %	9 %	0 %	0 %	0 %
Not stated, inad. descr./ not sure	12 %	10 %	8 %	9 %	0 %	0 %	20 %
Total	100 %	100 %	100 %	100 %	100 %	100 %	100 %

Note: Groupings and notes are as for Table 5.3.

**Table 5.21****Fathers' current religion**

Source: Adelaide Fertility and Family Size Study 2003-04, Parent Questionnaire; data for Australia is from Weston et al (2004:28) providing a 2001 census 1% sample of men in a similar age range to most AFFSS fathers

	Australian males aged 20-39	AFFSS Total (n=39)	Highest (n=11)	Upper-middle (n=11)	Lower-middle (n=7)	Lowest (n=10)
No religion	20 %	46 %	18 %	54 %	43 %	70 %
Catholic	26 %	5 %	18 %	0 %	0 %	0 %
Anglican	17 %	5 %	0 %	9 %	14 %	0 %
Old Protestant	17 %	18 %	27 %	36 %	0 %	0 %
Other Christian and New Protestant	(Christian unspecified)	8 %	9 %	0 %	14 %	10 %
Buddhist, Hindu, Islam, Judaism and Other Religions	6 %	3 %	9 %	0 %	0 %	0 %
Not stated, inad. descr./ not sure	13 %	15 %	18 %	0 %	28 %	20 %
Total	100 %	100 %	100 %	100 %	100 %	100 %

Note: Groupings and notes are as for Table 5.3.

## **5.4 THE PRECONCEPTION RESPONDENTS**

### **5.4.1 Socio-economic characteristics**

Although the preconception survey was arranged via seminars organised by a private health company at private hospitals, these were open to the general public. Respondents were from across metropolitan Adelaide but the vast majority were better educated, on higher incomes, and in higher level occupation groups than the general population. Similarly to the AFFSS mothers, the preconception women were better educated than the men, even in the same occupation groups. However, only a quarter of the women were in manager or director positions compared with half the men. The women were spread evenly across five-year age groups from 24 to 39, but the men were almost all aged 30 to 39. Most respondents were married and were buying, or already owned, their own home. Almost two-thirds gave a religion (close to the national proportion for people aged 20-39, as shown in tables 5.20 and 5.21).

Almost half the preconception respondents were from high income couples (earning over \$80,000, or almost three times the metropolitan average of \$31,000), almost half were earning \$50-80,000 pa, and few earned under \$50,000. Of the 31 women, almost half were in clerical/sales positions earning a couple income of \$50-80,000, while another eight were in the manager/professional group with a high couple income. The under-representation of lower income groups may have resulted from the seminars being held near the CBD, furthest from the main areas of low socio-economic status. However, it may also suggest that people with higher education and higher income levels are more attracted to private hospitals. Indeed, higher status is linked with a higher propensity to have private health insurance (South Australian Health Commission 1990:154). Alternatively, people in these groups may have more concerns about parenting and therefore be more likely to seek preconception information.

### **5.4.2 Thinking about family**

Four-fifths of those returning preconception survey forms were planning their first pregnancy within 12 months (and another 7 per cent were already pregnant). Approximately two-thirds said they were already highly likely to become parents. Most always thought they would have



children one day, although 13 per cent of the women and 21 per cent of the men had never wanted children. Most who wanted children cited psychological benefits, such as having their own children to love and to watch grow, and expecting children to bring fun and enrichment to their life. A third saw parenthood as part of a loving relationship. A small number of women saw having children as “natural” for women or wanted babies and children because they just loved them.

Most respondents were attending seminars for a general idea of what to expect from pregnancy, birth and parenthood. Around a third wanted information on the health and emotional aspects of childbearing, and a quarter wanted information on the financial aspects. A fifth were seeking information on how to conceive, or overcome or avoid infertility. The number of children respondents would have if there were no obstacles ranged from one to ten children. The mean size was 2.86 children (counting sizes higher than 5 children as 5 to prevent skewing), and just over 50 per cent said they would ideally like three or more children. This is considerably higher than the ideal sizes of 2.4 for men and 2.5 for women cited in a recent national survey of 20-39 year olds, where one quarter saw three children as their ideal (Weston et al 2004:50). However, the higher fertility preferences among the AFFSS preconception group may be partly explained by the fact that this group was already more likely to want children, and by the fact that the “pre-fathers” were less well-educated, with only 14 per cent having university qualifications compared with 44 per cent in Weston et al’s national survey.

## **5.5 CONCLUSION**

Since the thesis seeks to better understand fertility thinking and behaviour within the social context it has been important to provide details about the study areas and the study participants. The chapter has described some of the characteristics of the study participants and their areas of residence. It showed that AFFSS parents were relatively representative of the general population and of their socio-economic areas. Parents were less likely to have a religious affiliation, and mothers were less likely to be in full-time paid professional work. However, the selection criteria resulted in those with higher education being over-represented, as were parents of larger families. While this influences the conclusions that can be drawn from the qualitative data, the over-representation was intended to enable consideration of influences on fertility of those who *have* progressed to higher parities.

The next five chapters will provide a nuanced interpretation of fertility thinking and behaviour at the individual and couple level, and will consider how this may be associated with differences in these background characteristics. The next chapter begins by considering the influence of childhood and later experiences within the family and the wider culture on the shaping of family size preferences.

## Chapter 6

# Constructing images of parenthood and family size

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When assessing the future trends of fertility in a low-fertility country... an attempt has to be made to evaluate information on views and attitudes on marriage and the family, how various generations... see themselves as parents

(Ruzicka & Caldwell 1982:228).

### 6.0 INTRODUCTION

Chapters 3 and 4 explained the rationale for investigating the influence on fertility thinking and behaviour of individual-level images and impacts of parenthood. This chapter will argue in agreement with Easterlin, Pollak and Wachter (1980) that in some cases the only influence on a person's family size can be cultural factors such as the size of their family of origin, with economics playing no part at all. Working from de Bruijn's framework (Chapter 3, section 3.6), this chapter argues that despite an increasing focus on individual choice as an influence on low fertility, the social context continues to influence individuals' anticipation and reflection processes which help shape preferences and choices in relation to both future work and family-related goals. Of particular interest is the influence of the individual's construction or image of what parenthood means or entails.

This chapter uses data from the Adelaide Fertility and Family Size Study (AFFSS) parent interviews and the preconception survey. Section one explores influences on decisions to have children or to remain childless which individuals perceived as based in the family of origin. Section two considers influences from the wider social context, while section three considers perceived influences from personality and coping style. The chapters which follow then consider how these aspects may be reshaped by experiences of conception, pregnancy, birth, early parenthood and everyday childrearing.

## 6.1 IMAGES FROM THE FAMILY OF ORIGIN

### 6.1.1 Thinking about parenthood in the life course

According to McGurk and Kolar (1997), individuals' ideas about parenting are constructed by combining explicit and implicit memories of their families of origin with current advice about childrearing and personal experience of rearing children. Work by Gerson (1985) and W.B. Miller (1992) shows that, against this background, experiences in childhood, adolescence and early adulthood shape conscious and unconscious assumptions about what individuals want out of life and how attainable they believe this is, and this includes both positive and negative motivations towards parenthood and other life course goals. This can occur because:

Parents, teachers and significant people in your early years teach you values and attitudes to live by. They do this by praising certain things that you do and punishing others... Coping strategies are learned from your childhood experiences and the attitudes and expectations of your society and culture. These factors shape your behaviour (Tanner & Ball 1999:15).

Family influences on fertility thinking are therefore neither random nor insignificant if one considers Reiss' idea (1981:233) that "family paradigms" or "shared conceptions" refine a structure which then acts as a "guide for everyday behaviour". Indeed, Reiss (1981:171) sees families as "bounded social groups with their own internal dynamics" which may be "originators of their own cultures with their attendant secular rituals and world views". In terms of fertility thinking and behaviour, families can therefore provide shared social constructions of the extent to which parenthood is a normative behaviour and having children (or larger families) is desirable and/or achievable. Although not discussing the concept in detail, McNicoll (1980:453) hypothesised that such socialisation processes could establish "images of family life" so that that family-size decisions aimed to recreate this instilled image.

In the AFFSS many parents expected children because they perceived parenthood as normal behaviour. Table 6.1 indicates that half the fathers and just over half the mothers always thought they would have children and had an idea of a number or range of family size, while another fifth of each thought they would have children but had no numbers in mind. Although another fifth of the mothers had felt definite that they would never have any children, or had never really thought about it, only one in ten fathers felt this way. By contrast, one fifth of the fathers had not thought about having children until they had got older or got married, and this was particularly the case for fathers in the lowest status area.

**Table 6.1**

**Responses to opening interview question “Looking back on your life do you think you always thought you would have children one day, thought you never wanted children, or you never really thought about it?”**

Source: Adelaide Fertility and Family Size Study 2003-04

Area	Always thought would have children, particular number or range	Always thought would have children, NO number or range	Did not think about children until got older or got married	Never thought about having children	Expected NO children or knew did not want them	Total
Highest status						
Mothers	36%	27%	18%	18%	0%	11
Fathers	33%	50%	17%	0%	0%	6
Upper-middle						
Mothers	45%	27%	0%	9%	18%	11
Fathers	86%	0%	0%	14%	0%	7
Lower-middle						
Mothers	86%	0%	14%	0%	0%	7
Fathers	50%	25%	25%	0%	0%	4
Lowest						
Mothers	67%	0%	0%	11%	22%	9
Fathers	29%	14%	42%	0%	14%	7
Total mothers	21	6	3	4	4	38
Per cent	55%	16%	8%	11%	11%	100%
Total fathers	12	5	5	1	1	24
Per cent	50%	21%	21%	4%	4%	100%

Micheli and Bernardi (2003) argue that fertility is lowered when increasing proportions of people question parenthood as a normative behaviour, or do not have children until they feel an almost “magical” urge. One AFFSS mother of four had experienced this:

I can’t remember if I THOUGHT I would go through life without kids, or I just didn’t plan that I would have children... I didn’t have that maternal urge, I didn’t have that feeling “I want a child”... very much went into my marriage without any expectation of starting a family... I think just more interested in having fun, a good time, just couldn’t see myself being a mum, didn’t think I was cut out to be good with little children. When I thought that we should start a family it was more of a “Well we’ve been married for four years, perhaps we should... shouldn’t we have children?” ... and I guess from people saying “Are you ever going to have kids?”.

(Danielle, 39, part-time office manager, lower-middle status area, mother of 4 – aged 8, 13, and “accidental” twins aged 1½)

One AFFSS father had found it difficult to identify his past thinking about having children because he felt that “different periods of life are obviously different periods of thinking”. Another mother had even found that “it was easier to say ‘Well actually we’re not going to

have them [children]’ because then everyone left us alone”. Even though she did want children later she “purely wasn’t interested in them” in her early 20s and was “quite happy to have them at 35” because she “wanted to live life without restrictions for a while”.

In comparison with parents who were unsure, those who were more definite about having children often wanted to repeat their own experiences of family life:

Oh I definitely knew I was going to have kids. Yeah...I planned to have heaps... I loved the big size family. My mum had a big sized family [one of 15] so...

(Molly, 41, unemployed agricultural labourer, lowest status area, single mother with 7 children from 5 relationships- aged 8, 10, 11, 17, 22, and twins aged 5 )

Indeed, several parents attributed their larger family size to what one mother called a “large-family culture” in the originating family, and two mentioned grandmothers who “loved children” and who encouraged children to be welcomed in the family. Such experiences, if interpreted positively, imbued individuals with an interest in children, confidence about their ability to parent a larger family, and knowledge that family support would be forthcoming:

For me four [children] is what I feel like I [can cope with]... I’m probably the one that finds it - chaos and so on - more difficult than he does... My husband would probably be quite comfortable with five or six... he’s just that kind of nature, big families, and we’ve already got one family with six [husband’s eldest brother] so it’s not like we’d be breaking new ground or anything... and he’s very competent with babies, he’s got lots of nephews and nieces... He was 15 when his brother came home with their three kids and lived with them in the house, so he’s very familiar with that. If I had a husband who had a high-flying job and was out for hours of a day and wouldn’t change a nappy in a fit, then I probably would have struggled [with four children].

(Abbie, 35, former diversional therapist, upper-middle status area, mother of 4 – aged 1, 4, 7 and 9)

This mother identifies a complex relationship between earlier experiences of family life, the parenting skills and confidence acquired by an individual, and images of family size.

### **6.1.2 Experiences of family life influencing expected childlessness**

Earlier chapters have discussed how higher levels of education and/or occupational status are associated with higher levels of childlessness (intended or circumstantial), and that life course orientations towards work and family can be influential. In the AFFSS lower fertility was associated for some parents with strong personal aspirations for achievement through education and career, which were not balanced by strong aspirations for parenthood. One

mother had aspired from the age of five to go to medical school and had never thought about having children. She eventually became a senior medical specialist. When discussing her childhood she suggested that her earlier family experiences may have influenced her focus on career, with her having not only idolised a female medical student who lodged with the family, but also having been aware of her father's thwarted desire to study medicine and her mother's journalism career being curtailed by motherhood. Another mother, Jesse, had been overtly encouraged by her mother to ignore partnership and parenthood and to prioritise getting "a good education and good job". Jesse implied that this reflected her own mother's negative experiences of becoming a mother at 18. If Jesse had not met her husband by chance at age 31 she believed she may have remained a childless career woman like her 36-year old sister.

In contrast to encouragement to focus on work rather than family, negative experiences of family life could give AFFSS parents what Marshall (1993:134) calls "awful warnings" about parenthood. Indeed, decisions to remain childless for both Australians and Americans have been found to relate to negative images of family life and motherhood based on observations in the family of origin, as well as on observations of the adverse impacts of parenthood on others (Cannold 2005; Marshall 1993; Toomey 1978). For some AFFSS parents, decisions to avoid, and to delay, having children were indeed based on such perceptions:

I saw her [my mother] as the person I never wanted to be. She created my feminism traits. She ingrained in me, not verbally [but] by watching her "Never allow yourself to be walked all over [and] children are difficult to have because they take up a lot of energy you don't have"... I look at her and think 'My God you haven't had a life' My mum was a cook in a hotel so she worked a split shift. She'd walk in and my dad'd say "Are you making a cup of tea?!" And she did that for YEARS... We talk about it sometimes now. She says 'Oh well, in those days Lucy, in those days...', and my dad now is waited on hand and foot, he's still treated like a gold clock!

(Lucy, 46, company director in family business, upper-middle status area  
mother of 1- aged 6)

Social messages from peers reinforced other influences to further discourage this mother:

I listened to people I knew who'd had children in their teens (bearing in mind I was now almost mid-30s), guys at work were coming in saying 'You're so lucky you haven't got kids, you're so lucky, you don't know what these... what they...' And I used to think, yes, [we] went out to dinner three times a week and still bought clothes, went to the gym EVERY day, I loved my life. Having a child was the worst thing in the world that could have happened to me.

Other parents had originally intended to remain childless due to childhood experiences of conflict or divorce in their family of origin, but they had eventually had children through meeting a partner who was keen to have children, or through conceiving “by accident”:

At [age] 15 I told my mother not to expect grandchildren from me. I didn't have a very happy childhood ... my dad was violent... [Mum's second husband] was MENTALLY abusive... so I thought I wouldn't put my child into a position where his physical and emotional well-being was going to be [jeopardised]. I stayed single until I was 33... I was NOT going to make the same mistakes as my mother.

(Stephanie, 38, cleaner/receptionist, lowest status area, mother of 1 – aged 2)

By contrast, negative images of parenthood could be reinforced within a couple relationship. Anne was a 42-year old PhD candidate in the upper-middle status area who accidentally conceived while on the Pill. Before this, she and her husband had “consciously decided that we could live our life without children”. She had been “put off” having children partly because of her “horrible” brother (8 years her junior) who was a “very difficult child”, while her husband had been negatively affected by childhood experiences of his parents' divorce. Fertility might be therefore be expected to be higher at both the individual and social level if positive messages and observations of parenthood and family life outweigh negative ones.

Other parents had expressed expectations of childlessness earlier in life but changed their minds as they faced different life situations and reassessed life priorities. Indeed, even in the preconception survey, 21 per cent of men and 13 per cent of women said they had never wanted children, although they were now considering starting a family. Case studies of “voluntarily childless” couples also find that childlessness is not necessarily a permanent state (Marshall 1993:138). This suggests that estimates that a fifth to a quarter of today's young women will never have children (Chapter 2, section 2.2.3) should be treated with some caution. It also shows that policies aiming to raise fertility which focus only on work-family compatibility and financial incentives could be balanced by policies addressing the relationship well-being of parents and families, and the images of family life that children grow up with.

### 6.1.3 Ideas of numbers of children

Whilst originally not a line of inquiry, during interviews the size of family of origin frequently emerged as influential on personal family size preferences alongside experiences of family life.



A prompt question was therefore incorporated to specifically further explore this perspective in subsequent interviews. In this way, against the backdrop of current debate focussing on individual “choice”, the AFFSS resumes interest in cultural influences noted in earlier research which investigated socio-psychological influences on fertility. Westoff and Potvin (1963:135), for example, found “images of family size” to be influential because “individuals’ perceptions of the number of children that constitute a ‘small’ or ‘large’ family... define limits on the normative range of fertility ideals in each group”. Later research suggests that subconscious socialisation processes shape family size preferences from childhood, with average family-size preferences increasing with the number of siblings (Gustavus 1973; Westoff & Potvin 1967:143). Others have found that mothers’ preferences influence their children’s fertility preferences through early adulthood, while sibling’s fertility is an additional determinant of family size preferences (Axinn, Clerkberg & Thornton 1994).

In the AFFSS direct reference to the *size* of the originating family was used to explain actual or preferred family size by two-thirds of mothers and almost half the fathers. Table 6.2 confirms this relationship and shows that all AFFSS families with three or more children had at least one parent who came from a family of at least three children themselves. In three-fifths of the larger families *both* parents were from a larger family of three or more children themselves, and none had been only-children. Land (1969:117) also found that almost half the mothers and fathers in her study of large London families were from a large family themselves, while Mencarini and Tanturri’s (2005) large scale random survey of Italian women aged 40-44 showed that those with three or more children had a higher number of siblings in their family of origin than did women who remained childless. Indeed, Mencarini and Tanturri (2005:12) suggested that women from larger families “inherit a higher propensity” to have more children even when socio-economic status and education are controlled for. Possible influences on this “higher propensity” will be discussed shortly.

An interesting point to note from Table 6.2 is the low prevalence of parents who were themselves from families of only one or two children. The table also shows that in the AFFSS families where parents believed they were unlikely to go beyond one or two children, one quarter of families had both parents from a family of two children or less. By contrast, none of the parents currently with, or expecting to have, three or more children had come from such smaller sized families. These findings echo those of Campbell (1976:48) who found that in

**Table 6.2****Numerical relationship between likely family size<sup>1</sup> and size of partners' families of origin**

Source: Adelaide Fertility and Family Size Study 2003-04

	With, or likely to have no more than, 1 or 2 children	Will possibly have 3 children	Has 3+ children
Both partners only-children (n=0)	0%	0%	0%
One partner only-child and one partner from 2-child family (n=2)	13%	0%	0%
Both partners from 2-child family (n=2)	13%	0%	0%
One partner from 2-child and one partner from 3+child family (n=14)	38%	20%	39%
Both partners from 3-child family (n=6, possibly n=4)	6%	20%	22% (or 11%) <sup>*2</sup>
One partner from 3-child and one from larger family (n=10, possibly 12)	25%	60%	17% (or 28%) <sup>*3</sup>
Both partners from family of 4 or more children (n=5)	6%	0%	22%
Total	16 (100%)	5 (100%)	18 (100%)

1 Several authors note that statements about expected future fertility are generally reliable (Freedman, Hermalin & Chang 1975; van Peer 2000; Young 1975)

2 Would be 11% if 2 families included here were moved to line below - two single parents were unsure about the exact size of their last partner's family of origin.

3 Would be 28% if 2 families were included here from line above (see note 2).

Sydney "the size of the family in which the interviewees had been reared bore a strong relationship to attitudes to contemporary family size" and that Sydney parents who "came from families of one and two invariably wanted two children [and] not a single interviewee who came from a small family favoured a large one". Other studies (eg Callan 1982; Mencarini & Tanturri 2005) have also found that childlessness in Australia and Italy is more common amongst those who were themselves only-children. Such influences on family size thinking originating in the wider social setting are discussed later in section 6.2.

In the AFFSS the size of the family of origin also influenced minimum desired sizes. Both the AFFSS parents and preconception respondents from families of four or more children were more likely to see three children as their minimum desired family size, while those from families of one to three children were more likely to see two as their minimum. Table 6.2 shows that, of the parents who thought they might increase their family size to three children

in future, all had at least one partner who had come from a family of three or more children themselves.

Although family size outcomes are not *determined* by the size of the originating family, the interviews showed that this was nevertheless used as a basis against which to reflect on the benefits and disadvantages of particular family sizes:

I guess I never thought I'd have a huge number, or just one, so somewhere in between... I'd probably at the most have three, between two or three... Yeah, it'd be either [two or three because] *my personal experience was three*, so I'd have three. I know what three's all about, and I understand having three, or two, cos I think that's probably more practical and realistic.

(Fiona, 34, psychologist, highest status area, mother of 1 – aged 1, emphasis added)

Another AFFSS mother wanted three children “like her mother”, while others wanted *more* siblings than they had, reflecting that they would have liked, for example, “another brother or sister to play with”. Others wanted to avoid repeating their own experiences, for example of being an only-child, a middle child, one in a big family, or having an “odd” number:

I always said to mum when I was very young “I'm going to have two kids”... cos I was an only child and I hated it... because the half-sister I've got who I really don't see, cos of the age difference [15 yrs]... My mum's got no-one, she was an only child, and dad was one of two... You watch a lot of the movies where you've got the kids that live out on the farm and what-not and they've always got six or eight kids and I LOVE that... I don't know if it's subconsciously doing the opposite of everything that my mum did.

(Veronica, 31, clerical worker, upper-middle status area, mother of 2 – aged 4 and 6)

Others wanted fewer children than their originating family but were still generally influenced by this family having been larger or smaller. Daven, for example, came from a five-child family himself but felt that “these days five is too many”. Nevertheless, he had still wanted not less than three children, and at the time of the interview had four. That individuals can hold ideas about a range of family-size preference, rather than an individual number, was also identified in earlier Australian research (Ware 1973).

AFFSS parents therefore demonstrated the existence of what can be termed a “zone of possibility” for family size thinking which resided within their image of family size and image of family life. Some of the comments which reflected this were:

- I always had this *ideal picture* you know, of the corporate husband with the nice house and 2 point whatever kids.
- I just don't *see myself* with four running in and out.
- I had this *perfect world idea*, I'd have a boy first and a girl later.
- I just *imagined* I'd have two or three. I never thought I'd have more.

The general impression from interviews was that when such “zones of possibility” for family size had been imagined, parents would rarely go beyond them by choice. In considering future fertility scenarios in Australia, it is significant that for AFFSS parents the transition to a larger family by choice occurred more when there was personal experience of larger-family life which was related to individuals either having a stronger desire for a larger family, or expecting to have to adjust their behaviour to a lesser extent when becoming parents than those who only had experience of smaller families. Indeed, in the preconception survey, those expecting larger families were less concerned about the impact of children on their life than those expecting smaller families. This corroborates recent Italian research which shows that those without children or with only one child generally worry more than those who have three or more children about labour, birth, baby health and their ability to cope with parenthood (Maggioni 2004:104). These influences of the size of family of origin on personal size preferences suggests that if any individuals are more likely to have larger families it will be those who themselves come from larger families.

Since affiliation to particular religious denominations is also linked with higher fertility (as demonstrated in previous chapters), it is not surprising that in the AFFSS interviews higher fertility was also linked with having *a religious affiliation*, or *a higher degree of religiosity* during childhood and/or in adulthood (interpreted as attending religious activities more frequently and placing a higher importance on religion/spirituality in one's life). However, this was only the case for higher status parents, and in lower status areas the intergenerational effects of family size applied regardless of religious influence. Religion is seen to influence fertility through “pro-natalist” ideologies, or sanctions and rewards, which in turn affect educational attainment, female employment and attitudes to pre-marital sex and divorce, all of which may affect the timing of union formation and childbearing, and the type of union (marriage or cohabitation) (Lehrer 2003:1). However, the AFFSS interviews suggest that these

influences are intertwined with experiences in particular sized families and experiences of family life, which in turn can influence images of parenthood. As one AFFSS mother noted:

You see a lot of large families in churches. I'm sure it's not the same ratio as in society in general. Part of that might be the teaching in the Bible about the value of human life and that a child is a gift from the Lord. The Christian teaching ... you know things like 'God said to Adam and Eve be fruitful and multiply' ... But we can't separate it because both of us were brought up in a Christian family... It's certainly not because we're Christians we'll have more children. And I know lots of people in the church who don't, who choose not to. But there must be something there because I think, well, there seem to be more bigger families within the church.

(Abbie, 35, former diversional therapist, upper-middle status area, mother of 4 – aged 1, 4, 7 and 9)

This family provided a good example of size norms at the group level and of what another interviewee called “large family cultures”. The mother was from a three-child family, the father one of five, and all four grandparents from families of three to six children. Five of the parents' siblings had at least three children. The couple's preference for a larger family was encouraged by enjoyable experiences of the “busyness” of larger families, belief that children benefited socially from more (rather than fewer) siblings, knowledge that the extended family provided parenthood support, and non-materialistic views which minimised the perceived financial costs of larger families. The influence of different family “cultures” was highlighted by another AFFSS mother:

I was always one of those people who wanted children, at least two probably... I didn't think it would be as hard as what it is... a husband that didn't help, and didn't cope... I don't think he knew HOW to... *Maybe our family backgrounds too.* His family were nothing like mine. They're not loving, caring, nurturing people. His dad didn't want kids. He admits he would never have had any if it wasn't for her [the mother's] pressure. He just flat out doesn't like them... The way [husband] was treated when he was a child was nothing like how I was treated... My parents LOVED kids... I was spoilt and loved, and he [husband] was just basically there. I think it's had a lot to do with him not dealing with [our kids].

(Mandy, 35, sales assistant, lower-middle status area, single mother of 3 – aged 6, 7 and 10, emphasis added)

Future research could investigate fertility influences at this extended family level, including a fertility history of the extended family, to explore more fully how these other influences interact with individual level thinking and behaviour. However, influences from the wider social context are also influential, and are discussed next.

## 6.2 THE WIDER SOCIAL CONTEXT

Alongside influences from the family of origin, AFFSS parents also discussed influences on their family size preferences from the wider social environment, particularly friendship, peer, neighbourhood and workplace groups. This is in line with Clifford's earlier contention (1971) that subcultures exist where clusters of individuals develop group attitudes or preferences towards childbearing and childrearing, and ties in with the concept of social learning and the social diffusion of ideas (as identified in Chapter 3). Indeed, Aries (1980:645) believes demographic phenomena are signs of collective attitudes. These can also be seen as social norms which are "more or less ordered patterns at the societal level" whose existence in relation to life course events benefits individuals by providing a guide for behaviour in an otherwise very complex environment (Billari, Prskawetz & Fuernkranz 2002:4). Empirical work also shows that there can exist "consensus on a normative range of family size" (Westoff & Potvin 1963:135-137; Ware 1973).

Although social interaction is not routinely integrated into contemporary low fertility research Kohler, Billari and Ortega (2002) believe that consideration of its effects can improve the understanding of the dynamics of fertility change. Indeed, the current thesis appears to confirm Birrell and Birrell's (1987:15) belief that normative influences, including those from other members of the social group, continue to influence fertility despite the assumption that in contemporary developed societies they have become unimportant. Billari, Prskawetz and Fuernkranz (2002:2) in fact comment that "the persistence of norms concerning demographic events in contemporary societies is... somehow surprising to some scholars who would expect a natural expansion of individuals' freedom also in the realm of demographic choices". Nevertheless, recent research in Italy, Poland and Germany confirms that personal networks and peer groups influence subjective perceptions of fertility and childbearing desires by providing role models of behaviour and commonly shared ideas of fertility (Bernardi 2003; Bernardi, von der Lippe & Keim 2005; Buehler & Fratczak 2005). Since the most crucial issue determining post-transitional fertility is "whether desired family size remains at or drops below two" (Bongaarts 2001a:276), this section argues that better understanding of the influence of such norms or images of family size can deepen the understanding of contemporary fertility in Australia and also inform considerations of future fertility scenarios based on past and current behaviour.

### 6.2.1 Social and peer group images of smaller family sizes

In forming their own size preferences, a considerable number of AFFSS parents referred to what appeared to be commonly shared images of particular sized families which further encouraged or discouraged them in imagining their own “zone of possibility”. For example, many AFFSS parents perceived an only-child as an undesirable *choice*. Some who had decided not to go beyond one child found it socially more acceptable to attribute this to not being *able* to conceive again, rather than to not *wanting* to. Of the 38 AFFSS families, 11 (28 per cent) had one child at the time of interview, but most said they would rather be at parity 0 or 2. This is supported by empirical research demonstrating a continued resistance in many developed countries to desired family sizes below two children (eg Ware 1973; Campbell 1976; Bongaarts 2001a; Weston et al 2004).

Reasons for not wanting an only-child were often based on the learning mechanism of personal observation. Many AFFSS parents referred to only-children they had known in childhood, perceiving them to be socially less competent, “spoilt”, “obnoxious”, “unable to go with the flow”, “unable to fit in” or “insular”. Interestingly, those AFFSS parents most strongly against having only-children were those who had been only children themselves and who had found life lonely without siblings. Some AFFSS parents at parity one also believed that only children placed additional pressure on parents to provide the company and social interaction otherwise provided by a sibling, so that having more children was perceived as impacting less on parental well-being. Some parents of larger families had specifically wanted a larger family for this reason. Those who were more content to stop at one child were those who had previously considered remaining childless and had become pregnant “by accident”.

Chapters 2 and 5 showed that in near-completed family size in South Australia, and ideal sizes nationally, the most common family size is two or three children. In the AFFSS interviews a two-child family was seen as the most “manageable” size to avoid the negative associations of only-children, but at the same time minimise any negative impacts on parental well-being:

Coordinating two rather than three, where you sort of have one each. Your child ratio is such that you can keep the situation under control. It’s just easy.

(Anita, 35, government planner, upper-middle status area,  
mother of 2 – aged 4 and 7)

A two-child family was seen as a “nice” number in that it enabled the possibility of having a child of both sexes (commonly known as “a pigeon pair”). However, many parents based their preference for two children on their perceptions of their ability to “cope” on a daily basis, with many not imagining that they would cope with three or more children (and such influences are discussed further in Chapter 9):

Well, even, you know, wanting to go and have your hair done... imagine if you had four children, wanting to have your hair done, you just rock up at the hairdresser with four kids – welcome to a nightmare! (laughs) “We’ll just destroy your shop!” You can do it with one [child] (laughing still) can’t you.

(Mary, 43, former nurse and manufacturing-project manager, upper-middle status area, mother of 1 - aged 3)

Material and lifestyle aspirations also limited family size beyond two children but this depended on the size of the family of origin and the degree to which external constraints were viewed as problematic (issues which are discussed further in Chapter 10). Several parents who were likely to stop with an only-child did see two children as “manageable” but felt strongly that three would be “a lot to handle”. Others felt that “two or three” would be acceptable, suggesting that with a more supportive social and economic environment more Australians might realise a desire for three children.

### **6.2.2 Social and peer group images of larger family sizes**

Understanding social constructions, or “images” of larger families is important because, as has been noted in previous chapters, larger families have prevented Australia’s fertility rate from so far falling into the very low category. Although the two-child norm has become so culturally established that beyond it there emerges suspicion of contraceptive failure (Lesthaege 1983), and “family sizes above three [are considered] almost deviant” (McNicoll 2001:231), nevertheless AFFSS parents’ images of larger families depended substantially on their personal experience. Different images highlighted different ways of thinking which gave preference to individualistic and materialistic views, or to collectivist and non-materialistic views, which in turn could influence family size and career-family/lifestyle preferences:

One [child] you can give a lot to, two you give a bit less, three... you know and by the time you get down to four, suddenly they start to notice that they’re missing out.

(Faith, 36, former nurse, student midwife, upper-middle status area, mother of 3 – aged 2, 4 and 6)



Bigger families create a different dynamic. If there's one [child], or sometimes two, that child doesn't experience things that I think are valuable like sharing and being able to go with the flow a bit more. [One or two children] it's all a bit "neat" for me, a bit ordered. The kids all have everything [and] I just wonder how much there's a challenge materially. I like character-building things. There were always a lot of people in our home, coming in and out, there was that sense of sharing your time and your possessions and stuff.

(Abbie, 35, former diversional therapist, upper-middle status area, mother of 4 – aged 1, 4, 7 and 9)

For some AFFSS parents, preferences for smaller families could result from perceptions that personal coping abilities were insufficient to deal with the "unknowns" of larger families. For many parents who had come from, or were staying at, a smaller family size, a family of three or more children was imagined to be "chaotic", "messy" and noisy" in nature, as "strange", "unusual" and "freaky" in size, and as too demanding on emotional, physical and financial resources. Those who only had experience of smaller families perceived that, in venturing into a "large family culture" (which would be unknown to themselves and probably therefore demand a greater degree of behavioural adjustment), parents of larger families were "brave". Contributing to this image was the fact that positive images of larger families were also less common in the reference groups of those intending smaller families:

[Three or four children] just didn't fit with me. It's probably because I've only ever grown up with having a sister myself... and it's always been a nice number. And since then we've got friends who live south who have four [children] under the age of five, that's pretty well much nailed it on the head that we're quite happy with one. And if [number] two comes along well that's good, but we're not going to have any more... They [the friends] pull their hair out getting in the car, it's just a nightmare, it's stressful, so in that case we are sort of happy with one, or if another one comes along, two, but that will be [it].

(Adam, 32, retail manager, lowest status area, father of 1 aged 4)

Since many AFFSS parents wanted their family size to be similar to others they knew, and this was particularly noticeable for some at higher parities, declining birth rates may contribute to a social environment in which having larger families feels "abnormal". Despite having other reservations about having more children, and despite being one of five herself, one mother of four said "we would be socially peculiar if we had five [children]... we're already way above the average — that's 1.6 or something". However, the acceptability of a larger family was reinforced in certain circles and could be highlighted by moving between different groups:

In the Catholic education system four [children] was of no consequence, but we've since put [daughter] in public education and you're introduced as a mother of four, like it's something different! I do remember when I was pregnant with my fourth... the enquiries as to whether

or not it was planned... This woman came up to me and said 'Ooh you're BRAVE!'... and I said what does THAT mean? [and she said] 'Well four, it's a lot having four'.

(Teresa, 44, former primary school teacher/ex-nurse, highest status area, mother of 4 – aged 2, 6, 8 and 11)

[In New Zealand] everyone was always saying 'Oh my gosh, are they all YOURS?'. We were in [a major city] but there's not many people I know with four kids in New Zealand. And we got involved in a great community here [in Australia] through a girlfriend who happened to be at the church. And there were lots of people with lots of kids! We weren't freaky cos we had four.

(Karen, 41, former travel manager, highest status area, mother of 5 – aged 4, 6, 8, 9 and 11)

Finding others with similar behaviour could therefore reassure people about their own fertility behaviour. Karen, for example, was self-conscious of having both her fourth and fifth children "by accident" until she found a friend whose "fourth was an accident too". However, similar social status was also influential, with Karen explaining that "she's an accountant and he's in business, and I thought 'Well I'm not so bad after all!'".

Family size preferences could also be raised or lowered on moving into a group or area with different family size norms. One mother had recently emigrated from South Africa and found herself now wondering about having a third or fourth child like some of her new Australian friends, whereas the different conditions in her home country meant that:

Back home [in South Africa]... it's pretty much two [children] is the most common, and then some people will have three. It's very very unusual anyone will have more.... you basically wouldn't have more than two generally because you are almost forced to send your children to private schools. I don't think it would put me off having a third [child in Australia – feels public schools more acceptable and less peer pressure for private schooling] but back home it would have... I must say, a couple of my friends [here in Adelaide] one is pregnant with her third, which obviously would have had some impact on me... cos she's quite a good friend and it would have been nice if we'd had a baby [as] a shared experience. And then my neighbour last year, that was when I particularly thought I should have another one, just before [second child] got too old as well. She was having a second... And then another friend's pregnant with a fourth so...

(Margaret, 33, accountant, highest status area, mother of 2 – aged 3 and 6)

This effect of different family-size cultures was also highlighted by a mother who had felt happy with an only child when only-children dominated her friendship group. However, when some friends had had a second child, or their children gained step-siblings, she wondered whether she too should have a second child to stop her daughter from feeling "different".

However, she was comforted knowing that the private school her daughter was attending provided an alternative culture of reassurance with its significant proportion of only-children:

That's sometimes because the mum's a professional who left it too late, like a doctor or a lawyer - there are some of them - there are also some who send them to that school BECAUSE they only have one, it's a very expensive school.

(Lucy, 47, company director in family business, upper-middle status area,  
mother of 1- aged 6)

These findings help explain how sub-replacement fertility ideals can develop, such as in German-speaking Europe where researchers hypothesise that the diffusion of a low-fertility culture through social networks and the media reflects younger cohorts who have increasingly “grown up in smaller families” of one or two children, and who are also “more and more likely to have had friends, classmates and cousins in smaller families as well” (Goldstein, Lutz & Testa 2003:13; Testa & Grilli 2005). This is the opposite effect of the “large family culture” identified earlier in this chapter. The AFFSS findings suggest that as average family sizes fall, people have fewer social learning opportunities to be exposed to larger-family life such that they increasingly imagine raising larger families to be more difficult than raising smaller families. In turn, society and lifestyles becomes less and less structured towards larger families. Indeed, in relation to car and house size, admission tickets, package holidays and the like, one AFFSS father of three children noted that “these days... nothing's really designed for four kids”.

On the basis of the above influences of family of origin and wider social networks on personal family size preferences, the AFFSS suggests that the higher fertility rates in Australia in the past, when compared with countries currently in the “very low” range such as Germany and Japan (as shown in Chapter 2), have therefore partly contributed to the rate so far not falling into the “very low” category. It also supports Danish findings (Murphy & Knudsen 2003) that the intergenerational effects of larger families keeps fertility rates higher than they might otherwise be. The thesis therefore argues that future fertility trends in Australia will depend partly on people's reactions to their own and others' experiences in their families of origin and wider social networks, and there is no reason why ideal family size should fall, and it might in fact rise. Lucy, for example, reasoned that if her daughter later felt she had been disadvantaged by having no siblings then “what's to stop her meeting someone, marrying and having THREE children”. It is important for researchers and policymakers to acknowledge the existence of

social constructions of different sized families because these can influence the degree to which various other issues are perceived as obstacles (which is discussed further in Chapters 10 and 11). Government policy can therefore only be influential within the “zone of possibility” for family size which individuals imagine.

### 6.2.3 Social and peer group norms about the timing of childbearing

A second influence on fertility from wider social groups was thinking about *when* to start a family. Section 5.3.2 in Chapter 5 showed that the mean age of AFFSS mothers at their first birth rose from around 25 years in the lower status areas, up to 32 in the higher status areas. One mother highlighted the impact of different social backgrounds on the age of first-time mothers:

It depends where you are, because where I grew up [in the lowest status area] no-one has their kids in their 30s. It'd be in their 20s.

(Jackie, 37, former high school teacher, upper-middle status area, mother of 3 – aged 2, 4 and 6)

Another mother reflected family-based norms about the “right” age to have children:

That's just the way I thought it went, you know. My mum had me at 22, and I just thought that's what happens when you turn 22-23, you'd find someone and have kids... [so] I thought I was late having a child [at 29].

(Elizabeth, 32, hairdresser, lower-middle status area, single mother of 1 – aged 2)

Although some women in the lowest status area became mothers in their teens, the mid-20s appeared to be a more preferred lower age limit if perfect contraception would allow fertility outcomes to reflect lifestyle preferences:

I've always wanted kids but I didn't think I was going to have them THIS young [19], right now... [I would have preferred] probably mid-20s, but I fell pregnant earlier than that (laughs).

(Ellen, 20, unemployed fast-food worker, lowest status area, mother of 1 – aged 1)

My mum had my sister when she was only 18; both my sisters had their kids when they were young [20-21]. I knew I didn't want to have them THAT early... I always wanted a house first and I've seen the financial struggle to get there afterwards. We were in our house when I fell pregnant with [first child] but it was still earlier than what we sort of planned. We still would have liked to wait at least another year or two... just to be a bit more financially secure.

(Joan, 26, former aged carer, lowest status area, mother of 1 – age 2, and pregnant again)

For others, images of family size were related to images of parenting older children:

Three [children] will be good. This one will be ten and I'll be 34 and it's OK. By the time I'm 40 I'll have 20-year olds. My dad, he's 50 and he's got a 3-year old! And I'm like, "No! I'm not going to do that!"

(Kathy, 24, trainee hairdresser, lowest status area, mother of 2 – aged 2 and 4, pregnant with third)

In terms of the increasing age of first-time mothers, Kohler et al (2002) argue that social interaction, particularly in friendship groups, also has an important influence. Therefore it is not surprising to find that while in the lower status AFFSS areas some who had had their children "early" expected their childbearing to be over by age 30, in the higher status areas some who had not started until their mid-30s were reassured by seeing others still having children into their 40s. However, the personal experience of later parenthood, particularly the first time, could result in an accumulation of age-related reasons not to have another child. Biological and financial considerations set the upper age limit, including issues such as the increased risk of birth defects, the physical difficulties of parenting young children, and potential future problems with health and income. As one 37-year old father explained:

I don't think I'm too OLD to have [another] child, but I do want to be of an age that I can still do things with my kids... One of my clients actually he's 61 and he's got a 6 year old child... she had her first when she was 45 and it's only one child... The kid's pretty full on and I think they're finding it pretty tough... Financially he can't retire when he originally thought he was going to... So, there would be an age where I [wouldn't want to do it again], even probably 40 and up, so I'm probably getting close to that.

(Harry, 37, finance manager, upper-middle status area, father of 3 - aged 2, 4 and 6)

Others had disliked their own personal experience of having "older" parents, which made them set their own age limits lower:

I just always felt they were older than any other parents, whereas these days it's not such an issue, there are a lot of older parents. I felt very conscious of it.... So I think 40 [would be my upper limit] in terms of I'll be 60 by the time it's 20, and you want a little bit of time to yourselves too before you get too old.

(Chloe, 38, primary teacher, highest status area, mother of 4 – aged 1, 2, 4 and 7)

These personal reflections have important implications when considering how long the median age of first-time childbearing will continue to rise, and today's children of older first-time parents may decide not to repeat their parents delayed parenting. However, the extent to which experiences of older first-time parents will diffuse to lower the age norms of others is unclear.

Some interviewees and respondents reflected the “changes in lifestyle” associated with the Second Demographic Transition (van de Kaa 2004) and talked about having delayed children so that they could “live” life first. However, AFFSS interviews showed that despite the trend to later childbearing at the social level contributing to lower TFRs, at the individual level larger family size was not necessarily related to an earlier start to childbearing, even in the higher status areas. Desired and eventual family size was more influenced by the strength of motivation to find a partner and establish a family (as compared with other life goals), than by the particular age at which childbearing commenced or was completed (and this is discussed more in Chapter 11 in relation to desire-size groups). Indeed, even where AFFSS mothers had not commenced childbearing until age 30 or later (n=16), including mothers in the highest status areas, 38 per cent had still had three to five children and 25 per cent had two. Even most mothers who had started at 38 or later (intentionally or by accident) considered it feasible to still have two children, if this was what they wanted. Earlier American research also found that “regardless of age at marriage, those wives desiring larger families either plan shorter intervals or else neglect effective contraceptive techniques and thereby experience shorter intervals” (Westoff, Potter & Sagi 1963:244). In the AFFSS it was either *conscious desire for* a larger family or *no obvious reason to avoid* a large family which meant a larger family size could be attained despite a later start.

### **6.3 PERSONALITY AND PERCEIVED ABILITY TO COPE AS A PARENT**

A third important influence on fertility which was raised by AFFSS parents was the degree of interest in, and desire for, babies and children and the individual’s assessment of how they might cope if they became parents. Earlier demographic research showed that personality characteristics and attitudes to children and family life are influential on fertility (Miller W.B 1992; Westoff et al 1955). This is in line with research in developmental psychology which shows that individual personality influences the transition to parenthood because it influences how individuals cope, or think they will cope, with parenting (eg Belsky & Kelly 1994; Dimitrovsky 2000; von der Lippe 2004). To this extent, individual reactions and coping styles can act as proximate determinants of fertility (von der Lippe, Billari & Reis 2002).

Some AFFSS parents specifically located the source of their earlier uncertainty about parenthood in their personality, feeling that traits such as being perfectionist, liking control

and order, and preferring peace and privacy were incompatible with having children:

The prime reason for not having a child [originally] was I realised then I didn't think I had the personality and *I still don't believe I've got the personality to be a parent.... I'm obsessive about her health. She's still not allowed food colouring, I don't allow her to have anything except healthy food... I'm obsessed with her being well adjusted, intelligent, focussed, responsible.. I'm very fussy about how I do things... See, it's my personality, when I do something I go all the way and that's why I'm not a good parent because I want her to be perfect.*

(Lucy, 47, company director in family business, upper-middle status area, mother of 1- aged 6, emphasis added)

Another mother felt that both her own and her husband's personalities were incompatible with parenting a larger family so that they felt unlikely to go far beyond two children:

And also I guess *because our personalities*, my husband and I, *we like order*, we're quite... I'm *on the perfectionistic side*, so we like things to be done, *being in control*, that's what we're used to, *but with a baby you can't*. It was an adjustment for both of us, looking back, and I think with a second one it won't be as hard because I know what to expect.

(Fiona, 34, psychologist, highest status area, mother of 1 – aged 1, emphasis added)

However, this mother highlights a complex interplay between “personality”, postmodern preferences and habitual behaviours when she notes the possibility of adjusting and gaining parenting skills through personal experience of raising children. This suggests that her problems stemmed more from her expectations and the behavioural adjustments required, than from her personality per se. Indeed, it is thought that “the availability of coping resources is itself the consequence of prior coping episodes and... over time these experiences become trait-like characteristics of personality” (Gore 1985:271). This difference between apparently “natural” characteristics and acquired skills is important in influencing the degree of stress experienced in the transition to parenthood, and is discussed further in Chapter 9.

Levels of confidence and personal assessments of ability in relation to parenthood also affected the fertility thinking of some of the preconception respondents. While 50 per cent of both men and women did not question their suitability for parenting, 21 per cent of the men and 26 per cent of women were concerned or very concerned. Those in managerial/professional occupations and those with university qualifications were more concerned about their suitability than those in clerical/service occupations or those with lower levels of education. One preconception woman added an explanation:

Fear that I will not be a good mother – generally have a short fuse.

(Female veterinarian, 29, preconception survey)

Marshall (1993) also found that of the childless women she interviewed 46 per cent said they didn't have children because they didn't think they would "make a good parent", while 60 per cent didn't want "the responsibility of having children" (by comparison 12 per cent cited financial reasons and 27 per cent said children didn't fit with their career plans). These influences were cited in other Australian studies (eg Weston & Qu 2001; Weston et al 2004). They show that levels of anxiety and confidence about parenting can be important influences on people delaying or avoiding having children.

Important traits for parenting identified by the AFFSS parents were patience and tolerance (although perhaps as suggested by Gore 1985, such traits actually develop or can be developed with experience of caring for children). One mother of seven believed that these traits were important in differentiating those who coped better with parenthood, and which facilitated progression to higher parities:

You DO have your ups and downs... but from what I'm experiencing with couples that have only got ... they've got 2 kids and don't want no more... they just can't cope. They stress heaps, you know. The kids do silly little things and they're stressing about it... I'll stress about it if it's major, but I mean silly little things that children do. They're CHILDREN, you know. They learn... They're children! They do make mistakes, they DO play up... If you let everything they [kids] do stress you out, well I'd be in a mental home by now.

(Molly, 41, unemployed agricultural labourer, lowest status area, single mother of 7 from 5 relationships- aged 8, 10, 11, 17, 22, and twins aged 5 )

There was also a perception that people with larger families had such traits in more abundance, with some parents of smaller families perceiving that parents of larger families were simply people who "LOVE having children. That's their goal in life, that's what they enjoy doing". Indeed, of the nine families with four or more children, four associated their size simply to the mother's love of children. Enjoying being in a "crowd" of people also positively influenced a desire for a larger family, compared with desires for quietness and privacy being linked to smaller families.

The perceived degree of compatibility between an individual's assessment of their personality, and their perceived ability to cope with what they imagine parenthood to entail also influences the degree to which people "liked" or were "interested in" having children. As levels of



childlessness increase, these are perhaps becoming more consciously considered prerequisites for parenthood. Indeed, in one Australian study 20 per cent of interviewees said they were childless because they did “not like children” (Weston & Qu 2001). Variables which correlate with higher fertility therefore reflect underlying values and attitudes towards children and parenting, as much as views on contraception (Andorka 1980; Caldwell 1982). This association between fertility behaviour and a need to “like babies and children” was highlighted in the AFFSS by one father of three children who may have remained childless had he not met and married a trained nanny who was keen to do all the childrearing:

While I thought “Yes” I could possibly have children *I’d never seen any that I’d liked (laughs)... I have very little tolerance* for people that don’t understand... asking questions but not really wanting answers and that kind of stuff... Just the way I’m put together. Things aren’t really getting any better even now... the oldest is 7 [the others 4 ½ and 3]. In fact I don’t think they’ll get good until they’re adults. *Children just aren’t my thing...* I’m not a baby-person.

(George, 40, car mechanic, lowest status area, father of 3  
– aged 3, 5 and 7, emphasis added)

Similarly, a 46-year old principal of a private high school, and father of two in the highest status area, felt he would have remained childless had he stayed married to a primary teacher who wanted no children because “that just wasn’t her”. Later he divorced and married a woman who wanted two children. Another father exhibited ambivalence towards having a third child, saying:

I probably would have, personally, been satisfied at two [children], but didn’t really mind if we had three. I bought a new Harley [motorbike] and [wife] always wanted a third child... I thought if it happened, it happened and if it didn’t happen, well we’d be happy with two.

( Chuck, 42, electrical technician, lower-middle status area, father of 4  
- aged 8 and 13, plus “accidental” twins aged 1½ )

One AFFSS mother of seven children felt that at the social level these negative attitudes towards children negatively influenced other’s desire to have them:

Our Western society doesn’t promote children... they don’t love children... Children I think here are considered a nuisance and a burden and people think then “Well why would I want to have children”... I don’t think they see the good things that children can bring and the richness that they can bring into their lives.

(Sarah, 41, former receptionist, now home-school teacher to own children,  
lower-middle status area, mother of 7 - aged 1 ½, 3, 5, 8, 14, 18 and 20)

Issues of personality and coping style will be discussed further in Chapter 9 in relation to how they can influence the behavioural adjustment involved in the transition to parenthood, which in turn can negatively affect desire for further children.

#### **6.4 CONCLUSION**

In taking a life course perspective, this chapter has shown that individual constructions or “images” of parenthood and family size develop through direct *number* thinking as well as through *experience-based thinking* about family life. This confirms McNicoll’s hypothesis that social learning mechanisms contribute to an individual’s “image” of parenthood, which in turn influences their personal family size thinking and behaviour. The chapter demonstrated that this image is influential because it shapes whether individuals believe that parenthood should be a priority in their life, what they believe parenthood entails, and whether they believe they have the personal skills to cope with this. At the same it could also influence the extent to which they pursued education and career aspirations instead of family, or chose to be childless. The chapter has therefore demonstrated that social interaction can act as an important filter to external forces that might otherwise negatively influence fertility; they may also negatively influence fertility despite positive external forces. Therefore despite rhetoric about modern reproductive “choice” at the individual level, the AFFSS has shown that individual fertility thinking and behaviour in South Australia continue to be influenced by the family and wider social group. The next five chapters explore how experiences and reactions to the processes of bearing and raising children may impact on fertility and family size preferences by reshaping these images of parenthood.

## Chapter 7

# Experiences of conception and pregnancy

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Evidently, even in an advanced industrial society, control over reproduction remains markedly imperfect

(Montgomery 1996:100).

### 7.0 INTRODUCTION

This chapter is the first of five exploring personal experiences of becoming and being a parent. Later, in Chapter 11, these experiences will be discussed against the background of the family and social contexts discussed in Chapter 6. Although earlier empirical research in demography suggested that individual reactions to the physical and socio-psychological experiences of bearing and raising each child might influence whether or not further children were born (eg Bulatao 1981; Cartwright 1976; Peel 1972; Young 1975), this has been generally overlooked both in in-depth contemporary research and the contemporary debate on low fertility in Australia. As such, the theoretical and policy focus has remained on women's education and work opportunities and only considers their childbearing and childrearing experiences in relation to this. In addition, any potential impact on family thinking and family size outcomes of *men's* expectations and experiences of the physical and socio-psychological processes of childbearing and childrearing have been all but ignored.

This chapter focusses on exploring how individual and couple experiences and expectations of conception and pregnancy can influence the desire for (more) children. The chapter contains two main sections, the first on conception and the second on pregnancy. The first part of each section outlines the extent to which experiences were influential on fertility thinking and behaviour among AFFSS parents, while the subsequent parts explore the influences in more detail. Further introductory material is provided in each section

where relevant. Both sections draw on the in-depth AFFSS parent interviews and the preconception survey.

## 7.1 CONCEPTION EXPERIENCES

### 7.1.1 The extent to which conception experiences impact on fertility

Experiences of conception contributed to the delay or prevention of further births for one in six mothers and just over one in ten fathers, as shown in Tables 7.1 and 7.2.

**Table 7.1**

**Family size limitations from conception experiences, by status**

Source: Adelaide Fertility and Family Size Study 2003-04

	Status area				Total	Number
	Highest	Upper-middle	Lower-middle	Lowest		
Mothers	27%	9%	14%	11%	16%	6/38
Fathers	17%	0%	25%	14%	13%	3/24

**Table 7.2**

**Family size limitations from conception experiences, by parity**

Source: Adelaide Fertility and Family Size Study 2003-04

	Parity				Total	Number
	One	Two	Three	Four or more		
Mothers	18%	20%	13%	11%	16%	6/38
Fathers	33%	14%	0%	11%	13%	3/24

A small number of couples (five) had had difficulties conceiving and/or had accessed assisted reproductive technologies (ART). However, as Table 7.2 shows, contrary to what might be expected, those with larger families had not necessarily all conceived more easily. Three families (with 3, 4 and 7 children) had experienced periods of infecundity of up to six years between children, or had conceived naturally (and sometimes “accidentally”) in spite of accessing ART. Nevertheless, most parents had conceived relatively easily, and indeed a situation which the thesis will term a “fertility overshoot” was found to be significant, where couples had gone beyond the family size desired by one

or both partners (usually due to contraceptive failure). This will be discussed further in section 7.1.3.

### **7.1.2 Pre-parenthood perceptions of the ability to conceive**

Although the literature discusses childlessness by choice (eg Baum 1994; Faux 1984; Marshall 1993; Wheeler 2001), and by partnership circumstance (eg Cannold 2005), the current demographic debate rarely acknowledges childlessness resulting from biological impediments or environmental impacts, even where these relate to the workplace. Several AFFSS mothers mentioned that when younger they thought they might remain childless because of biological impediments. For example, irregular menstruation led some women to think they might have difficulties conceiving even if they wanted to:

I think I thought I WOULD have children...[but] I used to think I'd have a problem even having children at all. I didn't expect... just irregular periods.

(Margaret, 33, accountant, highest status area, mother of 2 – aged 3 and 6)

I actually knew I was going to have a problem because I have very irregular periods. I would have had maybe four or five cycles [in a year].

(Jesse, 38, economist, highest status area, mother of 2 – aged 2 and 3)

Another mother thought she would not bear any children herself after a physical injury:

I came to the conclusion that I wouldn't have them [children] of my own and I MAY look into adopting when I got older... I was involved in a car accident on my pushbike and I had a brain injury and... then they said that the pituitary gland, or something, whatever it is that controls hormones, when I was 15 they worked out that nothing was working properly and I had to go onto hormones. And basically, if I ever wanted to actually fall pregnant I'd have to go through the whole IVF and that sort of stuff... I dealt with that and said "OK I'm not going to have kids of my own".

(Rayleen, 30, shop assistant, lowest status area, mother of 1 – aged 4)

Two fathers mentioned that their fertility may have been negatively affected by work-related conditions. Doctors believed that one father's fertility had been negatively affected by regular hand contact at work with chemicals over at least 10 years, while another father believed that work-related mental stress had negatively affected his fertility which contributed to longer birth intervals between their first children, whereas their later children had been born closer together after he had changed jobs.

### **7.1.3 Unintended conception and “fertility overshoots”**

Unintended births and situations where people have more children than intended must be considered in any attempt to explain fertility differences and patterns, as well as in consideration of possible future fertility scenarios. Although there is some assumption that the development of the Pill and access to abortion has led to perfect contraception (see Aries 1980; Ruzicka & Caldwell 1977), one US study of popular women’s magazines found “countless” discussions of unintended pregnancy, although “almost totally absent was the possibility that a woman might end up with more children than she wanted” unless she belonged to a minority group such as welfare mothers or adolescents (Bledsoe 1996). Estimates of “unwanted” fertility set the figure at around 10 per cent for Western Europe (Bongaarts 2001a:267), while in Australia it is estimated that around 14 per cent of women have more children than they want (de Vaus 2002). Other estimates from Australia, the US and the UK are that 25 to 30 per cent of pregnancies are “unintended” or “unplanned” (Brannen 1987; Frejka & Kingkade 2003; Montgomery 1996; Morgan S.P. 1996; National Institute for Health & Clinical Excellence (NICE) 2005; Webb & Holman 1992). For Japan estimates for “unplanned” births are around 20 to 23 per cent of all births (Retherford, Ogawa & Sakamoto 1996). Montgomery (1996:100) is therefore right to comment that “evidently even in an advanced industrial society, control over reproduction remains markedly imperfect”, and this was noted by one higher status AFFSS mother who said “Most people have accidents. Well, quite a lot of people I know have ‘oopses’”.

An individual or couple cannot always, or do not always wish to, be clear whether a pregnancy was consciously planned or intended. The literature is contentious on the extent to which pregnancies can be labelled as “unintended”, “unwanted” or “unplanned” and methods for estimating unwanted pregnancy are not always reliable (see Casterline & El-Zeini 2005; Williams, Perez & Sobieszcyk 2001). In the AFFSS interviews, explanations could be complex, perceptions could change over time, and it appeared that there were different degrees to which a pregnancy could be considered to have been “planned” or “unplanned”. However, parents generally described their children as “accidents” or “surprises” if they were conceived when the family size was considered complete by one or both partners (including at zero children for some):

It wasn't on the cards to have another child... I came home from netball that night [and] didn't take my Pill...[because] I'd snapped my ligament and I was in pain. I have missed enough Pills in my life to not worry... And it was about 6 weeks after the fact, and I hadn't sort of got my period and it just twigged to me... And I just thought "This shock to my system has upset my periods so I'm all out of whack"... And I more thought maybe I'm going through early menopause cos... my sister went through it at 40. [I went] to the doctors for my knee and said "You know by the way, my cycle's all mucked up" and he just said "Well before we worry about that we'll have to do a pregnancy test" [and] we were just talking about everything else... and he goes "You're PREGNANT!"... So [later] I went to have the CVS [genetic screening test], I went on my OWN not thinking it wasn't any big deal... and he said "Look, I'm sorry Mrs [X] but we can't do [the test] you've got two babies in there and we can't do this test on twins"... and I just went out in the carpark... I rang [husband] and I said "You're not going to f\*\*\*ing believe this, it's f\*\*\*ing twins!" (laughs). And he went "F\*\*\* and f\*\*\* and f\*\*\*" lots and lots of times!

(Danielle, 39, office manager, lower-middle status area, mother of 4 – aged 8 and 13, and "accidental" twins aged 1½)

Such situations of "accidental" conception were related to approximately one quarter of the children of parents in the study families, or 27 per cent, which mirrors the national estimates of unplanned and unintended conception in the previous section.

A breakdown of what the thesis terms "fertility overshoots", where the actual family size was greater than the desired size (in contrast to "fertility gaps" which are the reverse situation), is given in Table 7.3. This shows that the percentage of children involved in fertility overshoots ranged from around a fifth to a quarter in the upper-middle status and highest status areas respectively, to approximately one third in the lower-middle and lowest status areas. Thoughts of aborting the pregnancy were mentioned in only two cases, with others discovering their pregnancy when they felt it was "too late" for an abortion (beyond three months gestation), or deciding to accept the situation. "Overshoot" situations obviously had a greater impact on family size where the additional pregnancy resulted in a multiple birth, as with the mother above, who went from two to four children.

Explanations of "overshoots" related to failure or misunderstanding of contraception and included conceiving whilst using the Pill (4 couples), assumed infertility leading to the non-use of contraception (3), misunderstanding/miscalculation of the "safe period" or the contraceptive effects of breastfeeding (3), and assuming that the partner was using contraception (3). There were also gender differences in attitudes to "accidents", with fathers more likely to say they would have stopped at a lower number of children than

**Table 7.3**  
**Children considered “fertility overshoots”, by status and parity**

Source: Adelaide Fertility and Family Size Study 2003-04

Status of area	Led to parity 1	Led to parity 2	Led to parity 3	Led to parity 4+	Per cent considered overshoot
Highest	1 intended zero children but Pill failed	Father would have had zero children	-	Father preferred 3 not 4; Both preferred 3 not 5.	6/27=22%
Upper-middle	2 intended zero but Pill or condom failed, or infertility was assumed	-	1 assumed infertility (previously used IVF)	1 failure of safe period; Father preferred 3 not 5.	6/31=19%
Lower-middle	-	-	Both would have preferred zero in that relationship	Father preferred 4 not 7; Both preferred 2, surprise twins.	8/22=36%
Lowest	1 assumed infertility; 3 assumed contraception being used; 1 Pill failed	-	1 unwanted – wife’s PND; 3 fathers preferred zero, mother preferred 2.	-	9/27=33%
Total	8 children	2 children	8 children	11 children	29/107 =27%

were mothers. This was reflected in couple mismatches over having more children, with fathers in only four couples wanting more children when the mothers did not (all in the highest and upper-middle status areas), whereas mothers in eight couples across all areas were interested in having more children when the father was not.

In some cases conceiving “by accident” led to an interest in having another child, even though previously the likelihood had been that no children would have been born:

I never really thought about it [having children]... Our lives were too complex even for it to come up in conversation... The career did get in the way but only in that you had to be there 100% of the time... He [child] was a surprise (laughs)... I was on the Pill when I conceived him [at age 40], so he wasn’t planned at all... I can only remember missing the end or beginning of the cycle. But we were very happy... I was pregnant [again] last year ... that was a conscious decision... had a miscarriage... It’s the same as before, che sera sera, if there’s another one that’s fine, if there isn’t, well he’s plenty.

(Georgie, 44, senior medical specialist, highest status area,  
 mother of 1 - age 4 with disability)



In other cases accidental conception dampened the desire for more children. For six parents accidental pregnancies had negatively affected their relationship and undermined a desire for more children. Mandy, a 35-year old sales assistant in the lower-middle status area, talked of how her first accidental pregnancy at the age of 22 had led to her relatively new relationship breaking down because her husband could not adjust to having baby in the relationship. Dougie, a 34-year old truck driver from the lower-middle status area, had also been put off having more children after his experience at the age of 19 when his 17-year old girlfriend became pregnant when he believed she was using contraception. The relationship had broken up a few months later when the girl moved interstate, but his experience of fatherhood at an age when he felt they were “both too young, didn’t know what we were doing... lack of communication, lack of maturity” and with too much pressure from the family meant that:

The first experience put me right off [having more children]. That just turned me right away, cos bad experience, and the money hassles with the child support and maintenance side of things.

(Dougie, 34, long-distance truck driver, lowest status area, father of 4 - aged 8 to 15 from two previous relationships, now living with girlfriend Rayleen, mother of 1- aged 4)

However, the similar experiences of Tas, a 34-year old forklift driver from the lowest status area, resulted in him wanting *more* children in his second relationship to build the strong family that he had not had the opportunity to provide for his first child.

While it may be assumed that those who stop at parity one either chose to have just one child, or are prevented from having more by certain obstacles, it is less often considered that having one child may have resulted from those who intended to remain childless conceiving unintentionally. Such conception whilst using the Pill was mentioned by two AFFSS mothers, both of whom previously fitted the “intentionally childless career woman” image described in Chapter 2. Both had postgraduate qualifications and were aged over 40 and explained a previous desire to remain childless, which had been reflected in effective contraceptive use in their long-term relationship. Two interviewees said they had heard that the Pill might become less effective with age, or with long-term use, or that there might be other contributing circumstances to such accidental conception:

I haven't met any other people [who conceived while on the Pill], but I HAVE met people who said "It happened to my sister-in-law" or something like that. I was really amazed actually. Someone had said to me that something on a documentary, how women towards the end of their fertile life the ovulation can get a multiple dose of eggs and that and I don't know how true it is, and it could also be because I've been on the Pill since I was a teenager, so I don't know. But looking back there was no, sort of, I don't know, no illnesses no antibiotics... no idea!

(Anne, 42, postgraduate student, upper-middle status area, mother of 1 – aged 2)

Considering the comments earlier in this section about the potential negative impacts of unintended pregnancy on a mother's or father's psychological, relationship or economic well-being, these anecdotal themes related to the Pill merit medical and sociological investigation. For one well-educated mother it had taken personal experience to explode her belief in the myth of perfect contraception:

I'm fairly intolerant... of people who don't help themselves. When people say "Oh it was an accident", I [don't believe them]. Then I realised accidents CAN happen, because it happened to me!

(Lucy, 47, company director in family business, upper-middle status area, mother of 1- aged 6)

The studies cited earlier estimated the average level of "unplanned" pregnancies in several developed countries to lie between approximately 10 and 30 per cent. Assuming that the people involved would never have chosen to become pregnant again had they been able to avoid the "unplanned" pregnancy, then this level of "excess" births could suggest a "fertility bust" waiting to happen, considering the ever-increasing developments in medical technology. Indeed, the UK's National Institute for Health and Clinical Excellence (NICE 2005) has recently issued guidelines to encourage UK health professionals to increase discussion with women about the benefits of long-acting reversible contraception (LARC) methods such as injections and implants. Their hope is to reduce the UK's rate of unplanned pregnancies (currently at 30 per cent), and particularly amongst teenagers. LARC methods are currently used by only 8 per cent of UK women aged 16-49, compared with 25 per cent using the Pill and 23 per cent using condoms (NICE 2005). If these methods, which are less open to user error, were quickly accepted by large proportions of women then any associated reduction in unintended pregnancies might quickly and dramatically reduce total fertility rates. Indeed, it is estimated that if 8 per cent of women transferred from the Pill to LARC methods, then unplanned pregnancies in England would fall by 70,000 per year. Future research might explore to what extent the difference

between lower and higher fertility groups relates to differences in contraceptive methods (including abortion) and the social and medical effectiveness of use.

#### **7.1.4 Assisted reproduction and higher fertility**

Assisted reproductive technology (ART) has been used in Australia since 1979 to help couples achieve pregnancy (AIHW 2004:61). In 2002, just under 6,000 babies were born in Australia following ART treatment, accounting for 2.3 per cent of all births; 20 percent of these were twins and 0.5 per cent triplets (ibid). Delayed childbearing is associated with an increased need to use ART, with the average age of mothers giving birth after ART being 33.7, which is 4.3 years older than the average for all mothers (ibid). Continuing the theme of “fertility overshoots” in the previous section, this section considers how ART experiences can also lead to family size being higher than intended even when multiple births are not involved, which was a surprising find. Four AFFSS couples (10 per cent) had used ART, covering all but the lower-middle socio-economic group.

ART experiences contributed to higher fertility when a couple assumed their infertility to be permanent, so that no contraception was used. Infertility is, however, defined as the inability to conceive after 12 months of unprotected intercourse, or the inability to carry a pregnancy to live birth, and it affects at least 15 per cent of couples at some point in their life (Serono Laboratories 1995; Webb & Holman 1992). The fact that infertility is not a condition for life was highlighted by several AFFSS parents who had conceived both with ART and “naturally”. One couple had considered their family size complete with two children conceived through ART. However, since using ART they believed they were infertile and used this as a de facto contraceptive. They then “accidentally” conceived a third child “naturally”, which they were nevertheless happy to have. Another couple had used ART after being told they were infertile in their early 30s, due to problems with the male’s fertility. However, they had subsequently conceived their four desired children “naturally” and relatively close together. In two cases couples perceived that “giving up trying” with ART had reduced their stress levels and helped them conceive “naturally”.

ART could also increase family size through the existence of frozen embryos. Despite at the couple-level feeling that they had completed their family, two mothers were less

against having another child than the fathers (a fourth and fifth child respectively) and wanted to at least implant these “children in the freezer” to see if they would grow:

See we've got a bit of a dilemma. If I could have talked [husband] into going back for a third we would have used our frozen embryos left over but [third child] turned up and we now still have four frozen embryos... It's a horrible issue, I can't deal with it at all, I don't know what to do with them. So I've got four potential children sitting in the freezer... that's how all these guys started [gestures to children playing]. It's a huge issue with [husband]... we don't talk about it. He won't discuss it cos he doesn't want four [children]. If I had my choice I would perhaps go back and have one put in at a time... probably none of them would work, but what if I got pregnant the first time, then I'd still have three frozen embryos... It's a shocking dilemma and I don't think there's an easy answer.

(Faith, 36, former nurse, student midwife, upper-middle status area, mother of 3  
- aged 2, 4 and 6)

By comparison their husbands seemed less emotionally tied:

She would probably go again, but I wouldn't... We've got some frozen embryos as well and there's a bit of a thing, you can only store them for so long... and after 10 years they either get flushed or we've got to do something with them... Personally, as a bloke, probably I'd be happy to say goodbye because to me they're, they're embryos... they're not important any more, but to [wife] that's quite different and she has a real issue, we've got to at least implant them... But I don't want to run the risk of having another child to make it number four, for various reasons.

(Harry, 37, finance manager, upper-middle status area, husband to Faith)

In comparison, ART could also contribute to lower fertility in several ways.

### **7.1.5 Assisted reproduction and lower fertility**

Assisted reproduction contributed to lower fertility in three main ways. The emotional stress of having ART was one, the financial stress was a second, and the amount of time taken to conceive was another. Some underestimated the emotional and practical demands:

I was 25 when we started trying to have kids... after about a year of trying... we went to the doctor and she referred us to Repromed [reproductive specialists]... We just didn't realise how involved... it's REALLY... it was really STRESSFUL, and I just really admire people that can do it more than once... I was working full-time in the city... I'd have to be at [public hospital] at 7 o'clock to have all the injections and the tests and everything, and then to be able to get to work by 8.30am... I don't think I could cope with [having IVF again] on top of everything else now... I'm very involved with the kindy, with [son] and work, and the house... plus we'd have to get him looked after when we were both going [to IVF appointments].

(Tammy, 33, clerical worker, lowest status area, mother of 1 - aged 4)

This woman's husband had experienced ART as both emotionally and financially stressful, and these were additional reasons for this couple to not have a second child:

To be honest with you I don't want to do that again anyway [IVF], because the stress and that that was on us at the time was pretty high... Cost and everything, you know... We were on it for, probably, a couple of years... It would have cost us upwards of \$30,000 at the end I think... that's a lot of expense to go through to get one kid... We just basically turned around and said "Stuff it, let's just forget the whole thing, it's just put too much stress on the marriage. Let's just go overseas for 12 months, have a working holiday and see what happens" and yeah, (laughs) three months later and, bang!, a little person's on its way.

(Adam, 32, retail manager, lowest status area, father of 1 - aged 4)

Another mother acknowledged that experience of the ART process could be "an emotional rollercoaster" but said that because she had conceived quickly it would not put her off using ART again. A third mother had three miscarriages with ART, all at eight weeks' gestation, before eventually conceiving the first of her two children at age 34. Another mother talked of other emotional issues with having ART, and of an acquaintance whose IVF experiences had delayed her second child:

They give you injections [of fertility drugs] and monitor when you're going to ovulate. You lose ANY sort of dignity and pride when you go for IVF. There is NOTHING sacred (laughs). It's all just out there. The nurses are lovely and the doctors are great too, and they try to be very discrete but you know... [One friend of mine] couldn't cope with the injections, there's a lot of injections you've got to take, and she did have one child and she wanted another one but she couldn't bring herself to go back to IVF. So she then went to a naturopath for about four years but they ended up going back to IVF. She bit her tongue at the end and then had another one.

(Jesse, 38, economist, highest status area, mother of 2 – aged 2 and 3)

The issues raised in these sections in relation to ART could influence fertility to a greater extent if ART becomes more widely used, particularly as childbearing is delayed until later in life when natural fertility declines (and this issue is discussed further in the next section in relation to social images of conception). Assisted conception rose from accounting for 1.9 per cent of all births in Australia in 2000-2001, to 2.3 per cent in 2002 (AIHW 2004).

### **7.1.6 Experiences and social diffusion**

The experiences of conception discussed in previous sections hold the potential to socially diffuse and affect the fertility thinking and behaviour of others, either through encouraging

optimism or anxiety about the ability to conceive. There is a degree of incongruity in Australia between medical knowledge about age-related fertility decline and the social phenomenon of delayed childbearing which is taking increasing numbers of women into age groups where they are less and less likely to conceive, either with or without ART. This can be explained in relation to de Bruijn's fertility framework (Chapter 3 section 3.6) which allows for fertility thinking and behaviour to sometimes result from ignorance, or from selective or incomplete understanding. In the AFFSS, personal observation of other women bearing children at or over age 40 encouraged some women to delay their first or subsequent child. Indeed, the finding that one third of well-educated Australian women believe they can delay childbearing until past age 40 (Beit 2002), was echoed in the AFFSS preconception survey where 82 per cent of those aged 35-39 expected they would still be able to bear two children. In some cases this may be encouraged by publicity about older first-time mothers, particularly in Hollywood, and others conceiving close to age 50 (albeit rarely) (eg McClusky 2005; Pengelley 2004).

However, such experiences obscure the medical reality that few women over 40 (and more often those who have not conceived before) can conceive without assisted reproductive technology (Ivell 2005), and that less than 15 per cent of embryo transfers from women's own eggs result in a live birth (Lane M. 2005). Medical knowledge and social observation are sometimes balanced in discussing the benefits and disadvantages of motherhood at different ages in women's magazines (eg Osfield 2002), and media coverage of older first-time mothers sometimes warns that if women leave it "too late" they may not conceive at all (eg Whitfield 2003). However, the situation is complex because, although the knowledge that ART exists can contribute to delayed fertility by encouraging a false sense of security in science's ability to overcome natural fertility decline (Kimberley-Smith 2003; Norman quoted in Macken 2005; Weston & Qu 2005), the increasing medicalisation of conception through ART may be creating anxiety and undermining others' belief in their ability to conceive without assistance. While people may always have wondered whether they will be able to conceive if they decide to start a family, just over 50 per cent of AFFSS preconception respondents were concerned about their ability to conceive, despite the majority saying they were highly likely to have a baby, and with only one of the 45 indicating specific infertility problems. Anecdotal evidence suggests that some young women now purchase private health insurance with ART options "just in case" they cannot

conceive naturally if they delay childbearing. However, considering the issues raised by AFFSS parents, it is important to publicly discuss and educate younger people to highlight potentially negative experiences of ART, since several other parents who had not used it were aware of the emotional and physical impacts and said they would never use ART however much they wanted more children.

### **7.1.7 Summary of conception experiences**

This chapter has shown that family size outcomes were negatively affected by the ability to conceive for only a small proportion of AFFSS parents. This related to the regularity of menstrual cycles, and physical, emotional or environmental impacts on the reproductive system. In contrast, while the concept of the “fertility gap” suggests that completed family size often falls short of a higher level goal, the AFFSS showed that a significant proportion of Adelaide parents also have a “fertility overshoot”, with more children than originally intended. It also showed that highly educated and professional individuals are not immune to contraceptive failure or misunderstandings. Assisted reproductive processes were also found to influence fertility outcomes both negatively, through the impact on personal and financial well-being, as well as positively through the lack of use of other contraceptive methods and the existence of frozen embryos. The section therefore argued that the process and timing of contraception can be linked to both biological and wider cultural influences.

## **7.2 PREGNANCY EXPERIENCES**

### **7.2.1 The extent to which pregnancy experiences impact on fertility**

Experiences of pregnancy for both women and men relate to both the physical changes to the mother’s body involved in adjusting to growing a baby, such as increased tiredness, nausea and breast changes, and emotional changes involved in adjusting to the developing new body shape (Kitzinger 1997). In the AFFSS most mothers said their experiences of pregnancy would not deter them from having further children because the pregnancies had not been problematic. However, Table 7.4 shows that across all socio-economic areas pregnancy experiences did contribute to the delay or avoidance of further children for approximately a third of mothers and a quarter of interviewed fathers (15 fathers were not

interviewed). The contributing factors included issues of body image, medical conditions, physical pain, and pregnancy nausea. Fathers in higher status areas were more concerned about such impacts on their partners than were fathers in lower status areas.

**Table 7.4**  
**Family size limitations from pregnancy experiences, by status**  
Source: Adelaide Fertility and Family Size Study 2003-04

	Status of area				Total	Number
	Highest	Upper-middle	Lower-middle	Lowest		
Mothers	46%	27%	14%	44%	34%	13/38
Fathers	33%	43%	0%	14%	25%	6/24

Table 7.5 shows that the impact of pregnancy experiences on fertility was most influential for mothers and fathers at parity two. Here three-fifths of the mothers and two-fifths of the fathers said future family size desires were lowered by a desire to avoid further medical conditions or physical pain or discomfort associated with being pregnant, and one-third of mothers wanted to avoid further negative impacts related to their body image.

**Table 7.5**  
**Family size limitations from pregnancy experiences, by parity**  
Source: Adelaide Fertility and Family Size Study 2003-04

	Parity				Total	Number
	One	Two	Three	Four or more		
Mothers	27%	60%	13%	33%	34%	13/38
Fathers	0%	43%	0%	33%	25%	6/24

### 7.2.2 The influence of medical conditions in pregnancy

Of all women giving birth in South Australia in 2003, medical conditions in pregnancy were recorded for 29 per cent and obstetric complications for 31 per cent (Department of Health 2005:17). In the AFFSS, experiences of such situations could contribute to desires to have no further children. Two mothers had life-threatening medical conditions which influenced both their desire and their physical ability to have more children. The 39-year old office manager in the lower-middle status area, who had had two children and then twins by “accident”, had done so despite an ongoing blood condition which could lead to excessive bleeding, coma and death. Similarly, a primary teacher from the highest status



area talked about toxæmia in her first pregnancy, a condition from which her own mother had almost died. Despite being advised not to have a second child, and knowing that the condition could either improve or worsen with subsequent pregnancies, this mother still went on to have the large family (of four children) which she had desired:

At times I thought “Oh God!”. It really terrified me actually. The third or fourth time I was pregnant I thought “Oh, why am I going through this again”. Yes, that would be one of the big reasons I think [not to have more children]. I’ve always said to myself if this doesn’t improve, that’s it [with children].

(Chloe, 38, primary teacher, highest status area, mother of 4 – aged 1, 2, 4 and 7)

Another mother had a complication because of a previous caesarean section and, although keen to have a third child, her expectations of a future pregnancy put her off:

I had caesareans because of the diabetes. There is the risk that if you just have a natural delivery you can end up having a hypo, where your blood sugars drop too low cos you’re pushing so hard... After I had [second child] about 8 weeks after, I found out I had an incisional hernia [on the caesarean scar]. The internal stitching had opened out so the bowel was sitting in the skin. So I had that repaired and three months later it happened again. Before I had the hernia I would have said I wouldn’t mind having another [child], cos they’re just SO good, but for just me physically there’s no way I could do it. It felt like a bag of cement in your stomach. The doctor told me that the hernia will rupture again when I’m pregnant and you’d just have to live with it, and then when they did the caesarean they’d have the surgeon there. IF I fell pregnant, and the chances of that are pretty slim [IVF used previously], I would cope with it, but I’m not looking out to fall pregnant, but also not to completely stop. And that’s my compromise with my husband, cos he would LOVE another one but he also understands it’s very difficult healthwise for me.

(Jesse, 38, economist, highest status area, mother of 2 - aged 2 and 3)

Such experiences could increasingly influence future fertility rates considering Australia’s increasing caesarean rates, which are over 40 per cent for first-time mothers in some private hospitals in Adelaide (Department of Health 2005:58). (The impact of such interventions on fertility is discussed in more detail in the next chapter on birth).

A second pregnancy-related influence on AFFSS parents’ fertility were desires to avoid further emotional impacts of preterm labour (occurring before 37 weeks of pregnancy). In South Australia in 2003 preterm births represented just over 8 per cent of total births (Department of Health 2005:62). One AFFSS mother who had always wanted a large family felt that only two or three children were now likely for her, partly because of

finances and house size but also partly due to the emotional impact of going into labour only two-thirds the way through her first pregnancy. She felt this was a common reaction:

Being in neonates [neonatal intensive care unit] so long, I know that there's still a group of seven of us [who had premature babies] and I know that four out of the seven don't want to have any more [children]. Just scary. Like the situation itself, and they're not willing to go through that again... But we were determined that we'd try again... We always wanted more than one so we're willing to take the risk... but four of the seven won't... It's just too much emotionally.

(Joan, 26, former aged carer, lowest status area,  
mother of 1 – age 2, pregnant again)

Her husband also felt that these experiences influenced their likely family size, along with the added emotional impact of a miscarriage with their second pregnancy:

[First child] was three months prem and he was in hospital for the first three months of his life... So we were going there mornings, nights and I was going there after work. With [second pregnancy] they did the ultrasound thing and we heard [him] kicking and his heart beat and saw him moving, and then 20 minutes later he was gone. And just seeing what [wife] went through there, just the emotional... and seeing what happened... We actually saw [him], we held him and everything... We had him cremated and brought him home, a little funeral service and all that... Even with this one [current pregnancy] she's in high risk... The pregnancies that we've had we've talked about actually not having any more, but now since she's pregnant and everything's been going great... This pregnancy might go really well, and she might have a decent birth and a healthy baby... but then again if she has bad experiences... I don't really want [wife] to go through any more pain than what she has.

(Tas, 31, forklift driver, lowest status area, father of 1 – age 2,  
and 8-year old from previous relationship)

Longitudinal research with mothers of preterm babies with a high-risk medical status shows that these mothers experience considerably greater parenting stress than mothers of babies born at term and that they require additional support services (Singer et al 1999). These physical and emotional impacts on fertility of preterm births may become more significant if preterm birth rates rise. In South Australia the proportion of preterm births increased from 5.5 per cent in 1981 to 8.4 per cent in 2003 (Department of Health 2005:62). Increasing use of ART could also lead to higher rates since, although preterm births represent only 8 per cent of births overall, they represent almost a quarter of births for babies conceived by ART (AIHW 2004:44, 58).

### 7.2.3 Physical pain and discomfort, nausea and vomiting

Some women did not have such severe pregnancy problems but still had physical pain or discomfort which made them not want to risk having a further pregnancy:

My husband's had the snip! [vasectomy] (laughs). We're definite, no more! (laughs)). Probably my body would be the biggest thing... I was advised by a doctor that my body probably wouldn't take another one... I went up to 100kg with my first child... I was a very low carrier as well so I just had this little ball way down low, it stretched my stomach muscles, bruised them, I've got really bad lower back pains, and because I was carrying so heavily I compensated with my neck, so I've got my neck problems... I can feel it now, which I'm a bit annoyed about because now I'm committed to a chiropractor that costs me \$1,800 a year, purely from having kids. I wouldn't change it for the world but my body I don't think would cope with another pregnancy.

(Veronica, 31, former call-centre supervisor, upper-middle status area, mother of 2 – aged 4 and 6)

The impact on fertility of increasing numbers of women participating in the workforce has been discussed in earlier chapters, but the idea of motherhood clashing with paid work because of body image issues and coping with pregnancy nausea (“morning sickness”) at work are rarely mentioned in contemporary debate:

I don't want any more [children]... I REALLY didn't like being pregnant (laughs). I wasn't one of these women who glowed and thought it was wonderful... I was hot and bothered and fat and ... That put me off... I was sick as a dog for the first couple of months... I had to eat every 3 hours on the dot... Then I kept getting sick, the middle three months I was puking, then the last couple of months just hot and heavy and I couldn't work. Cos I'm a bit of a workaholic - I was bored and just wanted to get it [the pregnancy] over and done with!!! (laughs).

(Rayleen, 30, shop assistant, lowest status area, mother of 1 – aged 4)

By comparison, people perceived that those with larger families must have had fewer pregnancy problems. One mother of five noted how people said to her:

Maybe if you'd had terrible pregnancies and morning sickness for the first 12 weeks with every one, you would definitely by number two [child] have gone “I'm NOT going there again” but I didn't so....

(Karen, 41, former travel manager, highest status area, mother of 5 – aged 4, 6, 8, 9 and 11)

However, the strength of desire for children and earlier images of family size must be considered when interpreting such reactions and their potential effect on fertility. Clare, for

example, had had five children *despite* extreme pregnancy nausea. Her love of children and a strong desire for a larger family helped her endure the problems she experienced with leaving work and being bedridden for nine months for each of her five pregnancies. However, after the first birth she was encouraged by knowing that the nausea disappeared the minute the placenta was born. Her husband said that because of the impact of her nausea, their family size was completely a reflection of *her* desires. Nevertheless, she had been strongly affected by her experiences:

The pregnancy stuff has ruled the size of my family... When I was pregnant with the first I never thought I'd ever go through that again... I vomited for the whole nine months. I vomited so much I tore my oesophagus and was vomiting clots of blood and that was so painful because they really wouldn't fit through... They had to put an endoscopy scope down to see what was happening. I was bedridden, that's why I had to stop working, because I wanted to work... in my head I was going to... pregnancy wasn't going to affect me... working right to the last minute, but nature didn't allow me to do that. And I would faint, like collapse completely when I was filing things at work and they'd find me behind the filing cabinet and I'd vomited while I was out to it. So I was spending more time at the bathroom than I was working and I couldn't get myself to work, drive the car.

(Clare, 45, former primary teacher, upper-middle status area, mother of 5  
– aged 5, 8, 12, 14 and 16)

Pregnancy nausea also led a few other mothers to decide to resign from work earlier than intended, which could mean they were ineligible for maternity leave:

[I was] sick with him all the time, having to take time off work all the time, so I just ended up giving up [work]... Whenever we decide to have the next one, well then I'd just see how I go with it and if I can't work with it, I'd just have to give it [work] up again, and then go back at it [later].

(Ellen, 20, unemployed fast-food worker, lowest status area, mother of 1 – aged 1)

Nausea and vomiting in pregnancy are associated with positive outcomes of a lower risk of miscarriage, stillbirth and premature labour (Klebanoff et al 1985; Tierson et al 1986). However, medical studies show that for many mothers the duration and severity of nausea are greater than is generally believed and at least 70 per cent of all pregnant women experience pregnancy nausea and over 50 per cent experience vomiting (Jaernfelt-Samsioe, Samsioe & Velinder 1983; O'Brien & Naber 1992; Tierson, Olsen & Hook 1986). In fact Jaernfelt-Samsioe et al (1983) found that only 17 per cent of the 855 women in their study *never* experienced nausea and 52 per cent *always* had it. Furthermore, vomiting in a first pregnancy is positively correlated with vomiting in subsequent pregnancies (Klebanoff et

al 1985). Knowledge of this might well encourage first-time mothers to stop at one child. Nevertheless, this study also found that those most likely to suffer were younger and less well-educated mothers, which could have an increasingly weaker effect on fertility decisions as the age of childbearing increases.

#### **7.2.4 Body image and self-image**

Continuing the theme raised in Chapter 3 of reproductive processes being influenced by social constructions of childbearing and childrearing, it is important to note that with the Western cultural ideal being that a beautiful body is a slim one, pregnant women can find themselves falling far from this ideal (Boscaglia, Skouteris & Wertheim 2003). This contributes to what Semans and Winters (2001:10) see as the “temporary dismantling” of sexuality and self-image in the transition to motherhood. To some extent contemporary women’s magazines aimed at younger, career women try to “glamourise” pregnancy with fashionable clothing (eg “Cosmopolitan Pregnancy” magazine). However, other women’s magazines and newspapers highlight the differential impact of pregnancy by comparing those Hollywood and Royal celebrity mothers who regain their pre-pregnancy body shape within weeks of the birth (aided by their financial ability to afford personal fitness instructors, personal nutritionists and paid domestic help), with other celebrities and “ordinary” mothers who take much longer to regain their shape (eg Cousins 2005; Masters 2005; NW Magazine 2002). It is therefore not surprising that in the AFFSS issues of changing body image related to pregnancy influenced some women’s desires not to have more children. This included problems with “feeling fat” and unattractive in pregnancy, having difficulty re-toning stomach muscles after birth, and not wanting to share one’s body again with a baby.

One AFFSS mother rebelled strongly against her changing body shape in pregnancy, partly because the pregnancy was unintended but also partly because she had previously been very health- and fitness-conscious:

I was so health conscious, I was amazingly fit... The gym was a big part of my life... I hated my pregnancy, hated getting big, I still went to the gym. I wore a leotard, size 12, cos my size 10 got too small. I was almost rebellious about it. I used to do weights and wore leggings with a crop top and my tummy sticking out, and I’d work out and wouldn’t care two hoots. I exercised until the day before I had her and I was really big.

Look that was two days before I had her [shows a photograph]... I rebelled against the pregnancy. I wore skirts shorter than I ever had before... My mum and dad have told me since they were worried about the baby cos they thought I was going to reject it... and I used to look at these women in CAFHS [child health clinic] getting pregnant again and think 'You are NUTS. How can you do this [again]?'.

(Lucy, 47, company director in family business, upper-middle status area, mother of 1 – aged 6)

Although embodied experiences can shape future fertility intentions through the subjective interpretations and reactions of the individual, they also partly reflect cultural influences which can clash with personal experiences and cause self-criticism. One mother found becoming a mother particularly difficult because she was the first of her friendship group to have a baby. She therefore relied on cultural portrayals of motherhood which she felt had not prepared her well for her own personal experience:

Unrealistic expectations... the media had influenced me a lot... I was quite thin before I had [baby] and for the first time in my life I put on lots of weight, I couldn't fit into any clothes but the media portrays mothers that one minute are pregnant, the next minute look fine. And none of my friends had had a pregnancy previously... I had a very strong perception that motherhood would be a gentle, loving experience with a happy baby lying asleep somewhere in a clean house, and it just wasn't like that at all... I was this fat frumpy person in a messy house with a screaming baby.

(Jane, 31, insurance supervisor/graduate, highest status area, mother of 1 – aged 1)

Most of the fathers whose concerns about pregnancy delayed or prevented further births were concerned about the medical implications. However, one mother said that her partner's dislike of her being pregnant partly contributed to them not having a third child:

I was very nauseous. Probably for at least six months, and I put on a lot of weight and I was just generally not well... I think it would put me off. It definitely does put me off, the pregnancy. But, I think it puts [partner] off as well, cos you know what they [men] are like.

(Margaret, 33, accountant, highest status area, mother of 2 – aged 3 and 6)

In support of the thesis' argument, related to Postmaterialist Values Theory, that experiences of the processes of childbearing can adversely affect fertility desires, the AFFSS found that mothers in higher level careers, or who wanted to resume paid work within six months after birth, were sometimes more concerned about the physical changes related to pregnancy. For one mother, feelings of being physically unattractive due to

weight gain from pregnancy affected her feelings of confidence, her ability to perform well at work, and hence affected her desire for more children:

Do I really want to have to try and lose all that weight afterwards... I wasn't selling very much [when I went back to work], I wasn't very successful... I was heavier than I used to be so I didn't feel I could dress really nicely cos I had all these daggy big clothes, so that had A LOT to do with it.

(Athena, 39, ex-sales manager/high school teacher, upper-middle status area, mother of 2 – aged 6 and 8)

Discussion with a mother of seven children showed that those who had desired larger families could be less concerned (and perhaps more so if they were not in paid work), or were more prepared to accept the personal impacts of the reproductive process:

RESEARCHER: And did you have a particular idea of numbers [of children], of larger or smaller?

SARAH: Six (laughs).

RESEARCHER: So is that what it was always going to be, six?

SARAH: (laughs) Yeah, yeah. I love children, I've always loved children, babies, and I always thought I'd be a mother and have children.

*Later:*

RESEARCHER: Some people might find it difficult that once they'd had maybe three or four pregnancies they'd think of the impact it had on their body. Has that ever been an issue for you?

SARAH: No, not really (laughs). I'm not really worried about that (laughs).

RESEARCHER: Well some people do worry about that.

SARAH: (laughs) Well I can understand that. Yeah. I mean I breastfeed children for so long too... I breastfeed them till they're four... I'm a good cow!

(Sarah, 41, former receptionist, now home-school teacher to own children, lower-middle status area, mother of 7 - aged 1 ½, 3, 5, 8, 14, 18 and 20)

The potential impact of pregnancy experiences on desires to be pregnant again is shown by a study which found that “loss of figure” and “being unhappy with appearance” were two of the top five complaints by American mothers about the transition to motherhood (Belsky & Kelly 1994). The fact that such experiences of pregnancy are rarely mentioned in contemporary research and policy related to low fertility may be reflected in the finding that the impacts are often unexpected even by women themselves. Indeed, one study found that over half of all first-time mothers in Australia had not expected pregnancy to change their body or to reduce their sense of sexual attractiveness (Leblanc 1999). Presumably women's bodies have always changed due to the physiology of pregnancy, which would

suggest that women in the past perhaps experienced the same impacts but were less likely to allow them to downgrade a higher family-size preference compared with contemporary women who are perhaps more subject to media, social and fashion pressure to be fit, slim and health-conscious. Alternatively, women in other times and places may have wanted to avoid the physical impacts of pregnancy but did not have sufficient practical or social control over their fertility or family size to allow them to avoid such impacts.

### **7.2.5 Cumulative impacts and desires for better experiences**

The negative influence of pregnancy experiences on fertility sometimes increased with parity, with one mother noting that:

Getting the body back together after the fifth would be a nightmare! I already have no waist and my tummy muscles are shot to pieces. It's been harder to get my shape back after every pregnancy.

(Julie, 40, human resources manager, upper-middle status area, mother of 4  
- 3 teens plus 3-year old in new relationship)

Other mothers were dissuaded by anticipation of not being able to cope with existing children faced with, potentially, months of feeling unwell:

If it happens it happens [a fourth child] but I don't really want to have to go through morning sickness with three young kids, and the stresses, it makes it harder. Morning sickness when I just had one [child] was easy, but morning sickness with two [children] was a LOT more strain. I don't think I'd be able to do that [again, with three].

(Kathy, 24, trainee hairdresser, lowest status area, mother of 2  
- aged 2 and 4, pregnant with third)

The impact of pregnancy experiences could also have a cumulative effect on tiredness where mothers found that, not only were they caring for existing children, but their body was also older. Several felt that having children at or over age 35 took a greater toll. For example, one woman who had had her second child at age 40 commented that:

I don't want any more (smiles)... I just think I'm too old (laughs). You wake up in the morning and you've got aches and pains and you think "Oh no!" (laughs). [Husband] would probably go for a third, but he doesn't have to be pregnant... I was just continually worn out (laughs). I just look at those women who are pregnant and think "Oh, the end result's great but getting there isn't much fun"... The first baby was fine but the second you're just that little bit older and you've got another one running around. Just getting tired and feeling cumbersome and big and you know, all that sort of stuff. I



would probably do it again if I was younger and my husband really wanted to have a third, but he's not that fussed.

(Belle, 44, former midwife and senior sales manager,  
highest status area, mother of 2 – aged 4 and 6)

With the number of first-time mothers in older age groups increasing in Australia (as detailed in Chapter 2), these perhaps additional unexpected aspects of motherhood may become more influential on dampening fertility in future.

Although the negative impacts of pregnancy influenced the majority of parents to want to avoid further pregnancies, in one or two cases parents actually wanted to have another child hoping that this would give them the chance to have a “better” experience:

The thing that I really wanted to do was to have a proper pregnancy. It's really stupid but (laughs) but I just wanted to have this perfect pregnancy and perfect birth, you know, no dramas no hassles, and I didn't want to have any excitement, I just wanted to, you know, breeze through my pregnancy and then go “Here's the baby, beautiful, let's go”... It was the thoughts behind possibly having a third [child].

(Danielle, 39, office manager, lower-middle status area, mother of 4  
– aged 1½, 8 and 13)

### **7.2.6 Experiences and social diffusion**

Consideration of others' pregnancy experiences might be expected, through social diffusion mechanisms, to influence the decisions of those as yet without children, and some indication of this comes from the AFFSS preconception survey. Some respondents noted on seminar evaluation forms that they would have liked more information about “how to cope with morning sickness; more details about pregnancy and birth; physical changes during pregnancy; pregnancy in more detail”. Overall 42 per cent of the female preconception respondents were concerned about whether they could cope with being pregnant, compared with only 14 per cent of the men. By comparison, 29 per cent of the men were concerned about the impact of having children on the mother's body (although this could include impacts from birth as well as pregnancy), and 52 per cent of the women were concerned with this. Whilst no direct questions in the preconception survey related pregnancy concerns to family size, overall the survey did indicate that those who had more

concerns about parenthood generally were those intending to have only one or two children, while those with fewer concerns were those intending to have larger families.

### **7.2.7 Summary of pregnancy experiences**

Pregnancy experiences affected family thinking and behaviour for a greater proportion of AFFSS parents than did conception issues. This is probably because each pregnancy generally lasts eight to nine months, and the range of negative impacts can also affect both the ability to care for existing children as well as the ability to undertake paid work. Whilst it is impossible to predict individual reactions, studies cited showed that in pregnancy a quarter to a half of all women experience nausea, vomiting, and medical or obstetric complications. Whilst the AFFSS demonstrated that a strong desire for children or a larger family could outweigh the significant negative impacts of such experiences on individual and couple well-being, these impacts encouraged many others to have no further children. These experiences therefore hold the potential to affect the fertility thinking and behaviour of a significant proportion of women, but this has not been considered in contemporary research or policy addressing low fertility. Although individuals and policymakers can have little control over some aspects, discussion about cultural images of pregnant and non-pregnant bodies could help both men and women better prepare for parenthood, which might reduce some of the unexpected negative impacts. Furthermore, increased social support at home and in the workplace might also help women to have less negative experiences of pregnancy nausea.

## **7.3 CONCLUSION**

This chapter has considered the ways in which men's and women's experiences of conception and pregnancy influence considerations of whether or not to have further children. It has shown that experiences of conception influenced family size in both a negative and positive way, with a substantial percentage of parents having more children than they would have chosen, while others fall short of earlier family size desires. The chapter highlighted both positive and negative impacts on fertility of assisted reproductive technologies. The AFFSS also demonstrated that the physical and emotional experiences of pregnancy can have a significant influence on desires for further children, particularly for

women. The preconception survey suggested that expectations of what is involved in both conception and pregnancy could also influence the desire to start a family for those as yet with no children. However, the parent interviews highlighted the fact that the impact of childbearing experiences on fertility outcomes must be understood within the context of the individual's background, their current and past relationship dynamics, and their strength of motivation to have children. The impact on fertility of experiences in the stages which follow pregnancy are covered in the next three chapters.

## Chapter 8

# Experiences of birth

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In a society that is enamoured with extreme sports, birthing is extreme living. It pulls for the strongest feelings and emotions, not to mention tremendous exertion

(Reed 2005:209).

### 8.0 INTRODUCTION

This chapter considers how experiences of birth influence fertility and family size desires. Whilst improved medical technology has contributed to the Second Demographic Transition, so too has the increased expectation of women's right to autonomy, self-actualisation and freedom from social control in relation to reproduction (Bernhardt 2004; van de Kaa 2004:9). Indeed, the United Nations Fourth World Conference on Women (UN 1996:36) states that women's basic human rights include the right to "have control over and decide freely... on all matters related to their sexuality, including sexual and reproductive health". In this respect, this chapter will argue that the dominant model of medicalised maternity care in Australia is out of line with the postmodern preferences of many childbearing women and men, and that the resulting conflict negatively affects their desire for more children. While improvements to gender-equity in family-oriented institutions is advocated as a way of stabilising or raising fertility levels (eg Bernhardt 2004; McDonald 2000b), maternity care systems are rarely considered as a family-oriented institution relevant to low fertility research.

In line with the theme of childbearing and childrearing being influenced by social constructions, it is important to note that the process and experience of birth are socially constructed (Katz Rothman 1991). Kitzinger (2000) points out that the increasing use of technology in maternity care in many developed countries has reconstructed birth from a social event to a highly medicalised, institutionalised and depersonalised event. Birth has come to be seen as a "problem to be solved" rather than a natural physiological process (Canadian Association of Midwives 2004). Several authors (eg Goer 1999; Odent 1984; Tew

1998) believe that while the medical view of birth as a risky event is used to justify medicalised birth for every woman, medical interventions introduce new and often unnecessary problems when applied to the majority of women, who have “normal” healthy pregnancies and births. Medicalised birth is also associated with women feeling disempowered as they confront hospital routines and treatment from male doctors (Newburn 2003; Oakley 1992). Indeed:

in most northern industrial cultures we have come to expect a certain kind of childbirth. It takes place in a hospital, among strangers. Pregnancy and birth are managed by care-givers who assume that they know more about what is happening than the woman who is bearing the child. Her body is treated as a machine which is constantly at risk of breaking down... Each woman having a baby in hospital [becomes] a temporary member of a tightly organised, hierarchic and bureaucratic medical system... *the institution takes control* over her body. The relationship between professional care-givers and patients, though it can be friendly and emotionally supportive, is basically one of *domination and subordination*.

(Kitzinger 2000:8-10, 246, emphasis added)

Women’s experiences of such institutionalised birth being painful, impersonal and frightening have been discussed by well-known writers since the 1940s, mostly in attempts to empower women to improve their own experiences (eg Dick-Read 1963; Kitzinger 1972; Rich 1976; Cohen & Estner 1983; Brook 1985; Goer 1999; Kitzinger 2002). It is not surprising therefore that Priest et al (2003) find that around one third of contemporary Australian women are dissatisfied with their birth experience (representing 80,000 women per year: AIHW 2004). While most fathers “feel good” about being part of birth, at the same time many also feel dissatisfied with the experience (Reed 2005).

The sections which follow explore firstly the extent to which birth experiences impacted on fertility and future family size desires in the Adelaide Fertility and Family Size Study (AFFSS). The second section then details some of the ways in which these experiences impacted on AFFSS mothers, while the third and fourth sections consider impacts on AFFSS fathers and babies. Section five discusses the implications of Australia’s high rates of medical birth interventions for its fertility rates, while the sixth section discusses how images of birth can socially diffuse to influence those as yet with no children. The final section draws on the AFFSS interviews to highlight ways that governments could make changes to maternity care systems so that they are more in line with postmodern preferences.

## 8.1 THE EXTENT TO WHICH BIRTH IMPACTS ON FERTILITY

In the AFFSS, birth experiences negatively affected fertility and family size desires if people felt they wanted to avoid risking a repeat of negative impacts which they had previously experienced on their mental and physical well-being and on their relationship health. These impacts related both to the process of labour and birth, the after-effects of birth, and the maternity care received from health professionals. While the data from the parent interviews cannot be viewed as representative of all Australian parents, because it was not based on a random sample, Tables 8.1 and 8.2 have been compiled to give some indication of the possible impacts of birth on future fertility desires. They show that negative reactions to birth experiences contributed to the temporary or permanent postponement of further children for a quarter of AFFSS mothers and almost a fifth of fathers. The tables also show that these experiences were influential across all socio-economic and age groups. Some parents had experienced birth as “sort of OK” and did not elaborate further, but it is important to note that

**Table 8.1**  
**Family size limitations from birth experiences, by status**  
 Source: Adelaide Fertility and Family Size Study 2003-04

Socio-economic status	Mothers describing at least one birth in negative terms	Mothers whose fertility desires were negatively affected	Fathers whose fertility desires were negatively affected
Highest status	55%	27%	33% <sup>*1</sup>
Upper-middle status	27% <sup>*2</sup>	18%	14% <sup>*3</sup>
Lower-middle status	86%	28%	0% <sup>*4</sup>
Lowest status	67%	33%	14% <sup>*5</sup>
Total	55%	26%	17%

NOTE: Due to some partners interpreting reactions differently, only first-hand accounts are counted and only interviewed fathers are counted here. Four cases were not counted, and are detailed in the notes which follow.

- 1 One father described as affected by the mother, but not included here since no first-hand account.
- 2 The proportion is lower than other areas since 3 mothers interpreted experiences positively because they had a caesarean (two had the elective caesareans they asked for, one to avoid the pain she associated with vaginal birth, and another to avoid back problems; the third gave no specific reason).
- 3 One un-interviewed father possibly also affected by what mother described as a “messy, horrible birth”, but not included in this count.
- 4 One un-interviewed father wanted no more children because of his experience of the birth, according to the mother, but this father is not included here since no first-hand account.
- 5 An additional father possibly affected by being asked whether to save mother or baby if mother’s severe haemorrhaging worsened, but mother not explicit on the father’s reaction, so not counted here.

**Table 8.2****Family size limitations from birth experiences, by age at affecting birth**

Source: Adelaide Fertility and Family Size Study 2003-04

Age group	Mothers (n=38)	Fathers (n=24)
19-24	3	0 <sup>*1</sup>
25-29	2	2
30-34	3	2
35+	2	0
Total all areas	10 (26%)	4 (17%)

\*1 One father strongly affected according to mother, but not included here since no first-hand account.

such apparent satisfaction can reflect resignation as much as it does accomplishment (Mirovsky & Ross 1989:26). Others were reluctant to discuss their birth(s) in depth and were only questioned further if it was mentioned as impacting on family size desires. However, Table 8.1 shows that negative reactions did not always dampen the desire for more children, yet positive experiences could even increase the likelihood of wanting more children. These aspects are discussed later (in sections 8.5 and 8.6). Indirect effects of birth are not counted here: for example, one mother's decision to have no further children was due to the after-effects of a caesarean *birth*, but the influential issue was her fear of an incisional hernia reoccurring in pregnancy, which was therefore counted as a *pregnancy* influence.

## 8.2 HOW WOMEN'S BIRTH EXPERIENCES IMPACT ON FERTILITY

### 8.2.1 The birth itself

Despite not being accorded much attention, experiences or expectations of negative birth experiences which contribute to reduced family size desires have been noted by some researchers and were found to be influential on a desire to have no further children for a third of mothers in one large random British survey covering 1,500 mothers (Cartwright 1976), and for a third of mothers in a small-scale Australian study (Baxter 1979). Fear of pain associated with birth has also been associated with some Italians and Australians expressing anxiety about becoming parents (Maggioni 2004; Weston et al 2004).

In the AFFSS interviews, conversation about birth was very intense for some mothers who used strongly emotive descriptions. One said that birth stories were "like any good war

stories”, and indeed some used images of war or butchery to describe their experiences, with phrases such as “blood everywhere”, “chop, chop”, “ripped”, “tore”, “trauma”, “REALLY scary”. Just over half the AFFSS mothers talked about one or more births in generally negative terms and, of these, a quarter described their births as “horrific”, “traumatic” or “shocking”. Many of these were first births which were perceived negatively due to the impacts on the mother’s mental and physical well-being due to unwanted or painful medical interventions (eg caesarean, episiotomy, forceps), “uncaring” care from staff (lacking emotion, concern and understanding), and treatment from many “strangers” (unknown health professionals). Although AFFSS interviewees were not randomly selected, the prevalence of such experiences is similar to that identified in recent medical research in Australia and Britain, where a quarter to a third of women suffer acute trauma symptoms associated with birth (Creedy, Shochet & Horsfall 2000; Murphy et al 2003).

Table 8.1 showed that a third to a half of AFFSS mothers who had negative birth experiences decided to have no further children because they “could not face going through birth again”, or they had decided to delay having further children while they came to terms with their birth experience or looked for ways to have a better experience the next time:

I want to have number two [child], it’s just a matter of when... The thought of going through the birth again and having a horrible experience... turns me right off... just scares me to death... Forceps had to be done, so epidural had to be done, episiotomy gets done... When I think back to how much I paid him [the obstetrician], how patronising... he would give me little glib answers and you know “He’s an expert, he knows best”. Then he’d come out with a comment like “Mothers, you’re well educated, so you don’t like control to be taken away, but you’ve got to understand that the birth... it’s so unpredictable”... Then at the birth he only came in when he had to, spoke to the nurses and hardly to me. The nurses would just show and say “How are you doing?”, check the monitor and that was it, see you later... And your participation is just to lie on the bed, you’re a vessel for everything else... And your husband’s just there in the background, he doesn’t know what’s going on and he’s feeling helpless... I want to do some research, which I haven’t got round to doing yet, but I... need to build up knowledge again, to feel comfortable about having a different birth experience.

(Fiona, 34, psychologist, highest status area, mother of 1 – aged 1)

Such experiences could have less impact if family size desires had already been met, although family size may well have been upgraded if a positive experience had occurred instead of a negative one. Some AFFSS mothers who were not dissuaded by negative experiences had only vague memories due to the influence of medication or anaesthesia. Another mother saw her birth as an extremely positive event, despite severe haemorrhaging, because it signalled the end of nine months of extreme pregnancy nausea:



If they'd said 'Look, I'm sorry, we need to take your leg off now' I would have said "Fine!" I was just so grateful and thankful, I had this perfect baby and I didn't feel sick [any more]. And it didn't matter what they did to me.

(Clare, 45, former primary teacher, upper-middle status area, mother of 5  
– aged 5, 8, 12, 14 and 16)

Others coped by placing the birth in a time perspective, with one mother saying that despite a birth which she described as extremely traumatic, where she had been “cut to smithereens” and her “pelvic floor destroyed”, the experience did not negatively affect her desire for more children as she saw it as “only a DAY” out of her life.

Furthermore, of those AFFSS mothers with larger families, not all had had positive birth experiences. Some had found a way to have a better experience in a subsequent birth, but four mothers had overlooked negative experiences because of a strong desire for a larger family:

Giving birth's not... they were long labours and things, but I can block that out enough... I've had problems with them all feeding and we never got on the breast, and I expressed for five months [with first].... But it didn't put me off having more babies. I suppose I see that as a short term issue, not one that's going to go on for five years. It was VERY hard at the time.

(Chloe, 38, primary teacher, highest status area, mother of 4 – aged 1, 2, 4 and 7)

Another mother (seven children) was “quite willing to endure whatever it took to have the number I wanted (laughs)” (six children originally). As with the impacts of pregnancy discussed in Chapter 7, antecedent strength of desire for children and particular family sizes must be considered when exploring the impact on family size desires of various experiences. Family size could be expected to be more affected by negative birth experiences for those with a weaker desire for children or a larger family. While some women were willing to endure physical and mental distress to have a child, one must question whether they should not be provided with care which maximises the quality of the conditions in which they enter parenthood, for clearly this *was* available to some women (as discussed later in section 8.7), and it could have had a considerable positive impact on their eventual completed family size.

### 8.2.2 After-effects from the birth

In Leblanc's (1999) study of first-time middle class Australian mothers 84 per cent experienced changes to their body after birth, which severely affected the ability to cope with

motherhood for 45 per cent, while health and fitness were affected for 41 per cent. Physical problems related to birth in developed countries can persist for months after and often go undiagnosed and untreated (Brown & Lumley 1998; Gunn et al 1998). These often relate to medical interventions during the birth. Considering that in 2003 in Australia anywhere from 9 per cent of mothers (in the Northern Territory) up to 21 per cent (in Victoria) had an episiotomy (AIHW 2005:37), it is important to note that six months after birth almost half of all Australian women who had episiotomies and forceps still have perineal pain and 40 per cent have sexual problems (Brown & Lumley 1998). This compares with less than 1 per cent of women who do not have such interventions and who have an intact perineum (ibid). Despite these findings, relatively little research has been conducted on the unintended health consequences of birth (Lydon-Rochelle, Holt & Martin 2001). This may contribute to such impacts having been overlooked in the demographic fertility literature.

In the AFFSS the after-effects of birth were a stronger influence on reducing fertility desires for some mothers than the actual birth:

It took me two hours and seven minutes to push him out... when his head was crowning... I actually felt like my bum was going to fall out!... I have this vision of trying to get him out, and I just don't think that I could go through that again... [but] it's not so much then it's like afterwards, cos I got a really bad haematoma bruise on the walls of my [facial gesture "you know" - vagina] and [it took] six weeks to heal and then about three months after that before it actually stopped being painful during sex!!! [ie 4 ½ months] (laughs). I got an abscess in my breast and that took three months to heal.

(Stephanie, 38, former cleaner/receptionist, lowest status area, mother of 1 – aged 2)

Physical damage related to birth could also reduce the chances of further conception. One AFFSS mother had already had difficulty conceiving her first child, and benign ovarian cysts discovered during her pregnancy had burst during the birth with the force of her pushing and the use of forceps. The resulting months of pain made her adjustment to new motherhood very difficult and the fluid from the burst cysts had covered her ovaries, further reducing her already-low chances of conception:

I've only been left with about a quarter of each ovary on each side, because of all the damage that was done. So they said "Well you had trouble getting pregnant in the first place, it's ten-fold now". And that's where I left it. And I think at the time because I was going through all that I didn't WANT to have any more [children]... then a couple of years ago I went through the whole year, it was like, "Well we're not using anything [contraception], maybe we'll get pregnant". And it didn't happen, and now it's been nearly five years [using no contraception and not conceiving].

(Tammy, 33, clerical worker, lowest status area, mother of 1 - aged 4)

Other mothers reported severe pain associated with breastfeeding in the early weeks, from bleeding or cracked nipples, but this did not generally downgrade family size desires as it was seen as either a short-term issue, or one which could be avoided in future by bottlefeeding. However, these physical impacts could be combined with a lack of practical support for breastfeeding from maternity professionals and a lack of social support from spouses and family, despite strong encouragement for breastfeeding from health professionals. The resulting resentment and anger on the part of the mother could contribute to an overall negative experience of motherhood which contributed to a desire to delay or avoid further births. Some women were discouraged in having further children by their partner or family who did not want to see them go through such difficulties again.

While an accumulation of smaller issues is often as influential as a single event in contributing to stresses in childrearing (Oestberg & Hagekull 2000:616), the same was true in the AFFSS in relation to birth. One AFFSS mother highlighted this when comparing her own “wonderful” vaginal births and babies who slept well, with the experiences of friends:

I've got quite a few girlfriends and the ones who have had postnatal depression ended up with long drawn out labours, caesareans, and then tried to breastfeed, and just went through hell. So to me it seems like a bit of a snowballing effect, that being extremely fatigued from trying to give birth, going through this traumatic surgery, then they've got this child that's not accepting this breastfeeding, it's [breastfeeding] just pushed and pushed and pushed, and the mother's just absolutely worn out, and then all of a sudden there's postnatal depression. It must be linked to something.

(Tayla, 39, model/retail manager, lower-middle status area, mother of 2 – aged 3½ and 5)

Experiences of exhaustion and depression however take us into the realm of early parenthood, and this will be discussed later in Chapter 9. The impact of these birth experiences on fathers could also negatively influence their desire to have further children.

### **8.3 HOW FATHERS' BIRTH EXPERIENCES IMPACT ON FERTILITY**

Over the course of history fathers have been excluded, invited, restricted, or expected at birth, according to prevailing social attitudes of the time (Reed 2005). In the AFFSS, men's reactions to their first-hand experiences of birth were a second influence on family size desires which have been rarely addressed in low fertility research. Such experiences can be expected to have influenced more and more fathers as they have been increasingly “allowed into the

delivery room” (since the 1960s in Britain and since the 1970s in the USA), with 80 per cent of fathers attending births in Australia by 1987 (Russell 1987:334). The presence of the father is now so accepted that some men feel pressured to attend even if they do not want to, and can feel alienated and bewildered by hospital practices (Kitzinger 2000). However, Reed (2005:31) points out that, since the medical model defines birth as a physical process undertaken by a female body, the subjective experiences of birthing fathers have generally been seen as insignificant. While the vast majority of fathers “feel good” about now being part of birth, many also feel unsatisfied with the experience of not knowing how to help the mother, feeling in a position of inferiority and subject to the direction of medical staff, and finding their own social and psychological needs not being met (Reed 2005).

One AFFSS father explained how his negative experience of a first birth had to some extent negatively impacted on his thoughts about having further children:

- RESEARCHER: OK, so was there anything in particular in any other aspect that would have made you think that’s it, one child’s it?
- JOHN: Probably the birth experience was fairly traumatic. It put us off a bit (laughs) thinking you have to go through that again.
- RESEARCHER: So, now she’s pregnant again, are you still thinking that or have you changed your thinking?
- JOHN: Umm... we’ve been a bit reassured by the fact that there was a suggestion after [first child] was born that we might be able to have... because she had to have an emergency caesarean... that an elective caesarean might be a reasonable option [for a second baby], which would take away a lot of that anxiety. So I think we saw a way round that probably.

(John, 32, medical specialist, highest status area, father 1 – aged 1)

This interviewee’s wife explained the birth impact in greater detail, highlighting how fathers’ consideration of delaying or completely avoiding having further children can result from the emotional trauma of witnessing their partner having medical interventions during birth, such as forceps, episiotomies and emergency caesareans:

He does NOT like talking about it at all. He has REAL trouble. If I bring it up... he gets upset... He was very powerless and the baby was stuck and they tried everything, like they tried the ventouse, the forceps and everything. There was blood everywhere and they lost the heart beat quite a few times and at that point they assumed [baby] had died, and so it was pretty traumatic for him... It’s probably [for me] a combination of that and the first few months. If we had a really POSITIVE experience next time we may change our minds... We’re actually thinking elective caesarean because after the last birth the obstetrician... said that’s an option. It’s not an ideal option but given the stress of the last one it might be.

(Jane, 31, insurance supervisor/graduate, highest status area, mother of 1 – aged 1)

Some fathers who had difficult experiences of birth used humour to cope, with one laughing as he talked about being “down the wrong end”. Another drew on pragmatism in a similar way to the mothers of larger families whose strong desire for children often led them to overlook difficulties:

[Birth] was tough the second time round because there were complications. I was really worried about her, the post-birth issues... there was very little you can do, apart from holding her hand and talking to her, that's always a bit of a challenge... she had to go back into hospital and so I slept there at nights because the hospital wouldn't look after [the new baby as well] and I had to do all that... We had friends who looked after [first child, aged two]... We're fairly pragmatic from the medical perspective, her being a nurse.

(Gary, 46, high school principal, highest status area, father of 2 – aged 4 and 6)

Men's experiences of birth could also influence fertility thinking at the couple level. Although one AFFSS mother said that her birth experiences were a “very minor” consideration and would not affect her own desire for more children, her husband saw birth as another factor in an accumulation of issues which limited his desire for more children:

The baby, that was the most exciting and important thing in my life. The worst part was the pain Athena went through, even though it was a natural birth, and that might sound silly, but that was the hardest part of it for me. The actual birth, and toddlers, was the most exciting thing... but I feel sorry for Athena going through the birth. That's probably one of the hardest things, you're sitting there, going “It's all right dear...” If it wasn't like that and it wasn't the pain factor, I'd have as many kids as possible.

(David, 32, sales representative, upper-middle status area, father of 2 - aged 6 and 8)

Men's birth experiences could also negatively affect individual and couple fertility desires in an indirect manner. In five cases where a father had traumatic experiences of birth (often the first birth), the mother also said that he had difficulty becoming involved with the new baby, or was reluctant to help with childcare or domestic work. Depending on the mother's reaction to this, and on alternative sources of support, the father's lack of involvement could undermine support for the mother, affecting her ability to cope with motherhood and, in turn, her feelings about coping with further children. For the father, it could lead to a work-family decision which favoured work:

When she was born... she was only a 3 (on the Apgar scale of 10). She had the cord around her neck but she recovered very quickly. And I was going through a bit of a hard time with the epidural so it was a very messy birth. In fact it was a horrible birth. That night was awful because I had a drip in and of course [husband] had to go. The nurse said “Aren't you staying?” but he said “I'm going to work”. He came in less than my visitors. I mean from that day I never saw him, he'd keep coming for an hour at night... I had a terrible time of

postnatal depression. [Husband] was useless, he was WORSE than useless because he didn't understand either... He's never been there, never baby sat her, never looked after her. I think he's used work not to be here for things that haven't been pleasant to him.

(Lucy, 47, company director in family business, upper-middle status area,  
mother of 1- aged 6)

Future fertility could also be negatively affected if the experience of becoming a parent negatively affected the couple relationship. Indeed, several of the single mothers explained how their resulting resentment had contributed to their separation or divorce:

RESEARCHER: So, there were no big surprises [about having children]?

DONNA: No, not really... except childbirth!!! (raucous laughter).

RESEARCHER: So what was it about that that made you...?

DONNA: Just cos I had heaps of stitches (laughs)... and I thought I'd never have another one after that (laughs)... Just painful, yeah you didn't expect THAT. You know you knew it would be painful, but you didn't expect THAT.

RESEARCHER: And do you know how he reacted to a new baby in the house?

DONNA: (laughs) That's why we separated! ... cos he wouldn't play a part in his life

[the baby's life], you know. I raised him completely on my own for the first three months, and then I left [the relationship].

RESEARCHER: So, was he there when the baby was born?

DONNA: Yeah. He didn't like it though. Thought it was foul, the... the childbirth.

RESEARCHER: And then what was his reaction to the new baby, can you remember?

DONNA: Distance.

RESEARCHER: So, even though he wanted to have a baby, or a child... coping with the new baby was hard for him. So, how did that end up leading to you separating?

DONNA: Just because he wouldn't play a part in his life, he didn't change him, didn't feed him, didn't get up to him, didn't pay any attention to him, nothing... Just didn't know how to deal with it I suppose. Too much of a shock I guess. He was immature [aged 20] ... still is... He's never had any more kids... and he's vowed he'll never have any more... I mean the birth was really bad you know, I mean yeah, so perhaps that was enough to put him off completely.

(Donna, 34, sales/service worker, single mother of 2 from 2 relationships - aged 5 and 13)

Although the numbers in the AFFSS were small, mothers in the lower status areas who had such experiences with lack of support seemed more prepared to initiate a separation, while women in the higher status areas were more likely to live with relationship conflict or breakdown. Pocock (2004) also notes that working class high-school girls in Australia are more determined that they would divorce men who did not contribute domestically, while middle class girls are more likely to tolerate lack of contributions and "do it themselves".

By comparison with such negative experiences, another AFFSS mother observed how a positive and enjoyable birth experience could help the father become involved with the baby, which in turn could help the mother. Julie was a 40-year old human resources manager who believed that her really easy labour with her third child gave the father a good birth experience that contributed to a strong father-son bond. This made it easier for her to cope with the two older children while the father cared for the baby. Although some fathers did discuss enjoyable birth experiences, these could still be overshadowed by later problems adjusting to life with a new baby:

- RESEARCHER: I didn't ask you if you were there at the birth with the first one, and what was your experience of that?
- SIMON: I can't put it [into words]... not anything like it... it was so fantastic.
- RESEARCHER: So it was really positive. Was there anything difficult?
- SIMON: Just that it took so long. It gives me a warm feeling just thinking about it.
- RESEARCHER: Oh that's lovely, that's great. Did you feel involved in the hospital?
- SIMON: Yes, I thought I contributed quite a bit, you know, like the first bath... I just did whatever I could.
- RESEARCHER: So that was all OK, so when did it start to not work?
- SIMON: Probably the second night coming home... In the beginning it [looking after the baby] was thrust upon me and I wasn't really resentful about it but I did it because I had to.

(Simon, 35, skilled labourer, lower-middle status area, father of 3 - aged 6, 7 and 10)

This exploration of fathers' birth experiences, the impact on their relationships with the new baby and their partner, and the flow-on effect on the desire to have further children, adds an interesting perspective to discussions of increasing gender equity in the home. If some fathers' lack of involvement in baby- or childcare is associated with difficult birth experiences, then they require better preparation and support in the pre- and postnatal stages, rather than just social pressure to "do more". Recent research confirms that Australian fathers' distress in the postnatal period can negatively affect their attachment to the baby (Buist, Morse & Durkin 2003), while a national survey shows that Australian fathers want to be better prepared for how birth experiences can negatively impact on men, as well as how mothers can be physically and emotionally affected by birth, including the possible negative impacts on the adults' sexual relationship (DFaCS 2004a:84).

#### **8.4 HOW BABIES' BIRTH EXPERIENCES IMPACT ON FERTILITY**

Babies' experiences of birth were a third influence on family size, albeit indirectly through affecting the parents' ability to cope with parenthood, and in turn the parents' assessment of

whether they would cope with further children. Tayla's comment has already suggested how birth experiences may "snowball", and the impact of the birth on the baby can constitute part of this. Four AFFSS mothers who had difficult births also said their babies had cried a lot, not slept well, and had feeding problems. One mother, a 38-year old former nanny with three children, believed that these aspects of her first child's behaviour were possibly related to her difficult labour, and to the baby being taken away from her after the birth. The effects of this were that, had she not conceived a third child by accident, she felt she would have stopped at two:

Well I actually thought I'd probably have bigger [family] when I was little, cos I've always been... sort of looking after kids, around kids... [and] "if you're gonna have one... well in for a penny in for a pound". You can't have just one... But third child was sort of "Hello, I'm here!" because... my eldest girl was always a bit of a hassle to look after, she was a very demanding baby... maybe because of her labour? It was a really long labour for her and it was a difficult labour, you know it wasn't a nice, moving, experience... it was a lot more intrusive... They prepare you for labour but until you actually go through it you can't actually... it's a bit of a culture shock to sort of have ALL these people concentrated on the bit of you that you're really not interested in showing to the world in the first place! (smile in voice)... When I had my second child he was as easy as!... I know he's the second and it's all looser anyway [but] if I'd had my son first, I probably would have thought "Hey this is an alright experience and I will keep going" ... [but] she's a strong personality. And I think because my own personality is so passive I find her very hard to cope with. And I thought "Well I've got her and I've got my son, that's probably enough of a contrast, we'll stop there".

(Christine, 39, former childcare worker/nanny, lowest status area, mother of 3 – aged 3, 5 and 7)

While some have long suggested that a "good" birth and a healthy pregnancy "set the pattern of the newborn infant and its relationship to its mother" (Dick-Read 1963:xii), recent research confirms a link between difficult births and anxiety in Australian children, where anxiety is defined as being fearful and having difficulties settling into novel care (such as childcare or school) or leaving the mother (Rapee & Szollos 2002:149). The study showed that:

mothers of anxious children reported a significantly greater number of birth complications (eg low birth weight, forceps delivery, caesarean section) than mothers of non-clinical children [and] anxious children were also reported to be more likely to spend time in intensive care after birth (Rapee & Szollos 2002:149).

Other related problems in this study (also reported by AFFSS mothers) included sleeping difficulties, feeding problems, pain, crying and excessive activity. Alongside birth complications, anxious children were also more likely to have experienced other severe stressors, including parental separation and parental violence. The federal Department of



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Family and Community Services has initiated and funded the Longitudinal Study of Australian Children (see Sanson et al 2002) which will include the collection of data that should allow further investigation of how birth experiences may affect children's later health and behaviour.

### **8.5 HOW OBSTETRIC INTERVENTION IMPACTS ON FERTILITY**

This chapter has so far argued that the demographic literature rarely considers how fertility rates might be adversely affected by negative birth experiences as described by AFFSS parents. Against this background, it is not surprising that Australia's high and rising obstetric intervention rates are also rarely considered as a potentially negative impact on the fertility rate. Nevertheless, a recent British study (Bahl, Strachan & Murphy 2004) found that, even three years after birth, 42 per cent of women who had an emergency caesarean and 51 per cent who had forceps or ventouse births said they would never have another child because they feared giving birth again. Even in another study five years after birth (Jolly, Walker & Bhabra 1999:231), 25 per cent of women were still frightened after such births and 10 per cent were frightened of giving birth after normal vaginal births. Alongside these psychological effects on fertility desires, these and other studies (eg Cohen & Estner 1983; Dickinson 1994; Senate Community Affairs Reference Committee (SCARC) 1999a; Smith, Pell & Dobbie 2003; Wagner 1994) show that caesarean birth and other birth interventions can have long term ill effects for both mother and baby and can damage the reproductive organs, thereby not only increasing the difficulty of conceiving again, but also increasing the risk of unexplained stillbirth and medical complications with subsequent pregnancies and births.

Since fertility rates are generally lower for professional/better-educated women, it is interesting to consider that women living in areas of higher socio-economic status are more likely to have private health insurance (South Australian Health Commission 1990:154), and that maternity care in Australian private hospitals is associated with higher rates of obstetric intervention than in public hospitals (Blanchett 1995; DHS 2003; Department of Health 2005; Roberts, Tracy & Peat 2000; Shorten & Shorten 2004). Indeed, in some South Australian private hospitals around 40 per cent of all first-time mothers have a caesarean, compared with rates under 20 per cent for some major public hospitals (Department of Health 2005:58). Furthermore, in 2003, the overall caesarean rate for one major private hospital in Adelaide was as high as 56 per cent, with 452 out of 797 mothers having a caesarean (Anderson L. 2005).

Although overall caesarean rates increase with maternal age (AIHW 2005:30), caesarean rates in all age groups are higher in Australian private hospitals (AIHW 2005:33).

This high rate of caesarean births in private hospitals, which are more likely to be patronised by higher status women who can afford private health insurance, is reflected in data for the selected AFFSS areas. Table 8.3 shows that in 2002 over a third of mothers in the higher status AFFSS areas had a caesarean birth, compared with closer to a quarter in the lowest status areas. The rates ranged from 21 per cent in one suburb of area Lowest A, where 14 out of 66 mothers had a caesarean, to more than double this, at 52 per cent, in one suburb of area Highest B where 45 of 87 mothers had a caesarean. In addition, between 1996 and 2002 there was a greater increase in rates for the higher status areas (the greater increase in the lower-middle status area may be explained by the establishment of a new private maternity facility close to this area in 2001). The fact that some suburbs in area Highest B have caesarean rates as low as 24 per cent may be explained by higher status women tending to be older first-time mothers. In this respect, older mothers are more likely than others to plan birth at home or in a public hospital birth centre (AIHW 2004:58-59), choices which are associated with reduced likelihood of medical intervention (Byrne, Crowther & Moss 2000; DHS 2003; SCARC 1999b). A certain proportion of higher status women in Adelaide may therefore be exhibiting the “avant-gardist” behaviour which Kravdal (2001:190) suggests is typical of the better-educated as they seek new ways of adjusting to new demands.

**Table 8.3**

**Caesarean section as percentage of all women giving birth in study areas, 1996 and 2002**

Source: calculated from unpublished data by postcode of mother’s residence, South Australian Perinatal Statistics Unit, Department of Health

Socio-economic status of area	% caesareans 1996	% caesareans 2002	% range 1996 <sup>*1</sup>	% range 2002	% increase 1996 to 2002
Lowest A	24.5	26.6	23-25	26-27	8.6
Lowest B	22.4	28.3	19-28	21-31	26.6
Lower-middle	22.5	36.4	18-26	32-40	61.9
Upper-middle	26.7	32.9	22-29	31-33	23.4
Highest A	26.2	37.4	21-39	27-52	42.8
Highest B	20.9	35.0	20-21	24-44	67.1
Adelaide	23.0	29.6	0-46 <sup>*2</sup>	5-56 <sup>*2</sup>	28.4

1 Highest and lowest percentages of postcodes in these areas

2 Postcodes with 0-5% rates generally had low numbers of women, eg 0 out of 15, or 1 out of 19.

Women having private maternity care also have higher rates of elective caesarean, which are planned before labour occurs or is induced. This occurred for 20 per cent of women at metropolitan private hospitals in South Australia in 2003, compared with 9.7 per cent in the public hospitals (Department of Health 2005:46). SCARC (1999a) found that many women do not understand the problems associated with caesarean birth compared with vaginal birth. Indeed, Wagner (1994) believes that the serious risks associated with a caesarean, for both mother and child, are among modern civilisation's best kept secrets. An elective caesarean may not affect voluntary fertility if it is an intervention of choice (see footnote 2 in Table 8.1), but it may still lead to involuntary infertility since it involves the same surgical procedure as an "emergency" caesarean. However, one AFFSS mother noted that some women may be more likely to choose an elective caesarean *because* they intend to have only one child and are therefore less concerned about the potential impact on their future ability to conceive or carry a second baby to term.

The thesis findings suggest that high and rising birth intervention rates may be negatively affecting Australia's fertility rate. Australian intervention rates are higher than most comparable countries (SCARC 1999c), and the caesarean rate increased by 50 per cent over the ten years between 1993 and 2003, from 19 per cent to 28.5 per cent (AIHW 2004:31, 2005:29). Current rates vary from 23 per cent in Tasmania's public hospitals up to 43 per cent in Queensland's private hospitals (AIHW 2005:32). Drawing on data in Bahl, Strachan and Murphy (2004), it is possible to calculate that around 13 per cent of Australian women giving birth each year will avoid having further children simply because of the way their baby was born (based on 16 per cent emergency caesareans and 11 per cent forceps/ventouse births: AIHW 2004:31). To this 13 per cent must also be added the percentage for whom such interventions contribute to *in*voluntary infertility, and those for whom fertility is adversely affected by other birth experiences or the after-effects birth, as well as those whose family size desires are negatively affected by the impacts on the father or baby. For the reasons outlined earlier, some argue that Federal Government policy encouraging women into private health insurance is increasing Australia's high obstetric intervention rates (Shorten & Shorten 2004). The thesis findings suggest that, since this is associated with births which are more likely to contribute to voluntarily and involuntarily lowered fertility, this policy results in outcomes which are counter to other government policy which seeks to stabilise or raise fertility rates.

## 8.6 EXPERIENCES AND SOCIAL DIFFUSION

Individuals' experiences of birth can become important inputs to the image of birth held by other individuals and by the wider society. Indeed, the widespread use of intervention and technology in birth has created fear and doubt about the adequacy of the female body to reproduce, contributing to a "culture of fear" about birth in many developed countries (Canadian Association of Midwives 2004). One AFFSS mother explained how her diminished desire for children in her 20s was partly influenced in this way:

As you get older and you're married for a while people tell you about their birth stories and I have a very low pain threshold, how could I POSSIBLY do that, I couldn't. So everything was very very negative.

(Athena, 39, ex-sales manager/high school teacher, upper-middle status area, mother of 2 – aged 6 and 8)

Against this background it is not surprising that in the AFFSS only three of the 38 mothers (less than one in ten) described births as "thrilling", "marvellous" or "wonderful. This was remarked upon by one mother who said of her own birth:

[The birth] was just like they tell you at the antenatal classes, right to like clock-work. It was excellent. *In fact I actually enjoyed it and people think it's quite strange.* I said I'd do it any day. I didn't like being pregnant at all but I did like the birth... Like I say, I'd do it EVERY day, I thought it was just wonderful!

(Tayla, 39, model/retail manager, lower-middle status area, mother of 2 – aged 3½ and 5, emphasis added)

Likewise, another mother reflected on the prevalence of negative birth experiences in Australia saying that, despite her own relatively easy births, "I must admit I do speak to a lot of women that say they had terrible births".

Although the numbers in the AFFSS preconception survey were small, some responses showed how the culture of fear about birth could contribute to women delaying or avoiding having their first child. In reply to what were the three biggest issues she was thinking about, one woman included:

how painful it would be giving birth... I overcame the fear of having a baby, giving birth, and then fell pregnant immediately. Now all the fear is back again.

(Secretary, mid-30s, preconception survey)

Anxiety about giving birth, at least under the conditions which currently dominate, can be seen to clash with postmodern preferences for maximising personal health and well-being. Findings from the preconception survey suggest that such anxiety may be more prevalent in women of higher occupational status, since 77 per cent of the women in professional/managerial occupations had major or medium-level concerns about giving birth, compared with 41 per cent of the women in clerical/service occupations. Recent focus group research with Italian women who had no children or only one child also found “a certain apprehension about the birth and the possible complications associated with the labour” (Maggioli 2004:104), and such concerns were also raised as an influence on fertility by some respondents in a recent national survey in Australia (Weston et al 2004:56). Future research could explore the extent to which such issues affect the family size desires of the increasing numbers of Australians who are expected to remain childless, along with their socio-economic variability, because:

when women have suffered in childbirth... it is not only they who are affected. They carry with them through their lives the memory of this experience and by their attitude towards childbearing affect... many others with whom they come into contact (Kitzinger 1972:17).

It is important to also note that in the AFFSS preconception survey 30 per cent of the women said they were more likely to have a baby because the seminars had addressed their anxieties. This effect was greater for professional/managerial women (46 per cent), although this group had had more concerns originally.

For some women the capacity to reflect on their experiences, to seek alternative care, or to know that a negative experience would not necessarily be repeated in a future birth, meant that negative birth experiences could sometimes have less impact on future fertility thinking:

I had a SHOCKING birth, but I think if they know... if we all learn from the mistakes of what my birth was like, if it was different, it wouldn't be as bad [next] time.

(Elizabeth, 32, hairdresser, lower-middle status area, single mother of 1 – aged 2)

I had placenta previa [placenta lying low in the uterus] so I was in hospital for weeks and weeks before I had [second child]... in case I haemorrhaged. And I did actually haemorrhage... I haemorrhaged everywhere and nearly died... then they couldn't put me under [anaesthetic], they couldn't find a vein to put it in... I've still got scars to this day, and that was REALLY scary... It was hard [but] I just hoped I wouldn't have that same problem again, which I didn't.

(Marie, 30, former unskilled industrial labourer, lowest status area, single mother of 3 from 2 relationships – aged 1, 4 and 5)

Counselling and the sharing of other women's positive experiences, along with an understanding of what contributes to better birth experiences, can also reduce anxieties (eg Newman & Hancock 2006; Saisto & Halmesmaki 2003). The differential impact on fertility between births which are perceived negatively and positively, and the encouraging social messages sent by women who have good experiences, is highlighted by another mother who described a "very difficult birth" with her first child, mainly because of medical intervention and a lack of support in the English maternity system. She suspected that this had all contributed to her postnatal depression. However, she was encouraged in her desire to have a second child by believing that a better experience was possible and by consciously seeking this, and she was keen to pass her knowledge and more positive experiences to future generations:

I'd hear these women's stories about this WONDERFUL birthing... [so] I put things in place so I wouldn't be in that same situation [as I was the first time]. Such as I went with an independent midwife *who I felt very connected to* and did share-care with a doctor that I felt very *comfortable with* [in Adelaide] and I checked out the whole birthing thing beforehand... [So the second birth] was just WONDERFUL... the time in the hospital, the people I had contact with. ... I just felt very differently right from the start. I felt *much more connected to* [second baby], I didn't feel connected to my [first child] in a way that I had hoped to... I was much more *looked after and I made sure that I was looked after* and that continued on for a while. The second experience was wonderful, almost healing of that first one. And I'm SO glad I went on to have that second baby... [The second experience was] very very different, which made me think I want another one [third child] and after that I STILL hadn't finished. But after the fourth one, I was 42 when I had him and that was it. It's hard for mothers to get what they need. I think since [that second] experience I've started my own account for when they [daughters] become mothers that they *CAN be looked after*.

(Teresa, 44, former primary school teacher/ex-nurse, highest status area, mother of 4 – aged 2, 6, 8 and 11, emphasis added)

The very different experiences of birth recounted by this same woman show how fertility desires can be positively influenced (or at least not negatively influenced) if women have access to others with positive experiences, and to maternity care which meets their desire for psychological and physical support.

## 8.7 REDUCING IDEATIONAL AND INSTITUTIONAL CONFLICT

Whereas section 8.2.1 suggested that negative birth experiences were less likely to dissuade those with strong desires for having children or a larger family, or those who believed that their experiences were "just the way things were", the thesis argues that delayed childbearing and fertility gaps are more likely to result from anticipated or experienced negative impacts of birth

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for those who hold stronger preferences for maximising well-being, empowerment, self-actualisation and personal achievement. One well-educated AFFSS mother, for example, had been strongly affected by hearing a midwife comment that she was “not coping at all” with her first labour and so this mother felt that she had “failed” at the task of giving birth. In relation to her experiences (noted earlier in section 8.2.1), Fiona commented that she had “all the things I didn’t want”, and when trying to discuss her birth preferences had felt she met a power barrier with her “patronising” obstetrician. While she had resented losing control to institutionalised routines during her first birth, she also resented not being treated as the well-educated individual that she was. Her obstetrician’s comment suggested that he too was experiencing conflict between his traditional practice based on medicalised maternity care and the preferences of women with postmodern values, in that he said he was used to rebutting the desires of “educated mothers” for autonomy and self-determination in relation to their birth.

According to K. Lane (1999), twenty years of new-wave feminism have failed to undermine the dominance of male power in medicine and obstetrics in Australia. Therefore, little has changed since the days when Rich (1976:164) saw birth as “an experience of passively handing over our minds and our bodies to [male] authority and technology”. The impact of this gender issue is rarely considered in low fertility research, probably because even by the year 2000 demography had focussed “relatively little to date on gender, let alone the question of power relationships and empowerment” (Presser & Sen 2000). However, Weaver (1998) notes that the issue of control is important to childbearing women and a woman’s memory of being deprived of control during childbirth is not obliterated by the pleasure of a healthy baby or the passage of time. In this respect, the thesis argues that the Australian maternity care system is another institution which is out-of-line with the expectations of many women today.

Although these impacts may negatively affect fertility, there is some possibility that they may be open to reconstruction, since, as was pointed out earlier, birth practices and maternity systems are a social construction. The thesis’ argument that institutionalised and over-medicalised maternity care present a potential cause of conflict and violated expectations for women and men who hold postmodern preferences is supported by research showing that women prefer maternity care where they can have the same care provider (usually a midwife in the first instance) through the whole pregnancy, labour, birth and postnatal period, because this results in greater feelings of being in control and being involved, of receiving more personalised attention and emotional support (which can include home visits), of having less

unnecessary medical intervention, and of having better outcomes for same-risk women (Brown & Lumley 1998; Children, Youth & Women's Health Service forthcoming; De Koninck et al 2001; Goer 1999; Hirst et al 1998; New Zealand Ministry of Health 2003; Oakley 1992; Waldenstrom & Turnbull 1998). One AFFSS mother has already noted the positive contribution to her positive birth experience of “feeling cared for” and being able to build a relationship with the main care provider, so that she did not feel treated impersonally “like a number”, and this was further highlighted by another mother who compared her fifth birth in Adelaide with her previous births under the New Zealand maternity care system:

The first [birth] was wonderful. Fortunately in New Zealand our medical system is such that I had *the same doctor and midwife* [each time]. So we had *a fantastic relationship* and by the time [fourth child] came and she was a girl it wasn't just “Here's your little bundle”; they all screamed “It's a girl!” . It was beautiful. My doctor ran his own GP practice plus he delivered and he had a group of five or six midwives that worked for him. He was at every delivery... So, it was just great, the whole experience was wonderful. And I must admit, coming and experiencing what I had here [in Adelaide] was not pleasant. [Fifth child] was my last one. Because I'd had natural births and no intervention I saw a Professor here [at a public hospital] and he put me through the Birthing Centre... but every visit I had *a different midwife* and at the birth I still had *a different midwife*. There's *no relationship building* there that I experienced. It's such an amazing experience [birth] and it's not cheapened, but it's ... almost like [*here in the Australian system*] *you're just a number*: “OK, great, out... next!”

(Karen, 41, former travel manager, highest status area, mother of 5  
– aged 4, 6, 8, 9 and 11, emphasis added)

In its latest Maternity Services Consumer Satisfaction Survey the New Zealand Government acknowledges that in describing their own experiences women provide a valid measurement of maternity services (NZ Ministry of Health 2003:4). Listening to women's stories about the differential impact on their birth experience from having different types of maternity care could provide great potential for Australian policymakers to change the types of care on offer here. For example they could bring Australia into line with the New Zealand government's system which provides women with funding for whichever care provider and birthplace they choose (NZ Ministry of Health 2003). However, Mason and Smith (2001) rightly point out that women's empowerment and right to dignity is a basic human right. Therefore, improvements to address these issues should proceed regardless of whether they will influence fertility rates or other demographic change. Nevertheless, Webb (1920) was correct in stating that a nation can hardly spend too much of its money in giving parents and babies a good birth, and this chapter has argued that governments which are concerned about minimising negative influences on fertility rates should particularly consider improving their maternity care system to minimise the negative impacts of birth on the health and well-being of all involved.



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## 8.8 CONCLUSION

This chapter has brought together findings from the Adelaide Fertility and Family Size Study and the medical literature to argue that, at a time when postmodern preferences are seen to be related to below-replacement fertility rates, birth experiences which negatively impact on an individual's physical and mental well-being can lead both mothers and fathers to avoid further similar experiences by delaying, or not having, more children. The chapter has argued that since both the effects and after-effects of birth can also influence frequency of intercourse and the biological ability to bear further children, birth must be considered as a reproductive event which has the potential to negatively affect individual fertility both voluntarily and involuntarily. The chapter showed how a good birth experience (or the hope of a good experience) could enable people to at least achieve their family size desires, if not to positively increase them. However, it also noted that interviewees describing overwhelmingly positive birth experiences were in the minority and that the predominantly negative experiences of birth socially diffuse to contribute to a "culture of fear" surrounding birth, which in turn can affect the desire to start a family or have additional children.

Policy initiatives, such as the introduction of pre-conception classes to discuss such issues, may help address such concerns. The chapter also argued that the predominance of over-medicalised birth in Australia, which is associated with high and rising rates of obstetric intervention, contributes to negative experiences and therefore indirectly affects the fertility rate. Since intervention rates are higher in higher status areas, the chapter also suggested that such effects could be impacting to a greater extent on the fertility of higher status individuals. The chapter concluded that changes to Australian maternity institutions which enable men, women and babies to have more positive experiences of birth, which would be more in keeping with postmodern preferences, could help reconstruct the "culture of fear" about birth into a "culture of confidence", and that this in turn could help stabilise fertility rates, if not help raise them.

## Chapter 9

# Experiences of early parenthood and everyday parenting

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I have had some pretty tough political times in my life, but it is nothing compared to coming to grips with a new baby at home. You have to give in. You cannot control or plan... I have a whole new sense of challenge

(Natasha Stott Despoja, former leader of the Australian Democrats, on first-time motherhood at age 35, in Bildstein 2004).

### 9.0 INTRODUCTION

The previous two chapters show that even before there is a child to parent, individual or couple family size desires may have been affected either positively or negatively by experiences of conception, pregnancy and/or birth. This chapter now considers experiences and reactions to experiences of *childrearing*. Chapter 3 noted how parenthood is often portrayed as “simple and relatively effortless”, with mothers at home assumed to be “doing nothing” all day. However, in contrast, many women experience motherhood as a time of transformations and contradictions, with a mix of great rewards but hard work, and of joy but intense stress (Grose 1992; Kitzinger 1994; Leblanc 1999; Sethi 1995). Fatherhood can also be a source of pleasure mixed with frustration, anxiety and challenge (Lupton & Barclay 1997). Some believe that having children enhances marital solidarity (eg Friedman, Hechter & Kanazawa 1999:30). However, psychologists find that although:

people believe children bring joy and happiness ... children do not improve the psychological well-being of parents, [and] satisfaction with marriage decreases with the birth of the first child, and does not return to pre-children levels until all the children have left home (Mirovsky & Ross 1989:101-103).

Indeed, one study on parenthood impacts cites nine earlier studies between 1960 and 1987 which found that “children tend to detract from rather than contribute to marital happiness” (Southern Community Health Services Research Unit 1988:3).

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Building on the concept of the Life Events Scale discussed in Chapter 3 is The Parental Stress Index, a widely used measure of 120 items which shows that major changes and/or an accumulation of minor “daily hassles” can contribute to stress for parents (see Fisher & Rowe 2004; Oestberg & Hagekull 2000). Discontent in the transition to parenthood or a larger family can particularly arise from such major lifestyle and behavioural changes as decreased time as a couple, social isolation, and reduced levels of inter-partner emotional support (Mirovsky & Ross 1989). Chapter 3 discussed how the sociological literature demonstrates these aspects of parenthood to contribute to difficulties for many mothers in developed countries, yet their potential impact on fertility rates has remained a sub-narrative in demography and has been rarely considered in government policy and contemporary debate.

This chapter draws on the AFFSS interviews and preconception survey to explore how fertility desires may be related to the anticipated and actual experiences of the transition to everyday childrearing. While issues of financial limitations and work-home preferences are interlinked somewhat with these, the main discussion of them follows in Chapter 10. The first section of this present chapter outlines the extent to which parents’ fertility thinking and behaviour was influenced by their personal experiences of childrearing, particularly in the first year after birth. The subsequent four sections explore some key influences in depth, while a summary section discusses their contribution to postnatal depression. The final section considers how parenting experiences may, through mechanisms of social diffusion, influence the fertility thinking and behaviour of others.

## **9.1 THE EXTENT TO WHICH EXPERIENCES IMPACT ON FERTILITY**

The continuous, extended and often intense nature of everyday parenting, especially in the first year after birth, was the main influence on parental well-being which negatively affected fertility thinking and behaviour for AFFSS parents. The key influences revolved around perceived limits to individual and couple resources of time and space, and of physical or mental energy. This could be in absolute terms, or relative to other aspirations. Perceived limitations often resulted from the privatised nature of parenthood, particularly for mothers. Tables 9.1 and 9.2 indicate that for around three-fifths of both AFFSS mothers and fathers the temporary or permanent postponement of further children stemmed from a desire to avoid further stresses (or negative impacts) from everyday parenting. This was most influential at

parity three, and for mothers in the upper-middle status area and fathers in the highest status area, while parents in the lowest status area were the least affected.

**Table 9.1**

**Family size limitations from impacts of everyday parenting, by parity**

Source: Adelaide Fertility and Family Size Study 2003-04, parent interviews

	Current parity				
Percent	One	Two	Three	Four or more	Total percent
Mothers	64%	40%	88%	44%	58%
Fathers	33%	57%	100%	56%	63%

**Table 9.2**

**Family size limitations from impacts of everyday parenting, by status**

Source: Adelaide Fertility and Family Size Study 2003-04, parent interviews

	Status area				
Percent	Highest	Upper-middle	Lower-middle	Lowest	Total
Mothers	55%	73%	57%	44%	58%
Fathers	83%	57%	75%	43%	63%

The negative effects of four key contributors to parental stress are addressed in this chapter.

These are:

1. Tiredness and exhaustion from childrearing and associated domestic work;
2. The differential impact of previous parenting experience, skills and support from friends and extended family;
3. Domestic isolation and the undervaluation of unpaid domestic work; and
4. The impact of parenthood on identity, status and gender equity.

## **9.2 HOW PARENTHOOD EXPERIENCES IMPACT ON FERTILITY**

### **9.2.1 Tiredness and exhaustion from childrearing and domestic work**

In the first twelve months after birth up to 75 per cent of mothers in Australia, Japan, Italy and France suffer from lack of sleep, tiredness and exhaustion (Brown & Lumley 1998; Jolivet 1997; Saurel-Cubizolles et al 2000). In one Australian study of first-time *middle class* mothers

90 per cent felt exhausted by motherhood, which made it difficult for two-thirds to cope (Leblanc 1999, pers comm). Fatigue and low energy levels can continue well into the second year (Troy 1999), and around half of all Australian parents feel unprepared for these impacts (DFaCS 2004a).

While many AFFSS mothers experienced tiredness from caring for babies and children, just over one in ten had felt severely exhausted, and some fathers were also affected. Tiredness affected mental and physical functioning, with one mother complaining that “your brain after you have a baby is like pickled octopus ... you can’t think, you can’t function”. In the AFFSS these experiences could lead to further births being delayed to allow a greater recovery time, and this particularly occurred where tiredness also negatively impacted on caring for older children, or on paid work:

You sort of get an idealised idea that you could pretty much carry on doing things as you did before [you had children], and for some people they seem to be able to do that, particularly if they [babies] are good sleepers... Whereas for whatever reason, [our first child] wasn’t like that at all – no sleep, continual crying, getting up ten times a night and trying to go to work [by day, for me]... Before [first child] started sleeping through the night, which wasn’t until she was about three [years old], we couldn’t have thought about another.

(James, senior medical specialist, highest status area, father of 4 – aged 2, 6, 8 and 11)

For others, the general demands of parenting led to perceived limits on physical and emotional resources, which they felt limited their family size:

[They’re] great kids, love them, but there are moments where you get worn out... We would survive with four, five and probably six [children], but there is a quality of life in there... making sure you can have time off for yourself to read a book, those sorts of things... The stress of three is about our limit and that’s an important point.

(Paul, 36, utilities manager, upper-middle status area, father of 3 – aged 2, 4 and 6)

Support from beyond the couple, particularly from the woman’s mother, often helped reduce the amount of stress and tiredness experienced by individuals or couples, and hence influenced perceptions of the ability to have more children:

I also haven’t got lots of family [in Adelaide]... I had very supportive parents [in South Africa] so that makes a huge difference... If he [child] was sick... I’d drop him off at their place... You can’t really do that to friends... I know a lot of people who have the same [situation here] cos they’re from Sydney or wherever, so there are lots of people who just don’t have the back-up.

(Margaret, 33, accountant, highest status area, mother of 2 – aged 3 and 6)

Levels of social capital and perceptions of likely social support networks for parenthood have recently been found to influence fertility intentions in Poland and Bulgaria (Buehler & Fratzak 2005; Buehler & Philipov 2005). In the AFFSS, the increased demands of parenting under privatised conditions, with little help beyond the individual or couple, were highlighted by one mother who had experienced a major change in family and domestic systems when she migrated to Australia from India:

Coming here [to Australia] it's become very hard for us because we have to manage the kids *and* the house... In India we always had help... I had a full-time maid to look after the kids, and then we had a maid coming in cleaning the house, and we had a maid coming in cooking... Everybody can't afford three maids, they can afford only one maid [but] everybody has one. [Here in Australia] I can't even afford to buy toys so I can't have a maid! (laughs).

(Natalie, 34, accountant, highest status area, mother of 2 – aged 3 and 6)

Two Australian studies (Craig & Bittman 2004; Warin & Turner 2004) have found that many Australian mothers cope with an increased amount of childcare, household and paid work by foregoing their own sleep, exercise and leisure time. In the AFFSS the anticipation of such personal impacts could construct limits to family size for mothers, whether or not they were also in paid work:

I wouldn't mind another one, another girl, but look I don't know in reality... We're struggling at the moment at times, and I think if four's a struggle five would be MORE work. There's a lot more washing, and they're at the age where... it's just continuous. I'm all day doing jobs... getting ready in the morning, getting out the door first thing, and they're still awake at night.

(Chloe, 38, primary teacher, highest status area, mother of 4 – aged 1, 2, 4 and 7)

Although some parents in the highest and upper-middle status areas employed a cleaner or gardener, others were reluctant to “outsource” domestic work despite acknowledging the potential benefits for themselves. Some were concerned that a nanny or maid, for example, might undermine the mother-child relationship or might become romantically involved with the father. Nannies were also seen as economically viable and socially acceptable only in certain circumstances:

RESEARCHER: In terms of coping, could anything make it easier second time round?

JOHN: A nanny?

RESEARCHER: Do you know anyone who's got a nanny or anything like that?

JOHN: Yeah, a couple. I'm not sure how much they do at night, but these are families with four children, actually one's got five. [The mother's] also working and studying... When we were in England, there seemed a lot of people there [with nannies] in Kent, a fairly affluent area... From what I

understand, [in England] they get younger women over from Scandinavia, there's some arrangement, and pay them very little and they live in... One of the people with a nanny here [in Australia] they have a full-time salary and have to pay Workcover and that. That would make it a lot harder.

(John, 32, medical specialist, highest status area, father 1 – aged 1)

The availability and acceptability of support from beyond the individual or couple therefore has major implications for parents' ability to cope with childrearing, and hence on the number of children they believe they can have. This may be more influential on fertility in nations like Australia with relatively high levels of independent (and mainly non-family) immigration and internal mobility, where those having children may be far from family-based support.

The impacts on fertility desires of exhaustion and stress were therefore more influential for parents who received little outside help, and were even more acute for those in more demanding situations, such as caring for twins, for children born less than two years apart, for children born prematurely, or children with behavioural difficulties, medical conditions (eg asthma) or disabilities:

I couldn't do it again with a disabled child... I was pregnant [again] last year and had a miscarriage... If I was presented with another potentially very disabled child... we would find it extremely hard to continue that pregnancy... It's been a SIGNIFICANT impact on all of us, and our family and our friends, and my [work] colleagues.

(Georgie, 44, senior medical specialist, highest status area, mother of 1 - age 4)

The impacts could also be greater for older first-time parents, which may contribute more to fertility gaps in groups with a greater proportion of older first-time parents:

When I meet with the parent group they're all a good ten years younger than I am. [They] just recover quicker from late nights... and when you spend your time talking about how bad your back is, and how your knees hurt... age is definitely the major consideration [in not having more children]... Just winning the million dollar Lottery, I'd maybe have a nanny. I MAY consider it, but I really know deep in my bones that it's too old.

(Anne, 42, PhD candidate, upper-middle status area, mother of 1 – aged 2)

Tiredness could also act as a biological determinant of lower fertility by reducing the frequency of intercourse. One mother with two children born within 18 months felt “just overcome a lot of the time... I was so tired I couldn't even think about sex, let alone more kids... till [the second child] was about five [years old]”. Another noted how such exhaustion meant that “sex life just about disappears”. Some parents believed improvements in childcare

availability and affordability would provide relief from these negative impacts of privatised parenting if parents were willing to use it. However, contrary to expectation, parents of larger families had not necessarily experienced less tiredness but did sometimes have different coping mechanisms. One full-time mother of seven coped by believing that, in respect to sleep and having a break, “it’s unwise to crave something you can’t get”. A father of two accepted tiredness as “just part of life”, and a mother of five saw tiredness as just “something you get through”. Indeed, the strength of desire for a particular sized family could be instrumental in how personal impacts were interpreted:

I LOVE the babies but I find that none of them have been good sleepers and so I find it quite exhausting... Number four was a little bit more of a head thing than a heart thing for me. I’d think, yes we DO want four and we’ll do it... We’re gradually getting clearer, almost getting a good night’s sleep regularly now, so it does end. It’s not good to focus on that too much.

(Abbie, 35, former diversional therapist, upper-middle status area,  
mother of 4 – aged 1, 4, 7 and 9)

The level of knowledge and skills related to baby care were also often instrumental in the extent to which such parenthood impacts affected individuals.

### **9.2.2 Knowledge and skills related to baby care**

Many women and men in Australia, New Zealand and Germany find new parenthood difficult due to their lack of knowledge and experience with baby care (DFaCS 2004a; New Zealand Ministry of Health 2003; Nickel & Koecher 1987). Indeed, the extent to which an infant cries and sleeps are critical variables in this and a third of new parents experience significant difficulties with their baby’s crying and sleeping (Matthey 2001). Dunham et al (1991:134) point out that “in our [Western] culture... a link is missing in the chain by which the tried and tested cultural lore of childcare is passed down”, and Dally (1982) and Oakley (1992) believe this results in women often lacking the knowledge and confidence to mother. In this sense, lower fertility not only results from social changes which Caldwell and Ruzicka (1978) suggest decrease social supports for mothers at home, but from such changes undermining the social knowledge base of parenting skills, which in turn can make parenthood more stressful.

Many AFFSS parents felt that knowing how to manage a baby’s sleeping, feeding and crying could minimise levels of frustration and tiredness. In the absence of previously acquired



parenting skills or “on-the-job” support, parents often reverted to what de Bruijn (1999:89) terms “tedious trial-and-error” methods, and the resulting impacts could affect fertility desires:

Motherhood’s MUCH more difficult than I could have thought possible... I knew it was always going to be hard work but I thought it would be fun and I thought that I would cope with it... It would be SO much fun to have four adult children, but... after the experience of number one I just think we thought it would be too hard. There was a REAL lack of support in the early months and I was quite shocked... When [my baby] was four weeks I went to [the child-health nurse] and at the end I said “So when do you want to see me again” and she said “I don’t need to see you again” and I was just shocked. I would have liked to have had some kind of regular thing... so I could think “Right, I’m not on my own. I’ve got someone who’s keeping an eye on me, so if I stuff up...”. I was really quite shocked, I thought you’re leaving me responsible for this four week old baby and I have no idea how to do this!

(Jane, 31, insurance supervisor, highest status area, mother of 1 – aged 1)

According to Fisher and Rowe (2004), many Australian mothers exhibit these high levels of anxiety about caring for babies and are disabled by it, and Matthey et al (2003) note that such experiences affect at least as many women as depression. In contrast, Reese (1992) notes that mothers with higher levels of confidence experience less stress, suggesting that mothers with low levels of confidence require interventions to provide them with the practical skills to cope with their new role. Low levels of confidence about coping with parenting also reduce the likelihood that men will become fathers (von der Lippe 2004), and influence which fathers become active and involved in childrearing and childcare (Lamb 1987). With older women feeling generally less competent as mothers than younger women (Tarkka 2003), the level of confidence in parenting skills may well contribute to overall lower fertility for those who delay childbearing to older ages.

### *9.2.2.1 Links with personality traits and postmodern preferences*

Chapter 6 discussed how some AFFSS parents believed certain personality traits made parenting more difficult. In relation to caring for a new baby, such difficulties were often related to attributes which could be beneficial for workplace success but which could be less compatible with baby care or childrearing. It especially included traits such as a strong desire for rationality, control and time management. Since an infant is by its very nature often in a “state of unpredictable behaviour [with an] ‘uncivilised’ lack of control over its body... [which] constantly threatens rationality” (Lupton & Barclay 1997:146), it would not be surprising if postmodern preferences for rationality and control were associated with a greater degree of stress in relation to parenthood. Israeli research (Dimitrovsky 2000) suggests that

caring for a baby conflicts with postmodern preferences since women who prefer control and independence adjust less well to first-time motherhood. A study of American college women also linked a higher rating on these traits and self-actualisation with intended childlessness (Toomey 1978). Indeed, in a recent book advising Australian women on how to successfully manage their career through pregnancy, birth and motherhood, Mitchell (2004:88) feels it necessary to point out that a baby cannot be “managed like an in-tray” and that any career woman who values control, order and predictability may find motherhood stressful, rather than joyful, if she cannot adapt. One AFFSS mother explained how, in comparison with managing 16 staff at work where “you could plan your day”, her lack of baby care experience led to frustration, which in turn made her not want more children:

When I was going through the hell of the first two years...I went to my obstetrician and said ‘Tie the tubes... I don’t want any more children, I couldn’t COPE’... [although now] I KNOW I would be heaps better [next time], it would just be so EASY because you’d know not to worry about the things that you worried about and you’d know if you want to go to the toilet and they cried, ‘Well it’s OK, it won’t kill you, I’ll be back in a minute!’.

(Lucy, 46, company director in family business, upper-middle status area, mother of 1- aged 6)

Fatherhood can also challenge men’s “sense of being in control” (Lupton & Barclay:1997:145), and along with preferences for quietness and individual space, this could constitute reasons for men to want no more children:

I don’t want to run the risk of having another child to make it number four, for various reasons... The chaos sometimes gets to me... it’s not SUCH a huge issue that I’d run away from home or anything, but it does annoy me... They’re lovely in the early years... but I find it quite stressful... it’s quite a madhouse and I’m just a person that likes a bit of quiet... I can’t wait until they’re over the... baby-toddler period, the crying... I love going home at the end of the day and seeing them all, and then often within half an hour I’m glad I was at work today.

(Harry, 37, finance manager, upper-middle status area, father of 3 - aged 2, 4 and 6).

Earlier in this chapter Table 9.2 showed that fertility was least affected by experiences of parenting for those in the lowest status area. A relationship between postmodern preferences, social status and fertility levels due to negative images of parenthood was also suggested in the AFFSS preconception survey, where 35 per cent of respondents in managerial/professional occupations were concerned about the “noise and mess” associated with having children in their house, compared with only 14 per cent of those in clerical/sales occupations, and none of

the trades-labourers. Indeed, some studies find that middle class parents regard childrearing as more problematic than working class or lower class parents (Handel 1970).

Lower fertility in higher status groups may also relate to increased stress from what Hays (1996) observes as “intensive parenting” among mothers who are well-educated and/or in professional occupations. In the AFFSS fertility was indeed negatively affected for some mothers who were exhausted by “intensively” parenting (ie devoting large inputs of time and energy to childrearing), but this was often due to a lack of parenting experience and an associated lack of confidence:

My mother BEGGED me to have the children [but] I wanted to do it myself. I felt exhausted... I think it was the constantness of it. You have to talk to children...always keeping them occupied, doing activities, reading books... I started reading up and that suggests that you DON'T give them a lot of crappy processed foods, so we were always doing the fruit, the veggies, the right nutritional balance... Sometimes I think you don't need, you just don't NEED any of that. I'd do things SO MUCH MORE simpler this time if I have more kids.

(Athena, 39, ex-sales manager/high school teacher, upper-middle status area, mother of 2 – aged 6 and 8)

Some fathers resented mothers reacting in this way, particularly if they had different views of parenting, or felt that the couple relationship was being abandoned in favour of the baby:

Well, the way [wife] reacted... having a first child. It was... well it was surprising... All I wanted was to let her know that she doesn't have to be so hard on herself... like at the slightest whimper from [baby] it was like, straight away, drop everything ... like *I* didn't know what to do... I felt quite lost actually... like the baby's making a noise crying or whatever – like “Just leave it for a while and let's continue this conversation”... The relationship comes first. Babies are tough, that's how I've been led to believe.

(Simon, 35, skilled labourer, lower-middle status area, divorced father of 3 - aged 6, 7 and 10)

Whilst less intensive forms of parenting could reduce the impacts on mothers, this father's experience suggests that, in terms of relationship conflict, this might also be reduced if couples entered parenthood better understanding each other's expectations about parenthood and baby care. Having opportunities to gain more experience with baby care, so that they might then better understand what care and attention is sufficient for a child's health and well-being, might also help people feel less pressure to parent intensively, since this intensity appears to be associated to some extent with lack of confidence and lack of prior experience. Some evidenced of this is provided by considering the experiences of those who parented differently.

### 9.2.2.2 *When confidence levels are higher*

In comparison to the impacts discussed in previous sections, higher fertility in lower socio-economic areas may also be partly linked to greater proportions of individuals with expectations, skills or social supports which minimise the behavioural adjustments required with parenthood. This would tie in with the socio-economic differences identified in Table 9.2. The minimal impacts experienced by one lower status AFFSS mother were related to her more “extensive” parenting methods, social supports and apparently “natural” baby care skills:

When I was younger... I used to look after my next-door-neighbour's kids all the time... My sister had her first baby when she was 15... It was just all natural to us... Yeah, I knew how to wrap them... I just knew that that was the way it went. I've brought [my daughter] up in a way that I like her to go to anyone... My friends would come and get her and they would put her in the capsule and take her [and the formula] and bring her back another day later... Another friend... she's got eight kids. She'd ring me and say how are you going. And she could tell by the tone of my voice that I wasn't OK. So, she'd come over and grab [the baby] and come back the next day... I learnt a lot through her, like not fussing, not stressing, just pick her up and wrap her up and just throw her on the lounge, she'll be fine.

(Elizabeth, 32, hairdresser, lower-middle status area, single mother of 1 – aged 2)

While several mothers in higher status areas had expected short-term babysitting experiences to prepare them for motherhood, they found that without continuous or longer-term experience babysitting gave “an idealised” view of motherhood. However, for some higher status parents their earlier 24-hour-7-day experiences or professional skills had minimised the behavioural adjustments experienced with parenthood:

I've always been involved with kids... I lived with [my sister] and her husband for about 12 months when she had the first baby... that was quite handy for her, quite handy for me too. And I did midwifery... [so] I just took [baby care] in my stride, just changing babies, pick them up, throw them around... No major hiccups. Maybe I should go for five [children]! (laughs) NOT!!

(Belle, 44, former midwife and senior sales manager, highest status area, mother of 2 – aged 4 and 6)

Chapter 10 (section 10.2.2.1) will further discuss links between a woman's occupation and the amount of behavioural adjustment (stress) that may be experienced with motherhood. To this extent, it is relevant to apply the theory of creativity (Cziksztmihalyi 1990), which posits that any environment or situation can create a state of frustration depending on the degree to which a person's talents or resources match the demands of the situation. In this way, differences in individual skills and education may impact on fertility in a similar way to how Furnham and

Bochner (1986:201) describe migrants adjusting to new cultures, where those who are “highly skilled in the customs of their own society... find their sudden inadequacy in the new culture to be quite frustrating, not having had many similar experiences of failure previously”. Furthermore, if higher levels of education and expertise are associated with traits of independence and higher-level problem solving skills, these may exacerbate parenthood stress by preventing individuals from seeking outside help:

We could have accessed some of the services that WERE available. We tended to try and fix things ourselves... [seeking help would have been] sort of an admission of failure... First time parents – it’s pretty challenging and you go into it a bit naively... I’m aware of the basic health issues and physiology and medical aspects, but in terms of the behaviour and how to manage their behaviour... The combination of being anxious, inexperienced and thinking “We should be able to do this”... it was probably 6 to 12 months [before we sought help] and we were exhausted by then.

(James, senior medical specialist, highest status area, father of 4 – aged 2, 6, 8 and 11)

As Friedan (1965:22) pointed out four decades ago, “academic training is not realistic training for wifehood or motherhood”. It is therefore important to note Rossi’s point (1968) that what may appear to be an individual lack of preparation for parenthood may actually represent a society’s failure to provide adequate preparation, training and substitutes for extended kin. Indeed, primate studies suggest that the human family was intended to provide opportunities for observation, practice and acculturation of the parental function *before* reproduction (Kaufman 1970). The achievement of family size preferences may therefore be more adversely affected in situations where there is less opportunity for, or inclination to allow, the intergenerational transfer of parenting skills and experience (which may particularly be the case for non-family migrants, highly mobile professionals, or older first-time parents). This has important implications for improving preconception and antenatal education, and support in the transition to parenthood, to not only raise levels of confidence and minimise negative impacts on parental well-being, but also to minimise any associated negative effects on the fertility rate.

### **9.2.3 Domestic isolation and the undervaluation of unpaid domestic work**

Caldwell’s theory of fertility decline (1982:199) suggests that “the collapse of domestic society” as women entered the workforce lowered fertility by undermining the support and valuing of motherhood and domestic work. Furthermore, Richards’ (1985:151-2) exploration of Sydney couples’ experiences of parenthood found that being isolated in the home with a

young baby was one aspect of motherhood for which many women were unprepared. It is important in this respect to note that social isolation can also undermine a woman's feelings of competence as a mother (Kitzinger 1994; Tarkka 2003). In the AFFSS the ability to compare domestic life with paid work made some reluctant to again experience the early months with a young baby if this meant being isolated from a full-time working partner, from established workplace social networks, and from the type of mental stimulation that they were accustomed to in paid work. To some extent it also conflicted with preferences for an egalitarian relationship where partners were expected to share the work:

The thing I WASN'T prepared for was the loneliness. You're just stuck at home, just feeding, and all night too just sitting up *on your own*, just feeding and dealing with the baby *by yourself*... I couldn't put him down, he'd scream, it drove me INSANE. The baby was *ALL my responsibility*... I was a bit of a perfectionist at work and I found that at home I was just failing... [Husband] was busy at work but I think he created the busy-ness a bit as well as an escape. I was INCREDIBLY angry and he avoided me and he was never home... We wouldn't have three or four [children now]. My husband probably would. I'm just more determined to stop because I just KNOW that ultimately it's going to be *my responsibility* and that he will ALWAYS have that option of opting out and spending all day at work and *I'll be the one at home*.

(Jane, 31, insurance supervisor/graduate, highest status area, mother of 1 – aged 1, emphasis added)

A British study finding that high status mothers were as keen to return to work because of dissatisfaction with being home full-time as for the satisfaction they derived from paid work (Brannen 1987) supports this chapter's contention that lower fertility in higher status groups might be ameliorated by improving the conditions for childrearing in the home, particularly in the early months with a new baby.

The common feeling that children and the parental role are undervalued in contemporary society (Belsky & Kelly 1994; Sanson & Wise 2001) also requires attention, since the need to be valued is an important component of postmodern values (Lesthaege & Surkyn 2004:7). Considering that the loss of individual identity on the transition to becoming "only a mother" is particularly significant for Australian women who are well-educated and/or professionals and who have pre-motherhood work experience (Pocock 2003:88), the impact on their fertility is likely to be greater. As one high status AFFSS mother observed:

I just think you feel more valued if you ARE working... You go to these balls and dinners and things, and you'd be sitting on a table of ten and they'd all be professional people and you'd be there, the wife, and they'd say - not everyone, but a fair percentage - "Oh what do

you do?” [and you’d say] “I’m home with the children” and the conversation would drop dead... And a lot of them [who asked] were women who were working.

(Belle, 44, former midwife and senior sales manager, highest status area,  
mother of 2 – aged 4 and 6)

Despite calls for fathers to take on a greater domestic role to reduce the unequal impact on mothers, observation of negative experiences of domestic life and the social undervaluation of parenting made some AFFSS fathers reluctant to increase their share of the load:

I was enthusiastic to [stay home with the children] was because I wasn’t enjoying my job... I thought it would be easier [than paid work]. And that’s often what’s happened when I’ve talked to women...[I was home] for one period of ten months... [First child] was at school and it was about five months before [second child went to Kindy]... Isolation was my biggest problem. [Wife] and I used to spend a lot of time together [before children] and being at work I was used to being around people... [Wife] just went to work and she concentrated on that, so I thought well I’ll do the bills and everything pretty much for the house. I didn’t really LIKE doing it all by myself. [Before children] we shared it. Both the neighbours are gone during the day [and] the women [at school] seemed to have sort of a social thing happening, but the blokes do what they’ve got to do and go home... There was just too many really boring chores. It was just dull really. So I have a whole different perspective of what it’s like for housewives... It just seemed to get duller and duller to the point where “I have to do something else or I’m going to go mad”... Males I’ve talked to, in the pub, the usual response is “Rather you than me”, which makes me think *a lot of men would be reluctant from the start to be in that situation.*

(Danny, 39, former storeperson, upper-middle status area,  
father of 2 – aged 4 and 7, emphasis added)

This father’s suspicion of men’s reluctance to take more domestic responsibility, due to the image of domestic life as unstimulating, lacking purpose and offering little opportunity for personal achievement, was confirmed by other AFFSS fathers’ responses to the question “*If without having to work you had a reasonable living income, would you still prefer a paid job or wouldn’t you bother working?*”. Indeed, only one of the 24 fathers said he would stay home full-time, while the other 23 (including two who had stayed home full-time for a while) said they would want at least part-time paid work or voluntary work for a sense of achievement and purpose in life (and two would want paid work to have an income which was *more* than reasonable). Many comments are represented by those selected below:

I need work for stimulation... I’ve got to win, I have to achieve... it could be voluntary.  
(Training consultant, 43)

I would work... for a sense of wellbeing, a sense of purpose. If I was fairly comfortable I’d have to be doing something, but I wouldn’t need pay.  
(Skilled labourer, 35)

I think we've all dreamed of NOT [working], but... I'd be in the same situation as [girlfriend], pulling my hair out, going "I want to go back to work". If I won Lotto tomorrow... I'd probably do a volunteer job, something to give me purpose.

(Long-distance truck driver, 34)

I would still do paid work... there's a level of professional sanity, interaction with other adults, it could be voluntary work... I DID take 4 months off last year, she was working full-time ... spent most of the time with the kids, but I still did consulting work... I did probably a little bit (laughs) of domestic stuff, but... I knew it was only 4 months.

(High school principal, 46)

However, such comments did not always acknowledge the feelings of many of these men's partners who also felt they "needed to work" outside the home for similar reasons, at least in a part-time or voluntary capacity. This supports the notion that policies which enable women [and men] to have some paid work during the childbearing years can lower the "costs" of children (Sundstroem 1999), at least for those who prefer some paid work. Some AFFSS mothers exhibited considerable resentment if they found parenthood impacted more on them than on the father, and this could affect relationship health and, in turn, fertility desires.

#### **9.2.4 Relationship conflict over inequalities in the division of domestic and paid work**

In many developed countries women bear the major responsibility for childrearing and domestic work, even when they also have paid work (Baker & Lero 1996; Bell & Adair 1985; Craig & Bittman 2004; Elvin-Nowak & Thomsson 2001; Hochschild 2003; Mencarini & Tanturri 2004). In Australia a first baby adds around three times more to the workload of mothers than to fathers and, although mothering is conventionally regarded as "not really working", mothers at home do as much "work" as employed mothers (Craig 2002). With many new parents surprised to find that pre-parenthood intentions of fifty-fifty parenting dissipate once a baby arrives, leaving them in traditional roles (Maushart 2001; Wolf 2001), many first-time mothers-to-be may be unaware that new parenthood impacts more on women than on men. Becoming a parent impacts more on women not only in terms of the changes to their body and their health related to pregnancy and birth, but also to their patterns of socialising and their employment status (Southern Community Health Services 1989). Some of these impacts were already discussed earlier in Chapters 7 and 8. Furthermore, mothers report a greater increase in role conflict in the transition to parenthood than fathers (Wilson et al 2000), and such inconsistency between partners' expectations and experiences can lead to relationship discord (Belsky & Kelly 1994; Mirovsky & Ross 1989; Tomlinson, Irwin & Irvin



1993). In Japan resentment about such gender inequalities encourages women against having a second child (Jolivet 1997:15), and in Australia it affects the ability to cope with first-time motherhood for two-thirds of middle-class women (Leblanc 1999). The impact of such experiences on fertility is the essence of Gender Equity Theory, as discussed in Chapter 3.

Issues of domestic isolation, loss of a sense of purpose and loss of freedom led to resentment on the part of some AFFSS mothers, who thought they might have another child if parenting and paid work were more equally shared:

RESEARCHER: So, your husband would go to three or four children do you think?  
 MARY: It's easy for HIM, he's working isn't it. He's never attached. If he wants to do anything, he can flit here and flit there, he can go anywhere... He's just totally dedicated to work, and he doesn't even get paid overtime.

(Mary, 43, former nurse and manufacturing project manager, upper-middle status area, mother of 1 - aged 3)

Whilst Hakim (2003) considers the impact of women's work-home preferences on fertility, AFFSS fathers' preferences also affected fertility by influencing the degree to which parenthood and paid work were valued, which in turn affected the amount of childcare and domestic support that they offered to the mother. Conflict and resentment particularly occurred when AFFSS mothers held egalitarian views about paid work *and* parenting but found their partner with traditional views about parenting but egalitarian views about paid work *but only for non-mothers*. This was more common in the higher status AFFSS areas:

This is what has struck me. Socially, politically, he's very egalitarian, we have similar views. But when it comes to childrearing and domestic labour he's very old-fashioned... My husband's not into the domestic stuff. That hasn't altered despite efforts on my part... With his work there's projects, they have a deadline, so you have to put 200% in... My husband would see that I got help from his mother [with the baby]. Well, we went over to his parents for a meal one night a week — to me that's not really support! I didn't get washing done, I didn't get meals cooked, I still had to get the house clean. I got everything done like I would if you hadn't had the baby... [Having more children would mean] no time with myself, no time to do ANYTHING for myself, careerwise, personalwise. I'd just be a mum. Even just saying that sounds as if it's demeaning to be a mum... I just couldn't see myself as a full-time mum with the lack of supports for the rest of my life.

(Fiona, 34, psychologist, highest status area, mother of 1 – aged 1)

While this mother indicates that lack of support from beyond the couple was also influential, the influences on fertility of fathers' attitudes towards paid and unpaid work may contribute more to lower fertility in higher status areas, if fathers' level of interest in giving time to the

Fertility and Family Size Study is any indication of their interest in family in general. Indeed, almost half the fathers in the highest status families were “too busy” to be interviewed for the AFFSS (5 out of 11), compared with only one out of nine in the lowest status area.

A second conflict situation negatively affecting fertility was where the mother’s ability to work was not restricted, or she did not want paid work, but she resented the father’s lack of involvement with babycare. This was more common in the lower status AFFSS areas, and the resentment could lead to separation or divorce and undermine a desire for more children:

[Husband] was hopeless!! (laughs)... He just didn’t cope at all, sleep deprivation-wise... I had no choice... Men do, don’t they. He basically went and stayed in our bedroom, and I got put in the baby’s room on a mattress on the floor. So his job was to go to work and my job was to be up all night with the baby... Eventually, after months and months of someone not dealing with something that YOU have to deal with all the time, it makes you resent them. So, that was why we broke up... I struggle with having a relationship with a male, let alone... I don’t think I’d ever trust anyone enough to have a child with them again.

(Mandy, 35, sales assistant, lower-middle status area, single mother of 3 - aged 6, 7 and 10)

Findings from the AFFSS preconception survey suggest that conflict over paid work and the division of domestic work and childcare may be unanticipated for many. Indeed, while around one quarter of both women and men were concerned about how housework and parenting would be divided after a first baby arrived, only one of the women felt that it would be a “big” issue, and two-thirds of the preconception women saw it as a complete non-issue; (in an attempt to use language that respondents use to talk and think, as per Bradburn and Sudman (1991), concerns were categorised as being “big”, “medium” or “small”, or “not an issue”). However, men may be increasingly aware of women’s expectations for them to be “involved” domestically, since around half the preconception men saw the division of unpaid work as an issue. Governments could encourage discussion of such expectations prior to parenthood because they affect not only relationship health, but potentially also fertility rates.

It is important to note that in the AFFSS it was *conflict* over expectations which affected fertility, rather than an unequal gender division of work per se. When partners had similar expectations, be that egalitarian or traditional, mothers felt less restricted:

I feel very much that I’ve been working [as a mother] and my husband reinforces that. I can see how you could feel otherwise if you had somebody pushing you to, say, go back to work, or really needing that money and giving you the push... My husband does help and he’s also not overly [tidy], for him the highest priority is the baby and me, rather than how clean the

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house looks. And if there's something bothers him [about the housework] he'll do something about it.

(Abbie, 35, former diversional therapist, home full-time but volunteer worker at church, upper-middle status area, mother of 4 – aged 1, 4, 7 and 9)

Indeed, insisting on shared roles where traditional roles are preferred might even *reduce* fertility. For example, one 40-year old auto electrician in the lower status area, a father of three, thought he would probably never have had children had he needed to be “more involved”, because of his low tolerance for babies and children. However, he was happy to have children because both he and his wife (a trained nanny) felt comfortable with traditional breadwinner arrangements.

Those AFFSS mothers who coped better with domestic life and who experienced less partner conflict were often those who preferred traditional arrangements until their last child started school. A belief in the traditional ideology of motherhood encouraged some women to accept the negative impacts of motherhood, with one mother of five in the highest status area saying that motherhood was “your role and you should adjust to that”. By implication, women with postmodern or egalitarian preferences would be less likely to accept any such negative impacts of motherhood and may therefore be more likely to reduce their family size desires if any negative impacts on their personal well-being are not addressed. However, it was interesting that some mothers with traditional arrangements did not always cope better because they accepted the negative impacts of privatised traditional motherhood, but because their traditional arrangements were associated with partners and families who valued family and children, and who therefore offered more support regardless of their hours in paid work. These mothers therefore experienced communalised, rather than privatised, parenthood.

Through exploring the impacts on fertility of parental stresses, conflicts and levels of partner and family support, the thesis provides some additional explanation to the work-based explanations of Preference Theory (Hakim 2000, 2003) by identifying some broader mechanisms of influence on fertility which are related to parenthood and domestic life. Indeed, where Hakim (2003:259) suggests that “Home-Centred people have ‘family values’ which emphasise sharing, caring and non-competitive family life” and “Work-Centred people have ‘marketplace values’ which emphasise competitive rivalry, achievement orientation and individualism”, the AFFSS has shown that differences lie not only in personal orientation but

also in socio-economic, social and environmental factors, along with differences in personal pre-parenting experience and the extent and nature of extended family and social connections.

### 9.3 POSTNATAL DEPRESSION

Chapter 3 discussed how, over the last four decades, researchers in various fields have demonstrated that mothers in many Western countries have major difficulties coping with the physical and psychological impacts of parenting discussed so far in this chapter (eg Friedan 1965; Rich 1976; Dally 1982; Dyck 1990; Oakley 1992; Kitzinger 1994; Leblanc 1999; Wolf 2001). In Australia these impacts contribute to between 15 and 25 per cent of all mothers experiencing postnatal depression (Astbury et al 1994; Barnett 1991; Bishop 1999; Boyce & Condon 2000; Brown & Lumley 1998; Priest et al 2003). However, Oakley (1986) also suggests that an additional quarter of mothers experience general unhappiness with their experience of motherhood. Particularly influential on the development of postnatal depression are the experiences of fatigue, exhaustion and limited social supports which were discussed earlier in this chapter, with fatigue as early as the seventh day after birth predicting depression after one month (Bozoky & Corwin 2002). Exhaustion from sleep disturbance plays a significant role in this (Barnett 1991; Matthey 2001; Lam, Hiscock & Wake 2003).

More recent attention to fathers' experiences shows that they can also suffer from trying to cope with their partner's depression, and from the changes which new parenthood can bring to relationships, with 5 to 10 per cent affected (Areias et al 1996; Boyce & Condon 2003; Bronte-Tinkew, Moore & Matthews 2005; Dudley et al 2001; Meighan et al 2004). The AFFSS found that such experiences could also negatively affect future fertility desires in several ways.

Table 9.3 indicates that in the AFFSS just under one tenth of mothers had depression professionally diagnosed, and just over one tenth described similar symptoms but received no help. These estimates are based on symptoms summarised from the medical literature, which include chronic exhaustion, irritability, loss of concentration, after-effects from the birth, feelings of anxiety and inadequacy as a mother, and inability to cope with motherhood or life in general (Bishop 1999; Kitzinger 1994).

**Table 9.3****Extent of postnatal depression (PND) and exhaustion in study parents**

Source: Adelaide Fertility and Family Size Study 2003-04, parent interviews

Situation	Number affected	Percentage affected	Total
Mothers sought help, PND diagnosed	3 out of 38	8 %	PND estimate 21%
Mothers had PND symptoms but no help	5 out of 38	13%	
Mothers with severe exhaustion	5 out of 38	13%	Depressed or exhausted 34%
Fathers who had difficulties with traumatic birth, partner's PND, severe sleep deprivation	4 out of 24	17%	17%

Without support or prior experience some AFFSS mothers were unsure when to seek help:

The day after [the birth] I could hardly move and every time I got up it was just disgusting, I felt like my insides were coming out. *I didn't really say anything because I thought maybe everyone feels like this and I just can't cope with it, cos I didn't know - it was my first child...* I was in hospital for about five days and then I came home. In the photos I was really pale from pain and I felt really bad cos this was meant to be the best time in my life... and I was absolutely hating it. Close to the six-week check... [baby] was just in the bassinet screaming his head off and I was just lying on the couch screaming my head off... I had a lot of pelvic pain... I had sore nipples from feeding ...and *I just thought maybe this is what all women feel and I'm just pathetic or something...* The [child health nurse] was going to refer me to [day clinic for support with infant crying and sleeping] but it was just all too hard with [husband] working and getting there... I remember calling the Parent Helpline once, about 2am, [baby] was just crying and crying and I didn't know what to do and the woman was saying to me "I can't hear you, step away from the child" and I was saying "No, I can't leave him, he's crying!" and I just hung up... I went to my six-week check-up and she [GP] was fantastic. She said "You shouldn't be in so much pain".

(Tammy, 33, clerical worker, lowest status area, mother of 1 - aged 4, emphasis added)

Others felt that seeking help would be a sign of failure or would necessitate discussing feelings which they felt "good" mothers should not express. These feelings could lead to such confusion that mothers could not imagine wanting to have another child:

I had a friend come round to see me when [first child] was about four months old and she was holding [my baby] and she said "Oh I miss having a baby in the house", cos her children had grown up, and I looked at her incredulously thinking "Take mine! You MISS this?" I was just FLABBERGASTED... I didn't have that connection [with the first] which really frightened me.... I got to a point where I wasn't psychologically as healthy as I should be... I wanted to ask questions about what I was feeling and thinking and there was no-one there, and the sort of questions I wanted to ask were almost socially unacceptable, such as "I don't know if I love this baby", "How long does it take?". Those questions frightened me as well.

(Teresa, 44, former primary school teacher/ex-nurse, highest status area, mother of 4 – aged 2, 6, 8 and 11)

In only one case was an AFFSS mother offered professional help, while two sought help because similar problems before having children made them aware of the need for assistance; another mother was diagnosed with severe sleep deprivation. Half of those with severe coping difficulties remained without help, and even those receiving help could be encouraged by partners or family to avoid having additional children:

After I had [first child] I had really bad postnatal depression and ended up in hospital with it. It stuck with me until she was about 6-10 months old... [Husband] didn't want me to have to go through that again... When we decided to have [second child] we had to sit down and write a big list of the pros and cons... In the end he said "Well it sounds like it makes sense".

(Kathy, 24, trainee hairdresser, lowest status area, mother of 2  
– aged 2 and 4, pregnant with 3rd)

These negative impacts on mental health experienced by around a fifth of AFFSS mothers were also acknowledged as a possibility by others, with comments such as "We're lucky we didn't end up in Glenside [mental institution]" and "I've managed to go through all that and I haven't ended up somewhere in some loonybarn".

The stress on fathers of coping with a mothers' depression could also negatively influence their desire for more children:

[Wife] had depression. I was actually worried for our marriage... [Second child] was just such a demanding baby... [Wife] couldn't get to her all the time, she was trying to look after [first child] as well — he was only 18 months — [and baby] would just scream and scream and scream. And if you spent a day with her it would get to you, you'd start going nuts... [Wife] just got worse and worse to the point that we had to get her to a doctor... She was convinced everyone had it in for her... all the signs of depression... I thought 'We've ruined it now, with two kids, I don't know what we were thinking. When we had one it was OK'... In the end we decided it was 'Thank your lucky stars we made it through the last one alive'.

(Michael, 33, IT Manager, upper-middle status area, father of 2 – aged 4 and 6)

Just under one in five AFFSS fathers also had difficulty coping with a new baby due to the impacts on their adult relationship, to trying to do paid work whilst also coping with sleep deprivation, coping with their partner's difficulties with parenthood, or coping alone at home while their partner was in full-time paid work:

I don't think he knew HOW to [get involved with baby]. In the hospital he was quite rapt in it but probably the first week home, he never... I don't know is there such thing as male depression? *You know women get postnatal depression, do fathers too?* I guess they're entitled to feel funny about it.

(Mandy, 35, sales assistant, lower-middle status area, mother of 3)

- aged 6, 7 and 10, emphasis added)

These thesis findings suggest that depression rates associated with the conditions of contemporary parenting in Australia can negatively impact on fertility rates. Furthermore, since mothers over age 34 can experience higher rates of depression (Astbury et al 1994; Chaudron et al 2001) this may contribute to an increased delay to, or lower likelihood of, parity progression for older first-time mothers. The Postnatal Depression Program of the BeyondBlue national depression initiative is currently seeking to improve screening and intervention (BeyondBlue 2005). It would be interesting to investigate whether any improvements might indirectly have a positive effect on fertility rates. However, the issues discussed earlier in this chapter show that even those mothers who do not show clinical symptoms of depression would still benefit from increased levels of social and physical support from their family, their community, and government agencies and services.

#### 9.4 EXPERIENCES AND SOCIAL DIFFUSION

Interview-based research confirms that childbearing is being delayed or avoided by men and women in Australia, Italy, Germany and the USA due to anxiety about parenthood which is often based on social observation of the types of negative impacts discussed in this chapter (Cannold 2005; Marshall 1993; Micheli & Bernardi 2003; von der Lippe 2004). However, it is important to acknowledge that such experiences are related to the conditions associated with privatised and intensive motherhood. Dally (1982:190) rightly points out that, with such experiences contributing to the social construction of parenthood, “it is no wonder that many young women, now faced with the decision of whether or not to have a family, are awed and scared at the prospect”.

In the AFFSS, through mechanisms of social diffusion, some parents’ ambivalence about parenthood was indeed based on observing negative impacts of parenting on others:

- TONY: I’d had sisters who’d had kids and I’d, you know, kind of shared some of their experiences, so I had a fair idea of what to expect... [that] having kids is generally, well quite a lot of, well quite a lot of work and it’s fairly difficult I suppose... [So] I wasn’t really that keen to have the first [child]. I mean I wasn’t really that keen to have the second but... [wife wanted it].
- RESEARCHER: So, if it hadn’t been for her, you would have been quite happy to stop at one, probably?
- TONY: Umm [yes]... yeah probably. Or none.

(Tony, 33, engineer, highest status area, father of 2 - aged 3 and 6)

In the same way that lack of opportunity to gain parenting skills in advance could lead to frustration and major behavioural adjustments in the transition to parenthood, such lack of opportunities could also contribute to anxiety about the ability to start a family. At the preconception seminar two-thirds of both the women and men were attending to find out what to expect from parenthood and to reduce their anxieties about parenting. One woman summed up her anxiety and lack of knowledge of what to expect in asking:

Are babies just little people or aliens? Just joking!

(Female computing professional and company director, age 32, preconception survey)

One potential father expressed his anxiety in greater detail, reflecting many of the negative impacts which AFFSS parents have highlighted earlier in this chapter:

I am concerned about the destruction of my lifestyle for the next twenty years, I can't undo it [having children] if I don't like it. I have concerns about a child with disabilities or ill-health, the impact on my marriage if I can't adjust to having a child, and what will I miss out on by becoming a father? Little previous contact with children is likely to be a factor in my lack of interest in them. It would help if someone could develop a baby that comes with remote control - mute, pause, sleep now, clean self and surrounds – just kidding!

(Male supermarket manager, age 33, studying for university degree and working part-time, preconception survey)

A greater concern about parenthood among the preconception respondents was also related to smaller family size desires, with those who thought they were likely to have only one or two children being more likely to doubt, for example, whether they could “cope with caring for babies, young children and adolescents”. Furthermore, 30 per cent of those who expected only one or two children saw the potential impact of parenthood as a “big issue”, and 16 percent saw it as an issue of “medium” concern. By comparison, such impacts were “not an issue” for any of the seven who expected three or more children, and this group also had few concerns about their ability to cope with parenthood. This provides further support for the contention that levels of confidence about personal abilities to parent are influential on family size desires.

Levels of confidence and interest in children may impact to a greater extent on fertility in higher status groups, considering that in the AFFSS preconception survey parenthood concern was higher among professional women. Indeed, 38 per cent of the professional women were “not sure if I really like babies and young children” compared with only 6 per cent of



clerical/service women, while 52 per cent of professional women were concerned about “staying home with a baby” whereas this concerned only 29 per cent of clerical/service women. However, it is significant for policymakers to note that while negative messages could build negative images of parenthood, positive experiences could overcome earlier anxieties:

People tend to talk about the negative things, and as someone who doesn't have children and who was a bit scared, that's what you pick up on, the bad things rather than the good things... I thought two [children] and then after the first, to be honest I thought this baby thing is actually a lot more fun than I thought it would be - our children have been very settled as babies and I had visions of pacing the corridors with a screaming child, and that has never happened... We may well have only had two, I think, but because they were both healthy, not colicky, no reflux, the baby experience was less scary than I thought it would be.

(Susan, 34, physiotherapist, highest status area, mother of 2 – aged 2, 3½, pregnant with third)

This suggests that if policies can help reduce anxiety and raise confidence about parenting, then this may have positive effects on future fertility rates.

Since this chapter has argued that considerations of domestic life and parenthood are influential on fertility, and compound issues of work-family compatibility and financial limits to family size, government policies to assist parents with the transition back to paid work (eg Government of South Australia 2004) need to be augmented by policies assisting in the transition to domestic life and parenthood, as well as by policies which provide greater support for mothers and fathers. Since low confidence levels negatively influence the experience of parenthood and provide negative feedback about parenthood experiences to others, governments and communities could also investigate ways of raising levels of confidence and well-being for parents. Provision of concrete support and ways of reducing isolation both increase the feeling of being valued and esteemed for the parenting work being performed (Tarkka 2003). It is also important to find ways of imparting parenting skills across all status groups because, according to Mirovsky & Ross (1989:144), psychological well-being is improved when individuals have a sense of personal mastery of the skills, abilities and training for the job they are performing.

## 9.5 CONCLUSION

Continuing the theme raised in previous chapters, this chapter has argued that fertility can be lowered when women and men seek to avoid negative impacts on their individual, couple or family health and well-being due to the conditions under which they enter and experience

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parenthood, at any parity. The chapter particularly highlighted the negative impacts on desire for additional children when childrearing and domestic life were associated with negative images and impacts, such as exhaustion, social isolation, and changes to social status and personal identity. Also discussed was the potential contributing effect on such impacts of different levels of previous parenting experience and skills, and of differing expectations and social supports for parenthood.

Another focus of this chapter was the argument that work-family preferences and arrangements could be related to the level of parental skills and support because these could influence the degree to which behavioural adjustments (stress) were experienced with the arrival of each child. Whereas Hakim's Preference Theory considers only how women's work-family preferences relate to their fertility, the AFFSS parents demonstrated that men's work-family preferences were also influential. Men's preferences affected the extent to which parenthood and family were valued in relation to paid work, which in turn could influence the level of emotional and physical support that the father offered to the mother for childrearing and domestic work. Although both mothers and fathers experienced negative impacts from parenthood, concern over gender differences in the extent and type of impact could lead to resentment on the part of some mothers, thereby supporting the Gender Equity Theory of low fertility which posits that greater equity in the division of paid and unpaid work (for those who want this) could help raise fertility rates.

The chapter also discussed how improving parenthood experiences which have a negative impact on fertility was more complex than simply calling for fathers to become more involved in parenting. It noted that the degree to which individual parenting skills were influenced by social conditions, support systems and the social valuation of parenthood could also affect the desire of men and women to be involved with childcare and domestic work. The chapter also argued that Australia's relatively high postnatal depression rates contribute negatively to its fertility rate and demonstrated how the social diffusion of negative impacts can negatively affect the family-related images and desires of those without children. This chapter therefore argues that policies which aim to stabilise or raise fertility rates by improving conditions for parents in the workplace should be augmented by policies to improve the home-based conditions under which women *and men* parent. Suggestions for change will be made in Chapter 11.

## Chapter 10

# Financial and work-related influences

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When Jack McTavish married sweet Marion McGillicuddy they counted their money and talked things over seriously. “We can afford either a wonderful, speedy car that never breaks down, or we can have lots of children,” said Jack. “Perhaps we can have a few children – just six or seven – if we make do with an old car” suggested the new Mrs McTavish. “That’s a good idea” cried Mr McTavish, looking pleased

*(The Rattlebang Picnic by Margaret Mahy, Puffin Books 1994).*

### 10.0 INTRODUCTION

The previous three chapters have focussed on how fertility is influenced by expectations and experiences of the embodied and social impacts of reproductive behaviour because these are less well addressed in contemporary research and debate. This chapter explores perceptions of the impacts of financial concerns and work-family compatibility on fertility and family size. The chapter contains two main sections, the first on financial limitations and the second on work-related concerns. Further introductory material is given at the beginning of each section. The first main part of each section outlines the extent to which experiences were influential on fertility for AFFSS parents, while the subsequent parts explore influences in more detail by drawing on both the parent interviews and the preconception survey. The final part of each section considers how issues may affect the fertility desires of non-parents.

### 10.1 FINANCIAL AND MATERIAL CONSIDERATIONS

#### 10.1.1 The extent to which financial and material considerations impact on fertility

Australian and European research shows that financial considerations are more influential on men’s desire for children than they are on women’s (Beets, Liefbroer & Gierveld 1999; Busfield & Paddon 1977; Callan 1985; Maggioni 2004). The AFFSS parents reflected this, with financial concerns influential on fertility desires for almost two thirds of fathers but only

for one third of mothers. Table 10.1 indicates that financial limitations influenced fathers across all but the upper-middle status area, where issues discussed in previous chapters dominated. Table 10.2 also shows that financial limitations concerned the majority of fathers at all parities, but that mothers at lower parities were more concerned than mothers at higher parities.

**Table 10.1****Family size limitations from perceived financial limitations, by status**

Source: Adelaide Fertility and Family Size Study 2003-04, parent interviews

Percent	Status area				Total
	Highest	Upper-middle	Lower-middle	Lowest	
Mothers	36%	18%	29%	33%	29%
Fathers	83%	29%	75%	71%	63%

**Table 10.2****Family size limitations from perceived financial limitations, by parity**

Source: Adelaide Fertility and Family Size Study 2003-04, parent interviews

Percent	Current parity				Total
	One	Two	Three	Four or more	
Mothers	36%	44%	13%	22%	29%
Fathers	67%	57%	80%	63%	63%

**10.1.2 How financial and material considerations impact on fertility**

Chapter 3 explained that economic influences on fertility included the costs of raising children and the impact of foregone earnings associated with unpaid parental leave. The most recent estimates for Australia show that the costs of raising children increase with the child's age and with family income, but that costs represent a greater proportion of income in low-income families (DFaCS 2005a). Costs are generally lowest for children under four years in low-income families and highest for teenagers in the wealthiest families, although wealthier families spend more on their children regardless of age (Percival & Harding 2005). This is often explained by their higher living standards, which can include a desire for private education, brand name clothes and expensive holidays (Peatling 2005; Tabakoff 2005). In Australia costs differ by capital city, with overall costs generally higher in Sydney; however, food costs are higher in Darwin and childcare costs higher in Hobart (DFaCS 2005b). Although costs rise with family size, each additional child generally costs less, and when

government family payments are taken into account then, for most families, the net costs of four or five children are no higher than for three children (DFaCS 2005a).

Despite these differences, and the offsetting costs of government benefits, the Australian and British media generally portray parenthood as “almost financially impossible” (Dunlevey 2005), with headlines such as “Million-Dollar Baby” (Tabakoff 2005), “Honey, We Can’t Afford the Kids” (P. Martin 2005), and ““Bundle of Joy Leaves You Tied Up In Debt” (Wilson 2001). However, Hamilton (2002) notes that while many lower-income Australians suffer genuine unmet needs, a group of suffering rich exists which reflects rising expectations and an Australian strain of consumption fever or “affluenza”. However, it is important to remember that perceived economic constraints on fertility have long been inextricably linked with social aspirations and the level of desire for social advancement for oneself, one’s partner and one’s children (Chesnais 1992; Davis 1937; Landry 1934; Notestein 1945). As Caldwell (1982:31) points out, fertility is therefore often related to “what people want out of life”. Relative, as well as absolute, financial limits must therefore be considered.

#### *10.1.2.1 Absolute and relative financial limits*

In the AFFSS it was *perceived* and not *actual* income which most affected family size, which confirms the findings from earlier British interviews (Cartwright 1976). Perceptions of financial limitations in the AFFSS were *relative* to other desires, *relative* to what individuals perceived children to require, and *relative* to their strength of desire for children or a larger family. When finances were perceived to limit family size in the lower status areas, parents often wanted to be “just comfortable”, without worries about paying debts and basic bills. However, others wanted financial security or were not prepared to “make do” with less:

Our income is just enough for our needs...[but] not really enough to have another baby, not without going seriously backwards. At the moment we’re just getting by, it’s not comfortable. It’s more stress to the partner because he’s the main income earner... You could make cut-backs of lots of things, but where do you draw the line? I guess we live comfortably... You don’t want [the children] to have to scrimp and scrape. You’d like to see them with their own house, their own future... The more we can put aside for them now will benefit them in 20 years time.

(Tayla, 39, model/retail manager, lower-middle status area, joint income double the metropolitan average, mother of 2)

In the higher status area, financial limitations were often related to personal aspirations:

Once upon a time, a generation ago, you just made do, but I'm not living in that mindset now... It's harder to achieve [husband's] ideals and his goals in life with more children... career, holidays, I guess greater income, investments, things like that. Opportunities - financial.

(Fiona, 34, psychologist, highest status area, joint income over three times the metropolitan average, mother of 1)

The desire to be financially very well-off and professionally successful in business has increased since the 1970s (Easterlin & Crimmins 1991) and may therefore be influencing fertility to a greater extent in areas with a greater proportion of managers and business professionals.

In the AFFSS financial issues could also relate to the trend to later childbearing. Firstly, later childbearing had allowed some more time to become accustomed to a lifestyle on a particular income, which was hard to forego to have children. For this reason, one preconception respondent now expected two children, rather than the six she had once imagined:

I am one of four children and enjoy having three siblings and a larger family, but it is expensive and time-consuming to have a large number of children AND to maintain the quality of life I am used to... I am materialistic and used to a disposable income... I like my current financial situation which enables me to spend money on myself eg regular beauty treatments, eating out, shopping, travel.

(Female human resources manager, 33, joint income over three times the metropolitan average, preconception survey)

Secondly, time spent in higher education or in establishing a career could make later childbearing appear more costly:

Because [husband] studied for five years that owes you a certain income... A normal couple earning a normal income would have had that money in the bank. Well, we were on Austudy for five years while all three of them were born... It's taking him a while to set up his business, so any more little hands out [children] he'd find stressful.

(Faith, 36, former nurse, student midwife, upper-middle status area, income not stated, mother of 3)

The complexity of explanations for financial influences, which must be acknowledged in policy and in survey-based research, was highlighted in discussion with two AFFSS mothers who said they would now only have one child because this was more financially viable. While this implied that finances prevented them having two children, in fact neither had ever

expected to have any children and their discussions of financial issues were therefore more explanations of what they *could* now do with only one child, rather than why they did not want more children:

If I'm out and [son] wants something then if it's a reasonable price I try and get it... it's easier to buy for one child when you're out, like a drink, take them to the movies, the zoo, than have six kids that you've got to come up with tickets for everything. Whether it's two, three, four, it's just that whole concept. And it really does come back to the fact that I didn't think I'd ever have kids.

(Stephanie, 38, former cleaner/receptionist, lowest status area, mother of 1)

Similar complexity was evident in relation to the impact of mothers' foregone earnings. Some clearly perceived this as a direct limit on their ability to provide for more children:

Expenses and taxes and that far exceed what your income growth is. It's only going to get worse... Going back to one wage just with two [children] you know you just don't have the cash flow, the income to adequately do what you want... going out more, buying them more, travelling and holidays, that sort of thing... You've have to look at investing for the future... it gives you a better quality of life with the ones you HAVE got, and it meets your bills without any worry.

(Billy, 40, emergency services officer, lower-middle status area, income double the metropolitan average, father of 2 - aged 3½ and 5)

However, while others saw foregone income as *an issue*, it was not necessarily an issue *which influenced fertility desires*:

It would be a big benefit if [wife] was earning as well, but because the kids are small we don't really want to do that... If we were wanting to have another one, her not going back to work wouldn't be the major issue... The main issue is basically that I don't want to have another one.

(Tony, 33, engineer, highest status area, father of 2 - aged 3 and 6)

It is the contention of some researchers (eg Birrell & Birrell 1987:20; Ware pers comm) that while financial explanations are often given as a reason not to have any children (or additional children), such explanations can be "something of a red herring" and closer investigation can reveal "a plethora of reasons, introduced by the safe one of economic constraints". Indeed, when AFFSS parents mentioned financial limitations they often revealed other underlying issues, or issues which were intricately linked with finances, when asked whether the situation would change if they suddenly became very wealthy (if they "won the Lotto tomorrow"):

Any more than three financially would be a huge issue... [but] even if I won the Lotto I wouldn't do it... It's the chaos that sometimes gets to me... If money was no object, you'd have your bigger house, and it wouldn't be as BIG an issue, cos you'd have a nook somewhere, my nook, with a lock on the door... I've got my shed, but you don't want to be stuck out there on your own either.

(Harry, 37, financial planner, upper-middle status area, father of 3 - aged 2, 4 and 6)

Other perceived financial limitations which related to considerations of the size of the family house and car, and these are discussed next.

### *10.1.2.2 Housing and transport limitations*

An important aspect of financial considerations, particularly for AFFSS fathers, were perceived limits on family size due to the size of the house and/or car which they believed they could afford, or were willing to purchase. The comments of some AFFSS fathers (including some with egalitarian household arrangements) suggest that such perceived limits may relate to men's traditional responsibility as a household's main income-earner. House and car size both influenced greater proportions of parents as parity increased, but became less important at parity four where parents had already adjusted by extending their house, putting more than one child in one bedroom, or buying a larger family vehicle. Perceived limitations from house size included the number of bedrooms and the amount of "social space" in the living areas. Time spent finding or saving for a house with the preferred amount of space, and in a preferred area, could restrict the number, or timing, of children:

The last place we were at we would never have been able to have another child. There was absolutely no way. And that was the time when I possibly WOULD have. Just because the house was too small, the garden was too small. It was just one of those houses where we felt that we were taking it up completely. Now we have actually got more space [here].

(Margaret, 33, accountant, highest status area, mother of 2 – aged 3 and 6)

The increased focus on individualism associated with postmodern preferences, which has led parents to feel that each child should have their own bedroom, as well as the increased use of home computers, also contributed perceived limits to family size:

Same-sex siblings can share, but more and more I'm hearing that every kid has their own room if there's a space... Then you have to look for a four-bedroom house. And also because my parents come down frequently I'd like a separate guestroom... Now with [only one child] we no longer have a guestroom — this is a three-bedroom house — [and]... you need a study because you need a private area, and it's become a necessity now.

(Fiona, 34, psychologist, highest status area, mother of 1)



Such limits on family size related to house size were particularly limiting if parents felt more children would necessitate additional space but perceived they could not afford, or did not want, to move house or add an extension:

I had to buy a seven-seater car and I now have to put a second storey on the house, so it's probably in the last 19 months [since twins were born] cost me about \$180,000, plus loss of income for [wife]... I'm sure people have lived in a smaller house, but if you can afford to... it would make life more comfortable.

(Chuck, 42, electrical technician, lower-middle status area, father of 4  
- aged 8 and 13, plus twins aged 1½ )

In the two highest status areas, four of the larger families had house extensions planned or underway, and a fifth already had a house with seven bedrooms. In light of the considerable costs of a new house or home extensions, it is not surprising that one father believed that in relation to addressing obstacles to higher fertility “the amount of change that a politician could do wouldn't have a lot of consequences”. Another explained how:

A tax cut of \$4 to \$5 per week isn't going anywhere near to covering the costs that I would need. If we had another child... then we'd HAVE to [extend] and the costs WOULD be [an issue]... There's no government incentives that are going to do that.

(Harry, 37, finance manager, upper-middle status area, father of 3 - aged 2, 4 and 6)

However, beliefs about children's needs were important, and some parents were happy with shared bedrooms so that the house size was made to fit the family size, and not vice versa:

We're having to extend because we're really living on borrowed time with the size of our house — it was a three-bedroom home and one girl's wardrobe is out on the landing... But I think it's also brought them very close because they've shared a bedroom. They talk away at night and they've got a wonderful relationship... The fourth would happily have her own [room], but we don't have enough space, but the fifth wants to be [in with her sisters]... Perhaps it's a generational thing, because so many people say “Oh I had seven brothers and sisters and we had a two-bedroom house” and people just coped.

(Clare, 45, former primary teacher, upper-middle status area, mother of 5  
- aged 5, 8, 12, 14 and 16)

Depending on preferences for individualist or collectivist living, such issues may be more influential on fertility where populations are concentrated in urban areas dominated by one- or two-bedroom units rather than larger family homes.

As with house size, car size was a financially-related concern for many fathers. This is linked to Australian legislation requiring each child to be individually restrained in a vehicle:

CHRISTINE: I was one of seven.  
RESEARCHER: OK, so what did YOU do with cars and bedrooms? When you went out did you take two cars?  
CHRISTINE: No, in those days you didn't have to have seat belts... kids sitting on mum's lap, and little kids sitting on older kids' laps... [We had] big humungous Chrysler cars, H-U-G-E big things with bench seats... We'd have about five kids in the back and mum and dad in the front, with one or two in between them on the bench seats. So yeah, we just all piled in.

(Christine, 39, former childcare worker/nanny, lowest status area, mother of 3  
– aged 3, 5 and 7)

Those with larger families by intention or accident often found ways to cope at minimal cost:

We found a way of doing it that was virtually cost neutral. We switched over from a Commodore sedan to a Falcon station wagon, very little price difference, and then we just put the dickie seat in the back. So really the expenses are coming now - extending the house and we'll have to get a proper people mover - cos the second youngest is growing out of that dickie seat in the back. You just sort of do these things. It's becoming expensive now, but you just cope.

(Wayne, 46, academic, upper-middle status area, father of 5 – aged 5, 8, 12, 14 and 16)

However, some AFFSS parents were reluctant to buy a larger car, a van, or a people-mover because of the increased expense or cosmetic unattractiveness when compared with a “normal” car. This could then limit them to having three children at the most:

If you only have three [children] you can have a normal car, but when you have four you've got to go to that (points outside). It's a Chrysler Voyager [seven-seater people-mover].

(Chuck, 42, electrical technician, lower-middle status area, father of 4)

Four [children] would make it a new car and I don't really want to do that.

(Paul, 36, state utilities manager, upper-middle status area, father of 3)

That's the whole reason why you'd stop at two or three if financially you've got to buy a car that's worth this much money to fit seven people in it, and if you couldn't afford it... We wouldn't [have gone] ahead and had any more [children].

(Bob, 41, managing director/industry, highest status area, father of 5)

Since larger sedans and station wagons are relatively common in Australia, even in urban areas, and can accommodate three children even with baby capsules and child restraints, this may be helping Australia to maintain a significant proportion of women with three children when compared with countries where smaller cars dominate.

### 10.1.2.3 Educational aspirations and costs

Aspirations for children to succeed socially and economically are interwoven with the type and extent of education which parents perceive their children to need. In Japan, fertility levels are negatively affected by around half of all parents seeing education costs as a major difficulty of raising children, particularly when they want their children to attend elite universities (Retherford, Ogawa & Sakamoto 1996). In Australia, parents are encouraged in major daily newspapers and parenting magazines to invest for what is constructed as the “major expense” of a child’s primary, secondary and tertiary education (eg AMP Financial Planning 2005; Fisher 2005; Lifeplan Funds Management 2005a; Zurich Financial Services 2001), and some Australian politicians suggest that parents with a new baby should start saving \$44 a week if they want the child to attend university (Anon 2003).

In the AFFSS, educational aspirations constituted financial limitations on family size, and aspirations for private schooling and university education were particularly influential. Considering that in South Australia some parents spend twice as much on private school fees as on mortgage repayments or weekly food bills (Goodfellow 2002), preferences for private education could have major limiting effects on fertility:

Everyone wants their children to go to a private school... If you’ve got [Private School] on your resume as where you went from reception to year 12, and university studies, you’re going to get more of a look in as opposed to the child who went to [Poor Area] High... Most people are opting for a private school because the classrooms are 15 to 18 students, as opposed to public schools with 22 to 30. There’s such high unemployment, you want to see your children get ahead. We’ve already planned for their high school tuition now [savings scheme]... If we had four [children] we definitely wouldn’t be able to pay for the private schooling.

(Tayla, 39, model/retail manager, lower-middle status area,  
mother of 2 – aged 3½ and 5)

The perceived need for private education might be reduced if governments raised the quality of public education through additional or redirected funding, or addressed perceptions of quality differences between public and private schools.

Others decided to avoid the perceived increased family stress from parents working sufficient hours to pay for private schooling and preferred to use public schooling and work fewer hours so they could spend more time with their children. Education costs were also reduced for some AFFSS families by home-schooling, or by using institutions supportive of larger families:

It's pretty scary numbers when you start adding up (laughs), but you do get discounts for the fourth, particularly in the Catholic [education] system. If they were DEFINITELY going to go to a private school and you'd do the sums, then maybe two or three [children] would be your maximum.

(James, senior medical specialist, 44, highest status area, father of 4)

With parents encouraged to see paying for higher education as their role, rather than it being funded by the students themselves (see Lifeplan Funds Management 2005b), the movement of higher education costs onto individuals via Commonwealth Assistance (formerly the Higher Education Contribution Scheme) could also increase parents' perceived financial limits on family size.

#### *10.1.2.4 Perceived financial pressure related to government philosophy*

All of the issues discussed so far relate to the overall perception of financial pressure and how this relates to perceived income and perceived needs. Although the Federal government encouraged "patriotic procreation" during the last election (Jackman 2005), some AFFSS parents felt that the philosophy of the current Federal government and some past State governments to increasingly privatise goods and services limited their family size by increasing perceived financial pressures, and countered any fertility-related financial incentives that the government was providing:

[Government maternity incentives] wouldn't go anywhere near the cost of having children, and certainly since Howard's been in [current Prime Minister], you just pay for everything. And they're really forcing you into [private] health insurance and stuff like that, and into private schooling. They'd have to do something like income-splitting so my income could be apportioned over my wife and myself. She has a nil taxable income.

(Daven, 35, musician, highest status area, father of 4)

Some AFFSS parents particularly mentioned the South Australian government's privatisation of power companies which they felt had led to increased power prices and hence to more financial pressure on themselves and their family size desires.

Despite such moves on the one hand, the Federal Government has introduced initiatives such as the Baby Bonus, subsequently replaced by the Maternity Allowance, with the intention of better supporting parents. However, while such initiatives are made with the concomitant hope of positively influencing fertility, they have no influence if parents perceive they are ineligible for such payments, or if other factors are more influential:

Anything the government does it seems we're never eligible, just out of their loop. Things that WOULD, things like work entitlements, like leave, that DOES influence me, but the little sums that the government give out... no, not in making a life-time decision of whether to have a child.

(Fiona, 34, psychologist, highest status area, mother of 1)

Highlighting the gender differences in concerns influencing fertility which were shown in Tables 10.1 and 10.2, some mothers said they would actually prefer governments to fund domestic support rather than make direct monetary payments:

A cash payment would go on the mortgage or something more practical... [I would prefer] more practical support that left more time for being with the children – that person has little to do with the kids, just relieves you from domestic chores to focus on parenting, relationship, later on as a worker, and on self, relationship. Cos let's face it... for most mothers, it [domestic work] is huge.

(Athena, 39, ex-sales manager/high school teacher, upper-middle status area, mother of 2)

Others felt that men overly focussed on financial issues and that this obscured concerns of importance to women (as discussed in Chapters 7 to 9), which in turn limited policy direction:

Even though I complained to my husband about his support, they [men] always think financially. I don't know what it is with men, it's not financial, it was just helping me out.

(Veronica, 31, former call centre supervisor, upper-middle status area  
mother of 2 - aged 4 and 6)

Some man who has no idea what he's talking about has sat there thinking 'Oh well, if we pay them [mothers] to stay home for six months maybe they'll have another baby'. That's just garbage. I think if you're going to have another child you will accommodate them... there's a whole PILE of other issues connected with families having more children.

(Lucy, 46, company director in family business, upper-middle status area  
mother of 1 – aged 6)

This leads to a discussion of what influences financial limitations to be perceived differently.

### **10.1.3 Differences in attitudes to perceived financial limits**

While the previous sections have raised the issue that differences in attitudes and perceptions towards income affect the extent to which finances limit family size, this section will argue that *desire for children* is also an important issue which low fertility research should consider more seriously alongside *perceived financial limitations*. As one preconception woman noted:

[I would have three children] if I were rich and could afford buying in help... [I think I will now probably have] one child, due to financial reasons and also wanting to still be able to have my own career and live. [My/our income is] more than enough at the moment [but] we still manage to spend it all!!

(Female finance professional, 33, joint income over three times the metropolitan average, preconception survey)

In comparison, even when a low income was *not* sufficient for current needs, it could still be perceived as sufficient to have another baby if an additional child was perceived to cost very little, or people felt they would find a way to cope by re-budgeting their expenditure or changing other aspirations:

Oh money's always an issue [but] yeah, you ALWAYS find ways of coping.

(Molly, single mother of 7, lowest status area, income around the metropolitan average from government payments alone)

You adjust your lifestyle, you don't have fast cars and golf clubs and... that sort of stuff goes out the window.

(Mark, 43, training consultant, upper-middle status area, father of 4, joint income four times the average)

Merlo's (2004) national study confirms that Australian women with a strong desire for children overlook financial security (and entry to home ownership) as limitations on fertility. In the AFFSS the cultural influences discussed in Chapter 6 could be strongly influential in this respect, with two mothers from the upper-middle status area explaining how their own mothers "had always said" that "another baby will fit in, even if it's the tenth", and that financial limitations were "a silly reason not to have four children".

Non-materialistic attitudes were evident among many AFFSS parents of larger families across all status areas and these attitudes could counter the fertility-lowering potential of individualism, materialism and consumerism. In some families such attitudes were interlinked with religious beliefs, which partly helps explain the relationship between religion and higher fertility identified in Chapter 5:

Our whole attitude, our Western world is very materialistic, very self-centred, it's always about "me", how good "I" feel, how good "I" look. Having children is just a nuisance factor and some people just do it because it's the accepted norm but they only have... one or two just to satisfy it. But a lot of people are choosing not to have any, or to have them very late. See, even on television the other day when one of the Royal family couples had a child, first thing in the paper is how much this child's going to cost them.... people are very much finance-driven that they HAVE to have the best car, the holiday every year, etcetera,

therefore they put those things and finance, money, before children... We chose to have a large family rather than have expensive holidays... I've never been one for desiring a lot of wealth... and [wife's] the same... If we had more children and we wanted to [do something], we'd find a way... Our children enjoy the simple things. If we go on a holiday it's a real treat... Part of our belief too, in our Christian... we actually believe that there are models of servanthood, caring for others, putting others before yourself.

(Graham, former building supervisor, now Associate Pastor,  
lower-middle status area, father of 7)

However, even parents with high incomes could choose not to spend as great a proportion of their income on their children as academic estimates suggest they do at the group level:

We're not rich, but we're not wanting for anything either, depends how you classify rich... I like specials and good deals... And I don't think it hurts for kids to have supposedly "less"... I don't see that material things, especially for kids, they don't HAVE to have all the latest and greatest or everything that opens and shuts and is perfect.

(Karen, 41, former travel manager, highest status area, mother of 5,  
income over three times the metropolitan average)

While most parents of larger families met a financial limit eventually, the impact was less than might be expected because the economies of scale noted by DFACS (2005a) came into play, particularly for same-sex children:

Children become, at least in the initial stages, a lot cheaper the more you have. Once you've GOT the baby capsules and all the stuff. And especially since they're all girls, you just pass it all down.

(Wayne, 46, academic, upper-middle status area, father of 5)

Also reducing financial pressures in the two largest families (both with seven children with some relatively wide birth intervals) were the oldest children who were working and contributing income or living elsewhere, leaving parents responsible for only five children at once. Family payments would also have been subsidising the costs of childrearing for larger families except those on the highest incomes (DFACS 2005a), although AFFSS parents did not mention this in interviews and focussed more on their attitudes.

The influence on perceived fertility limits of personal background, desire for children, and social context as it influences aspirations, are highlighted by comparing two AFFSS fathers. Darren was an unemployed labourer in the lowest status area, receiving around half the average metropolitan income from government payments alone. John was a medical specialist living in the highest status area, earning over three times the average income. John had always

thought he would probably have two or three children. At the time of interview he already had one child but expected to stop at two, partly due to a traumatic birth experience, and partly due to the time demands and sleep deprivation which he associated with a baby. However, John also felt that contemporary peer pressure influenced his lifestyle aspirations, which in turn limited his family size:

There's a bit more of an expectation now of things that really make having children more expensive, like just your friends and things. The people I work with - private school education. All these various activities that you can do - they can all add and cost a fair bit... There's always these things in the newspaper saying how much it costs to raise a child... I don't think it would be a major factor but it might stop you going on too far, more if you were looking at four or more. Cars, and all sorts of things... Education... would be one of the major factors I think. Four would seem pretty crazy (laughs). Three seems like a possibility, but we'll just see how it goes. Extra money would make it easier. It wouldn't necessarily be a determining factor, but paid maternity leave, those sorts of things, baby bonuses.

In contrast, Darren was on the Work-for-the-Dole scheme while his wife was home full-time with their four pre-schoolers, awaiting the birth of a fifth child. Darren had always had a strong desire to have children and a strong interest in spending time with them; he had spent a year as a sole parent caring full-time for his first child. Despite now providing for a large family on a low income, while John provided for one child on an income six times greater (and over eight times greater when John's wife had also been working part-time), it was John on the high income and not Darren on the low income who perceived financial limitations to his family size. Indeed, Darren believed that the only limit to a sixth or subsequent child was the small size of their publicly rented house:

Money isn't something that would stop me having more kids, even though we aren't bringing in much. It's not much, but at least it's regular and I can budget with that... Our income is enough if we wanted to have another baby, but we don't have room in the house.

This comparison suggests an interesting dilemma for theorists and policymakers. It could be argued that governments who desire higher fertility rates should provide financial assistance to anyone who perceives financial limitations to their fertility and family size. However, to have any impact this would need to be scaled relative to income, and some might feel that high income earners should be self-funding and use better budgeting and forward planning, or consider less material-intense lifestyles. It may be preferable therefore for governments to encourage wider discussion at antenatal classes and in the wider community of what babies and children "really need" and to encourage parents of larger families to discuss their coping methods more widely so as to dispel fears of "not being able to afford children".



#### 10.1.4 Financial influences on non-parents

This section briefly considers potential influences on those without children, based on the data from the preconception survey. Recent research shows that those who delay parenthood or decide to remain childless may be more concerned about various issues than those who become parents (Weston et al 2004). Although the individuals in the AFFSS preconception survey represented a select group of people without children, of whom the majority intended to have children within the following two years, it is interesting to note the issues which contributed to a “fertility gap” between their group’s average desired and average likely family sizes of 2.86 and 2.06 respectively. Indeed, financial limitations were the single most frequent unprompted factor that respondents felt might be an issue when thinking about having children, and these were cited by 25 per cent. However, when specifically prompted about financial concerns in a later question, 60 per cent saw as a “big” or “medium” issue of concern whether they could afford the money to raise a child or to take unpaid maternity leave. More preconception respondents on the highest incomes (three or more times the Adelaide average) saw costs as a prohibitive factor (42 per cent) than did those in the lower category (earning around twice the average) (25 per cent). The two-father comparison in section 10.1.3 illustrated the social context of such differences, but gender differences were also evident, with female preconception respondents more concerned about financial issues than males. Their thinking was therefore more similar to AFFSS fathers than AFFSS mothers.

However, in interpreting such concerns, the strength of desire for children was often weighed against the strength of desire for paid work or a particular income:

I want the children to have company, ie more than one child, but I don’t want to be out of the workforce too long... To have three is not practical, I run my own business and need to ensure this has an income.

(Female, engineering professional, 28, joint income \$80-99,000 pa, preconception survey)

The preconception respondents saw government as the main facilitator to starting a family, and the most popular initiatives suggested were government-funded parental leave and increased family payments (noted by 24 and 20 per cent respectively). Overall, one fifth of respondents said having paid leave would help them have a baby earlier by removing the need to accumulate savings or leave. More women in clerical occupations were influenced than those in managerial or professional occupations (more of whom already had access to paid

leave), and they were also more concerned about foregone earnings. This may explain why British mothers in lower status areas are more likely to return to work for financial reasons than mothers in higher status areas (Brannen 1987). A third of preconception respondents said paid leave would be a welcome bonus but not a strong influence on their fertility behaviour.

The AFFSS preconception group also exhibited a continuum of concern, where level of concern was inversely correlated with family size desire, with those saying they would have four or more children believing paid parental leave would have no influence on their fertility decisions, while lack of paid leave was more influential where maximum preference was for one or two children. However, the complexity of influences and the extent to which any one factor influences fertility alone is shown in the fact that despite these comments, three quarters of preconception respondents said they were already highly likely to have a baby. In relation to government financial support, even a quarter of those on joint annual incomes of over \$100,000 (three times the Adelaide average) believed increased government family payments would make it easier for them to start a family.

In contrast with such concerns, some AFFSS parents found that pre-parenthood financial anxieties were unfounded once they actually had their own children:

When we found out that I was pregnant, it was “Can we afford this?”. And money was the only factor that we considered... Initially the transition from one wage was really hard. Because I’d worked half the year, the money we got from the government wasn’t a lot and it was a real struggle... Once we got used to the money, we CAN survive on one wage. We know we don’t have heaps of money but we keep the house running and we have two cars.

(Joan, 26, former aged carer, lowest status area, income around the metropolitan average, mother of 1, expecting another child soon)

Pre-parenthood financial anxiety for some stemmed from the costs of children advertised in the media which, nevertheless, could appear unduly exaggerated once parents compared them with personal experience, and if they found less expensive parenting methods:

[Before I had children] you know I thought I had to BUY everything and then of course it’s all given to you and you’ve got double, triple, of everything and you end up throwing it all out brand NEW... If you’re like my cousin it WOULD be \$500,000 to raise a child cos you’ve got to buy all the clothes at [the best shops] and you’ve got to renovate your house all at the same time and you’ve got to send them to the best schools... I do a lot of my shopping at the [second-hand shops] because children and babies wear things for such a limited time... We don’t spend a lot of money on our kids really... we do a lot of free activities.

(Athena, 39, ex-sales manager/high school teacher, upper-middle status area, mother of 2 – aged 6 and 8)

Other strategies to reduce financial pressure included saving in advance, which was particularly mentioned by mothers in the lower-middle status area. One had purchased baby requirements (eg nappies) during her pregnancy whilst still in paid work to minimise her expenditure during unpaid maternity leave. Another mother had been advised by a friend to save enough money to cover her mortgage whilst on unpaid leave. Yet a third mother believed that budgeting skills could make finances less restrictive. Rather than, or in addition to, increasing financial payments to families, governments could therefore address perceived financial limitations by encouraging people to save and budget for a family, or by encouraging a reassessment of material aspirations. This might help people feel less of a need to delay childbearing, which can result in some never having children:

We put off having baby until now to pay off our mortgage, but now we're ready we can't seem to get pregnant!

(Female senior analyst programmer, 32, preconception survey)

In seeking to formulate policies to stabilise or raise fertility rates it is important to be aware that women and men currently with no children, but who intend eventually to start a family (like those in the AFFSS preconception survey), may be affected by different issues to those who currently have no children and who intend to remain childless, and again different to those who already have children. While the AFFSS findings in this section show that some of those who intend to have a family eventually may well be assisted by financial and paid leave initiatives, two recent Australian studies on childlessness (Weston & Qu 2001; Wheeler 2001) note that financial concerns are not a major issue raised by those intending to remain childless, and that dislike of children and an unappealing image of parenthood are more influential for them. Chapter 12 will discuss potential policy initiatives to address the latter.

## **10.2 WORK-FAMILY COMPATIBILITY ISSUES**

### **10.2.1 The extent to which work-family compatibility issues impact on fertility**

#### *10.2.1.1 Desire for the mother to resume paid work*

A desire for the mother to resume, or increase her hours in, paid work delayed or prevented additional births for a quarter of AFFSS mothers and a fifth of fathers, as shown in Table 10.3. Although fewer upper-middle status mothers and fathers were concerned about financial

limitations (Table 10.2), Table 10.3 shows that more were influenced by a desire for the mother to resume paid work, often for the social reasons explained in Chapter 9 (section 9.2.3). As with financial limitations, Table 10.4 indicates that mothers with smaller families were also more influenced by a desire to return to work than mothers of larger families.

**Table 10.3****Family size limitations from desire for mother to resume paid work, by status**

Source: Adelaide Fertility and Family Size Study 2003-04, parent interviews

	Status area				
Percent	Highest	Upper-middle	Lower-middle	Lowest	Total
Mothers	9%	55%	0%	33%	26%
Fathers	17%	43%	25%	0%	21%

**Table 10.4****Family size limitations from desire for mother to resume paid work, by parity**

Source: Adelaide Fertility and Family Size Study 2003-04, parent interviews

	Current parity				
Percent	One	Two	Three	Four or more	Total
Mothers	45%	30%	13%	11%	26%
Fathers	0%	29%	20%	22%	21%

*10.2.1.2 Work-family incompatibility and childcare issues*

Tables 10.5 and 10.6 show that most AFFSS parents did *not* perceive issues of work-family compatibility and childcare as limiting their family size. However, this does not mean that these issues were not important per se. Furthermore, the preconception survey suggests that

**Table 10.5****Family size limitations from work incompatibility or childcare availability, by status**

Source: Adelaide Fertility and Family Size Study 2003-04, parent interviews

	Status area				
Percent	Highest	Upper-middle	Lower-middle	Lowest	Total
Mothers	9	9	0	0	5
Fathers	0	14	0	0	4

**Table 10.6****Family size limitations from work incompatibility or childcare availability, by parity**

Source: Adelaide Fertility and Family Size Study 2003-04, parent interviews

	Current parity				
Percent	One	Two	Three	Four	Total
Mothers	18	0	0	0	5
Fathers	0	0	0	11	4

such issues may be more influential on family size for those without children, and this is explored in section 10.2.3.

## **10.2.2 How work-family compatibility issues impact on fertility**

There has been widespread discussion of work-family compatibility issues such as women's ability to resume paid work after childbearing, workplace flexibility, and various aspects of childcare, including availability and cost (eg England 1996; Fincher 1993; Goward 2002; Grace 2003; Human Rights & Equal Opportunity Commission 2002; Joshi 2002; Kruesmann et al 2003; Moen 2001; Pocock 2003). A relationship has also been investigated between national fertility trends and trends in female labourforce participation, childcare usage and government policy (eg Hakim 2003; Kruesmann et al 2003; Rindfuss, Guzzo & Morgan 2003). This section of the chapter explores in particular the impact of general life course orientation towards work and family, of women's occupation, and of childcare issues. Work-family compatibility issues which directly impact on reproductive processes are less well covered in the low fertility literature and have already been discussed in previous chapters. These included the negative effects of working conditions on natural fertility (section 7.1.2), and difficulties in taking time off paid work to attend IVF treatment (section 7.1.5), the difficulties of working with pregnancy nausea (section 7.2.3) or parental tiredness (section 9.2.1), and ways in which fathers' work-family priorities affect the domestic and childcare support available to mothers (section 9.2.4).

### *10.2.2.1 Life course orientations*

In terms of family size being influenced by work-family compatibility issues, low fertility is generally seen to result when women seek education and work outside the home (Davis 1937:303; McDonald 2000; Ruzicka & Caldwell 1977:36-43). Gerson (1985) shows that earlier life course experiences shape women's orientation towards work and/or family, while Rosenfeld (1996) suggests that women have "labour force plans" and coordinate their productive and reproductive roles around this. These findings are supported by the AFFSS findings discussed in Chapter 6 on the influence of family background on family size thinking and behaviour. Several studies show that fertility is negatively related to strong preferences for spending time in paid work and positively correlated with strong preferences for spending

time at home raising children (eg Hakim 2001, 2003; Rosen & Simmons 1971; Scanzoni 1977; Toomey 1978).

In the AFFSS the work-family relationship was complex and was indeed more often linked to individual and couple life course orientations than to point-in-time reactions to perceived constraints. Although time out of the workforce has long-term negative effects on employability (Craig 2002), such work-family limitations concerned more mothers with one or two children than it did mothers with larger families (as indicated earlier in Tables 10.3 and 10.4). This appears to confirm the negative relationship between family size preferences and preferences for being in paid work. Conversely, for mothers at higher parities family size was less limited by a desire to resume paid work, often because they had a lifelong preference for spending time on childrearing, which equated with work and children being sequential rather than more simultaneous undertakings:

KAREN: I'd lived fully before I had kids.  
 RESEARCHER: So, you didn't feel the need to go back to work at any point?  
 KAREN: No, I still don't. We joke about it now, cos [fifth child] will be at school next year. It's been a long time [12 years out of paid work] but [I've] been there, done that and financially we probably wouldn't have been any better off because I would have had to pay for a nanny or something to mind them these odd hours... With [husband's] work, being owned by such a big company it could be sold tomorrow. That would be an opportunity to work for ourselves... maybe in the future.

(Karen, 41, former travel manager, highest status area, mother of 5 – aged 4, 6, 8, 9 and 11)

However, the AFFSS also found that work-family preferences and perceptions could change over time, with some mothers having stopped paid work as family size grew, which moved them from the work-centred childless group to the mother group. Therefore it is not surprising that Hakim (2000, 2003) finds that fertility is higher for home-centred and adaptive women:

I was already senior when he came along and felt empowered enough to resign... I don't see myself as a career person now... I see myself primarily as a mum... but I'd like to be able to reinstate some of the professional things because I really enjoy my work. That'll be a reassessment of my working life... For me the [paid] work is [now] on the side.

(Georgie, 44, senior medical specialist, highest status area, mother of 1 - age 4)

The complex relationship between work and family is interlinked with the issues of identity, personal achievement, the valuation of paid/unpaid work, and social learning related to the development of confidence to parent, as discussed in Chapter 9.

With work-family compatibility a contemporary issue, it is interesting to consider one AFFSS example of intergenerational influences on beliefs about work-family compatibility and life course orientations as they affect family size preferences. One of the few AFFSS mothers with a large family who was also working full-time (45 hours a week, plus one interstate business trip per month) described herself in a way which contradicts Preference Theory, saying she was at the same time “Work-centred” in her behaviour but “Home-centred” in her thinking:

*Having children is part of our family culture... I had a job [before the children and] I never thought about resigning... I like the money but I also like the challenge and novelty of work. I really admire women who can stay at home and say they have done more for their children than anyone else could have done [because I couldn't do it]. *Having had a mum who worked I felt comfortable[working], very comfortable... The parents' attitudes and desires are what count. If the child goes to childcare and just gets "plonked" there then that's not good, but if the parent takes time to be interested in what the children are doing, collects their pictures they've made, interacts with the childcare staff and provides a good loving home environment the rest of the time, then it's OK to go to childcare... Mothers should do what suits them and make it work.**

(Julie, 40, human resources executive, upper-middle status area, mother of 4 - 16, 18 and 19, plus 3-year old in new relationship, emphasis added)

This mother's attitude reflects that of strongly religious Catholic college women in the USA in Westoff and Potvin's study (1967) whose higher fertility related to a belief that commitment to work or career was quite compatible with having children. In the AFFSS this particular mother was influenced by the positive role models of her mother and grandmother, who had raised five and four children respectively and also worked full-time. This combination in this woman's "family culture" may have related to the family's Presbyterian background. However, her husband also worked full-time (50 hours plus in his own business), so that household tasks and child-care were shared when both were home, and domestic work, gardening and weekday childcare were outsourced. Although this mother was exceptional among AFFSS interviewees, she demonstrates how a desire for both work and family can drive arrangements to fit, as long as other people are available, and women allow them, to perform more of the domestic work and childcare. Indeed, Caldwell's research in Nigeria (Caldwell 1982:101) showed that women are able to have large families *and* undertake paid work outside the home if non-maternal childcare is fully accepted, and employers and relatives make arrangements to help them accommodate both work and family life.

### 10.2.2.2 *Childcare quality and beliefs*

Continuing the theme of non-maternal childcare, in-depth interviews in Australia and Scandinavia show that, more than anything else, women's employment and work-family arrangements are influenced by their *beliefs* about child care and what is good and possible as regards mothering and work (Clarkberg & Hynes 2002; Elvin-Nowak & Thomsson 2001; Hattery 2001; Ware 1973; Young 1977). In the AFFSS, work-related limitations on family size often related to social, partner and/or mother's own preferences for maternal childcare (which reflected the traditional ideology of motherhood discussed in Chapter 3) and which clashed with women's desires when they wanted to minimise time out of the paid workforce. One AFFSS father explained how this limited his family size. Interestingly, this was the husband of Julie, the mother in the previous section, who was quite comfortable with her daughter attending a full-time childcare centre from the age of six months:

It's not as if childcare's a bad place, it's just, well, they're supposed to be with their parents, aren't they... Childcare in the first two years in particular ... has its risks on the development of the child and most of those risks centre around the amount of attention the child gets and who gives that attention... Both of us are working quite long hours and because [daughter] is in full-time care I have this feeling that she should get as much of our time as she can when she's at home ... if we had another child it might really be a bit hard on her while she's in full-time care.

(Mark, 43, training consultant, upper-middle status area, father of 4 – twins age 16, one age 13, plus 3-year old in new relationship)

Lack of childcare places also concerned some parents, but did not generally limit family size. However, childcare *quality* could also influence fertility if it restricted women's ability to work by making them feel that, at least for now, maternal care was of higher quality:

If I was to have three [children] I wouldn't have a career... I'd have to take time off work, longer probably, to have two young kids under five.... because our current childcare arrangement is that my parents-in-law look after [son]... I don't think [they] would cope with two... My husband doesn't agree in paid, in childcare. So I would end up being at home, looking after kids ...[and] I just couldn't see myself as a full-time mum with the lack of supports for the rest of my life... I studied in fact probably longer than him, an extra year. And we've had these arguments and my husband will say 'Well one career's got to suffer'.

(Fiona, 34, psychologist, highest status area, mother of 1 – aged 1)

Due to such family pressures and beliefs about non-maternal care, another mother had allowed the grandparents to provide the childcare despite the difficulties this caused for her:



My husband's parents looked after the children. They didn't want us to put them into childcare... I actually think [paid institutional] childcare would have been easier for us. It was a lot of work taking the one child there [to grandparents] because they didn't want ANY baby equipment in their house at all, but they also wanted to do it. I had to take EVERYTHING – a vegemite sandwich, the cot, the toys, the little highchair – two days a week... I felt I couldn't say no.

(Susan, 34, physiotherapist, highest status area, mother of 2  
– aged 2, 3½, pregnant with third)

Another mother had organised mixed arrangements which she felt would be harder to do if she had a second child. However, to overcome the limits she felt would require both a change in the childcare beliefs of herself and her family, as well as higher quality childcare:

[If I had a second child] I'd like to go back to work again, but I suspect that after the second I'm going to have to give up all together because I don't think that we're going to be able to continue this home arrangement [with the nanny]. If it was a REALLY good childcare centre that I felt really comfortable about then that would be fine. I rang around but the ones I rang had HUGE waiting lists [and husband's] family were VERY very negative about me going to work... completely disagree with childcare. They have an issue with the ratio of carers in childcare. I've read a LITTLE bit of the research and it is mixed, but there's a lot of negative research which concerns me a bit. The perception from [husband's] family is that I'm a bad mother - I knew if I put him into childcare the hostility would be even worse. MY mum and dad were fine, they could see that I was going insane and wasn't coping [being at home and not in paid work].

(Jane, 31, insurance supervisor/graduate, highest status area, mother of 1 – aged 1)

It is interesting that these three cases where grandparents' attitudes caused conflict for women in their desire to work were where the *father's* parents had migrated from countries where Gender Equity Theory addresses lowest-low fertility (Italy in two cases; Germany in one). Such intergenerational ethnic influences may help explain the bimodal distribution of family size for university-educated Catholic women discussed in Chapter 5, section 5.1.5.3. Whereas Day (1965:165) suggests that Australian Catholics of Italian heritage have smaller families than other Catholics due to higher social aspiration levels, less attendance at church-based schools, and weaker attachment to the broader Catholic value system, such smaller families may also result from this intergenerational conflict over traditional motherhood ideology.

### 10.2.2.3 Childcare affordability

The high costs of childcare concern Australians, and many women spend all their income on childcare fees (Bryden-Brown 2002; Markson 2005; Peatling 2005). However, the extent to which this influences fertility at the individual level is not straightforward and limitations

should be seen within the context of life course orientations discussed earlier. Childcare costs were indeed a concern for some AFFSS parents and some mothers felt it was not worth working just for an income which would be spent mostly on childcare. Whilst no-one said this directly limited their family size, such parents perceived family size to be restricted because of their resultant reduced family income. Family size could also be indirectly limited if the inability to pay for childcare limited the ability to obtain relief from the stresses of everyday parenting (as discussed in Chapter 9, section 9.2.1). As with finances, childcare costs were of more concern to preconception respondents, which is discussed later in section 10.2.3.

In their national survey, Weston et al (2004) found that just under half their respondents cited childcare as an important factor in fertility decisions, and women who had never had children were slightly more concerned than their male counterparts, and than mothers. This represents some discrepancy with the AFFSS findings. However, informal care is more widely used in South Australia than in other States and Territories (ABS 2004a), which may reduce the perceived costs of childcare for AFFSS parents. Furthermore, the Weston et al question combined affordability with quality concerns, and childcare affordability may be less influential on fertility in Adelaide considering Henman's estimates (2005:7) that childcare costs are lower in Adelaide than in any other Australian capital city. The discrepancy may also reflect a difference between responses from AFFSS in-depth interviews and responses to Weston et al's selected list of issues in a 30-minute telephone survey where the difference between "important issues" and "important issues *affecting fertility*" might be less obvious.

#### *10.2.2.4 Women's occupational field*

Chapter 2 considered fertility trends and patterns in relation to educational level and occupational status. However, combining the theme of life course orientations discussed earlier, and the role of caring experience and skills in minimising the amount of behavioural adjustment (stress) experienced with parenthood as discussed in Chapter 9 (section 9.2.2), women's occupational/educational field also emerged as influential on fertility in the AFFSS. Table 10.7 shows that while only one of the fifteen mothers intending to stop with one or two children could be considered to be in a hands-on caring or health occupation (the doctor), many of those with three or more children had experience in such roles. Studies in Britain, France and the USA have found that well-educated women with higher fertility or home-centred preferences are concentrated in social and health occupations such as nursing and

teaching, while those with lower fertility or career-centred preferences have more scientific interests (Ekert-Jaffe et al 2002:50; Rodenstein & Glickhauf-Hughes 1979 in Kerr 1994:105). Indeed, recent analysis of Swedish data (Hoem, Neyer & Andersson 2005) shows that “field of education” is at least as important for fertility behaviour as level of education, and that field is actually better than level as an indicator of permanent childlessness, with women educated for jobs in teaching and health care having much lower levels of permanent childlessness than any other group.

**Table 10.7****Mothers’ family size and occupation (current or most recent)**

Source: Adelaide Fertility and Family Size Study 2003-04, parent questionnaires

Number of children	Current or most recent occupation (number of mothers)
4 or more	Primary school teacher (3), childcare worker/receptionist in paediatrician’s office, occupational therapist, human resources manager, travel manager, unskilled labourer, finance clerk
3	Nanny (2), midwifery student, high school teacher, physiotherapist, hairdresser, sales assistant, assembly line worker, dressmaker
1 or 2, likely to have more	Aged carer, psychologist, hairdresser, sales manager, injury rehabilitation assessor
1 or 2, unlikely to have more	Doctor, sales assistant (2), retail manager (2), economist, accountant (2), town planner, business manager (2), computer operator/admin assistant (2), kitchen hand (2), postgraduate student in archaeology

Ekert-Jaffe et al (2002) hypothesise that either social/health occupations offer more flexible work schedules which facilitate work-family compatibility, or that a stronger desire for children prompts the choice of more compatible employment. In addition, Hoem et al (2005) hypothesise that studying in female-dominated areas encourages childbearing by promoting more traditional women’s roles, and/or that the choice of education [and presumably also occupation] also mirror a woman’s interests, preferences, talents and professional and economic aspirations. In addition, the AFFSS interviews suggest that being a parent or having a larger family, *and* entering a caring occupation also both reflect an individual’s life course orientation towards nurturing and caring roles (particularly with dependents such as young children or the aged). An example of this was provided in the AFFSS by Clare, a mother who felt satisfied only once she had five children, and who felt that her interest in becoming a primary teacher *and* having a larger family both stemmed from her strong love of children.

The AFFSS interviews also suggest that skills and experience related to caring occupations such as teaching and health increase the ability and confidence for parenting, hence

minimising the behavioural adjustment required with parenthood. Since this should minimise the negative impacts, it would stand to enable individuals to more easily achieve their desired family size. This finding can help inform policy which seeks to minimise the impacts of parenthood and any associated negative influences on fertility, by showing that raising the level of skills and experience in caring for dependents could minimise some of the negative impacts of parenthood. It would be an interesting area for further research to compare field of study or occupation with number of children ever born.

#### *10.2.2.5 Parental exhaustion*

Chapter 9 discussed influences of tiredness and exhaustion on parenting ability, and mentioned that this could also influence fertility as it interacted with paid work. The fact that fertility is lower for women who combine work and family than for those who focus on motherhood (Hakim 2003) may be related to the fact that mothers in paid work at 12 months after a birth suffer from tiredness even more than mothers who are not in paid work (Saurel-Cubizolles et al 2000). Previous chapters have shown that this influences not only biological determinants, such as frequency of intercourse, but can also contribute to resentment about partner roles. One AFFSS mother, a casual sales assistant, had found life extremely stressful from being awake much of the night with her second child's ear infections and then going to her work by day (16 to 20 hours over four days). Additional stress from her third child being hospitalised with pneumonia three times in her first year contributed to separation and divorce:

Once you've got three children, basically we just couldn't cope without that extra money [from me working]... My mum was going into the hospital during the day and as soon as I finished work, about 4pm, I was going in to the hospital, sleeping there, getting up having a shower in the hospital, getting ready for work. My mum would come in and take over and I'd go to work and go back to hospital again (laughs)! No wonder we didn't work out [relationship with husband].

(Mandy, 35, sales assistant, lower-middle status area, single mother of 3 - aged 6, 7 and 10)

It is important to note that this mother felt that access to three months paid maternity leave, or preferably six months on half-pay, would have reduced such negative impacts on many aspects of her well-being and her relationship.

Some fathers were also negatively affected by work-home interactions. One father, a shift worker, found it difficult to get "quality rest" during the day when he could hear his children

crying. Another, a sales assistant in the lowest status area, had found it difficult to go to work when he was tired from the night-time feeds and nappy-changes which he did to help his wife to get sleep in order to minimise her depressive symptoms. When their second child was born his access to even one week's paid paternity leave was important for improving their well-being. This father's wife pointed out that a fourth child was unlikely because he felt "After this, no more [children], I need a sleep, I want to be able to sleep!".

Situations where fathers had non-standard work hours, or were unemployed, could reduce the negative impacts by providing better support for the mother or reducing her social isolation. One 20-year old unemployed fast-food assistant, for example, felt that her boyfriend's unemployment since their first child's birth had been a "blessing in disguise", enabling him to do the domestic work and support her with the baby. Another husband working afternoon and night shifts was able to give the baby its night-feeds when he came home at 2am, allowing his wife to sleep all night. These experiences highlight ways in which paid parental leave for both parents in the first six weeks, along with flexible work schedules thereafter, can potentially benefit fertility rates by reducing work-family pressures.

### **10.2.3 Work-family compatibility influences on non-parents**

Similar to financial issues, issues of work-family compatibility in the AFFSS were also more influential on preconception respondents than for parents. While few of the preconception men were considering the potential impact that having a baby might have on their work or career, around half the preconception women were thinking about whether they wanted to take time off work, whether they wanted to stay home with a baby, how this might affect their future career, whether they would be able to resume work easily, and whether they would have problems combining work and family. These issues particularly concerned those who were also concerned about their ability to cope with everyday parenting (as discussed in Chapter 9, section 9.4). However, as with the parents, these issues interlinked with childcare and motherhood beliefs, financial aspirations and work-family preferences:

I want to work and since I'm over 30 if I have too many children I would have to stay home and look after them; I don't know if I could leave my kid and go back to work – I might have to send him/her to childcare. I want to work to be independent and have my own money to spend it how I want; plus financial issues eg private school later on and general spending for baby.

(Female computing professional, 32, preconception survey)

I'm worried that three months paid maternity leave won't be enough and I'm worried I'll feel like I'm a bad mother if I leave my child at home in the care of its father.

(Female part-time health professional, 24, preconception survey).

A relationship between lower family size and higher levels of anxiety about parenthood has been discussed earlier in relation to other issues, and in the preconception survey levels of concern about work-family compatibility were also greater for those expecting fewer children. Indeed, work and childcare issues were a “big” or “medium” concern for 70 per cent of those expecting one or two children but for only 14 per cent of those expecting three or more. Those expecting a larger family may have had fewer concerns in this regard because women intending larger families also said they were likely to be full-time mothers for a significant amount of time, so that they would be unlikely to contend with combining work and family simultaneously. However, this finding also echoes the findings in Chapter 6 on cultural influences on overall life course orientations and family size.

### **10.3 CONCLUSION**

This chapter has argued that the extent to which, and ways in which, fertility and family size desires are influenced by concerns about financial, material and work-related issues are complex. It has confirmed findings from previous research that financial considerations are more influential on men than on women. It has also shown that limitations from house and car size are influential on fathers' family size thinking, particularly as this relates to perceived needs for personal space and the ability and willingness to purchase alternatives. Furthermore, based on the preconception survey and the parent interviews, the chapter suggested that the level of concern about finances and work-family issues was inversely related to intended family size. Indeed, work and childcare issues concerned the majority of women expecting to have only one or two children, but concerned very few of those expecting three or more children. Similarly, the parent interviews suggested that women at lower parities were more concerned about financial limitations than were women at higher parities.

The chapter has also demonstrated that while some issues were important to parents, they were not necessarily important influences *on fertility*. For these reasons, the chapter suggests that researchers and policymakers must acknowledge that different factors may influence different groups, with those who decide to remain childless being influenced by different factors when

compared to those who decide to start a family eventually, and those who have already had one or more children. An overall conclusion from this chapter is that the extent to which issues influence fertility must be considered from the perspective of the individual's upbringing and overall life course orientation towards work and family, the strength of their desire for children or a larger family, their social context, and the extent to which financial security and workplace attachment are concerns for them. Indeed, financial concerns in particular were found to be relative to perceived needs, rather than relative to income per se. Such considerations help explain how some lower-income families believe they can afford larger families, while some higher income families believe they can barely afford more than one child. These issues will be discussed further in Chapter 12 on the implications of the thesis findings.

# Chapter 11

## Discussion: Images and impacts of parenthood

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“My name is Mary Poppins”, she said, taking off her coat and hat. “Come along children. We’ll begin with a game that’s called ‘Let’s Tidy Up The Nursery.’” Jane didn’t like the sound of that. “Are you sure it’s a game?” she asked. “That depends on your point of view”, said Mary Poppins

(Walt Disney’s Story of Mary Poppins, 1964).

### 11.0 INTRODUCTION

Chapters 6 to 10 have considered how fertility thinking and behaviour is influenced by images and impacts of parenthood. This chapter draws together arguments from these previous chapters to consider the relative and cumulative influences so that the next, and final, chapter can consider the achievement of the original objectives and the implications of the findings for future research and policy. The chapter begins by considering a way of measuring the impacts of parenthood and then discusses the relative impact on fertility of the various influences covered in Chapters 6 to 10. The second section considers the cumulative impacts, and these are discussed further in section three by introducing a new concept called “The Baby Stage”. Section four discusses the role of desire for children and for particular family sizes in overcoming perceived obstacles and impacts in The Baby Stage, while sections five and six identify different desire-size groups and discuss how these can provide a deeper understanding of aggregate fertility patterns. Section seven summarises the findings and presents a model of how images, and particularly impacts, of parenthood influence fertility thinking and behaviour.

### 11.1 MEASURING THE IMPACT OF PARENTHOOD

Chapter 3 referred to the Life Events Scale of Holmes and Rahe (1967) and suggested that it could be used to measure the impact of various aspects of parenthood so that potential effects on fertility could be better understood and could be compared with the impact of other



major life events. Table 11.1 indicates that using this scale to count only the most basic changes gives a score of 159 (Pregnancy = 40; Gain of new family member = 39; Change to new line of work = 36; Outstanding personal achievement = 28; Change in sleeping habits = 16). However, since many women leave paid work on having a child and have some difficulty adjusting to being out of the workforce and in the home (as discussed in Chapter 9), adding a score involving similar changes to “retirement” raises the total to 204. If other changes are added (marked in Table 11.1 with \*\*, such as an impacts on the parents’ health, a change in their financial state, a change in the number of arguments between spouses, and a change in recreation and social activities - changes which the literature identifies as common and which were also noted by AFFSS parents), then the score rises to 450. This is considerably higher than the “high” score of 300 for new migrants which Furnham and Bochner (1986:178) believed was by any standard “a large score and might be associated with serious psychological and physical breakdown”. The parental score of 450 does not include other events which might also apply in particular cases (as indicated in the right-hand column but without \* or \*\* against the value). Nevertheless, this assessment provides some indication that parenthood is not a benign life event, and that it is reasonable to suggest that the changes which it brings at any parity could influence parents to delay or avoid having additional children while they recover from these changes or life impacts.

The Holmes and Rahe scale was based on the belief that both positive and negative changes can have both positive and negative consequences and that “absolute amount of change is what counts if various social conditions are not arranged to prevent it” (Furnham & Bochner 1986:180). However, a review of 20 studies (Thoits 1983) found that rather than the amount of change, the amount of *undesirable* change was most influential. This difference was highlighted in previous chapters of the thesis in how individuals reacted differently to similar parenthood experiences. It is important to note in this respect Antonovsky’s observation (1980:72) that

whether a given phenomenon, a given experience, a given stimulus is a stressor or not depends both on the meaning of the stimulus to the person and on the repertoire of readily available, automatic homeostatis-restoring mechanisms available.

More recent research has refined instruments to measure parental stress, such as the Parental Stress Index, in order to correlate this with other variables, such as perceptions of self-efficacy, maternal competence, and levels of social support (see eg Goldberg et al 1990;

**Table 11.1****Social readjustment scale applied to the potential impact of parenting**

Source: Compiled by the author based on T Holmes & RH Rahe (1967), 'The social readjustment rating scale', *Journal of Psychosomatic Research*, 11:213-218, Table 3

Rank	Life Event	Mean value	Potential relationship to parenthood
1	Death of spouse	100	
2	Divorce	73	
3	Marital separation	65	
4	Jail term	63	
5	Death of close family member	63	
6	Personal injury or illness	53**	Pain/injury from birth or breastfeeding
7	Marriage	50	
8	Fired at work	47	
9	Marital reconciliation	45	
10	Retirement	45**	Commencing maternity leave
11	Change in health of family member	44**	Mother's health in pregnancy, after birth; pre-term baby/baby in intensive care
<b>12</b>	<b>Pregnancy</b>	<b>40*</b>	
13	Sex difficulties	39**	From tiredness, after-effects of birth
<b>14</b>	<b>Gain of new family member</b>	<b>39*</b>	
15	Business readjustment	39	Possible if self employed
16	Change in financial state	38**	Especially if no paid parental leave
17	Death of close friend	37	
<b>18</b>	<b>Change to different line of work</b>	<b>36*</b>	Adjustment to new "job" of parenting
19	Change in no. arguments with spouse	35**	Disagreements over gender roles or parenting
20	Mortgage over \$10,000	31	
21	Foreclosure of mortgage or loan	30	Possible if lost income on unpaid leave
22	Change in responsibilities at work	29	
23	Son or daughter leaving home	29	
24	Trouble with in-laws	29	Disagreements re childrearing/childcare
<b>25</b>	<b>Outstanding personal achievement</b>	<b>28*</b>	
26	Wife begins or stops work	26	Additional stress for fathers
27	Begin or end school	26	
28	Change in living conditions	25	May be required, or eventuate
29	Revision of personal habits	24	May be required, or eventuate
30	Trouble with boss	23	
31	Change in work hours/conditions	20	
32	Change in residence	20	
33	Change in schools	20	
34	Change in recreation	19**	
35	Change in church activities	19	
36	Change in social activities	18**	
37	Mortgage or loan less than \$10,000	17	
<b>38</b>	<b>Change in sleeping habits</b>	<b>16*</b>	
39	Change in no. family get-togethers	15	Could change, may be welcome or not
40	Change in eating habits	15	Possible if exhausted/no support
41	Vacation	13	

Oestberg & Hagekull 2000; Oestberg, Hagekull & Wettegren 1997; Sheeran, Marvin & Pianta 1997). These could be incorporated into future low fertility research to investigate such influences on parity progression differences at the individual and couple level.

## **11.2 THE RELATIVE IMPACT OF INFLUENCING FACTORS**

Previous chapters noted the suggestion in earlier empirical research that the experience of bearing and raising each child might influence whether or not further children were born and that these experiences have received little attention in contemporary demographic research and debate. This section brings together the various issues of reproduction, raised by interviewees and respondents in the previous five chapters, to consider their relative influence on fertility thinking and behaviour. Graphs are used to provide an indication of the extent to which parents perceived various issues to affect their fertility. The graph data was based on assessing whether or not each issue was mentioned as influential (prompted or unprompted) during each interview. While the sample of parents was small and not randomly selected, nevertheless the graphs allow some insight into the extent to which issues were influential on parents delaying or avoiding having further children.

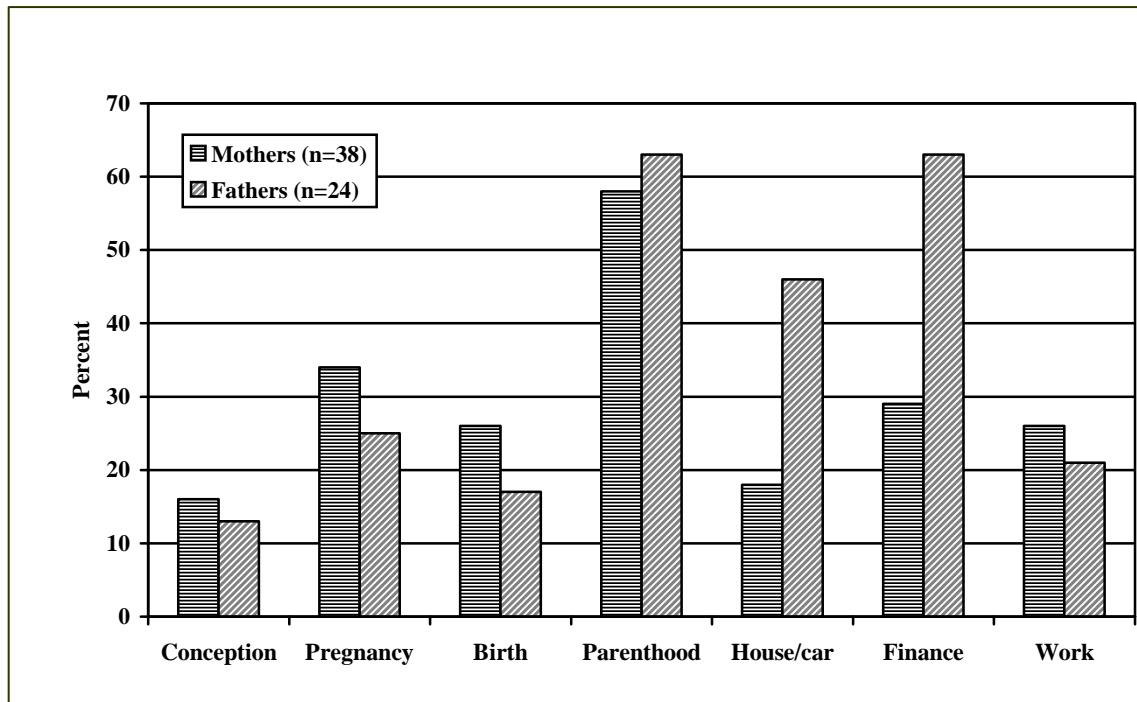
For mothers, Figure 11.1 indicates that out of all the main groups of factors discussed in Chapters 7 to 10 the most common influence on a desire to delay or avoid having further children was consideration of what was involved in everyday parenting (as discussed in Chapter 9). Furthermore, issues related to conception, pregnancy and birth (discussed in Chapters 7 and 8) influenced as many AFFSS mothers as did financial and work-related issues (discussed in Chapter 10). For fathers, issues of everyday parenting also influenced a large proportion, and were as influential as financial concerns and the related issues of house and car size. On the basis of these findings the thesis argues that research and policy need to diversify to acknowledge that alongside financial and work-based issues there are other important aspects influencing parity progression for both mothers and fathers. These particularly include the embodied and social impacts of reproduction which influence the fertility desires and outcomes of mothers.

It is also important to consider how influencing factors may differ by parity (Bulatao 1981; Namboodiri 1974). Figure 11.2 shows that experiences of everyday parenting influenced the

**Figure 11.1**

**Factors contributing to delay or prevention of further births (past, present, future)**

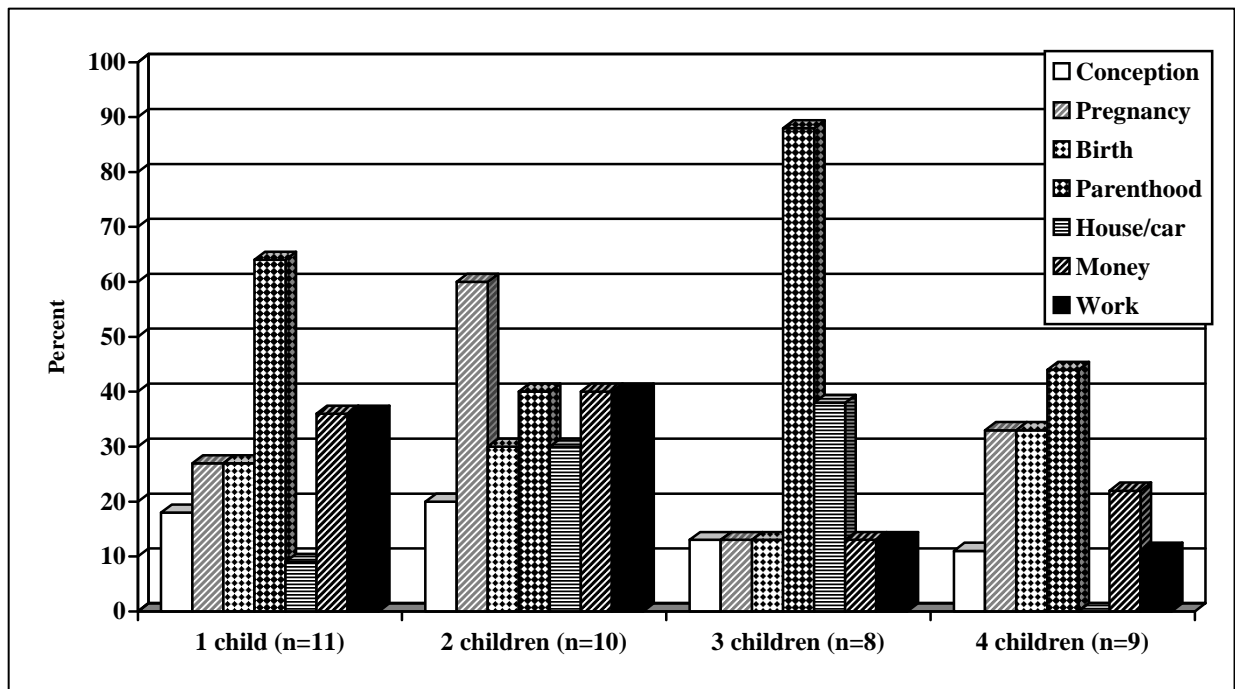
Source: Adelaide Fertility and Family Size Study 2003-04, parent interviews



**Figure 11.2**

**Mothers' factors contributing to delay or prevention of further births, by current parity**

Source: Adelaide Fertility and Family Size Study 2003-04, parent interviews

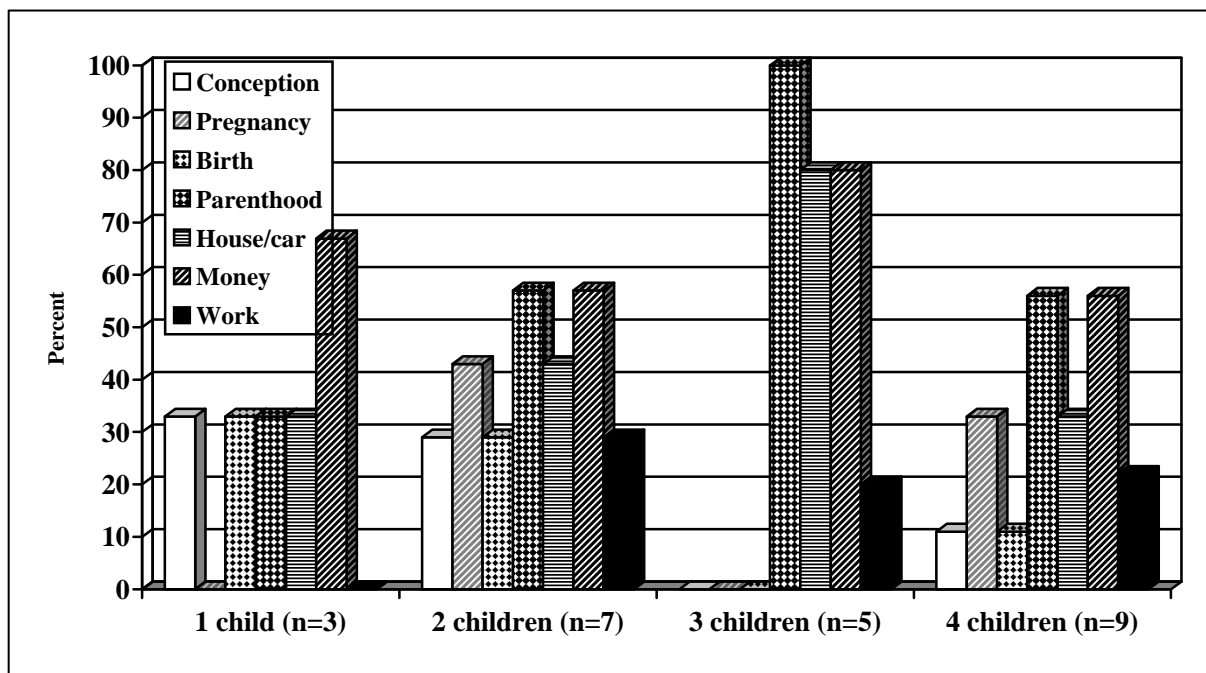


greatest proportion of mothers at all parities except at parity two, where considerations of a further pregnancy influenced more. Furthermore, at all parities it was a range of factors, rather than a single factor, which was influential. Individual chapters have already discussed other parity differences in individual influences. Figure 11.3 shows that while the issue of most concern to fathers at parity one were financial considerations, this issue concerned the greatest number of fathers at parity three. However, beyond parity one, issues of everyday parenthood (as discussed in Chapter 9) concerned an equal if not greater proportion of fathers than did financial limits. The level of concern amongst both AFFSS mothers and AFFSS fathers at parity three may help explain why in 1996 although 21 per cent of Adelaide women had three children, only 9 per cent had progressed to four or more (see Table 5.2, Chapter 5).

**Figure 11.3**

**Fathers' factors contributing to delay or prevention of further births, by current parity**

Source: Adelaide Fertility and Family Size Study 2003-04, parent interviews

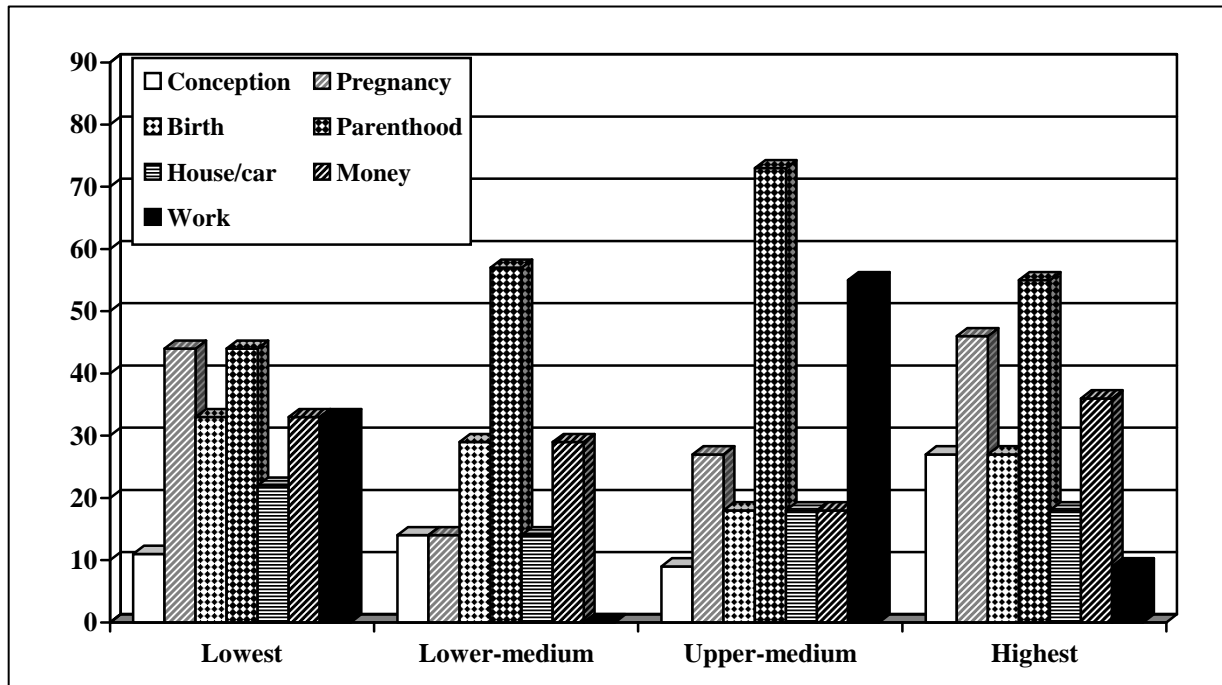


Figures 11.4 and 11.5 show the relativity of impacts by socio-economic status. Figure 11.4 indicates most noticeably a greater proportion of upper-middle status mothers and a lower proportion of lowest status mothers saying their fertility was limited by their experiences of everyday parenting. Explanations for a link between such experiences and a desire to resume paid work were suggested in Chapters 9 and 10. Also interesting is the pattern of influence for

**Figure 11.4**

**Mothers' factors contributing to delay or prevention of further births, by status**

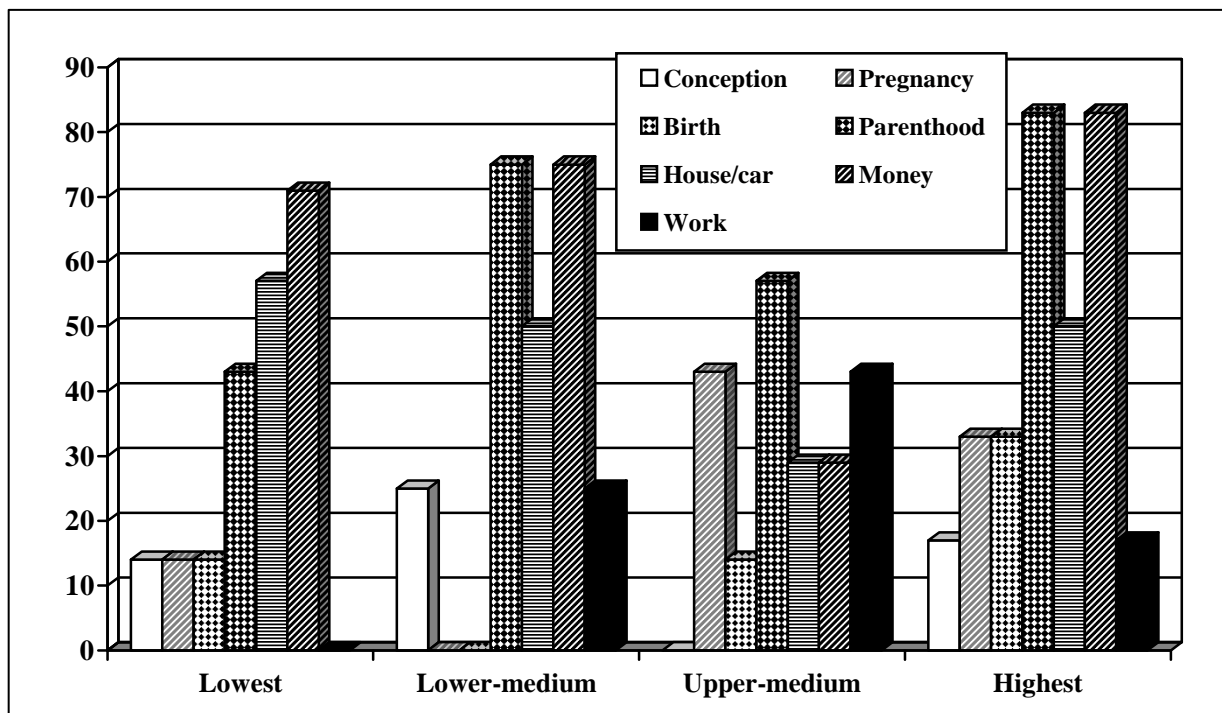
Source: Adelaide Fertility and Family Size Study 2003-04, parent interviews



**Figure 11.5**

**Fathers' factors contributing to delay or prevention of further births, by status area**

Source: Adelaide Fertility and Family Size Study 2003-04, parent interviews



work-related issues. Mothers in the upper-middle status area were the most concerned about their ability to work being affected by having further children, as were some mothers in the lowest status group. The fact that fewer mothers in the other groups saw this as an influential issue may be explained by greater proportions of these mothers either already being in full- or part-time work, or having no strong desire or financial need to enter the workforce. This finding supports the notion that fertility is lowered (by further births being delayed or avoided) when mothers are frustrated in their desire to undertake paid work. It also suggests that this frustration may be more acute for mothers in certain groups.

In the groups where issues of work or everyday parenting were not influential on mothers' fertility, other aspects of childbearing were. Only two mothers (one each in the upper-middle status and highest status areas) said that no aspects of their childbearing or childrearing experiences had influenced their fertility desires. Although Figure 11.5 shows that a desire for the mother to return to work was higher for fathers in the upper-middle status area (reflecting the comments of the mothers, as already noted for Figure 11.4), Figure 11.5 also shows that the fertility of a good proportion of fathers in every status group was influenced by some combination of everyday parenting and perceived financial limitations. Furthermore, gender differences in perceived impacts raise the issue of complexity from couple dynamics.

### **11.2.1 The influence of couple dynamics**

A mismatch between partner's family size preferences can account for discrepancies between desired and achieved fertility (Cannold 2005; van Peer 2000). Indeed, if particular issues prevent one partner wanting to start a family or have more children they generally downgrade any higher desires held by the other partner (Thomson, McDonald & Bumpass 1990). This may be particularly influential on women's desires considering that, according to van de Kaa (1998:30), women generally expect more children than men in the same age group. The influence of couple dynamics should therefore be borne in mind when analysing fertility statistics and drafting policies. Indeed some AFFSS parents made this point:

It can't be 100% my decision of how many kids we're going to have, I've got a partner as well.

(David, father of 2)

If I was married to someone who [thought] the bigger the better then I'd probably definitely have another one, but I'm influenced by his happiness as well.

(Faith, mother of 3)

Many AFFSS fathers ultimately deferred to their female partner's family size desires, seeing the woman as the one who would generally bear the greater burden of any physical and socio-psychological impacts of pregnancy, birth and the early months of baby care. This is not to say that mothers had sole influence on family size, because they generally considered the father's desires, but the finding that the female partner's aspirations carry greater weight confirms other recent Australian research (Weston et al 2004:118). If government policies aiming to stabilise or raise birth rates are to be effective they must therefore particularly consider issues which are important to women in relation to their expectations and experiences of conception, pregnancy, birth and early parenthood. However, to be more effective policy and research must also consider how issues may have a cumulative impact.

### **11.3 THE CUMULATIVE IMPACT OF INFLUENCING FACTORS**

Whilst surveys can indicate what issues concern people about starting a family or having more children they rarely provide information on cumulative influences. Images or impacts of parenthood in one domain may alone delay or overturn a desire for more children, but in the AFFSS an accumulation of factors was often influential for one or both parents. Although the graphs presented earlier show which issues were discussed as influential across each whole interview, it is also possible to consider which issues were raised spontaneously by interviewees before issues-based probing began. Rubin and Rubin (1995:12) explain that interviewees usually direct discussion into matters of interest and importance to themselves, which gives in-depth interviews their depth and reality.

Table 11.2 indicates that, without prompting, almost two-thirds of mothers focussed on how their family size was influenced by their experiences of bearing *and* raising children, while another third talked about a combination of social *and* economic influences. By comparison with Figures 11.1 and 11.3 which showed that over the whole interview a large proportion of fathers said financial concerns influenced their family size, Table 11.3 shows that financial limits alone were not spontaneously mentioned by as many fathers as a combination of economic *and* social issues (influencing two-fifths), while another two-fifths saw childbearing and childrearing issues as influential *without* any financial concerns. Based on this finding, the thesis argues that government policy and research need to diversify to address a broader range of influences on fertility thinking and behaviour if they are to be more effective. The influence



on fertility thinking and behaviour of a combination of factors can be better understood by exploring what parents conceptualised as The Baby Stage.

**Table 11.2****Mothers' influential issues mentioned before issue-based probing**

Source: Adelaide Fertility and Family Size study 2003-04, parent interviews

AFFSS area	Social issues		Economic issues		Combined issues	Total
	Demographic and relationship factors alone (older age, single parent)	Childbearing and childrearing issues alone	Financial limits alone	Career-work issues alone	Combination of social and economic issues	
Highest status (n=11)	9%	45%	0%	0%	45%	100%
Upper-middle (n=11)	9%	56%	0%	0%	36%	100%
Lower-middle (n=7)	14%	86%	0%	0%	0%	100%
Lowest (n=9)	11%	67%	0%	0%	22%	100%
Total mothers	4	23	0	0	11	38
Per cent mothers	11%	61%	0%	0%	29%	100%

**Table 11.3****Fathers' influential issues raised before issue-based probing**

Source: Adelaide Fertility and Family Size study 2003-04, parent interviews

AFFSS area	Social issues		Economic issues		Combined issues	Total
	Demographic and relationship factors alone (older age, single parent)	Childbearing and childrearing issues alone	Financial limits alone	Career-work issues alone	Combination of social and economic issues	
Highest status (n=6)	17%	33%	0%	0%	50%	100%
Upper-middle (n=7)	0%	57%	0%	14%	28%	100%
Lower-middle (n=4)	0%	50%	0%	0%	50%	100%
Lowest (n=7)	0%	29%	29% <sup>1</sup>	0%	43%	100%
Total fathers	1	10	2	1	10	24
Per cent fathers	4%	42%	8%	4%	42%	100%

<sup>1</sup> Includes one father for whom the only limit was the space in his public-rental house, which could be construed as a financial limit

## 11.4 CONCEPTUALISING “THE BABY STAGE”

Chapter 3 noted how human behaviour is influenced by mental schemes and social constructions or “images” of reality. Within the life course perspective taken by the AFFSS it was possible to define a distinct stage within the life event of parenthood which was conceptualised by parents, and which the thesis will term The Baby Stage. At any parity this incorporated the reproductive processes of conception, pregnancy, birth and the first 12 to 24 months of baby care (as discussed in Chapters 7 to 9). However, The Baby Stage was not simply a life course stage, but symbolic of a group of reproductive experiences. Many parents conceived of a tunnel which, once entered, was normally travelled through to the other end. Parents identified the Stage by describing what they experienced when they were “in it” and their feelings when they “came out of it”. Most importantly, based on the theoretical and analytical framework outlined in Chapter 3, parents’ perceptions of, and reactions to, the impacts of The Baby Stage could influence their desire to “go through” this Stage again to have additional children (or to “go through it all again”, as it was colloquially termed).

Considering that Figure 11.1 showed reproductive experiences from conception to early parenthood to individually influence a considerable proportion of mothers in their fertility thinking and behaviour, interviews were analysed to understand the combined impact of these experiences. This is summarised in Table 11.4 and shows that experiences of The Baby Stage influenced over four-fifths of all mothers in delaying or avoiding having more children. One or more of the experiences of childbearing alone influenced over half of all mothers. Along with the direct impacts of The Baby Stage, in the absence of previous experience some

**Table 11.4**  
**Baby Stage phases delaying or preventing additional children for mothers**

Source: Adelaide Fertility and Family Size study 2003-04, parent interviews

AFFSS status area	Experiences of childbearing alone (conception, pregnancy and birth)		Experiences of childbearing and childrearing		Total mothers
	Number mothers	Percent	Number mothers	Percent	
Highest	8	73	10	91	11
Upper-middle	5	45	10	91	11
Lower-middle	3	42	5	71	7
Lowest	6	67	8	89	9
Total	22	58	33	87	38

individuals found it difficult to cope with this Stage because they overestimated their abilities or underestimated what could be involved in certain aspects of the Stage. Either way, they had originally imagined having a larger family than they found they could cope with in reality, a situation which contributed to a fertility gap for some. Given a particularly large gap between desired and actual fertility among the more-educated, at least in Western Europe (Heiland, Prskawetz & Sanderson 2005), the thesis argues that not only are policies required to facilitate career-family compatibility so that desired family size can be realised, as these authors suggest, but that policies also need to reduce the impacts of The Baby Stage on personal well-being or raise individuals' level of skill and confidence related to parenthood.

#### 11.4.1 Reflecting on The Baby Stage

In the AFFSS the first time that parents went through The Baby Stage was particularly influential on reducing their earlier ideas about family size, or on contributing to delays in having further children. This confirms Peel's (1972) suggestion that pre-parenthood optimism about family size can evaporate after personal experience of becoming a parent:

I have a girlfriend, her husband wants to have four, five, whatever [children], *but after her experience* and the practicalities of looking after a child, I think she would want two... I don't think she'd want as many as her husband ... and they're really in to having kids.

(Fiona, 34, psychologist, highest status area, mother of 1 – aged 1, emphasis added)

For others, the attraction of a particular sized family or contact with another baby was weighed against the perceived ability to cope again with this particularly intensive phase of reproduction, with comments such as “I LOVE babies but...”, “I'd like more in theory but not in practice”, “Now I know what's involved...”. One father explained how:

If I see a small baby, there's something about them, they're quite cute [but] I just sort of check myself and think about nappies and things, what an effort it is. When I was younger I thought, oh yeah babies – great. But after having children, as fun as it was, I mean it was great, but it really is a lot of effort and I'm not sure if I'd be up to now again.

(Danny, 39, former storeperson, upper-middle status area, father of 2 – aged 4 and 7)

Due to the negative impacts on well-being, as discussed in Chapters 7 to 10, many parents felt that they only wanted to be in The Baby Stage for a certain amount of time, and for a certain number of times, before being ready to move on to a new stage of life:

Now that we ARE *going forward*... Cos we've got friends doing that scenario now [just had another baby] and [husband] even says when we go over there "Oh my God, life's just crazy! They've got one just about going to school and there's a newborn and life's just turned upside down". Well, we're pretty much... no formulas, no nappies, no bibs, it's like "Kids, jump in the car and away we go". *I don't think I could go back* to that now. I couldn't do it. Life's going too easy. The hard part's over.

(Tayla, 39, model/retail manager, lower-middle status area, mother of 2  
– aged 3½ and 5, emphasis added)

At all parities there were parents who discussed wanting to "move on" past The Baby Stage. Some saw children as competitors for scarce resources of time, money, love and space. Mary, for example, felt that having children took something away from her and that having a larger family would "take years out of *my* life". Some envisaged that caring for another baby would further postpone the resumption of "normal" life and the return of their non-parent identity, which they were only prepared to do to have a particular number of children:

The MAIN things would be my health, my relationship with [husband]... plus the physical stuff, being pregnant, having the baby – the birth – having a little one - the settling, the late nights, exhaustion - all those things I suppose, and the fact my life is easy at the moment. My children are at school *and I have my own self back* and it's taken SO long, I just like things the way they are. No, *my life is easy*.... And I have lots of time for my kids, for their school... and the uncertainty of that [having another baby] – will I be the same as when I had my other babies? will I go through this real transition, like *I lose myself for a few years*... Cos, I've got my person back now and I'm really quite happy, and that's why our marriage is going so much better.

(Athena, 39, ex-sales manager/high school teacher, upper-middle status area,  
mother of 2 – aged 6 and 8, emphasis added)

Pre-parenthood family size preferences, as discussed in Chapter 6, could also be influential on parents not wanting to go beyond their "zone of possibility" for family size, and they could use a desire to avoid The Baby Stage again as a way of explaining this. Others had been keen for more children at one point, but various delays could lead to new ideas about the future:

Our kids were our priority but our priorities have changed ... I would love to have more children, but no, we wouldn't now, because now there's that gap where we're looking at making something for later on in life. So Athena's looking at going back to full-time work sooner or later, there's the gap of the kids being 6 and 7. We might have thought about it earlier but then we went through the stage of Athena's illness [cancer]... now we want to start making money, doing quality things with our kids, retiring one day.

(David, 32, sales representative, upper-middle status area, father of 2, aged 6 and 8)

Such reactions suggest that while parenthood may at other times and places be seen as a lifetime undertaking, certain groups of people in developed countries are only prepared to

allocate a certain amount of time and energy in their life to the most intensive phase of growing and raising a young baby. For some parents, seeing The Baby Stage as a specific phase which would pass actually helped them cope better. Indeed, some focussed on imagining life “after children” when they would again have more time and space as individuals and couples while they were still healthy and active enough to enjoy it.

It is also important to recognise that when experiences of The Baby Stage were positive, they could at least allow pre-parenthood size preferences to be more easily achieved. In some cases they even led to a desire for a larger family than previously planned, although the latter seemed to be a minority experience. AFFSS mothers who loved motherhood and felt they wanted to bear children as long as physically possible were also a minority:

- SARAH: I'm happy, I'm contented with what we've got now, whereas I didn't have that before, that same contentment [with six children]. I feel like I can move on to the next phase of life now.
- RESEARCHER: So, at this stage would you think of more? If there were no obstacles would you consciously choose more?
- SARAH: (thinks) If... yeah, I probably would, myself, yeah. I'd probably have children until I couldn't have them [ie until natural fertility runs out].
- RESEARCHER: But you're stopping because...?
- SARAH: Because [husband] doesn't want any more!

(Sarah, 41, former receptionist, now home-school teacher to own children, lower-middle status area, mother of 7 - aged 1 ½, 3, 5, 8, 14, 18 and 20)

Since cumulative experiences in The Baby Stage affect perceptions of whether or not people want further children, it is important for governments, communities and families to find ways of reducing the impacts of this intense phase of parenthood on individual and couple health and well-being. Furthermore, any delays can allow a change to circumstances which would otherwise have been conducive to higher fertility, and for other obstacles to arise so that desires for further children are never realised. Others would not be affected by government incentives if they came at a time when they had decided they were happy with the number of children they had and were ready to “move on” and meet other aspirations. Considering the above experiences, it is important to recognise that since individuals live in social groups, their experiences of the intensity of The Baby Stage (at least under contemporary social conditions of privatised parenthood) may influence others through mechanisms of social learning and social diffusion. This was discussed in separate sections in Chapters 7 to 10. Indeed, Carl

(2000) notes the contribution of such negative expectations of pregnancy, birth and childrearing to intended childlessness in Germany.

### **11.5 THE ROLE OF DESIRE FOR CHILDREN IN INTERPRETING EXPERIENCES**

This section considers the interplay of experiences of The Baby Stage with AFFSS parents' earlier desires for children, or their images of family size (as discussed in Chapter 6). While most government policy aimed at stabilising or raising birth rates focusses on removing obstacles to higher fertility (as discussed in Chapter 3), the desire for children is one of the four key determinants of fertility, alongside biological determinants, the extent of control over conception, and chance consequences of intercourse (Friedman, Hechter & Kanazawa 1999). Recent research in Australia, Italy and Germany reflects the psychological theory discussed in Chapter 3 in finding that fertility is not only affected by consideration of various conditions, but also by how strongly these conditions are valued and by the strength of an individual's (or couple's) desire for children (Merlo 2004; Micheli & Bernardi 2003; von der Lippe 2004). Alongside the loss of parenting skills and knowledge (as discussed in Chapter 9), a decline in the strong desire to have children in modern societies which is noted by Micheli and Bernardi (2003) may account for the increasing extent to which individuals are concerned about reproductive processes, and the extent to which various external influences lower fertility in certain groups. The AFFSS findings confirm this interaction between the perception of limitations and the strength of desire for children, or for particular sized families, and therefore highlight an additional area for policy consideration.

In relation to issues discussed in section 11.3, only five of the 38 AFFSS mothers said that experiences in The Baby Stage had *not* influenced their future fertility desires, and the strength of desire for children was often influential in this. Of these five mothers, one had an only child but two had five children (one each in the highest and the upper-middle status area) and two had seven children (one each in the lowest and lower-middle status area). While the mothers of the four larger families had not all had completely positive and low-stress experiences of parenthood, nor strong social support systems, the two significant factors in achieving higher fertility were a strong and long-term interest in having a larger family, and confidence in their parenting skills (at least after the first child, if not before). The AFFSS therefore supports von

der Lippe (2004) in calling for the role of desire for children and family to be accorded greater attention in low fertility research.

The findings of the AFFSS can be used to build upon other research which has considered the influence of life course orientations towards parenthood and work (eg Gerson 1985; von der Lippe 2004), in order to identify different pathways to smaller and larger families. Analysis of the AFFSS interviews suggests that desire to have children can be subdivided into *strength* of desire (whether strong, or more vague) and *durability* of desire (whether enduring or changeable over the life course), with an indication of *the family size, or range of size, towards which the desire may be directed*. The *degree of interest* in spending large amounts of time with children also requires consideration, since it influences participation in domestic roles and the ability to cope with the conditions of everyday parenting. The differentiation between “desire to have” and “interest in spending time with” children is important because some AFFSS parents were keen to have children but reluctant to spend time raising them under the conditions which they anticipated. Investigating the different ways in which desires are shaped and the ways in which they confront obstacles can illuminate our understanding of situations where family size might have been higher under different circumstances. Identifying what these different circumstances could be can assist future policy.

## **11.6 RELATIONSHIPS BETWEEN FAMILY SIZE DESIRE AND OUTCOME**

Chapter 3 explained how the concept of the “fertility gap” proposes a mismatch between latent family size desire and actual fertility behaviour. However, although some plan their family size on a lifetime basis at the start of their reproductive careers, others “plan” their families on their way through the experience of parenting (Mason 1997). Chapter 7 has already shown that other fertility scenarios also exist at the individual/couple level, including the situation of “fertility overshoot”. Although the sample of parents was small and non-randomly selected, nevertheless grouping of the AFFSS families according to their combination of family size desires and outcomes provides some insight into categories of fertility thinking and behaviour. Parents could be grouped as follows as those having:

- Intentional desires — where a particular family size (or range) was aimed for;
- Evolving desires — where family size evolved more than being consciously planned;
- Downgraded desires — where family size was lower than intended or expected;
- Overshot desires — where family size was higher than intended.

Further re-reading of all interview transcripts and the construction of interpretive summaries for each family led to further subdivision by current family size to give six desire-size groups:

### **Smaller Families (One or Two Children)**

Intended Small Families – Fertility Match, 7 families across all areas

Downgraded Small Families – Fertility Gap, 9 families all areas, 6 in two highest areas

Unintended Families – Fertility Overshoot, 5 families, all areas except lower-middle

### **Larger Families (Three or more children)**

Intended Large Families – Fertility Match, 6 families across all areas

Evolving Large Families – No-Target Fertility, 7 families, all areas except lower-middle

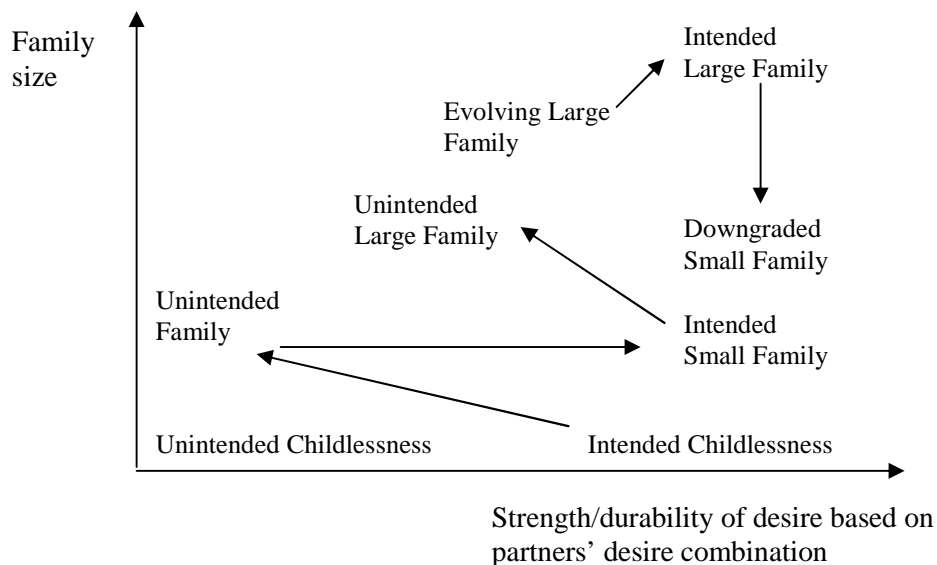
Unintended Large Families – Fertility Overshoot, 4 families, all areas except highest

Figure 11.6 represents the relationship between strength of desire for children and the size of family to which this is directed, giving a variety of desire-behaviour outcomes. It also shows common pathways of change, where the strength of desire can increase or decrease, and where the family size preference can also change. The thesis therefore argues that “desire-based” factors should be considered alongside the “issues-based” factors considered in contemporary policy debate. The groupings are not deterministic and some parents move between different groups as their circumstances change. Furthermore, as Chapter 7 showed, some situations

**Figure 11.6**

### **Family size desires, outcomes and common pathways of change**

Note: pathways from unintended childlessness were not explored in the AFFSS





were complex because partners had different views on the extent to which their current family size was in line with earlier preferences. The six groupings are based on an interpretation of the degree of match between preferred and completed (or likely eventual) family size within the couple setting. It is important to remember that the discussion below is based on a small sample of parents and is therefore only suggestive. However, the discussion points out how identification of clusters of desire-behaviour influences can be informative for further research and policy. Since the study was not designed to specifically explore childlessness, there were no families in this group.

### **11.6.1 Downgraded Small Families – with one or two children instead of more**

The Downgraded Small Family fits the traditional concept of the “fertility gap” whereby parents said their one- or two-child family was smaller than the previous family size desires of at least one partner. Issues about the gender division of paid and unpaid work were influential on five of the nine families (and all five were in the two highest status areas) who were delaying or avoiding further children due to the effects of parental stress and/or lack of practical or emotional support from the father. However, the other four families (across all areas) were avoiding further children due to medical conditions related to conception and pregnancy. In considering ways of stabilising or raising fertility it is important to note that issues raised in Chapter 6 (such as the size of family of origin or more positive earlier experiences of family life) were influential on those with Downgraded Small Families because all had one partner whose family size preferences were already low before having children. This was often due to higher aspirations for career achievement or material standards for themselves or their children. These other aspirations may have led to both higher levels of stress in early parenthood *and* a less strong motive to overcome difficulties (as discussed in Chapter 9) which parents in the Intended Large Family group *had* overcome.

Since most parents in this group came from families of three or four children, the issues discussed in Chapter 6 suggest that their family size desires and outcomes may have been higher had they had more positive childhood experiences of family life and/or greater encouragement to prioritise family alongside paid work. A later start to childbearing was not a key reason for downgrading family size in any of these families. Furthermore, encouraging all individuals to consider compatibility of partner preferences early in a relationship may help

maximise the opportunities for fertility outcomes to reflect both partners' preferences to reduce the potential impact of a mismatch on relationship breakdown.

### **11.6.2 Intended Small Families – of only one or two children**

Intended Small Families usually resulted from one or both partners only ever wanting one or two children, or having only vague ideas about family size or becoming a parent, so that when this size was reached most felt they were highly unlikely to have more children. Family size was often less limited by contemporary considerations than by one partner's earlier family experiences and family size preferences. Five of the seven Intended Small Families had one partner from a one- or two-child family:

I never said that I NEVER want children, but I realised that I wouldn't be a *big family woman*, and because of my experiences with being brought up with my sister I felt fairly strong that I only wanted one.

(Mary, 43, mother of 1, emphasis added)

In four of the seven families both partners were certain they would not go beyond the one or two children previously intended. In the other three, one husband was keen for a second child but the mother was adamant this would never happen, while in the other two families one single mother wanted a second child if she could find the "right" partner within three years (before turning 35) but thought a third child was unlikely, and the other family were certain about having a second child but less certain about having a third child, which they felt would be highly conditional on their future parenthood experiences and economic situation.

Although several mothers in this group had not started childbearing until their late 30s, family size was influenced more by lifetime aspirations for a small family than by reaching an age- or natural-fertility limit. An Intended Small Family could also be the simultaneous outcome of a general life course orientation towards paid work/career and a belief that having only one or two children would make this more achievable because of less need to take time out of the workforce. Many mothers in this group were strongly work-centred before having children and had taken 12 months or less off work after a birth. Their earlier lifestyle preferences to focus on work meant that some women may well have remained childless had they been unable to find a partner "in time", or had they only found one with who was not keen to have children. These explanations of Intended Small Families support earlier research which found that women's preferences for combining family and work are related to smaller family sizes

because the preference is for individual rewards for individual effort through occupational achievement and not through mothering large numbers of children (Booth and Duvall 1981; Rosen & Simmons 1971; Scanzoni 1978).

It is important for researchers and policymakers to further investigate the desire-size relationship in this group because they show that certain groups are less likely to respond to policies if they already have the small number of children that they desire. Indeed, completed family size in this AFFSS group would often only have risen if family size desires had been raised as they formed much earlier in the life course. However, the existence of this group does highlight possibilities for publicly discussing work-life balance and financial and lifestyle aspirations, as well as the need to provide better supports to de-privatise parenthood, so that perceived “coping limits” to family size are raised and desires might be set higher earlier in life. However, Chapter 6 explained that being raised in a smaller family could alone provide the model for intending to have a smaller family of one’s own. The unwavering strong desire for a small family of at least one partner in the Intended Small Families means that although these parents talked about an inability to have more children, they seemed unlikely to go beyond their earlier “zone of possibility” for only one or two children. This group epitomises the outcome of falling ideal family sizes at the group level and highlights the importance of considering social and intergenerational influences on family size, as discussed in Chapter 6.

### **11.6.3 Unintended Families – from intended childlessness to unintended parenthood**

Despite the assumption noted in Chapter 6, section 6.2.2, that contraceptive failure occurs more at higher parities, in the AFFSS Unintended Families resulted where parents said they had not intended to have any children, but had conceived a first child due to contraceptive failure. Chapter 7 showed that this occurred both in higher and lower status areas. Three women conceived a first child unintentionally whilst on the Pill, one due to a vasectomy reversal which had not led to conception in 10 years, and one where the mother assumed being age 41 made conception unlikely. All Unintended Families had at least one partner whose strong desire *not* to have children had dominated the partnership so that children would never have been intentionally conceived. Remaining childless had been a joint consideration in three cases, and in the other two the long-term desire of the woman not to have children was eventually overturned by contraceptive circumstances. Four of the five couples had at least one partner from a two-child family, while two had both partners from a two-child family.

Earlier intended or expected childlessness was associated with strong work aspirations or strong aversions to children and/or family life for four of the five women (see discussion in Chapter 6, section 6.1.2). For the fifth, a physical condition worked alongside a strong aspiration for personal achievement through paid work.

Despite originally intending to have no children, after having had one child two of the five couples had considered having a second for sibling benefits. However, they were unlikely to go beyond two children because a larger family had never been within the “zone of possibility” of at least one partner. Although four of the five women were in second relationships, partnering issues had not been a major influence on their initial fertility behaviour, which had been more strongly influenced by aversions to motherhood or aspirations for paid work. Two mothers were stopping at one child because their partners already had financial obligations to children from previous relationships.

This group is rarely considered in contemporary fertility research, which generally seeks to explain cases where fertility is *lower* than intended and assumes that “accidents” occur mainly at higher parities. As with the Intended Small Family group, raising fertility in this group would necessitate addressing earlier life course experiences which contributed to aversions to children and family life, or to a focus on work/career rather than family.

#### **11.6.4 Unintended Large Families – going to three or more children unintentionally**

This is a second group where fertility is higher than intended, and is a group which perhaps needs greater recognition when investigating international differences in low fertility rates. Intentions in this group were to have only a small family (generally of two children) due to the preferences of at least one partner, but additional children had been conceived “by accident”. Similarly to those with Intended Small Families, three of the four had at least one partner from a 2-child family which had influenced their original desire for an Intended Small Family. In Unintended Large Families unintended conception occurred for similar reasons as in Unintended Families, but also because of a misunderstanding of the contraceptive effects of breastfeeding, a missed Pill, previous need for ART, and contraceptive reliance on the partner.

Emotional and/or financial difficulties had already been issues for at least one partner in Unintended Large Families and the generally lower family size desires of at least one partner

were often combined with the fathers' lack of interest in spending time with babies (and preferences for focussing on work) which meant that difficulties coping with various aspects of parenthood led to family sizes beyond two being considered unlikely. This group is complicated by some cases where one partner (usually the woman) thought they *may* have had more children under different circumstances, for example a partner with a stronger desire for children, or a less "difficult" baby. Even though all of these couples had met by the time the mother was 25 and started childbearing by 29, they all considered childbearing complete by her early 30s.

The presence of this group is significant in Australia's low fertility context since it shows that a proportion of the women with three or more children, who are keeping Australia's birth rate from falling into the "very low" category (according to McDonald 1998, 2000b), are in this category by chance rather than choice. Australia's fertility rates may therefore be higher than they might otherwise be if contraception were more effective, as noted in Chapter 7.

#### **11.6.5 Evolving Large Families – gradually upgrading to three or more children**

The main difference between these parents and those with *Intended* Large Families was that a larger family size had been a less specific goal and more a general possibility. Although most partners expected to have children at some point, they were more vague about timing and numbers than those with Intended Large Families. Partners in these families often approached life as a series of phases and kept going in their "parenthood phase" until the number "felt" right or matched their coping limit, or until they were no longer prepared to use unreliable contraception:

I suppose having five [children] you'd think "Gee, they must have thought about having a big family to start with", but it really just happened, it just evolved that way. There was never a conscious decision to say let's have x number of kids, it was just "Let's start a family" and basically it just kept going.

(Wayne, 46, academic, upper-middle status area, father of 5 – age 5, 8, 12, 14 and 16)

In these families, however, usually one partner was not so keen on a smaller family (or so averse to a larger one) to encourage the use of more effective contraception. Most had also always had a larger family within their "zone of possibility" from having at least one partner from a larger family themselves, or who had had positive exposure to a large family. They also

had at least one partner who liked spending time with children. In the upper-middle status and highest status areas parents of Evolving Large Families all had at least one partner from a large *religious* family (whereas in *Intended* Large Families this was true for *both* partners) (see Chapter 5 for further exploration of the relationship between fertility, religion and socio-economic status in contemporary South Australia). By contrast, in the lower status AFFSS areas the larger *size* of the origin families was still influential, but religion was less influential. Financial and other limitations were rarely a limiting factor for these families, even for those on low incomes who found ways of coping as family size increased. These parents were similar to those with Intended Large Families in that, even if they had not started childbearing until their later 20s or early 30s, they had usually met and/or married in their early to mid 20s.

The presence of this group is important for policy consideration in that it shows that family size is not always fixed and can rise if circumstances are favourable. However, it again highlights the positive influence of exposure to larger families in shaping “zones of possibility” for personal family size preferences. This demonstrates the importance of government support in The Baby Stage and beyond if people are to achieve larger families, because more positive experiences in these stages can provide positive influences on fertility for their own children and for others, both now and in the future. Nevertheless, this finding does not augur well for future fertility scenarios because, if people from larger families are those more likely to have their own larger families, then fertility seems likely to continue to fall where couple dynamics and other factors lead the proportions having intended or evolving larger families to continue to decline.

#### **11.6.6 Intended Large Families - of three or more children intentionally**

The strong and unwavering desire for a larger family enabled parents of Intended Large Families to “push past” or overlook many of the anticipated or experienced difficulties which contributed to the lower family size desires of those in all other groups (except for the Evolving Large Families). This helps explain the finding noted in earlier chapters that the level of concern about various issues appears to be inversely correlated with a strong and enduring desire for a larger family. Across all areas at least one partner in every Intended Large Family came from a family of three or more children themselves and had had positive experiences of life in that family. Usually at least one partner had a strong and unwavering desire for three or

more children, and at least one partner enjoyed spending time with children. Couples in the upper-middle and highest status areas with this family type all had both partners from families who had attended religious activities regularly in childhood. However, in the lower status areas a larger family of origin was often positively influential regardless of religious influences. Mothers of these families in the lower status areas had often started childbearing in their early- to mid-20s. However, even though those in the higher status areas had often not started until their later 20s or early 30s, they had often met and/or married in their early- to mid-20s, reflecting their belief that relationships are an important part of life.

Financial limitations were rarely a consideration for these families, and even those on low incomes found ways of coping to have the number of children they desired. Similar to Evolving Large Families, emotional, physical, financial and space stress only became issues once the desired family size was reached. In contrast to the “quality-quantity” trade-off which is seen to encourage smaller families (see Chapter 3, section 3.2), parents of larger families often believed that better “quality” children were achieved through being raised amongst a larger “quantity” of siblings (usually for perceived social benefits). The strong desire of mothers in these families to have children was usually reflected in a higher level of parenting skills or determination to learn them, and interest in spending large amounts of time with their children, not only for the children’s benefit but also for their own pleasure. This helps explain the link between higher fertility and Home-centred preferences as discussed in Chapter 10. Mothers of Intended Large Families often took long blocks of time out of paid work (of two years or more), and were often assisted in this by having occupations with skills and networks which allowed, or could withstand, several years of detachment. Most also had looser ties to work and/or had gained satisfaction with their work achievements before having children. It is important for researchers and policymakers to acknowledge the existence of this group and the influences on their larger family size, because the ability to compare these with influences on other groups provides a deeper understanding of contemporary fertility.

### **11.7 THE SIGNIFICANCE OF THE DESIRE-BEHAVIOUR GROUPS**

Current low fertility research and policy focus particularly on Downgraded Small Families. However, the identification of the desire-behaviour groups based on the AFFSS data shows that research and policy do not address all the issues which influence such downgrading of

family size. Furthermore, it is also important to consider the other groups which have been identified, and the influences upon them, if effective policies are to be formulated to stabilise or raise fertility rates. Other groups show, for example, that in some situations policy would have little influence on changing family size due to the presence of an already strong desire for only one or two children, an already higher-than-intended number of children, or a physical inability to conceive or bear more children. Although the AFFSS findings therefore show that Australians exhibit similar behaviour to the Italians in Maggioni's research (2004:104) where people "with three or more children had often desired to have a big family long before their marriage" and those "with only one child had been, through their lives, more uncertain about the number of children they desired", the AFFSS shows that the same family size outcomes can reflect different desire-behaviour interactions.

The disaggregation of fertility by these desire-size groupings helps to better understand the factors contributing to one Total Fertility Rate for an area. For example, it helps show that the 13 per cent of women in metropolitan Adelaide who had one child (Chapter 5, Table 5.2) can comprise four different groups: those who intended to remain childless but conceive accidentally (Unintended Families), those who intended to have only one child (some of the Intended Small Families), those who believe they would have two or more children under different circumstances (Downgraded Small Families), and those who may still have additional children. Similarly, it is possible to see that the 30 per cent of women with three or more children in Table 5.2 represents those who not only always had strong intentions to have a larger family (Intended Large Families), but also those who gradually drifted towards this size (Evolving Large Families), and those who "accidentally" had more than two children (Accidental Large Families).

This desire-behaviour analysis also shows that those with a strong and enduring desire for children may be more likely to make partnership and parenting part of their future goals, even if they leave childbearing until later. This can be related to concepts in motivational psychology, whereby goal-setting (as used for example in corporate management and personal development) is seen as influential on behavioural choices, effort and persistence at tasks (eg Carroll & Garavalia 2004; Karniol & Ross 1996). While some believe that better-educated women "end up" childless not through design but because of their circumstances of spending many years studying and establishing a career, and then being unable to find a partner



(Cannold 2005; Franklin & Tuono 2004), the AFFSS desire-size analysis raises questions about whether such “circumstantial” childlessness is totally beyond individual control and suggests that it may relate more to different strengths of desire for children earlier in life and to different life course priorities, with unfavourable circumstances further supported by misunderstandings about natural fertility decline with age. Hewlett (2002) in fact confirms through her survey of “high-achieving” and “high-earning” US women that those who had children by age 40 were those who had always had a strong desire for family and therefore prioritised finding a partner *alongside* career goals. In contrast, those US women without children at age 40 were those who had generally prioritised education and career over partnership and family. The thesis findings suggest that future research investigating childlessness and fertility gaps should go beyond assessments of strength of desire for children only from the beginning of the fertile years (as in Cannold 2005:3) to consider how fertility desires have fluctuated over the life course, and also to consider the size of family towards which such desires have been directed. Increased discussion of “family life” planning, alongside the more common “education and career planning” might help those who otherwise appear to “forget to have children” until it is too late.

### **11.7.1 Factors supporting higher fertility**

Considering that the most crucial issue determining post-transitional fertility is “whether desired family size remains at or drops below two” (Bongaarts 2001a:276), it is important to identify factors influencing those women who have actually had three or more children. The desire-size groups show that the most likely circumstances contributing to a woman having three or more children by choice (as in Intended and Evolving Large Families) was where both the mother and father had always strongly desired a large family, and where both had also grown up and now lived in a cultural environment which supported and reinforced the desirability and achievability of not only of having some children, but of having larger families. This was true regardless of educational, occupational or work status, and even if parents had focussed at earlier stages on other life goals, because the presence of a strong desire for children and positive images of larger families usually led them eventually into parenthood. A particular suite of factors also contributed to a greater confidence when faced with parenting difficulties, a greater determination to overcome them, or to a perception that there were fewer obstacles in the first place. These factors were:

- A strong desire for children developed from positive experiences of family life; encouraging exposure to a "large family culture" earlier in life, either their own larger family or through friends or the media. Continued exposure to the norms of larger families (instead of or alongside encouragement to undertake higher education or career);
- 24 hour-7 day hands-on experience with babies/children which raised levels of confidence in relation to parenthood and reduced parental stress;
- A higher tendency to be in caring, nurturing or "people-focussed" occupations, giving transferable skills to parenthood and reducing behavioural adjustments to home-life, and also possibly providing more flexible work pathways and work conditions for those who wanted to combine family and paid work;
- Predominantly positive experiences of parenthood; and/or positive experiences or strong family size desires which sufficiently overshadowed negative experiences;
- Coping mechanisms and personality traits (which could also be learned behaviours) better suited to baby care and domestic life;
- Social, physical and emotional support and information from partner and/or family, and/or health professionals;
- A partner with similar family size preferences whose prioritising of family life (alongside or instead of work) was associated with higher levels of emotional and/or practical support.

The absence of these factors, or the presence of their opposites (for example, *negative* experiences of family life, or minimal prior experience of caring roles) were therefore likely to contribute to lower family sizes, including childlessness. Throughout the chapters the thesis argues that the lower fertility of women in higher status groups can be partly attributed to a greater proportion of them having fewer of the above factors influencing their lives. In particular, the thesis argues that an extended time in education or the workforce in non-caring occupations, along with preferences for independence, rationality and control, could lead to a greater degree of behavioural adjustment in the transition to parenthood (unless education and professional skills had related to caring roles).

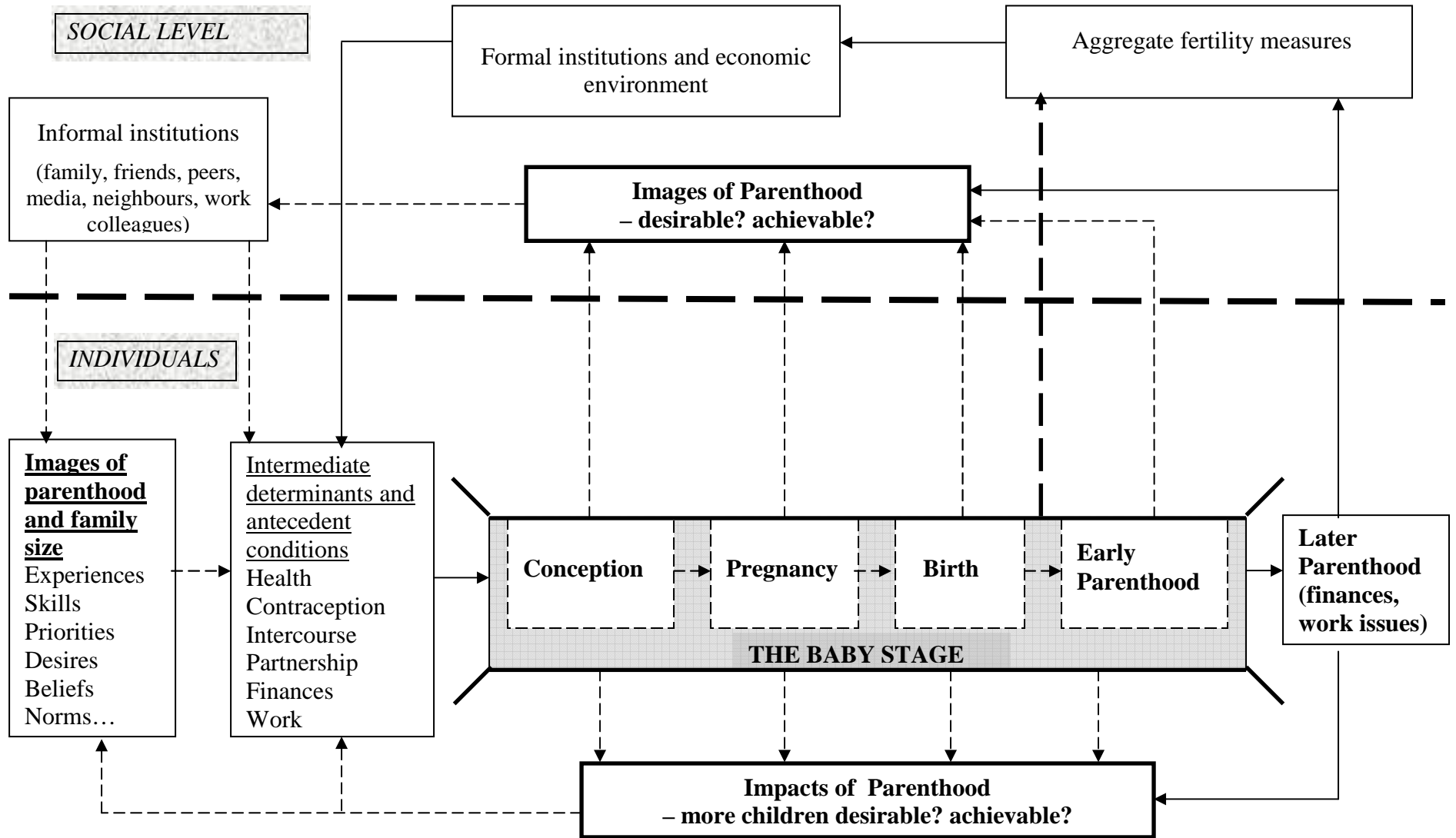
## **11.8 A MODEL OF HOW IMAGES AND IMPACTS INFLUENCE FERTILITY**

The pathways of influence on fertility of the images and impacts of parenthood identified from the AFFSS are summarised in Figure 11.7. Based on the issues raised in Chapter 6, the model includes influences on general life course orientation from earlier life experiences and on

Figure 11.7

**Model of how Images and Impacts of Parenthood influence fertility thinking and behaviour**

*Dashed lines show influences which the AFFSS demonstrates require greater acknowledgment in fertility research and policy debate.*



particular “zones of possibility” related to family size thinking, particularly coming from the family of origin and other informal networks, along with individual personality and coping skills. The model also emphasises the influence of *informal institutions* which the thesis has argued can filter or even counter influences from formal institutions. The issues discussed in Chapters 7 to 10 lead to the model including *images of family size* and *images of family life* as well as *the impacts of*, and the associated *social constructions of, conception, pregnancy, birth and parenthood*.

Since earlier chapters have also considered the influence of social interaction mechanisms in leading experiences of parenthood impacts to become information input to the images of others, in the model a feedback loop runs between individual experiences of The Baby Stage and images of The Baby Stage at the society level. The thesis argues that this information input strongly influences the fertility thinking of Australians currently without children. Many of the arrows of influence are dashed to indicate influences which are currently overlooked in the dominant low fertility research and debate in developed countries. In particular, the thesis has identified that a significant proportion of parents are influenced in their fertility thinking and behaviour by the individual or cumulative impacts of the processes and experiences of conception, pregnancy, birth and early parenthood. These can influence not only the intermediate determinants of fertility (for example where medical birth interventions contribute to involuntary infertility, and parental exhaustion undermines frequency of intercourse or relationship health), but they also influence the personal image of parenthood and the perceived ability and willingness to have further children. The “oil” in the machinery which helps the model run with greater or lesser impacts on health and well-being are social learning mechanisms, which the thesis has argued can influence the ability of individuals to be prepared for the skills required for parenthood, and informal and formal support processes, which influence the extent to which negative and positive impacts occur each time that individuals and couples pass through The Baby Stage. These will be considered further in Chapter 12.

## **11.9 CONCLUSION**

In preparing for the final chapter which will consider the implications of the research for theory and policy, this chapter has brought together findings from the previous chapters to

consider how the relative and cumulative impacts of bearing and raising children can affect fertility and family size desires. Using a measurement scale, the chapter demonstrated that parenthood is a life event which, even when only the most basic changes are counted, can have a significant impact on parental well-being. It was suggested that measures of parental stress, self-efficacy, maternal competence, and levels of social support could be usefully incorporated into future research on low fertility and fertility differentials in Australia. In considering the relative impact of parenthood experiences, the chapter confirmed earlier research showing that mothers are more influenced by affective, embodied and social experiences and fathers are more influenced by financial concerns. However, experiences of everyday parenting influenced a good proportion of both mothers and fathers. In considering the focus of contemporary theory and policy it is also important to note that AFFSS mothers were as influenced by the embodied and social impacts of conception, pregnancy and birth as they were by finances and work-related issues. Furthermore, although fathers were concerned about finances and the size of their house and car, they were equally as influenced by considerations of everyday parenting. The chapter made some attempt to quantify cumulative impacts of parenthood and found that fertility was often influenced by both experiences of childbearing *and* childrearing, and by a combination of social *and* economic issues. On this basis it is reasonable to conclude that research and policy need to diversify to acknowledge a broader spectrum of influences on parity progression, and to acknowledge that certain groups are influenced more by some aspects than by others.

The chapter also introduced the concept of The Baby Stage as a synonym for the social and embodied experiences from conception to early parenthood. Reflections on this Stage were shown to influence the likelihood and timing of parents having more children, while anticipations of this Stage were shown to influence the likelihood and timing of non-parents starting a family. The chapter also highlighted the need to consider how fertility can be affected by desire for children, since a strong desire could help individuals overcome or overlook the negative impacts of parenthood. Specific desire-size groups were identified, along with their significance for policy and research. Finally, the chapter provided a model to illustrate how experiences of The Baby Stage feed into social constructions, or images of parenthood, to influence the fertility thinking and behaviour of others. Transferring these findings to the macro level, where both total fertility and completed cohort fertility have been

declining, suggests that all or parts of the childbearing and childrearing process may be being reconstructed as undesirable or unachievable by increasing proportions of Australians. The chapter argued that lower fertility rates in higher socio-economic areas may be indicative of greater proportions of individuals and couples in these areas holding images of parenthood (at least under current social conditions) as undesirable or unachievable if they also wish to maximise their quality of life and personal well-being. The implications of this for theory and policy will now be expanded in Chapter 12.

# Chapter 12

## Implications and conclusion

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The transition to parenthood is a burning issue that rarely gets a mention... This invisibility allows governments and authorities to intentionally ignore needs and cut back resources... This silence leaves individual women [and men?] struggling to navigate this new territory without a compass, companions or resources

(Redden 2000, xi-xv: *Baby Daze: Becoming a Mother and Staying You*).

### 12.0 INTRODUCTION

Influences on fertility thinking and behaviour have been the subject of demographic and social inquiry now for over a century and a plethora of related variables and issues have been identified. This thesis has argued that the more recent theory and policy debate concerning Australia's currently low fertility rate has been focussed on issues related to women's ability to combine work and family, and to the financial costs of children, and has paid too little attention to other important factors. In the analysis in previous chapters the thesis revisited sub-narratives in demography which have considered influences on fertility from the more embodied and social aspects of reproductive behaviour. In so doing, it has drawn on the life course perspective to view parenthood as a major life course transition and life event which requires individuals to adjust their behaviour to varying extents compared with their pre-parenthood life and expectations. In seeking to explain low fertility in Australia in terms of the broader changes associated with the Second Demographic Transition the thesis has particularly drawn on a socio-psychological framework which facilitates the application of Postmaterialist Values Theory to incorporate consideration of how fertility rates at the population level may be affected by the impacts on individual health and well-being of what the thesis has conceptualised as The Baby Stage of parenthood.

This final chapter summarises the major findings of the thesis in light of the initial research questions set out in Chapter 1. The findings are based on the analysis of the Adelaide Fertility

and Family Size Study (AFFSS) as presented in previous chapters. The first section of this final chapter summarises the findings relating to images and impacts of parenthood. Based on this, the second section offers brief comments on future trends in Australian fertility, while section three considers some policy implications of the findings. Section four considers the limitations of the thesis, and the final section suggests implications for theory and research.

## **12.1 SUMMARY OF MAJOR FINDINGS**

**A) The first research question focussed on ways in which parents' fertility and family size might be influenced by personal experiences of conception, pregnancy, birth and early parenthood.**

### **12.1.1 The influence of Impacts of Parenthood**

The thesis contributes new knowledge on contemporary low fertility in Australia through its in-depth exploration of how fertility and family size preferences are affected by personal experiences of childbearing and childrearing. Chapter 11 presented the concept of The Baby Stage to encompass the reproductive phases of conception, pregnancy, birth and early parenthood. Chapters 7 to 10 had showed in detail how various experiences within The Baby Stage particularly influence women, but also men, to voluntarily delay or avoid having further children when these processes have impacts which clash with men's and women's postmodern values or preferences. In this way the thesis argues that, in line with ideational, cultural and institutional theories of fertility change, lower fertility is related to a clash between postmodern preferences, such as for maximising individual health and well-being, and for increased autonomy and self-actualisation, in the face of the continued domination of privatised parenthood and institutionalised maternity care which can have major negative impacts on individuals and couples. The thesis also argued that such impacts are greater for those with a preference for sharing parenting and domestic work, as compared with those who adhere to traditional motherhood ideology. The thesis analysis therefore helps better explain why fertility falls where postmodern values rise to prominence. Since higher education levels are also associated with a greater likelihood of individuals holding postmodern values, the thesis has also provided an additional explanation of why fertility rates would generally be lower for higher status groups.



Although the sample of AFFSS parents was small and not randomly recruited, Chapters 7 to 9 showed that certain experiences within The Baby Stage (such as pregnancy nausea, traumatic birth, and parental exhaustion) affected considerable proportions of women, and that the prevalence of such impacts was similar to levels cited in the medical literature. On this basis, Chapters 7 to 9 contribute new knowledge to low fertility research by demonstrating that such experiences can negatively impact on both men's and women's desire and physical ability to bear and raise further children. However, Chapters 10 and 11 confirmed the findings of other research which shows that such factors are more influential on the fertility thinking and behaviour of mothers, while financial considerations are more influential on fathers. Nevertheless, issues related to everyday parenting were the most influential factor for both mothers and fathers. The thesis also contributes new knowledge by showing in Chapter 11 that the *cumulative* impacts of The Baby Stage could be even more influential on parents delaying or avoiding having further children than experiences in one stage alone, thereby suggesting the need for a more diversified policy approach which addresses a wider range of both economic *and* social and embodied issues.

### **12.1.2 Not forgetting chance and biology**

Despite a myth in Western countries of perfect contraception aided by the availability of abortion, the analysis in Chapter 7 identified "fertility overshoots" as being common. In policy terms this means that initiatives aimed at raising fertility will not influence all individuals, since there is a group who already consider themselves to have more children than intended. Chapters 7 and 8 also showed that medical conditions and biological changes to the reproductive system caused by processes in The Baby Stage could also contribute to fertility being lowered involuntarily. The thesis therefore suggested that Australia's high and rising birth intervention rates have serious implications for the fertility rate. In this respect, the thesis contributed new knowledge by demonstrating in Chapter 8 some ways in which maternity care systems are an important institutional influence on fertility which have so far been overlooked in low fertility research, but which can be subject to government policy influence. Chapter 9 also showed how experiences in parenthood, such as exhaustion and resentment of an unequal share of unpaid domestic work and childcaring, could influence intermediate determinants of fertility, such as frequency of intercourse and relationship health.

**B) The second research question focussed on investigating ways in which fertility and family size might be influenced by expectations of the likely personal impacts of future childbearing and childrearing experiences.**

### **12.1.3 The influence of Images of Parenthood**

Taking a life course perspective, and seeing parenthood as socially constructed rather than a predominantly innate behaviour, Chapter 6 found family size thinking and behaviour to be strongly shaped by cultural influences, commencing in childhood and including family background and upbringing, and peer group influences. This is an important finding at the current time because, although the tendency is to see modern reproductive decisions being made by individuals in a context of free choice, the thesis shows that such “choice” continues to be shaped by social interaction in informal reference groups. There is therefore a need for policy and research to consider longer-term and more indirect channels of influence on fertility, alongside the more formal economic influences. These are more often considered in fertility research and policy in developing countries, such as in relation to the implementation of family planning programmes, but they are less well addressed in contemporary Australia.

The analysis in Chapters 6 to 11 also demonstrated the need to consider how fertility is affected by the strength of an individual’s desire to have children or to become a parent, as much as considering the influence of perceived obstacles. Furthermore, earlier life experiences and aspirations in other domains were shown to influence the extent to which various issues were perceived to be obstacles to first-time parenthood or higher parities. The discussion in Chapters 6 and 11 also showed that assumptions of a “fertility gap” at the individual level overlook the fact that in other cases achieved fertility has already met desires. In these cases attempts to encourage higher fertility would fall on “unfertile” ground, and only changes which could increase the strength of desire or the family size preference at an earlier life stage would stand to raise the likelihood of higher fertility outcomes.

### **12.1.4 Social diffusion of Images and Impacts**

Although earlier chapters noted how previous research showed that images of parenthood could encourage intended childlessness or delayed parenthood, the thesis contributes new

knowledge to fertility research in demonstrating that observation or images of the impacts of parenthood can spread through mechanisms of social diffusion to also affect the fertility thinking and behaviour of those at other parities. The thesis argued that while positive images of parenthood could strengthen a desire to have children or a larger family, negative influences could have the opposite effect. While de Bruijn's socio-psychological framework encourages consideration of the influence of *formal* social institutions on fertility, the thesis has particularly highlighted the additional importance of *informal* feedback mechanisms, and in particular the role of the *social construction of parenting under current social conditions*.

The thesis also contributes new knowledge to the understanding of low fertility by highlighting how the “culture of fear” surrounding birth in Western cultures, which has been identified in other literatures, negatively impacts on fertility outcomes. It also suggested that a “culture of anxiety” appears to be developing around conception, even while some are influenced by myths about the ability of science to overcome natural fertility decline. Since “changing *perceptions* ultimately drive fertility change” (Mason 1997:450), Chapter 11 identified a role for governments to play in changing images of parenthood by helping individuals and couples of all socio-economic levels better prepare for and cope with parenthood by providing education about fertility and infertility, and in raising pre-parenthood confidence levels. Strategies which improve the childbearing and childrearing experiences of those who *do* have children stand to have a positive flow-on effect to the images of parenthood held by those as yet without children.

**C) The third research question asked whether differences in expectations and experiences related to parenthood would be noticeable between socio-economic groups and whether this could help explain differential fertility rates.**

### **12.1.5 Insights from socio-economic analysis**

A strength of the thesis is its investigation of influences across the socio-economic and family-size spectrums which allowed comparisons of differences and similarities in influences. Analysis in Chapter 5 showed fertility to be negatively correlated with socio-economic status at the 1996 Census in metropolitan Adelaide. Reflecting findings in section 12.1.1, contemporary fertility outcomes and differentials were found to some extent to reflect historical differentials

working through the influence of experiences in families of origin. While the research confirmed earlier suggestions that fertility outcomes could reflect different attitudes towards family and children, it also identified “large family sub-cultures” across the socio-economic spectrum which help keep Australia’s fertility higher than it might otherwise be.

The findings also suggested that difficulties in the transition to parenthood stood to have a greater negative impact on fertility in individuals or groups with little prior experience of baby care and, in particular, little support for everyday parenting. These circumstances led to parenting demanding greater levels of physical and emotional adjustment, and therefore often to having greater negative impacts. Furthermore, the research showed that individuals with more egalitarian or postmodern preferences appear to react more strongly to the negative impacts of The Baby Stage, while those with more traditional views are either less concerned about the negative impacts, or have stronger desires for children, which lead them to overlook or find ways of coping with potential negative impacts. This finding provides a deeper understanding of how fertility differentials are linked to differences in gender/family systems and field and level of education and occupation. For this reason, the thesis argues that the influence on fertility of “pushes from parenthood” must given more weight alongside consideration of “pulls from education and work”, and that “pushes from privatised parenthood” stand to be more influential at the aggregate level in better-educated groups.

Considering the research discussed in Chapter 2, which suggested that lower fertility amongst the better-educated results not from lower family size preferences but from a lower ability to realise such preferences, the thesis findings relating to parenthood experiences provide some empirically-based explanation of this. However, the thesis also found that other influences (such as religion, or professional or earlier experience with baby care) could counter the fertility-lowering effects of higher education by shaping stronger desires for children and parenthood instead of, or alongside, personal achievement through education and work, whilst also providing more effective mechanisms and support networks for coping with the transition to parenthood and higher parities. This helps explain why tables in Chapter 5 show that all socio-economic areas of Adelaide had women with five or more children, although there were greater proportions with larger families in the lower status areas.

**D) The fourth research question was to consider the implications of the research for future fertility trends in Australia, for government policy and for future research. This section addresses these three aspects, as well as the limitations of the study.**

## **12.2 SOME COMMENTS ON FUTURE FERTILITY TRENDS**

### **12.2.1 Levels of childlessness**

Considerations of future fertility trends were not a major focus of the thesis but some interesting points can be made. The analysis in Chapter 6 supports the contention of Weston et al (2004) that high estimates of future childlessness should be treated with some caution. The thesis supported other research in showing that childlessness is not always a permanent state. Chapters 7 and 11 showed that even those with intentions to have no children can become parents through changes to earlier decisions, through “accidental” conception, or under the influence of a partner who is more keen to have children. However, if the negative impacts of childbearing and childrearing are not addressed, and negative images of parenthood continue to spread, then greater proportions of individuals may in future decide to delay or avoid parenthood because their image of parenthood is that it is undesirable and unachievable for them.

### **12.2.2 Distribution of family size**

A second comment relates to the distribution of family size which can affect the overall fertility rate. The significant proportion of Australian women continuing to have three or more children is an important factor in preventing the birth rate from falling to very-low levels (McDonald 1998, 2000b). The fertility influences discussed in Chapter 6 suggest that intergenerational and social influences, in South Australia at least, will continue to allow families of three or more children to be seen as both desirable and achievable for some time to come. This is also reflected in research on the distribution of ideal family size. Chapter 10 demonstrated that such ideals and outcomes are particularly supported by the general availability in Australia of larger sized family cars which can accommodate three children. At the other end of the spectrum, images of one-child families seem likely to continue to limit the proportions having an only child by choice, at least for some time. However, as in Europe, the

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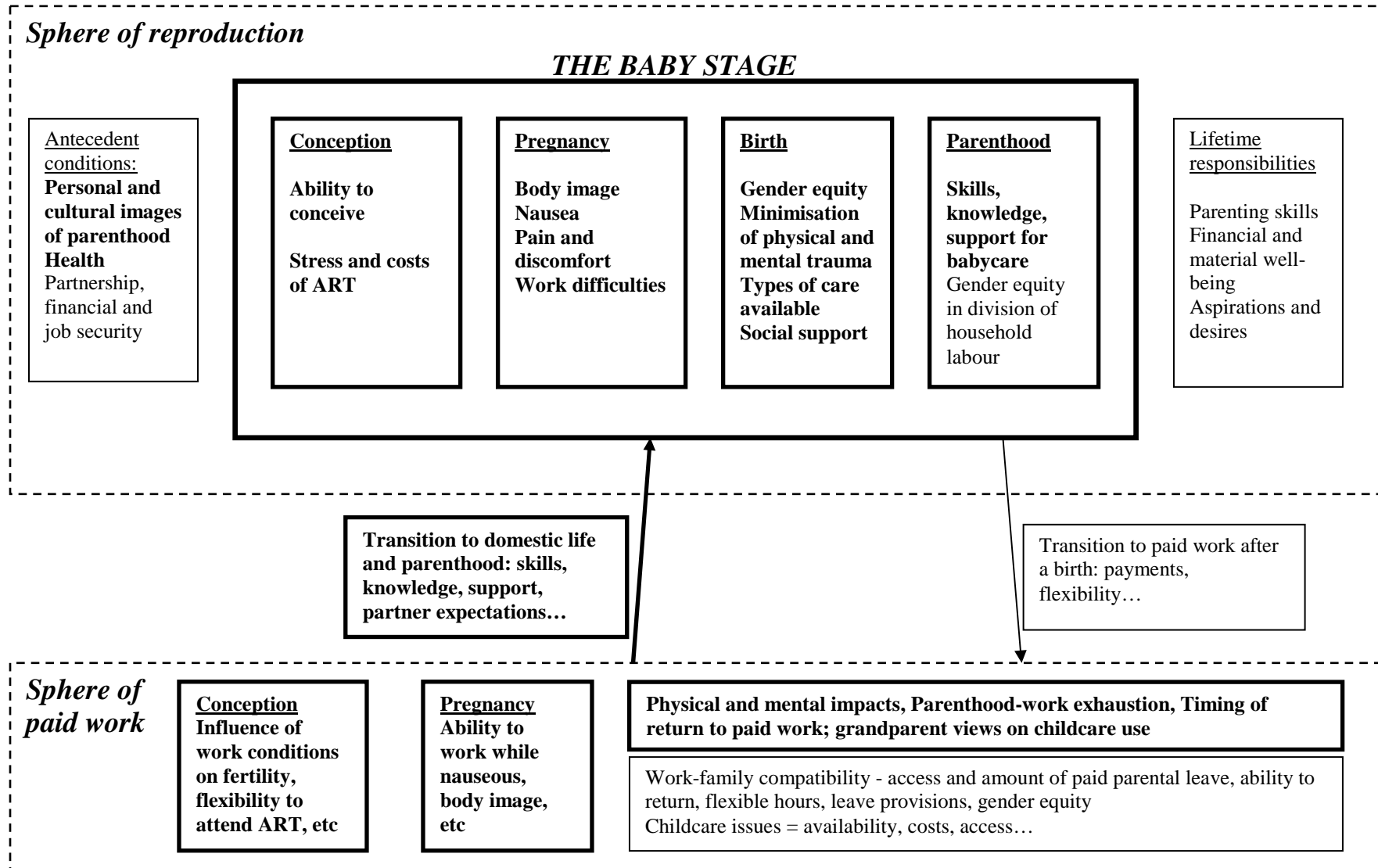
more common that smaller-sized families become, the more acceptable an image they may acquire. Furthermore, issues discussed in Chapters 7 and 11 showed that the situation of “fertility overshoot” continues to take a good proportion of Australians beyond their earlier size desires, included beyond intended childlessness. It is, obviously, impossible to predict the future course of fertility but the thesis suggests that there are several areas where government policy could encourage more supportive conditions for parenthood which should have positive impacts on future fertility, and these are discussed in the next section.

## 12.3 POLICY IMPLICATIONS

### 12.3.1 Expanding the definition of “the problem”

Chapter 3 noted research in overseas countries which showed that policies offering work-focussed change and modest financial contributions have had either limited or unreliable effects on fertility rates, and that empirical evidence for any link remains inconclusive. In light of this, it is important to note the thesis findings, which support the sub-narratives of earlier fertility research, that concerns about finances and work are balanced by a concern, particularly on the part of *women as mothers*, about the physical, social and emotional impacts of childbearing and childrearing. The current study contributes new knowledge to fertility research by also showing that these impacts also affect men’s fertility desires. In seeking to address low fertility as a “social problem”, it is therefore important to note Schulz and Rau’s belief (1985:132) that a culture will only establish formal and informal support systems to help the individual cope with an event “to the extent that a culture judges an event to be both common and potentially stressful”. Whilst some aspects of *childrearing* have been considered in theory and contemporary policy debate (in particular in Gender Equity theory and in discussion over work-family compatibility), the thesis has argued that other aspects of childrearing, and *all* aspects of *childbearing*, have been overlooked in both research and policy, despite parents commonly agreeing that they are commonly experienced and commonly stressful. For policy to be effective, the thesis therefore argues that policymakers must acknowledge the issues which are important to parents if they are to diversify policy to address these issues as they arise between the consideration of antecedent conditions for parenthood and the return to work after a birth. Figure 12.1 highlights areas which the various chapters of the thesis argue require further attention by policymakers and researchers.

Figure 12.1

**The location and omission of parenting influences in policy and debate on low fertility**Note: Areas which the thesis argues require **further attention** in policy and research are **in bold**

The thesis has identified a complexity and diversity of influences on fertility within and between different groups, and has particularly demonstrated how reproductive processes influence fertility through their impact on the health and well-being of women. Nevertheless, some writers believe that the ability to broaden policy perspectives to address issues of importance to women is limited where government and business is dominated by men who adhere to traditional motherhood ideology, so that policies reflect the interests of men and the concerns of liberal feminism rather than modern women's concerns with the impacts of motherhood (Pocock 2003; Rich 1976; Russell 1987; Wilkinson 1986). Despite the sociological literature identified in Chapter 3 of the thesis suggesting that a "Crisis in Motherhood" is occurring in Western nations, the United Nations Population Fund (UNFPA 2004:52-53) is right to comment that "women's needs often do not rank high on government's or communities' list of priorities". Furthermore, several writers (Maushart 1997; Nedelsky 1999; Rossi 1968) contend that although many childbearing and childrearing difficulties are experienced at the personal level, they are structurally created. In this respect, change will be more difficult in societies, such as contemporary Australia, where neo-liberalism more commonly attributes such difficulties to individual failings (Coburn 2000). However, the thesis argues that women's needs in relation to aspects of reproductive behaviour in Australia must be addressed as a matter of course, not only to support women's basic human rights (as discussed at the beginning of Chapter 8), but particularly since governments wish to stabilise or raise fertility rates.

### **12.3.2 Accepting that policy cannot "fix" everything**

Although the thesis argues that contemporary policymakers in Australia are focussing on only part of the fertility "problem", the findings also suggests that policymakers may have a false assumption that low fertility is a problem that can be completely "fixed". The thesis makes three comments on this. Firstly, Chapter 7 showed that elements of chance still affect reproduction in Australia, even in well-educated groups. Secondly, Chapter 11 showed that many parents are open to policy influence only for a limited period, after which they move "beyond" the Baby Stage and are unlikely to have more children by choice. Thirdly, for a certain group, a lifetime of influences shape individual and couple desires for a particular family size and these desires may not be overturned by short-term policy initiatives.



However, the thesis argues that policy can have an influence where:

- People can achieve their preferred family size because government policy helps to minimise the likelihood of negative impacts from childbearing and childrearing and to maximise the likelihood of positive experiences;
- Others may upgrade their family size preferences if they, or others they know, have very positive experiences of parenthood or of larger families;
- Intentions of childlessness are reduced by more positive images of parenthood flowing from the more positive experiences of those having children, which in turn reduce anxiety levels and raise confidence levels prior to parenthood.

In the discussion of specific policy initiatives which follows, policies can be seen as facilitating instruments which reduce the negative impacts or increase the positive impacts of childbearing and childrearing on individuals, couples and families. Although the emphasis here is on government initiating change, in light of the influences on parenthood discussed throughout the thesis it would also be beneficial for families, communities, local governments and workplaces to also consider ways to initiate such changes.

### **12.3.3 Possible initiatives to help stabilise or raise fertility rates**

McDonald (2002b) identifies three types of policy which can address falling fertility:

1. Financial incentives;
2. Support for parents to combine work and family; and
3. Broad social change supportive of children and parenting (including the need for a more child-friendly built environment, the potential for relationship counselling, and the development of positive attitudes towards children and parenting).

All of these potential policy types are aimed at reducing the impact of having children on the individual or couple. While Chapter 10 explored possibilities in relation to policy types 1 and 2, this section focusses on extending possibilities in relation to policy type 3 because these have been less addressed elsewhere. Broad social change supportive of children and parenting is seen to offer limited scope for policymakers (McDonald 2000a), and governments may perceive they have little influence over the more private aspects of reproductive behaviour so

that policies focus mainly on addressing finances and work-family compatibility (eg Government of SA 2004). Nevertheless, the thesis argues that governments can influence expectations and experiences related to processes of childbearing and childrearing because governments usually control or influence the institutions of education, maternity care, health, and family and community services. The single point included in the South Australian Government's Population Policy to introduce a one-off maternity nurse home visit for new mothers (as discussed in Chapter 5) is testimony to this influence. Furthermore, government initiatives do exist which focus on improving parenting experiences and parenting skills per se, in particular for those in lower socio-economic groups, yet their potential in terms of influencing fertility outcomes is not acknowledged as part of fertility-related policy, and they rarely consider the parenting needs of higher socio-economic groups.

A further reason why governments can help improve the private aspects of reproduction is that they control the maternity care system which provides education and support for childbearing and early childrearing. The thesis supports Caldwell and Ruzicka's contention (1978) that women's increased participation in education and work undermines social supports for motherhood, where these are defined as "resources provided by others" (Cohen & Syme 1985:xv). However, earlier chapters of the thesis suggested that such social change also undermines the opportunity for the social learning of baby care skills, which can lead to "culture shock" in the transition to parenthood, and which in turn can negatively impact on fertility. The thesis argues that alongside improving social supports, government fertility policy could help address this "skills shortfall". In other words, as well as considering ways of raising the psychological benefits of having children, it is important to reduce the socio-psychological costs, and arguably more so for those who hold postmodern preferences (more likely the more-educated) who stand to have greater concerns about such impacts.

The psychological and sociological literature contains reference to various techniques of improving parenting skills and social support. Social Skills Training, for example, is a technique which Furnham and Bochner (1986) highlight as effective in reducing "culture shock" related to migration. This encourages individuals to determine their likely level of competence and support for succeeding in the new culture and then to use social learning techniques to gain the required skills, including role play and simulation of real-life situations (ibid:240). Such approaches are highlighted in the sociological and medical literature on

parenthood (see Chapter 9), but could be equally given more prominence in fertility policy as initiatives to improve experiences of parenthood. Screening to identify the level of baby care skills and support could be incorporated universally in antenatal care, or be combined with depression screening in pregnancy. Consideration of the factors supporting higher fertility (Chapter 11, section 11.7.1) can also be used to inform policymakers of how to substitute for what were once both socially supported and socially learned processes, and to ensure better preparation for the “job” of parenting by improving pre-parenthood training, on-the-job mentoring and daily working conditions. In light of pre-parenthood anxieties and “culture shock” in the transition to first-time parenthood, the thesis argues that such initiatives would be particularly useful considering Kippen’s (2004) observation that Australia’s future fertility will depend heavily on the proportions progressing to having a first, and then second, child.

#### *12.3.2.1 Provide training in advance – Discuss Images and Impacts in school and family*

Since the thesis identified that *desire* for children and family influences fertility and family size alongside consideration of *obstacles*, governments could encourage schools and educational institutions to discuss aspects of family life and family size as part of existing healthy lifestyle programmes. Existing encouragement for education and career planning, and academic or vocational competency, could be balanced by discussion in schools and families of what individuals see as a healthy work-family balance and how to combine what might be called the “3Ps” of Partnership, Parenthood and Personal achievement. Improving understanding of age-related fertility changes, infertility, and experiences and success rates of ART, might counter the continuing delay of childbearing to later ages despite evidence that natural fertility declines well before menopause. To reduce the likelihood of partner incompatibility on family size desires and gender role preferences, schools and families could also encourage greater discussion of factors contributing to successful friendships and relationships. Encouragement could also be aimed at greater preparation and counselling at pre-defacto/pre-marriage and pre-parenthood stages.

#### *12.3.2.2 Provide training in advance – Provide more parenthood preparation opportunities*

Chapters 7 to 11 have discussed how anxiety about parenthood can reduce family size desires and the preconception survey showed that many respondents were keen to reduce their level of

anxiety about parenthood and found the seminars helpful in addressing this. Whilst these seminars were organised by a private company, government or community agencies could provide similar public seminars in easily accessible locations such as community health centres. The preconception stage would also be a good point at which to discuss the major physical and emotional impacts, which a good proportion of women and men experience in the transition to parenthood, so that individuals and couples are better prepared. This should be balanced by discussion of parenting as a social and learned behaviour, not a privatised and innate one, and lists of local support services could be provided. Secondly, government and community services could offer more community-based groups where pregnant mothers and fathers can learn skills from new and more experienced parents and be supported by health professionals. The Northern Women's Community Midwifery Programme in the lower status area of north-eastern Adelaide offers weekly drop-in groups for this reason. However, in light of the thesis' contention that higher education can be linked to individuals being less prepared for, or experiencing greater behavioural adjustment in the transition to, parenthood it is important to find ways of providing such community-based services also for better-educated women and men in their first pregnancy, and particularly for those who may be working full-time and cannot attend weekday groups.

#### *12.3.2.3 Maximise consumer well-being in maternity care systems*

Whilst reproduction may be considered a private issue, the fact that governments fund and manage maternity services brings private reproduction into the public sphere. Chapter 8 argued that governments can help improve women's and men's experiences of pregnancy, birth and early parenthood by re-shaping maternity care systems to better reflect postmodern preferences for maximising well-being, autonomy and self-actualisation. Chapter 8 therefore argued that governments could extend to all Australian women the continuity of carer models of midwifery care and Mothercarer services which have so far been introduced only for restricted geographic or socio-economic groups. This would bring Australian maternity care into line with World Health Organisation and UNICEF best practice guidelines (see Liljestrand 1998; WHO 1997). It would also acknowledge the importance of increasing the focus on primary health care which, for example, was suggested in the Generational Health Review, a blueprint for reform of the South Australian health care system to meet community needs over the next 20 years (Government of SA 2003).

In light of the impacts on both voluntary and involuntary infertility of medical birth interventions discussed in Chapter 8, it is important to note that this model of midwifery care reduces obstetric intervention rates for women of all risk categories when compared with standard medical-based services (Children's Youth & Women's Health Service 2005, forthcoming; Ryde Midwifery Group Practice 2005). It also provides the more personalised care which Australian parents feel is essential with a newborn baby, or when infant sleeping or feeding problems develop (DFaCS 2004a:73).

#### *12.3.2.4 Provide "on-the-job" training and mentoring*

Although the provision of information is useful in helping with adjustment to new experiences, role modelling and support from others are also important (Furnham & Bochner 1986; DfaCS 2004a). Marten (2002:107) has also found that "fertility behaviour depends more on interaction with people who can provide emotional and other types of support, rather than just ideas and information". Although some AFFSS parents had difficulties in the transition to parenthood where they had not previously acquired the necessary skills and had no social support for parenting "on-the-job", both the AFFSS parents and preconception respondents felt that personal, face-to-face and "on-the-job" teaching, mentoring and discussion about parenting should augment printed information to help raise confidence levels and minimise negative experiences. One mother of five children in the upper-middle status area believed that "sending new mothers home without any support is a nightmare waiting to happen" and that visits by maternity professionals *to the home* would provide better support than parents having to travel for outside help. Another mother of five, in the highest status area, believed there was a "huge market out there for postnatal teaching". Such help could remove the need to resort to the exhausting "trial-and-error" method of learning parenting skills which led AFFSS parents to delay or avoid having further children.

Policymakers can therefore consider how to offer more positive social learning opportunities to raise levels of parenting skills and confidence. Specific examples of ways of extending support include the "Mothercarer" programme currently run from the Lyell McEwin Health Service in north-eastern Adelaide, which provides hands-on in-home support for baby care in the first few weeks after birth. The Federal Government's \$3 million Parenting Information Project is also a step in the right direction to ascertain "what parents want to know about

parenting and when and how they would prefer to receive this information” to provide support for the parenting role (DFaCS 2004a). However, government programs in both Australia and the USA aimed at early parenting intervention and “good beginnings” which focus on individual support, home visits, skills education and community development are often provided only for “special needs” groups such as single parents, and those in poorer areas or ethnic groups (DFaCS 2004b; Government of SA 2004; Martin G.T. 1997). This thesis shows that, if their fertility is not to be adversely affected by their parenting experiences, then higher status parents, married persons in a nuclear family, and skilled migrants also need such social supports where this is not already available in their other networks.

#### *12.2.3.5 Expand the job to a team role – Provide more support from beyond the couple*

While Gender Equity theory seeks to reduce the “burden” of parenting and domestic work on individual mothers, Chapters 7 to 9 have shown that the ability to cope with motherhood relates to more than just the partner-division of domestic work and childcare, and that negative impacts of parenthood which in turn negatively impact on fertility could be reduced where support was available from beyond the nuclear family. Indeed, while social support and improved personal coping mechanisms can act as stress-moderators (Swendsen & Mazure 2000), membership in a network also reduces stress by providing opportunities for social interaction and role models (Cohen & Syme 1985). A recent panel survey of over 10,000 individuals in Bulgaria (Buehler and Philipov 2005) in fact found that social capital built from network-based resources, in particular from the couple’s own parents, had a major positive influence on fertility intentions. The thesis therefore supports Folbre (1997) in calling for longer term change so that parenthood is transformed from a predominantly private venture (which the thesis has shown to have major negative impacts on individuals and couples) to a wider family and community venture (which stands to minimise the impacts on any one individual or couple). The thesis argues that reducing the negative impacts of parenthood could benefit not only fertility rates but also help reduce rates of postnatal depression, separation and divorce, and perhaps also encourage men to reassess their image of domestic work and childcare.

Such changes to parenting could be encouraged by government agencies through education from primary school onwards. Although the provision of more childcare places and improved

quality of childcare could reduce the stress of childrearing on parents, community groups might also provide support, and this would tie in with the contemporary government focus on strengthening communities (Stone & Hughes 2002). One Adelaide church, for example, includes support for new mothers as part of its Health Ministry where phone calls, visits and meals are coordinated by a small group of retired nurses, and a crèche is provided for weekly new mothers' meetings. Where older people can be involved in such networks this could reduce isolation for them as well as for new parents, and if predictions of increased levels of childlessness are realised, there will in future be increasing numbers of older Australians without grandchildren who might like to support future generations in this way. Social services provided to the elderly, such as Meals on Wheels, could also be extended or replicated to reduce social isolation for parents who have little alternative support.

#### *12.2.3.6 Improve Occupational Health and Safety*

For many AFFSS parents the physical and mental strains of childbearing and childrearing were significant and unexpected. For some this affected their desire for more children, but through social diffusion mechanisms it also affected others' images of parenthood. Section 12.3.2.3 has already discussed ways of minimising physical and mental injury in relation to birth. In addition, compared with a standard working day in Australia where employees are required to work no more than five hours without a break, creative thinking might find new ways for parents at home to be relieved of their parenting duties during the day in order to minimise parental stress. The community support groups mentioned in the previous section could address this to some extent, and new parents could also be encouraged to forge support networks (perhaps based on the drop-in groups noted in section 12.3.2.2) where they spend one or two days a week "sharing the parenting" at one individual's home or a public location.

The thesis also provided some alternative perspectives on work-family compatibility, including the difficulties of combining work with early parenthood, especially where sleep deprivation was problematic. Psychological studies investigating workplace safety show that even relatively short periods of poor quality sleep and inadequate recovery lead to moderate levels of fatigue which impair the ability to think and function to a greater extent than a blood alcohol content of 0.05 per cent (Dawson & Reid 1997; Falleti et al 2003; Marnff et al 2005). Therefore, if new parents are to perform adequately at home, and also in any paid work that

they might have, then they require either greater support to reduce the impact of parental sleep deprivation, or improved parental leave provisions so that early parenthood and paid work do not unduly affect each other.

#### *12.3.2.7 Send positive messages through government policy*

Chapter 3 noted how social messages are an important influence on behaviour, and indeed Gille (1954:190) argued that even in Scandinavia the main effect of government policy on raising fertility rates may sometimes be solely through the psychological effects of people perceiving government to have a “favourable attitude” towards parenthood. The thesis therefore agrees with McDonald (2002b) that governments need to send the general message that “society will support you if you have children”. The thesis suggests that such support would be demonstrated by Australian governments introducing the policy initiatives outlined in this chapter, which would at the same time provide public acknowledgement of the considerable impact which contemporary childbearing and childrearing can have on individuals and couples, as well as demonstrating a willingness to address the variety of issues which concern parents, and in particular those concerning women as mothers.

In seeking initiatives to stabilise or raise fertility rates, the thesis has also argued that at the same time governments must be more aware of the impact of overall government philosophy as reflected in the wider policy arena, because this can counter policies aimed specifically at stabilising or raising fertility. For example, increased state government encouragement for skilled business migrants to come to Australia along with a reduced focus on family migration runs counter to the conditions which support higher fertility. Chapter 8 also noted that federal government encouragement for individuals to buy private health insurance encourages women into maternity care which is more likely to reduce their fertility.

## **12.4 LIMITATIONS AND SUGGESTIONS FOR FURTHER RESEARCH**

While the thesis has contributed new knowledge of fertility influences at the individual and couple level, and has addressed aspects of childbearing and childrearing which have previously been overlooked or not investigated in depth, there are some limitations which offer opportunities for further research.



### **12.4.1 Conducting in-depth research in other social contexts**

The thesis findings are limited to explaining fertility in metropolitan South Australia. It would therefore be useful to conduct similar in-depth inquiries in rural areas and in other States and Territories in order to be able to compare and contrast influences. Chapter 11 in particular highlighted how financial and housing issues might be of greater concern in higher-cost areas such as Sydney. However, the thesis focus on one social context is at the same time a strength because explanations of fertility apply to particular places at particular points in time (Graham 2000; Hirschmann 2001; Notestein 1945). Furthermore, since the thesis took a feminist approach it gave precedence to situating knowledge within the context of people's lives and to seeing interpretations as context-bound and partial.

Nevertheless, whilst the findings are limited in their geographical context and do not reflect the views of specific ethnic groups or indigenous Australians, Chapter 5 showed that they do represent the views and experiences of mothers and fathers who were relatively representative of South Australian parents on many aspects. This allowed comparison of experiences across socio-economic areas and parity, rather than focussing only on well-educated childless women as some studies do. Furthermore, since The Baby Stage is a fundamental aspect of human reproduction, experiences of this stage can be expected to influence voluntary and involuntary fertility levels in other areas of Australia, as well as in countries with similar parenting conditions, such as Britain and the USA.

However, since the thesis saw childbearing and childrearing as influenced by social constructions, different images and impacts of parenthood would be expected to exist in different cultural groups. Indeed, even within Australia parents from certain cultural backgrounds perceive greater pressures with their parenting than others (Kolar & Soriano 2000:57). The AFFSS study did not specifically select parents from different cultural backgrounds to compare this aspect, and although AFFSS mothers were representative of the birthplace diversity of all mothers giving birth, Asian mothers were under-represented. In light of Australia's ethnic diversity, which is being further increased by new migrants on humanitarian programmes, it would be informative to consider how images and impacts of parenthood influence fertility in groups with traditionally higher fertility, such as those from Indigenous or Asian cultures, and those coming from Horn of Africa and Muslim cultures.

### **12.4.2 Expanding research on preconception concerns**

The findings from the preconception survey cannot be generalised due to the small sample size of 45. However, this is a group which could be difficult to recruit on a random basis and it was felt that the responses raised some interesting issues, particularly in relation to concerns about potential impacts of The Baby Stage on family size thinking. To repeat the survey with a randomly selected larger sample would help confirm which issues were influential in a larger group and would provide further insight into the extent to which aspects of the physical and mental impacts of conception, pregnancy, birth and early parenthood influence images of parenthood, and hence Australian fertility rates. A larger survey would also allow better comparison of between- and in-group differences, such as for different socio-economic groups or different levels or fields of education and occupation.

### **12.4.3 Incorporating more socio-psychological theory into fertility research**

Working within the cultural and ideational paradigm, and seeing fertility behaviour as strongly influenced by perceptions and thought rather than by objectively measured “reality”, the thesis has incorporated theories from sociology and psychology which are based on principles of human behaviour within the social context. This included consideration of Social Construction Theory, Culture Shock Theory, and de Bruijn’s Psychological Developmental Theory of Fertility. Incorporating Social Construction Theory allowed consideration of how the ideas people have about The Baby Stage are influenced by their social context and are therefore open to reconstruction if conditions change. Furthermore, it was argued that issues only influence fertility for individuals, and issues are only addressed by governments, to the extent that they are constructed as problematic. Considering the increasing interest in psychological influences on parenthood and fertility in Europe (eg de Bruijn 1999; Dimitrovsky 2000; von der Lippe 2004; von der Lippe, Billari & Reis 2002) and on the influence of anxiety about parenthood affecting the transition to parenthood (eg Cannold 2005; Micheli & Bernardi 2003, von der Lippe 2004), future Australian fertility research could incorporate specific psychological measures such as the Parental Stress Index and Predictors of Maternal Competence into longitudinal research on parity progression and birth intervals. It could also explore in greater detail the effects on fertility and family size of social capital, social interaction, social contagion and social diffusion.

#### 12.4.4 Choosing to research the private aspects of reproduction

Chapter 4 explained that the thesis took a feminist approach because this foregrounds investigation of the *private* sphere of parenthood experiences and encourages a specific focus on “making women visible”. As was argued in section 12.3.1 in relation to government policy, the thesis also demonstrates that the private aspects of reproduction for both women and men have not been seriously addressed in contemporary low fertility research in Australia. At the disciplinary level, Greenhalgh (1996) believes that the social construction of scientific inquiry influences which research questions demographers and population geographers deem worthy of investigation and which aspects emerging from analysis are given prominence. Indeed, Thurer (1994:291) suggests that researchers play a major role in preventing change if they frame their research questions to reflect their cultural myths. For example, she notes that psychologists continually look for bad outcomes from maternal employment and non-maternal childcare *instead* of looking for bad outcomes from the lack of societal support to mothers.

Weston et al’s research (2004) provides an example of how childbearing issues in particular can be relegated to a less prominent position in “fertility decision-making” research. In this study statistical analysis of fertility influences was based on responses to a list of 28 items identified as influential *in the literature*. The subsequent small-scale qualitative telephone survey, however, found that pregnancy and birth concerns, and concerns about the ability to conceive, were raised as influential even though these had not been included in the 28-item list. Yet, having not been included in the original list, these additional aspects of concern were omitted from the statistical analysis. There is therefore a need to incorporate the full range of issues raised in qualitative research as items in quantitative surveys so that a more complete picture of influences is provided, because the findings from such surveys can also influence which issues governments choose to address in policy. As Watkins (1993:570) suggested some time ago, researchers could be more attentive to the ways in which their expectations and theoretical frameworks attach importance to some aspects of women’s (and men’s) lives but ignore others.

The exclusion of maternity care systems as an institutional influence within fertility research can be seen as a particular casualty of the dearth of feminist perspectives in demographic fertility research. The thesis argues that demographers and population geographers should

make a greater effort to include feminist and gender perspectives and to investigate more broadly the influences related to the private sphere of home, and to childbearing and early parenthood, in order to keep pace with developments in the field of medicine and feminist social inquiry. At the same time, whilst Gender Equity Theory does at least address some gender issues, the thesis has argued that greater consideration be given to gender *conflict* to allow the inclusion of couples who are content with traditional gender roles and for whom gender equity arrangements might even lower fertility preferences and outcomes.

#### **12.4.5 Including “others” in fertility research**

The thesis showed benefits in selecting interviewees for difference by gender, parity and socio-economic status because cross-group comparisons provide a broader understanding of both higher and lower fertility. As has been found in other research, it was easier to recruit mothers than fathers for the AFFSS research, but the thesis does at least introduce fathers’ viewpoints into the debate and shows that fathers’ fertility desires are influenced by aspects of The Baby Stage. The impacts of fathers’ embodied and social experiences of conception, pregnancy, birth and early parenthood have rarely been investigated in depth in demographic research and the thesis shows that considering influencing factors by gender deepens the understanding of individual fertility outcomes. It also enables consideration of how couple dynamics influence behaviour and allows fathers to provide complementary perspectives. Although parents were willing to discuss intimate details with the researcher, the strong resentment and embarrassment related to some experiences suggests that research into the private aspects of reproduction in Australia is best conducted with each partner separately.

The thesis also specifically included larger families and people from different socio-economic groups which allowed a comparison of factors influencing higher and lower fertility, the identification of different desire-behaviour groups, and the identification of parity differences in influences on fertility. Considering the thesis findings that some concerns were less influential on parents than non-parents, and sometimes also less influential as family size increased, future research should include larger families alongside smaller families.

Although the strengths of the thesis include investigation of influences on people from across the socio-economic spectrum and from a range of family sizes, it was difficult to recruit

fathers and mothers in professional occupations who were working full-time. Considering that those in higher status groups generally have lower fertility, it would be interesting to research a group of professionally employed mothers and fathers of larger families to see how factors common to them might inform policy and theory.

## 12.5 CONCLUSION

This chapter has drawn together the findings and arguments of the thesis. It shows that the main argument is that within the context of the Second Demographic Transition, fertility and family size preferences are negatively affected when negative images of, and impacts from, the processes of childbearing and childrearing under prevailing social and economic conditions clash with postmodern preferences for autonomy, rationality, control, personal achievement, social value and identity, and quality of life and relationships. This is particularly so when negative impacts are not outweighed by more positive experiences, or by a strong desire for children or a larger family. The thesis has argued that negative impacts are more likely to occur in situations where social change has led to individuals having minimal or no experience of childbearing and childrearing before having a first child, because this raises the level of behavioural adjustment required in the transition to parenthood. Negative experiences were also shown to be more likely where there were low levels of parental support from beyond the individual or couple.

The thesis also argued that negative impacts from such experiences of parenting can diffuse socially and contribute to negative images of parenthood for those with no children or those at lower parities. In renewing investigation into the private aspects of reproduction and considering impacts and images of parenthood, the thesis argues that these aspects merit further attention in low fertility research and policy in the contemporary context of developed countries. The thesis concludes that current social conditions not only make it difficult for many Australians to *combine* work and family life, but also make it difficult for them to *bear and care* for babies and young children in a way which does not negatively impact on their health and well-being. The thesis concluded by suggesting some ways in which governments, communities and families can make childbearing and childrearing more compatible with postmodern preferences. This should not only improve individuals', couples' and families' quality of life but also stands to help stabilise or raise Australia's fertility rate.

## **APPENDICES**



THE UNIVERSITY  
OF ADELAIDE  
AUSTRALIA

OFFICE OF THE DEPUTY VICE-CHANCELLOR (RESEARCH)

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CRICOS Provider Number 00123M

Applicant: Dr MR Ripper

Department: Social Inquiry

Project Title: *Explaining fertility and family size in contemporary Australia*

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THE UNIVERSITY OF ADELAIDE HUMAN RESEARCH ETHICS COMMITTEE

**Project No:**

**H-03-2003**

RM No: 0000005429

APPROVED for the period until: 30 April 2004

on the basis of minor modification to the information sheet and reference to the Committee's contacts/complaints document. Noting that this study is to be conducted by Ms Lareen Newman, PhD student.

Refer also to the accompanying letter setting out requirements applying to approval.

Professor CE Mortensen  
Convenor

Date: 26 FEB 2003



OFFICE OF THE DEPUTY VICE-CHANCELLOR (RESEARCH)

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26 February 2003

Dr MR Ripper  
Social Inquiry

Dear Dr Ripper

**PROJECT NO:** *Explaining fertility and family size in contemporary Australia*  
**H-03-2003**

I write to advise you that I have approved the above project on behalf of the Human Research Ethics Committee. A copy of the endorsed application is enclosed for your records. Please note that this may include conditions applying to this approval.


Approval is current for one year. The expiry date for this project is: **30 April 2004**

Where possible, subjects taking part in the study should be given a copy of the Information Sheet and the signed Consent Form to retain.

Please note that any changes to the project which might affect its continued ethical acceptability will invalidate the project's approval. In such cases an amended protocol must be submitted to the Committee for further approval. It is a condition of approval that you immediately report anything which might warrant review of ethical approval including (a) serious or unexpected adverse effects on participants (b) proposed changes in the protocol; and (c) unforeseen events that might affect continued ethical acceptability of the project. It is also a condition of approval that you inform the Committee, giving reasons, if the project is discontinued before the expected date of completion.

A standard annual renewal and progress report form is available from the Committee's website. Please submit this prior to the above expiry date.

Yours sincerely

 **CE MORTENSEN**  
Convenor  
Human Research Ethics Committee



PROJECT NO: H/

**THE UNIVERSITY OF ADELAIDE HUMAN RESEARCH ETHICS COMMITTEE**

Applications will be considered in terms of the University's guidelines on the ethics of human research, based on the requirements of the National Statement on Ethical Conduct in Research Involving Humans, 1999 - refer application information material, including the list of headings applying to all applications. Submit the completed application including Information Sheet and Consent Form (ELEVEN copies in total), to the Secretary, Human Research Ethics Committee, Office of the Deputy Vice-Chancellor (Research), Room 661b Wills Building, The University of Adelaide (Ph. (08) 8303 4014, Fax (08) 8303 3417, email helen.malby@adelaide.edu.au)

**APPLICATION FOR ETHICAL APPROVAL OF PROJECT INVOLVING HUMAN SUBJECTS - COVER SHEET - SUMMARISING PROTOCOL & INCLUDING INVESTIGATORS' SIGNATURES**

Please attach this to the front of the application

**APPLICANT Name** include title Professor/Dr/Ms/Mr and Position

DR MARGIE RIPPER

HEAD OF DEPT, GENDER STUDIES & LABOUR STUDIES, SCHOOL OF SOCIAL SCIENCES.

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**OTHERS INVOLVED**

MS LAREEN NEWMAN (PhD Student), DEPT. GEOGRAPHICAL & ENVIRONMENTAL STUDIES,  
WHO IS JOINTLY SUPERVISED BY DR. RIPPER & PROF. GRAEME HUGO,  
PROFESSOR OF GEOGRAPHY & DIRECTOR OF GISCA.

If this is a student project please indicate name/department/candidature

**PROJECT TITLE**

EXPLAINING FERTILITY & FAMILY SIZE IN CONTEMPORARY AUSTRALIA

**LOCATION OF RESEARCH**

ADELAIDE

**DATE PROJECT TO BEGIN**

1.4.03

**ESTIMATED DURATION OF PROJECT** 12 MONTHS

**SOURCE OF FUNDING**

NORMAL DEPARTMENTAL PHD FUNDING FOR STUDENTS.

**AIMS OF PROJECT** please give concise description in lay terms

TO INVESTIGATE MORE DEEPLY THE UNDERLYING CAUSES OF AUSTRALIA'S CURRENTLY BELOW-REPLACEMENT FERTILITY RATE, SPECIFICALLY TO ESTABLISH FACTORS THAT PARENTS THEMSELVES PERCEIVE INFLUENCE THE NUMBER OF CHILDREN THEY HAVE & BARRIERS TO ACHIEVING THEIR DESIRED FAMILY SIZE, AND THE ROLE OF PARENTAL EXPECTATIONS & EXPERIENCE IN THIS.

**ETHICAL IMPLICATIONS OF PROJECT**

HUMAN ETHICS COMMITTEE GUIDELINES STATE QUESTIONNAIRES TO BE UNEXCEPTIONABLE, HOWEVER GUIDANCE / APPROVAL IS SOUGHT SINCE QUESTIONS RELATING TO FERTILITY MAY BE DEEMED SENSITIVE.

**PLAN/DESIGN OF PROJECT** brief description in lay terms

OPEN, IN-DEPTH INTERVIEWS WITH 25 MOTHERS AND AT LEAST 10 FATHERS IN DIFFERENT AREAS OF ADELAIDE (LOW, MIDDLE & HIGH SOCIO-ECONOMIC STATUS) TO INVESTIGATE RANGE OF FEELINGS & FACTORS RE FAMILY SIZE.

TO ACT AS RICH, QUALITATIVE INPUT FOR PHD THESIS & AS INPUT TO HELP FORMULATE SHORTER, QUANTITATIVE SURVEY FOR LATER, LARGER GROUP OF 100± PARENTS TO SEE HOW COMMON THE VARIOUS ISSUES ARE.

A SEPARATE ETHICS APPLICATION WILL BE MADE FOR THIS LATER SURVEY.

**DRUGS**

Will drugs be administered to subjects?

YES / NO

- If so give name of drug(s)
- Dosage:
- Method of administration

Is the administration for therapeutic purposes?

YES / NO

Will the project be conducted under the Clinical Trials Notification (CTN) Scheme?

YES / NO

Clinical Trials Exemption (CTX) Scheme?

YES / NO

Is Commonwealth Department of Health permission required?

YES / NO

If so, has permission been obtained?

YES / NO

**SUBJECTS**

- Source: PARENTING / CHILD RELATED ORGANISATIONS eg KINDERGARTENS, CHILDCARE CENTRES, PLAYGROUPS, WITHIN SELECTED AREAS.
- Age range: 18 - 50
- Selection criteria:
  - LIVING IN SELECTED SOCIO-ECONOMIC AREA.
  - PARENT (SINGLE OR COUPLE) OF AT LEAST ONE CHILD AGED 1-6 YRS.
- Exclusion criteria CHILDLESS PEOPLE (COVERED BY PREVIOUS SURVEY IN THIS RESEARCH - DETAILS IN APPLICATION).  
THERE ARE SEVERAL OTHER STUDIES CURRENTLY UNDERWAY IN AUSTRALIA ON CHILDLESS PEOPLE.

SIGNATURE OF ALL INVESTIGATORS NAMED IN THE PROTOCOL

Date

# INFORMATION SHEET FOR PARTICIPANTS IN RESEARCH PROJECT

## *Explaining Fertility and Family Size in Contemporary Australia In-depth Parent Interviews 2003*

My name is Lareen Newman. I am undertaking this research project as part of my PhD in the School of Social Sciences at the University of Adelaide. My study is looking at things that have influenced people in the number of children they currently have and what sort of things they think will influence whether or not they will have additional children. I am hoping to get about 15-20 mothers and at least 10 fathers in Adelaide to go through a questionnaire and in-depth interview with me about these issues. This should take about 1½ - 2 hours. Talking through the issues may provide an opportunity for you to reflect upon both positive and negative aspects of being a parenting, and the study results may help to improve the support provided to parents and may eventually be of benefit to you or your community. At a later date I hope to get another 100 or so Adelaide parents to go through a form with me, more ticking boxes than discussing things in-depth, to see how common various issues are.

The study is completely confidential so nothing that you say will be reported in a way that will identify you or your remarks. I would like to tape record the interview to eliminate the possibility of quoting you inaccurately and so I can concentrate on what we talk about instead of writing. I will ask you to verbally consent to this on the tape. I will use the recording later to make notes for analysis. The tapes will be destroyed after all the data have been published. All the information will be put together to give an overall picture of people's views and everything will be framed so that no individual can be identified. If you decide to participate in the study you are free to change your mind and withdraw at any time before the study has been completed. Also, you are not obliged to answer questions or to discuss any issues that you do not wish to discuss. You may withdraw your questionnaire up until the time that I have finished talking with all the parents involved. You do not have to give any reasons if you do decide to withdraw.

If you need to contact me or have any questions about the study, my contact details are:

Ms Lareen Newman, PhD Research Student, Dept of Geographical & Environmental Studies,  
9<sup>th</sup> floor, Napier Building, University of Adelaide SA 5005.

Phone: 8303 5645. Email: [lareen.newman@adelaide.edu.au](mailto:lareen.newman@adelaide.edu.au)

Should you have concerns or questions that you do not wish to discuss with me directly, you may contact the supervisors of my study, whose details are given on the reverse of this sheet. Also provided is a contact should you wish to discuss any concerns with an independent person.

THE UNIVERSITY OF ADELAIDE  
HUMAN RESEARCH ETHICS COMMITTEE

*Document for people who are subjects in a research project*

CONTACTS FOR INFORMATION ON PROJECT AND INDEPENDENT COMPLAINTS PROCEDURE

The Human Research Ethics Committee is obliged to monitor approved research projects. In conjunction with other forms of monitoring it is necessary to provide an independent and confidential reporting mechanism to assure quality assurance of the institutional ethics committee system. This is done by providing research subjects with an additional avenue for raising concerns regarding the conduct of any research in which they are involved.

The following study has been reviewed and approved by the University of Adelaide Human Research Ethics Committee:

Project title:

EXPLAINING FERTILITY AND FAMILY SIZE IN CONTEMPORARY AUSTRALIA  
- INDEPTH PARENT SURVEY 2003

1. If you have questions or problems associated with the practical aspects of your participation in the project, or wish to raise a concern or complaint about the project, then you should consult the project supervisors:

*Name* ... Professor Graeme Hugo

*Telephone* ... (08) 8303 5646

*Emai:* ... graeme.hugo@adelaide.edu.au

*Name* ... Dr Margie Ripper

*Telephone...* (08) 8303 5947

*Email* ... margie.ripper@adelaide.edu.au

2. If you wish to discuss with an independent person matters related to
  - making a complaint, or
  - raising concerns on the conduct of the project, or
  - the University policy on research involving human subjects, or
  - your rights as a participant

contact the Human Research Ethics Committee's Secretary on phone (08) 8303 4014

## CONSENT FORM FOR A PARTICIPANT IN A RESEARCH PROJECT

I (*print your name*) ..... consent to take part in the study titled *Explaining Fertility and Family Size in Contemporary Australia*.

I acknowledge that I have read the attached *Information Sheet* that describes the aims and purpose of this study. I confirm that I have had the study, so far as it affects me, fully explained to my satisfaction by the researcher, Lareen Ann Newman. My consent to be interviewed for the purpose of the study by Lareen Ann Newman is freely given.

Although I understand the purpose of this study is to improve support for Australian parents and families, it has been explained to me that my involvement in the study may not be of any benefit to me or my community.

I understand that I can request that my name not be connected with any information that I provide, and that, if I do not wish to be identified, Lareen Ann Newman will use an invented name for me.

I do/do not (*circle one*) wish to be identified

I understand that my participation is completely voluntary and that:

- I am free to withdraw the information that I provide at any time during the information gathering stage of the study;
- I do not have to give reasons for withdrawing the information that I provide;
- I am under no obligation during the interview to divulge information or to discuss issues if I do not wish to do so.

I understand that I will be provided with information about the results of the study.

I do/do not wish (*circle one*) to be provided with information about the results of the study.

**If you answered yes to the above question, please provide your contact details**

Street: ..... Suburb: .....

Postcode: ..... Home ph: ..... Work ph: .....

I am aware that I should retain a copy of this *Consent Form* when completed, and the attached *Information Sheet*.

**Signature (participant)** ..... **Date** .....

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### WITNESS

I, Lareen Ann Newman, have described to (**name of participant**) ..... the nature of the interview to be carried out. In my opinion she/he understood the explanation.

**Signature (interviewer)** ..... **Date** .....

# THE UNIVERSITY OF ADELAIDE

## Department of Geographical & Environmental Studies and Department of Social Inquiry

### “FERTILITY AND FAMILY SIZE SURVEY”

#### IN-DEPTH PARENT SURVEY 2003

#### INTERVIEW SCHEDULE

In this part of the interview I'll ask you about your feelings about family size, parenting and other related issues. I am interested specifically in what factors have influenced your family size, and what factors are or will be most likely influence you in whether or not to have more children in the future.

(For fathers – explain that partner already answered some basic questions like where they were born, grew up, age, occupation, education etc. Explain no right or wrong answers in this discussion, want to find out how *they* see things. Explain “As it mentioned on the information sheet, I would like to tape record the interview so as to produce the highest-quality data and to eliminate the possibility that I will quote you inaccurately. Everything you say will be held confidential. In a minute I will start the tape and ask you to consent to our discussion being taped”).

**I'll just put your first name on here and your suburb so I can match this up with your questionnaire (the questionnaire your partner/wife filled in).**

Questionnaire No.:

First name:

Suburb:

Interview date/time:

Edited:

Entered:

*I'd like to start by chatting about how many children you ever imagined yourself having.*

1. Looking back over your life, did you always think you would probably have children one day, did you think you'd never have children, or did you never really think about it?

**Prompts/checks**

- A. a. I never thought I would have any children/I never used to want any.  
b. I never really thought about it.  
c. I always thought I would probably have children some day - GO TO (C)  
d. I'm not sure/I don't know what I thought.  
e. Other explanation: \_\_\_\_\_
- B. [If never thought would have children] so was there any particular reason why you have actually had children now? GO TO (E)
- C. Did you always have an idea of how many children you would like to have?  
a. I always wanted to have/thought I would like to have \_\_\_\_\_ (number)  
b. I never had any idea how many, I just knew I wanted children/big family/small family.
- D. Where did that idea come from, about how many to have? (Family of origin, friends, norms, desire to not conform etc).
- E. If there were no obstacles at all and you could have exactly the number of children you wanted in your lifetime, how many would that be?
- F. What is the SMALLEST NUMBER of children you would want to have/be happy with?  
\_\_\_\_\_  
(number)  
Is there any particular reason for this?
- G. What is the LARGEST NUMBER of children you would want to have/be happy with?  
\_\_\_\_\_  
(number)  
Is there any particular reason for this?

2. Do you know how your partner/husband feels (felt) about numbers and having more? Same as mine/different: explain

**THE NEXT QUESTIONS ARE ABOUT WHY YOU HAVE THE NUMBER OF CHILDREN THAT YOU HAVE**

3. Some people plan the number of children they want and just have that number, while others sort of decide as they go, or the babies just come along. How do you think things happened in your case? [**Prompt:** *Did you consciously decide to have each one for a particular reason, did you intend to get pregnant each time, or maybe some of them just sort of happened or came because of the failure of a contraception method?*]

Reasons for having 1<sup>st</sup> child:

Reasons for having 2<sup>nd</sup> child: etc

4. (If they were consciously planned) Was the decision to have any of them particularly more difficult than with the others? (eg to have 1<sup>st</sup> or 3<sup>rd</sup> harder than 2<sup>nd</sup>). Why? How long did the decision take? (Is your current decision proving harder? Why?)

**MORE CHILDREN?**

*Now I'd like to talk about whether you think you'd like to have more children and whether you think you will actually have more and what things might influence that.*

5. So, would you like to have more children if you could? [Numbers/boys/girls?] Pros and cons? Rank?

[**Prompt:** How do you feel about your current family size? How would you feel about one more, two more etc? Do you know many other families/friends who have (x number) children like you /or the number you would like to have? Do you feel unusual having (x number) or similar to others you know? What about if you had one more, two

more etc? Compared with other families in your area/at your children's school/kindy/siblings' families/friends/co-workers.]

6. And do you think you will, *in reality*, have any more children in the future?
7. How definite are you about that then?  
(Very definite/Fairly likely/Likely/Maybe or not sure/Unlikely/Most unlikely/Definitely not)
8. Are you doing anything in particular to make sure you get the number of children or sex preference that you want? (or taking any precautions so you definitely don't have any more?).
9. Do you feel any pressure to have/not have another child? From anyone particular?
10. Do you think there is an age at which you will be too old to have another? Why? What about your partner?
11. Would anything at all stop you having another child (make you have another child? eg change of circumstances/income).

## **RELATIVE INFLUENCE OF FACTORS**

*Now I'd like to focus on some particular things to see whether they might put you off or make you want to have another baby – some of them might go into more detail about things you've just mentioned; we'll cover things like your experience of becoming and being a parent; financial issues; work; other things you might want to do for yourself or your children.*

### **A. EXPERIENCE OF GETTING PREGNANT, GIVING BIRTH, BEING A PARENT**

*Some people are influenced in whether or not to have another child by their experiences with the one(s) they already have.*

12. Is there anything in particular that makes you want to have another baby, or not have another one, because of your or your partner's experiences with the first/others? [Were any of the following things ever an issue in the past in going from 1 to 2, 2 to 3 etc?].

*[Get details on: Conception, pregnancy, birth, coping/liking new babies, sleep deprivation, settling/crying issues, problems with feeding (starting, frequency), breast/bottle issues, physical/mental health of mother, health of child, impact on mind/body, etc, coping with becoming a mother after being at work – ease/difficulty of adjustment, amount of support, children's personality ie demanding/easy-going? general worries re parenting? Partner's coping?]*

#### ***Motherhood push/work pull***

13. Is motherhood anything like you expected it to be? Is it worse in any ways? Better in any ways? Is there/was there anything particular in your case which made parenting especially easier or especially difficult? What about your partner's experience?
14. Does any of this affect your desire to have more children? And your partner? Could anything be done to overcome these issues that would mean you could have more children?

*Now I'd like to talk about your ideas of being a parent. Different people have different ways of being parents. I'd like to know what is important in guiding the way you parent and whether it affects the number of children you want/have.*

15. Would you say you think a lot about how you mother or do you do it mostly without needing to think about it really? And your partner? Do you read/discuss a lot about parenting ideas? Your partner? Who with? About what? Do you feel you need to read about new ideas on raising children?
16. Are you raising your children differently or the same as you were brought up? Does trying to be different make parenting more difficult? More difficult to have more children?



17. Everyone has their own idea of what it is to be a good mother. Do you think if you had more children it would affect your ability to be the sort of mother you want to be, or do you think you could be that regardless of how many children you had? In what ways? How many children do you think you could have and still be the sort of mother you want to be?
18. Would having more children affect your husband/partner's ability to be the sort of father he wants to be? The sort you want him to be?
19. Maybe there are things you do well as a parent, but other things you feel you would have to do or be better in order to have more children? (eg calmness; confidence?).
20. Do you think having more children would in any way affect the children you have already, either in a good or bad way?
21. What do you think are the **most** important things for you as a parent to do or to provide for your children? (Mothers, fathers?). Would there ever be a limit on the number of children because of these things?

## **B. LIFE GOALS AND ROLE STRAIN**

*Now I'd like to talk a little about how you see your life and your life goals.*

22. What do you see as your main priorities in life? Are you overall
  1. Overwhelmingly committed to your work/career or other outside interests (politics etc)
  2. Overwhelmingly committed to family and children, preferring not to do paid work
  3. Preferring to combine both, you like work but you like to balance it with home/family.

Has this change since you've had children? Will it change in the future?

23. Can you indicate to me how important the following things are personally in your life.  
[1 Essential, 2 very important, 3 somewhat important, 4 not important]

	Ess	VI	SI	NI
1. Being very well-off financially	1	2	3	4
2. Being successful in my line of work	1	2	3	4
3. Raising a family	1	2	3	4
4. Giving my children better opportunities than I had	1	2	3	4
5. Finding purpose and meaning in my life	1	2	3	4
6. Making a contribution to society	1	2	3	4
7. Working to correct social and economic inequalities	1	2	3	4
8. Being a leader in my community	1	2	3	4

24. Do you think having more children would in any way affect you achieving your aims?

*Now I'd like you to think about the different roles you play in your life, there are about seven of them – they are listed here on this card.*

25. Can you tell me which roles have priority at the moment? (energy, time, resources)? Has having children affected which get priority? How do you feel about that? What would it mean if you had more children? On self, mother, worker, etc (check all). Could anything change that so that you *could* have (would want) more children? Will this change as the children grow in a way that will enable you to have more children?

### **TRY THIS OUT – RELEVANT?**

26. Which roles are most important to you?  
Which do you get most personal satisfaction from - rank? Least satisfaction?  
Which do you think are most valued by others? – by whom? Least valued?  
Which do you get most problems with? Least problems?

Which gives you most status with others?

27. Do you know how your partner feels (felt) about these things?

### C. MOTHER-WORKER ISSUES

*Now I'd like to talk a bit more about mothering and work issues and how they might affect your family size.*

28. How do you feel about being a mother and doing paid work? What are the main reasons you are working/not working right now? (Imagine if you were working/home right now, how would you feel about it?). Is there anything about this that affects you having more children?  
Are things different for your partner? Are your jobs/careers equally important or is one more important than the other?

#### IF HAVE WORKED SINCE HAVING CHILDREN:

29. *I see you have worked since you first became a mother.* In your experience is there anything particularly difficult or easy about working *and* having a family that affects the number of children you can have? How? Why?  
[**Prompt:** work-end or home-end issues? work-end eg hours, flexibility; home-end: coming home with tired kids, stress of juggling, guilt, need to use childcare etc]

30. Combining work and family – was it OK up until a certain number of children?

#### IF HAVE *CEASED* WORK SINCE HAVING CHILDREN

*I see that you haven't been in paid work since ...*

31. Even though you don't currently work outside the home, do you still see you yourself as a "\_\_\_\_" (career identity)?

32. Is there anything particularly easy or difficult about working *and* having [more] children that made you decide to give up or not to do paid work? [**Prompt:** work-end or home-end issues? work-end eg hours, flexibility; home-end: coming home with tired kids, stress of juggling, guilt, need to use childcare etc]. Do you think you'll ever go back to work? No. days/hrs?

33. Do you think the type of work you or your partner does, or the positions you have/had that makes it easier or more difficult to have a larger family? Do you think anything could overcome these problems?

34. There has been some talk in the media recently that if there were certain changes in the workplace or with paid leave, etc that this might help people have more children. Do you have any views on that? What things might make a difference for yourself/others you know?

35. In your case, does the fact that you do or do not have PAID maternity/paternity leave affect your decision to have another baby? Is there an amount of paid leave which would make you more likely to have a baby, or would it make no difference? How much? What about the government's new Baby Bonus – will that make a difference?

### H. CHILD CARE ARRANGEMENTS

*Different people have different preferences for how their children are cared for, and we can't always achieve the ideal arrangements.*

36. How are your children cared for at the moment (when not at school/kindy)?  
[**Prompt:** who, where, when]

37. What is your idea of an ideal childcare arrangement. Who/when/where? [**Prompt:** Role of professional childcare, extended family, immediate family, friends, informal care/occasional etc].

38. Do you have any particular views about the benefits or disadvantages for children of childcare centres or family day care? (out-of-school care; day care; occasional ...). What no. hrs/days are you happy with? Do you decide when/how often to work based on these preferences, or do you just use however much childcare is needed according to work demands?
39. Is there anything about childcare that is influencing you in wanting/not wanting more children? [**Prompt:** cost, quality, accessibility, impact on children, guilt?]. Could this be changed/overcome? How? Would you then have more children?

#### D. ECONOMIC COST OF HAVING CHILDREN

*Some people say they couldn't have another baby because it costs too much, while others would have more children however much it cost.*

40. Are costs a consideration for you in any way when you think about having more children?  
How important v other things?  
[**Prompts:** What exactly? And why? – cost of education? cost of clothes, activities, outings? travel? - what is it specifically about xxx that makes it expensive?  
[If education isn't mentioned]: Do you think the cost of education is an issue? Do you prefer *your* children to have a public or private education for primary school? Why?. For high school? Why? University?]
41. Could anything overcome these issues? Would you then have more children?
42. How would you rate your income (your household income) at the moment?  
1. My/our income is ENOUGH for our needs at the moment  
2. My/our income is MORE than enough at the moment  
3. My/our income is LESS than I/we really need at the moment

Explain?

43. How would you rate your income (your household income) as regards having more children?  
1. My/our income is ENOUGH to have another baby.  
2. My/our income is MORE than enough to have another baby.  
3. My/our income is NOT ENOUGH to have another baby (because ...)

Explain?

44. Have you ever felt you had to stop (or would have to stop) after a particular number because of practical limits, eg with:  
House/garden size (bedroom numbers) – why?; Car size/transport – why?; Education – why?; Outings/travel/holidays – why?

#### F. DIVISION OF LABOUR AND GENDER ROLES

*Some women say they would be inclined to have more children if their partner did more of the housework and childcare, although other women are happy with the amount their partner does now (which may be a lot, nothing at all, or somewhere in between).*

*Can you tell me how your household is arranged regarding work inside and outside the home. (Or how it was arranged before partner left?)*

- |   |        |           |
|---|--------|-----------|
| 45. <u>Demands of paid employment</u>                                   | Actual | Preferred |
| Woman's paid work more demanding than man's (in hours/responsibilities) | A      | P         |
| Woman and man have equally demanding paid work                          | A      | P         |
| Man's paid work more demanding than woman's                             | A      | P         |
| Only the man has paid employment  | A      | P         |
| Only the woman has paid employment                                      | A      | P         |

Neither partner has paid employment (explain)                      A                      P

46. Who is the main income earner?

47. If without having to work you had what you would regard as a reasonable living income, would you still prefer to have a paid job, or wouldn't you bother working? And your partner?

48. Responsibility for care of children (feeding, playing, school)

Primarily mother	A	P
Primarily father	A	P
Shared 50/50	A	P
Other (childcare paid/unpaid): describe	A	P

49. Responsibility for indoors domestic tasks (cleaning/cooking etc)

Primarily mother	A	P
Primarily father	A	P
Shared 50/50 (all the time, or when both home?)	A	P
Other (children, paid cleaner, family) describe:	A	P

50. Responsibility for outdoors domestic tasks (garden, car, etc)

Primarily mother	A	P
Primarily father	A	P
Shared 50/50 (all the time, or when both home?)	A	P
Other (children, paid cleaner, family) describe:	A	P

51. People talk about the changing roles of mothers and fathers. Here are three kinds of family. Do any of them correspond to what you are currently doing?

- i) A family where only the husband has a job and the wife runs the home.
- ii) A family where the wife has a less demanding job than her husband and where she does the larger share of housework and caring for the children.
- iii) A family where the two partners each have an equally absorbing job and where housework and the

care of the children are shared equally between them.

iv) None of these three families. Describe:

52. In an ideal world, if money were no problem, which would you personally choose for yourself? Why? Are there any particular barriers to reaching your preferred arrangements?

53. Do you think you would have more children if things were different? Would you *want* your partner to participate more with the housework or children? Why/why not?

[**Prompt:** Do you think that *he* would *want* to do this? Be able to do this? Do you think he does it well; as well as you?]

54. Are there other household arrangements that *would* enable you to have more children? What is the likelihood of adopting them? [**Prompt:** pay housecleaner, lower standards, children/family take more responsibility?].

55. Do you think to be a good mother/for your children's sake you *should* be doing something different to this? Why? Do you think this changes with the age of the children?

	Home f/t	Work p/t (hrs/days?)	Work f/t
A child under 1			
A child age 1-<3			
A child age 3-<5			

Kindy year?  
 All children at school  
 After the children leave school

56. Is the Kindy year in any way different? Influence on more children/paid work. What about if something similar were introduced for 3 year olds, which is what they have in England and France? Would you feel differently about that than about childcare? Impact on more children/paid work?

## SUMMARY OF INFLUENCES

57. Considering now all the things we've discussed, I'd like to write down the main things you see influencing the number of children you have and whether you'll have more.

SUMMARY:

58. What could change these things? Would that mean you could have more children?

59. Do you see any priorities for the government to help in this, for yourself/others you know? Would it make any difference to the no. of children you have or just make life somewhat easier?

60. Is there anything at all that *would* induce you to have a larger family? (that *would* stop you having another baby) or make it easier for you to have another baby? Why? How?

[**Prompt:** (Government (federal, state or local); Your employer/employers in general?; The local community/church/other organisations etc?; your family? your partner? Anyone/anywhere else? *Change of circumstances?*)]

61. *To finish, I have a set of statements that people sometimes make about children and parenting. For each statement, there are no right or wrong answers: I am interested in **your opinion** about the statement, not necessarily your personal experience or what you think others think. We'll circle the number which indicates how strongly you agree or disagree with each statement.*

** negative scaling	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree	Don't Know	Depends
1. Children are better off home with a parent than in paid childcare	1	2	3	4	5	DK	D
2. A pre-school child is likely to suffer if their mother works	1	2	3	4	5	DK	D
3. A woman should devote almost all her time to her family	1	2	3	4	5	DK	D
4. Family life suffers if the woman has a full-time job	1	2	3	4	5	DK	D
5. In times of high unemployment, married women shouldn't work	1	2	3	4	5	DK	D
6. Mothers who do <i>not</i> work have a better relationship with their children than mothers who do work	1	2	3	4	5	DK	D
7. It is more difficult to raise children successfully when both parents work full-time	1	2	3	4	5	DK	D
8. The husband's job is to earn the money and the wife's is to look after the family and home	1	2	3	4	5	DK	D
9. Even when women work, the man should still be the <i>main</i> breadwinner	1	2	3	4	5	DK	D
10. Mothers who work can have just as warm and secure a	1	2	3	4	5	DK	D

relationship with their children as mothers who do *not* work\*\*

11. Children are better looked after by women than by men	1	2	3	4	5	DK	D
12. Children under school age benefit from having some time in paid childcare rather than being home the whole time**	1	2	3	4	5	DK	D
13. Women should do the majority of housework and childcaring	1	2	3	4	5	DK	D
14. To learn well a toddler really needs the attention of a full-time mother	1	2	3	4	5	DK	D
17. <i>In the workplace</i> men deserve better opportunities and pay than women	1	2	3	4	5	DK	D
18. <i>At school</i> boys deserve better opportunities than girls	1	2	3	4	5	DK	D
19. Though many children may benefit from having mothers who stay home with them full-time, mothers may be restricted by this arrangement**	1	2	3	4	5	DK	D
20. I always enjoy having children near me	1	2	3	4	5	DK	D
21. I believe it's my duty to society to have children	1	2	3	4	5	DK	D
22. In our modern world the only place you can be really happy and at ease is at home with your family and children	1	2	3	4	5	DK	D
23. You can't be really happy in life unless you have children	1	2	3	4	5	DK	D

Now we're down to the last two attitude questions.

65. Which of the following best describes your opinion about abortion?

1. Should be legal and a matter for the woman to decide
2. Should be legal when the woman and her husband/partner agree
2. Should be legal only under certain circumstances (describe)
3. Should not be legal
4. Not sure/don't know

66. And if you accidentally got pregnant with another child? ...

67. Generally speaking, which of the following best describes your political views

Strong                  Not very strong

Liberal/National

Labour

Democrat/Greens

Independent

Left generally (Labour/Democrats/Greens)

Right generally (Independent/Lib/National)

Thank you for taking part in this survey. I really appreciate your time because I know parents are always busy! SNOWBALLING: I'd really like to get a good number of fathers to go through this sort of discussion with me as well. Do you think your husband/partner would be willing to do this sort of interview with me? [if not already arranged]. Do you know of two or three other mothers or fathers who you think would be willing to do this sort of interview with me? I'm looking for people who (have x children; work f-t, p-t/don't work; live in this area, etc ...).

**THE UNIVERSITY OF ADELAIDE**

**Department of Geographical & Environmental Studies**  
**and Department of Social Inquiry**

**“FERTILITY AND FAMILY SIZE SURVEY”**

**IN-DEPTH PARENT INTERVIEWS 2003**

**QUESTIONNAIRE**

This questionnaire is designed to get some background details about yourself and your family. Could you please complete as much of it as possible **before** I come to do the in-depth interview with you. This will save us some time on the day. If there are sections that you are unsure how to answer then leave it blank and we can go through it together before the interview. If you need more space, use the back of a page or add a new sheet, clearly indicating the question number for which you are providing more detail.

When I come to interview you I will go through the Information Sheet and Consent Form with you first. Then we'll go on to a discussion so you can tell me your ideas about family size and parenting. I will be interested in how you feel about things and especially what factors you think have influenced your family size, and what factors are/will be most likely to influence you in whether or not to have more children in future. If you have time, you might like to give these things some thought before I see you, but it does not matter if you do not do this beforehand.

First name:

Questionnaire No.:

Suburb/postcode:

Interview date/time:

Edited:

Entered:

*I'd like to start by getting some details about your family and your children. We will start with some straightforward questions.*

1. What is your current age? \_\_\_\_\_ What year were you born? 19 \_\_\_\_\_
2. Where were you were born? (Suburb/town/state) \_\_\_\_\_
3. If not Adelaide, was this a country or urban area? Country / Urban (*circle one*)
4. Where did you grow up?  
\_\_\_\_\_
5. How many years have you lived in Adelaide? \_\_\_\_\_
6. How many children did your parents have? \_\_\_\_\_
7. Which child were you? (eg 1<sup>st</sup> of 3, only, 2<sup>nd</sup> of 2) \_\_\_\_\_
8. Where were your parents born? Mother: \_\_\_\_\_ Father: \_\_\_\_\_
9. Are your parents currently living in Adelaide?
  - a) If yes, which suburb  
\_\_\_\_\_
  - b) If no, which town/state/country  
\_\_\_\_\_
10. At the moment, as far as relationships go, would you say you are (*circle one*)
  1. Single (never married, never in de facto relationship), no current partner/boyfriend GO TO QUESTION 24
  2. Single, with regular partner/boyfriend GO TO QUESTION 14
  3. In a de facto relationship
  4. In 1<sup>st</sup> marriage
  5. Divorced/separated (before/after child no. )
  6. Widowed (before/after child no. )
  7. Other: \_\_\_\_\_
11. How many years have you been (were you) married/considered yourselves de facto? \_\_\_\_\_
12. How long did you know your current/last partner/husband before you married/became de facto?  
\_\_\_\_\_
13. How many years were you married/in this de facto relationship before you had children?  
\_\_\_\_\_

*I'd like to get a few details about your partner(s) and/or the father(s) of your children.*

14. What is your current/last partner/husband's first name? \_\_\_\_\_
15. What is his current age? \_\_\_\_\_ What year was he born? 19 \_\_\_\_\_
16. Where was he were born? (Suburb/town/state) \_\_\_\_\_
17. If not Adelaide, was this a country or urban area? Country / Urban (*circle one*)
18. Where did he grow up? \_\_\_\_\_



19. How many years has he lived in Adelaide? \_\_\_\_\_
20. How many children did his parents have? \_\_\_\_\_
21. Which child was he? (eg 1<sup>st</sup> of 3, only, 2<sup>nd</sup> of 2) \_\_\_\_\_
22. Where were his parents born? Mother: \_\_\_\_\_ Father: \_\_\_\_\_
23. Are his parents currently living in Adelaide?
- a) If yes, which suburb  
\_\_\_\_\_
- b) If no, which town/state/country  
\_\_\_\_\_

*Now I'd like to get some details about the outcome of any pregnancies you've had, including any babies or children who might have died at any stage, or any pregnancies that might have only lasted a short while.*

24. Please fill in this chart for any pregnancies you've had, starting with your first pregnancy.

First name:	Sex	Month born	Year born (age)	Living with you now?	Biological Parents?	Mthr's / age at birth
Child 1 Mth _____ Fth _____	M/F	_____	_____	Here Died Elsewhere	Our child My child Adopted/foster/other	
Child 2 Mth _____ Fth _____	M/F	_____	_____	Here Died Elsewhere	Our child My child Adopted/foster/other	
Child 3 Mth _____ Fth _____	M/F	_____	_____	Here Died Elsewhere	Our child My child Adopted/foster/other	
Child 4 Mth _____ Fth _____	M/F	_____	_____	Here Died Elsewhere	Our child My child Adopted/foster/other	
Child 5 Mth _____ Fth _____	M/F	_____	_____	Here Died Elsewhere	Our child My child Adopted/foster/other	
Child 6 Mth _____ Fth _____	M/F	_____	_____	Here Died Elsewhere	Our child My child Adopted/foster/other	

25. Does your partner have any children from any previous marriage or relationship? No – GO TO Q 26

If yes, please complete:

	First name:	Sex	Year born (age)	Living with you now?	Mthr's / fthr's age at birth
Child 1	_____	M/F	_____	Here Died Elsewhere	Mth____Fth_____
Child 2	_____	M/F	_____	Here Died Elsewhere	Mth____Fth_____
Child 3	_____	M/F	_____	Here Died Elsewhere	Mth____Fth_____
Child 4	_____	M/F	_____	Here Died Elsewhere	Mth____Fth_____

26. Are you currently pregnant? (circle one) Yes / No / Maybe / Unsure /Not as far as I know

Now I'd like to get some background about your education and work training.

27. First I'd like some details about your education (you may be currently studying). Please circle the number(s) of the level that you have completed, indicate what your qualification(s) is/are in (if applicable), whether this was before or after having particular children, and whether you are currently studying.

- |  |   |
|--|---|
| 1. High School Year 10 or 11   | In progress/Before/After Child No. ____ |
| 2. High School Year 12 or equivalent   | In progress/Before/After Child No. ____ |
| 3. TAFE or trade/business qualifications<br>diploma or certificate (in _____?) | In progress/Before/After Child No. ____ |
| 4. University degree or equivalent (in _____?)                                 | In progress/Before/After Child No. ____ |
| 5. Graduate diploma or certificate (in _____?)                                 | In progress/Before/After Child No. ____ |
| 6. Masters degree (in _____?)  | In progress/Before/After Child No. ____ |
| 7. PhD, doctorate (in _____?)  | In progress/Before/After Child No. ____ |
| 6. Other: _____  | In progress/Before/After Child No. ____ |

28a. If you attended a high school was it 1. Public/state OR 2. Private

28b. Was your high school church-based? No/ Yes it was Catholic/Lutheran/Other: \_\_\_\_\_ (circle one)

28c. Was your high school 1. Boys only/girls only (Single sex) OR 2. Boys and girls mixed (coeducational)

29. What is the main occupation for which you consider yourself trained?  
(eg primary teacher, registered nurse, car mechanic, lawyer)

\_\_\_\_\_

30. What has been your main occupation or type of work throughout your life? (If you have had one or more major career changes, please include these also).

\_\_\_\_\_

Now I would like to get an idea of your work/family history.

31. Please provide a list of work you have had and indicate at which stage you went on maternity leave, returned from maternity leave or resigned to have children. (If you have had lots of changes you may show this all together eg as “various positions in sales/computing 5 years”)  
As an example: eg 1. After school, worked as computer operator 4 years  
2. Worked as receptionist 2 years  
3. Pregnant with child 1: took maternity leave 3 months paid, 6 months unpaid  
4. Returned to work as receptionist  
5. Pregnant with child 2: resigned before going on maternity leave  
6. Currently home full-time and not looking for work/currently looking for part-time work etc)

**My work/family history**

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

11.

12.

If you require more space please continue on the blank sheet opposite.

32. What is your current employment status?

1. Currently in paid employment

2. Currently looking for work
3. On parental leave
4. Not working and not looking for work
5. Home full-time or part-time (caring for children?)
6. Studying
7. Other \_\_\_\_\_

*Now please provide some details about your current or last job.*

33. For my current / last job (circle which one)

a Main type of work

b Permanent, temporary, contract, casual (circle one)

c Full-time or part-time (circle one)

d Average number of hours per week \_\_\_\_\_

e. No. days per week \_\_\_\_\_

f. No. shifts per week \_\_\_\_\_

g Is your employer:

1. A private or family business
2. Government: federal, state or local government
3. Self
4. Other \_\_\_\_\_

h. Where do you usually work?

1. At home
2. Mobile
3. Employer's premises
4. Other: (eg home-work combined)

34. a Is/was that job

1. At clerical or assistant level under direction
2. At clerical or assistant level with minimal supervision
3. At supervisor or team leader level
4. At manager level
5. At director level
6. Other: \_\_\_\_\_

35. Did/do you have access to PAID maternity leave from your current/last workplace?

1. Not working, nor on leave
2. Yes I can/could get PAID maternity/paternity leave for \_\_\_\_\_ (number of months)
3. No I can't/couldn't get PAID maternity/paternity leave, I would have to take UNPAID leave
4. No I can't/couldn't get PAID maternity/paternity leave, but would take some long-service or annual leave
5. I'm not really sure whether I can/could get PAID maternity/paternity leave
6. Other: \_\_\_\_\_

36. Have you done any voluntary work since the child(ren) were born? (eg at Kindy, for voluntary organizations...)

Yes/No

a. If yes, which organization was it for?

\_\_\_\_\_

b. What type of tasks did you do?

\_\_\_\_\_

c. Approximate number of hours per week? \_\_\_\_\_

d. What were your main reasons for doing this work? \_\_\_\_\_

*Now I'd like some details about your partner's education and work training*

37. Can you please circle the number(s) of the level that your partner has completed, indicate what his

qualification(s) is/are in (if applicable), whether this was before or after having particular children, and whether he is currently studying.

- |  |   |
|--|---|
| 1. High School Year 10 or 11   | In progress/Before/After Child No. ____ |
| 2. High School Year 12 or equivalent   | In progress/Before/After Child No. ____ |
| 3. TAFE or trade/business qualifications<br>diploma or certificate (in _____?) | In progress/Before/After Child No. ____ |
| 4. University degree or equivalent (in _____?)                                 | In progress/Before/After Child No. ____ |
| 5. Graduate diploma or certificate (in _____?)                                 | In progress/Before/After Child No. ____ |
| 6. Masters degree (in _____?)  | In progress/Before/After Child No. ____ |
| 7. PhD, doctorate (in _____?)  | In progress/Before/After Child No. ____ |
| 6. Other: _____  | In progress/Before/After Child No. ____ |

38a If he attended a high school was it 1. Public/state OR 2. Private

38b Was his high school church-based? No/ Yes it was Catholic/Lutheran/Other: \_\_\_\_\_ (circle one)

38c Was his high school 1. Boys only/girls only (Single sex) OR 2. Boys and girls mixed (coeducational)

39. What is the main occupation for which he considers himself trained? (if he has re-trained at various times, please indicate this also) (eg primary teacher, registered nurse, car mechanic, lawyer)

\_\_\_\_\_

40. What has been his main occupation or type of work throughout his life? (If he has had one or more major career changes, please include these also).

\_\_\_\_\_

41. What is his current employment status?

1. Currently in paid employment
2. Currently looking for work
3. On parental leave
8. Not working and not looking for work
9. Home full-time or part-time (caring for children?)
10. Studying
11. Other \_\_\_\_\_

42. Please provide some details about his current paid work, or last job

For his current / last job (please circle which one)

a Main type of work

\_\_\_\_\_

b Permanent, temporary, contract, casual (circle one)

c Full-time or part-time (circle one)

d Average number of hours per week \_\_\_\_\_

f. No. days per week \_\_\_\_\_

g. No. shifts per week \_\_\_\_\_

- h. Is his employer:
1. A private or family business
  2. Government: federal, state or local government
  3. Self
  4. Other \_\_\_\_\_

i. Where does he usually work?

1. At home
2. Mobile
3. Employer's premises

4. Other: (eg home-work combined)
43. a Is/was that job
1. At clerical or assistant level under direction
  2. At clerical or assistant level with minimal supervision
  3. At supervisor or team leader level
  4. At manager level
  5. At director level
  6. Other \_\_\_\_\_
44. Did/does he have access to PAID paternity leave from his current/last workplace?
1. Yes he can/could get PAID paternity leave for \_\_\_\_\_ (number of months)
  3. No he can't/couldn't get PAID paternity leave, he would have to take UNPAID leave
  4. No he can't/couldn't get PAID paternity leave, but would take some long-service or annual leave
  5. Not really sure whether he can/could get PAID paternity leave
  6. Other: \_\_\_\_\_
45. Has your husband/partner done any voluntary work since the child(ren) were born? (eg at Kindy, for voluntary organizations...)
- Yes/No
- a. If yes, which organization was it for?  
\_\_\_\_\_
  - b. What type of tasks did he do?  
\_\_\_\_\_
  - c. Approximate number of hours per week? \_\_\_\_\_
  - d. What were his main reasons for doing this work?  
\_\_\_\_\_
46. How long have you lived at your current address? \_\_\_\_\_(months or years)
47. If less than 5 years, where did you live before this? (suburb, state)  
\_\_\_\_\_
48. In the place you currently live, are you renting, purchasing, or do you own it?
1. Owned it outright for \_\_\_\_\_ years now GO TO QUESTION 52
  2. Purchasing/paying home loan GO TO QUESTION 49
  3. Renting (from SAHT/government) GO TO QUESTION 51
  4. Renting privately GO TO QUESTION 51
  5. Other: \_\_\_\_\_ GO TO QUESTION 52
49. With regards to the home loan for the house you live in have you
1. Just taken it out in the last 2 years
  2. Been paying it for 3-5 years
  3. Been paying it for 5-10 years
  4. Nearly paid it off (regardless of how long you have had it).
50. Roughly how much is your **monthly home loan** repayment for the house you live in?  
(If you have a line of credit, please indicate approximately how much would be taken out per month)
1. \$0-\$199 per month
  2. \$200-\$399 per month
  3. \$400-\$599 per month

4. \$600-\$799 per month
5. \$800-\$999 per month
6. \$1000-\$1199 per month
7. \$1200-\$1399 per month
8. \$1400-\$1599 per month
9. \$1600 and over per month

NOW GO TO QUESTION 52

51. Roughly how much is your **rent** per week?

1. \$0-99 per week
2. \$100-\$149 per week
3. \$150-\$199 per week
4. \$200-\$299 per week
5. \$300-\$399 per week
6. \$400-\$499 per week
7. \$500 and over per week

52. Do you have other properties or land that you own or are paying for, but don't live in? No – GO TO Q 53.  
If yes, please indicate which type (house, unit, land) and how many of each you have.

	Number owned	Number paying loan for
Other houses	_____	_____
Other units	_____	_____
Parcels of land	_____	_____ (Location(s): _____)

53. Do either of you have a HECS debt? No – GO TO Q 54 If yes: Self / Partner (circle one or both)

54. Is maintenance being paid for other children? No – GO TO QUESTION 55

If yes,  
Number of children: \_\_\_\_\_ Ages \_\_\_\_\_

55. Do you get income from sources other than your paid work? (eg family, govt) \_\_\_\_\_

\_\_\_\_\_

**Now some final questions about religion**

56. When you *were children* were you and your partner raised in a particular religion?

	a SELF	b PARTNER
None	1	1
Roman Catholic, Catholic	2	2
Anglican Church	3	3
Uniting, Baptist, Methodist, etc	4	4
Other: _____	8	8
Don't know, not sure	9	9

57. How regularly would you have gone to church/religious activities as children?

	a SELF	b PARTNER
--	--------	-----------

At least once a week	1	1
About once a fortnight	2	2
About once a month	3	3
Less than once a month, more than twice a year	4	4
Only once or twice a year	5	5
Never, or almost never	6	6

58. In guiding your life NOW, would you say religion, religious values, faith or spirituality is at all important to you?

	a SELF	b PARTNER
Religion/spirituality not at all important	1	1
Religion/spirituality somewhat important	2	2
Religion/spirituality very important	3	3
Don't know/Not sure	4	4

59. Do you consider yourselves members of a religious group today?

	a SELF	b PARTNER
No	1	1
Roman Catholic, Catholic	2	2
Anglican Church	3	3
Uniting, Baptist, Methodist, etc	4	4
Other: _____	5	5
Don't know, not sure	9	9

60. How often do you usually attend a religious service or activity (eg bible class).

	a SELF	b PARTNER
At least once a week	1	1
About once a fortnight	2	2
About once a month	3	3
Less than once a month, more than twice a year	4	4
Only once or twice a year	5	5
Never, or almost never	6	6

61. We usually like to get a rough idea of people's income level. Please indicate the number of the category you think you fall into. It only needs to be a rough guess (gross in last tax year - the taxable income amount on your tax returns).

	SELF	PARTNER
1. Less than \$2,000	1	1
2. \$2,001 - \$ 9,999	2	2
3. \$10,000 - \$19,999 pa / \$192 - \$394 per week	3	3
4. \$20,000 - \$29,999 pa/ \$395 - \$576 per week	4	4
5. \$30,000 - \$39,999 pa/ \$577 - \$769 per week	5	5
6. \$40,000 - \$49,999 pa/ \$770 - \$961 per week	6	6
7. \$50,000 - \$79,999 pa/ \$962 - \$1,539 per week	7	7
8. \$80,000 - \$99,999 pa/ \$1,540 - \$1,929 per week	8	8
9. Over \$100,000pa / Over \$1,930 per week	9	9

Thank you for completing this questionnaire. If there were any parts you had difficulties completing, I can help you with them before we start the interview discussion.

I look forward to meeting you for the interview and hearing your views.

I will see you on \_\_\_\_\_.





4. Tick a box ie tick ONE BOX ONLY.

FIRST WE WOULD LIKE YOU TO ANSWER A FEW QUESTIONS ABOUT YOURSELF.

1. Are you male or female?
  1. Male
  2. Female
  
2. In what year were you born?  
19 \_\_\_\_\_
  
3. What is your current marital status?
  1. Single
  2. Married
  3. De facto relationship
  4. Divorced/separated
  5. Widowed
  6. Other: \_\_\_\_\_
  
4. How long have you been in your current relationship or marriage?
  1. Less than 12 months
  2. 1-2 years
  3. 3-5 years
  4. 6-9 years
  5. 10 years or more
  
5. What is the suburb and postcode of your main residential address?  
  
Suburb: \_\_\_\_\_ Postcode: \_\_\_\_\_
  
6. Do you already have your own children or have parenting responsibility for children?
  1. No, I do not have any children and I/my current partner and I are not expecting any.
  2. No, but I/we are expecting our first baby.
  3. Yes, I have \_\_\_\_\_ (number) of children of my own (from previous relationship)
  4. Yes, my current partner has \_\_\_\_\_ (number) of children from previous relationship and I am responsible for helping to parent them.
  5. Other situation: \_\_\_\_\_

NOW SOME QUESTIONS ON FAMILY SIZE

7. Looking back over your life, did you always think, expect or hope that you would have children some time?
  1. I never thought I would have any children/I never used to want any.
  2. I never really thought about it.
  3. I always thought I would probably have children some day - GO TO QUESTION 9

4. I'm not sure/I don't know what I thought.

5. Other explanation: \_\_\_\_\_

8. If you never thought you would have children, or only started thinking about it in the last few years, what made you start thinking about it?

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PLEASE NOW GO TO QUESTION 10

9. Did you have any idea how many children you would like to have?

1. I always wanted to have/thought I would like to have \_\_\_\_\_ (number) children.

2. I never had any idea how many, I just knew I wanted children.

10. What is the SMALLEST NUMBER of children you would be happy with/want to have?

\_\_\_\_\_ (number)

11. What is the LARGEST NUMBER of children you would be happy with/want to have?  
(This may be the same as the smallest number if there is a particular number you want).

\_\_\_\_\_ (number)

12. Do you have any particular reason(s) for wanting this number of children or this family size, or for thinking you would not want more or less than this?

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13. If there were no obstacles at all and you could have exactly the number of children you wanted in your lifetime, how many would that be?

If there were no obstacles, I would have \_\_\_\_\_ (number of children).

14. In REALITY, how many children do you think you will probably have in your lifetime?

I will probably now have \_\_\_\_\_ (number).

15. If the number you think you will now have is DIFFERENT from the number you always wanted to have, or the number you would really like to have, please EXPLAIN why it is different.

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16. How many children did your parents have?

My parents had \_\_\_\_\_ (number) children.

17. Looking back now, how do you feel about the number of brothers and sisters you had?

1. I would rather have had MORE brothers and sisters than I had
2. I would rather have had FEWER brothers and sisters than I had
3. I was happy with the number of brothers and sisters I had

PEOPLE HAVE ALL SORTS OF REASONS FOR WANTING OR NOT WANTING CHILDREN.

18. Can you please give your three main reasons for HAVING children.

Main reason: \_\_\_\_\_

Second reason: \_\_\_\_\_

Third reason: \_\_\_\_\_

19. Please also rank the following reasons you might have for WANTING children. Start numbering at 1 for the biggest reason out of this list, until you reach 10 – the least important reason for you.

- It just feels like it's time to start a family
- I don't want to miss out and NOT have any
- I want someone to care for me in my old age
- I want someone to carry on the family name/family business
- I want someone who will love me, so I don't feel so alone
- People I know are having babies and I want to do the same
- We got pregnant by accident and weren't actually going to have children at all
- We got pregnant at the wrong time, but would have started sooner or later anyway
- I want to see what it's like to be pregnant and create another human being
- I want to see what it's like to give birth
- I want to experience parenthood
- It will bring my partner and I closer together
- Having a child is the natural extension of our love
- I just love children and want to have my own to love and care for
- I want the fun of children in my house
- I want the pleasure of watching children grow up
- My parents or parents-in-law want grandchildren

20. Please also give any reasons you might have for NOT wanting children.

Main reason: \_\_\_\_\_

Second reason: \_\_\_\_\_

Third reason: \_\_\_\_\_

21. Please also rank the following list of reasons why you MIGHT NOT want to have children, starting with 1 (the biggest reason for you) until you reach 10 (your least important reason).

-- If you have NO reasons against having children tick here and GO TO QUESTION 22.

I think children cost too much and would be too much of a financial burden

I'm too worried about pregnancy

I'm too worried about birth

Children would be too much work

Children would be too much responsibility

I/we feel too old to start a family

Children are hard to discipline

Children get sick too often

Having children would make less free time for myself

Having children would make less free time to spend with spouse

Having children would make less free time to spend with friends/family

It might be hard to combine children with my work/to go back to work

There are too many people on earth already

NOW SOME QUESTIONS ABOUT WHAT MIGHT BE INFLUENCING YOUR DECISION

22. What reason(s) did you have for attending the ACHA Pre-Conception Seminar? Did you want any particular information?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

23. Before the seminar, how likely would you have been to have a baby?

1. I would NOT have had a baby at all.
2. I was fairly UNLIKELY to have a baby
3. I was fairly LIKELY to have a baby.
4. I was highly LIKELY to have a baby (also tick box if already pregnant: ))

24. Before the seminar, roughly how long had you been thinking about having a baby?

1. I hadn't been thinking about it at all.
2. I'd only just started to think about it.
3. I'd been thinking about it for around \_\_\_\_\_ (number MONTHS)
4. I'd been thinking about it for around \_\_\_\_\_ (number YEARS)

25. Did the information from the seminars make you any more or less likely to want a baby?

1. I am neither more nor less likely to want a baby now.
2. I am MORE likely to want a baby now.
3. I am LESS likely to want a baby now.

26. What are the THREE BIGGEST ISSUES you are/were thinking about as you try to decide whether or not to have a baby?

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27. Please indicate on the following list how much each factor has been an issue in trying to make your decision. (For example, if something is a Big Issue you've been thinking about a lot, it's been affecting your decision and/or it bothers you a lot – so you circle 1).

	Big Issue	Medium Issue	Small Issue	Not an Issue
a) Attitudes: Am I ready or willing to have a child?	1	2	3	4
b) Money worries/ practicalities	1	2	3	4
c) Work and child care issues	1	2	3	4
d) Issues on division of housework and caring for child	1	2	3	4
e) Impact on personal life and relationships	1	2	3	4

28. NOW LET'S GO INTO MORE DETAIL:

	Big Issue	Medium Issue	Small Issue	No Issue
Q(i)				
a Am I ready physically? (eg do I have time, energy)	1	2	3	4
b Am I ready emotionally? (eg. feel grown-up enough)	1	2	3	4
c Am I ready mentally? (eg willing to postpone other goals)	1	2	3	4
d Am I a suitable person to be a parent?	1	2	3	4
e Is raising children too much responsibility?	1	2	3	4
f Do I really like babies/children?	1	2	3	4
g Do I want to have children in my house (noise, mess)?	1	2	3	4
h Could I cope with caring for babies ... adolescents?	1	2	3	4
Q(ii)				
a Am I at the right time financially to start a family?	1	2	3	4

b	Can I afford the money to raise a baby/child?	1	2	3	4
c	Can I afford to change things for a baby (eg get bigger car)	1	2	3	4
d	Do I live in a suitable place/need to move?	1	2	3	4
e	Is my job/work stable and reliable enough?	1	2	3	4
f	Is the economy stable enough?	1	2	3	4
g	Is the world safe enough?	1	2	3	4

Q(iii)

a	Do I WANT to take time off work/my career?	1	2	3	4
b	Can I AFFORD the reduced income?	1	2	3	4
c	How will having a baby affect my future career chances?	1	2	3	4
d	Do I want to stay home with a baby?	1	2	3	4
e	Will I be able to go back to work easily?	1	2	3	4
f	Will there be problems combining childraising and work?	1	2	3	4

Q(iv)

a	Will I cope with the increased amount of housework?	1	2	3	4
b	Do I want to become a housewife/husband? ( <u>and</u> parent)	1	2	3	4
c	Will our current housework arrangements work?	1	2	3	4
d	Will my partner help more with housework?	1	2	3	4
e	Will there be conflict over who does what/how much?	1	2	3	4

Q(v)

a	Impact of baby free time and freedom (eg social life/sleep)	1	2	3	4
b	Fear of losing my identity as an individual	1	2	3	4
c	Worries about impact on mother's body	1	2	3	4
d	Worries about impact on mother's mental health	1	2	3	4
e	How would I cope with birth mentally/physically?	1	2	3	4
f	How would I cope/whether I really want to be pregnant	1	2	3	4
g	How would I cope/whether I really want to be a parent	1	2	3	4
h	Do we have sufficient personal/practical support available?	1	2	3	4

Q(vi)

a	Impact on time available to be with partner/sex life	1	2	3	4
b	Is our relationship ready?	1	2	3	4
c	Is either of us too old?	1	2	3	4
d	Is either of us too young?	1	2	3	4
e	Will we be able to conceive?	1	2	3	4

29. If you feel the COST of children is a problem/issue, what is it SPECIFICALLY that you are concerned about or thinking about?

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30. Are there any other things at all that might put you off or stop you from having a baby (or if you are already pregnant, was there anything stopping you which you have now managed to overcome?).

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31. Would anything have made you, or helped you, start a family earlier?

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32. How much opportunity would you say you have had in your life to be around babies and children? (eg while visiting friends/neighbours, in your family, doing babysitting, at work etc)

1. I have had LOTS of contact with babies and children.
2. I have had A FAIR AMOUNT of contact with babies and children.
3. I have had NOT MUCH contact with babies and children.
4. I have had NONE, OR ALMOST NO contact with babies and children.

33. Do you think the amount of contact you have had, or not had, with babies and children is in any way influencing your decision about whether to have your own children? Please explain.

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34. How much contact have you had with people who are already parents?

1. I have had LOTS of contact with people who are already parents.
2. I have had a FAIR AMOUNT of contact with people who are already parents.
3. I have had NOT MUCH contact with people who are already parents.
4. I have had NONE, OR ALMOST NO contact with people who are already parents.

35. Do you think the amount of contact you have had, or NOT had, with existing parents is in any way influencing your decision about whether to have your own children? Please explain.

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NOW WE WOULD LIKE TO ASK YOUR THOUGHTS ON PARENTING AND WORK

36. Do you feel that your decision whether to have a baby or not is in anyway affected by how easy or difficult you think it would be to combine paid work with parenting?



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37. Please indicate what your present thoughts are about what YOU YOURSELF would probably do regarding parenting and paid work, as far as you have thought about it.

	Parenting full-time, no paid work	Paid work, part-time	Paid work, full-time (35hrs p/w +)	Don't know yet
When child is 3 mths	1	2	3	4
When child is 6 mths	1	2	3	4
When child is 12 mths	1	2	3	4
When child is 2 years	1	2	3	4
When child is 5 years	1	2	3	4

38. Please indicate what your present thoughts are about what YOUR PARTNER would probably do regarding parenting and paid work, as far as you know.

	Parenting full-time, no paid work	Paid work, part-time	Paid work, full-time (35hrs p/w +)	Don't know yet
When child is 3 mths	1	2	3	4
When child is 6 mths	1	2	3	4
When child is 12 mths	1	2	3	4
When child is 2 years	1	2	3	4
When child is 5 years	1	2	3	4

39. If you think YOU would return to paid work at some stage after the birth, what do you think the main reasons would be (tick any or all).

-- If you don't expect to return to paid work ever, tick here )and GO TO QUESTION 40.

1. To continue my career path
2. So I don't lose my skills and/or fall behind my colleagues
3. Because I NEED the money
4. Because I LIKE the money
5. Because I like my job/work
6. For social contact/a change from parenting
7. Other: \_\_\_\_\_

40. Do you have access to PAID maternity/paternity leave from your current workplace?

1. Not currently working
2. Yes I can get PAID maternity/paternity leave for \_\_\_\_\_ (number of months)
3. No I can't get PAID maternity/paternity leave, I would have to take UNPAID leave
4. No I can't get PAID maternity/paternity leave, but would take some long-service or annual leave
5. I'm not really sure whether I can get PAID maternity/paternity leave
6. Other: \_\_\_\_\_

41. Is the fact that you do or do not have PAID maternity/paternity leave affecting your decision to have a baby?

1. No, whether I have PAID leave is NOT affecting my decision.
2. Yes, having NO access to PAID leave is putting me off having a baby

Please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

42. If you could get 3 months PAID maternity leave at FULL PAY (or 6 months at half-pay) would that make you more likely to have a baby, or would it make no difference?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

43. Is there anything any of the following could do to make it easier for you to have a baby?

i) Government (federal, state or local)? \_\_\_\_\_

\_\_\_\_\_

ii) Your employer/employers in general? \_\_\_\_\_

\_\_\_\_\_

iii) The local community? \_\_\_\_\_

\_\_\_\_\_

iv) Your family? \_\_\_\_\_

\_\_\_\_\_

v) Your partner? \_\_\_\_\_

\_\_\_\_\_

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vi) Anyone else or anywhere else? \_\_\_\_\_

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44. On balance, considering the pros and cons and things you have been thinking about, how likely are you to try and get pregnant within the next 2 or 3 years?

1. Already pregnant/probably already pregnant
2. I think I will be avoiding pregnancy completely for the next 2-3 years
3. Have decided we definitely don't want children now
4. I will avoid pregnancy until I feel really ready myself
5. I will avoid pregnancy until my partner feels really ready
6. I will leave pregnancy completely up to chance (ie won't try but also won't try to stop it)
7. I will definitely try to get pregnant in the next:  
3 months/6 months/12 months/1-2 years/2-3 years (circle your choice)
8. I am not sure/don't know what I am going to do
9. Other: \_\_\_\_\_

#### FINALLY, A FEW LAST QUESTIONS ABOUT YOURSELF

45. What is the highest level of education you have completed?

1. High School Year 10 or 11
2. High School Year 12 or equivalent
3. TAFE or trade/business qualifications /diploma or certificate
4. University degree or equivalent
5. Postgraduate qualifications (Master, PhD, Graduate Diploma etc)
6. Other: \_\_\_\_\_

46. If you attended a high school was it:

- a 1. Public/state high school OR 2. Private high school  
b 1. Boys only/girls only OR 2. Boys and girls mixed (coeducational)

47. What is/has been your main occupation or type of work throughout your life, or the main occupation for which you trained?

(Please answer in detail eg "motor mechanic at garage", not just "mechanic"; "nurse" working in GP's surgery" not just "nurse").

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48. Please would you give some details about your current work?

-- If you are not currently working tick here and GO TO QUESTION 50.

a Type of current work \_\_\_\_\_

b Basis (full-time, part-time) \_\_\_\_\_

c Permanency (permanent, temporary, contract, casual) \_\_\_\_\_

d Average number of hours per week \_\_\_\_\_

- e Employer:
1. A private or family business
  2. Government: federal, state or local government
  3. A self-employed position
  4. Other: \_\_\_\_\_

49. a Is your position:
1. At clerical or assistant level under direction
  2. At clerical or assistant level with minimal supervision
  3. At supervisor or team leader level
  4. At manager level
  5. At director level
  6. Other: \_\_\_\_\_

- b Do you consider yourself:
1. A career person or
  2. A person doing a job

50. a How many years have you been in regular work since you were 16? \_\_\_\_\_

b How many full years (or equivalent) have you studied since you were 16? \_\_\_\_\_

51. In the place you live, are you renting, purchasing, or do you own it?

1. Own it outright
2. Purchasing/paying mortgage
3. Renting (from SAHT/government)
4. Renting privately

5. Other: \_\_\_\_\_

52. In guiding your life, would you say religion or spirituality is at all important to you?

	a SELF	b PARTNER
Religion/spirituality not at all important	1	1
Religion/spirituality somewhat important	2	2
Religion/spirituality very important	3	3
Don't know/Not sure	4	4

53. How often do you usually attend a religious service or activity (eg bible class).

	a SELF	b PARTNER
At least once a week	1	1
About once a fortnight	2	2
About once a month	3	3
Only once or twice a year	4	4
Never, or almost never	5	5

54. What religious group, if any, do you and your partner belong to?

	a SELF	b PARTNER
None	1	1
Roman Catholic, Catholic	2	2
Anglican Church	3	3
Uniting, Baptist, Methodist, etc	4	4
Other Christian	5	5
Hebrew	6	6
Muslim	7	7
Other: _____	8	8
Don't know, not sure	9	9

55. How would you rate your income (your household income) at the moment?

1. My/our income is ENOUGH for our needs at the moment
2. My/our income is MORE than enough at the moment
3. My/our income is LESS than I/we really need at the moment

56. Please indicate into which category your individual and combined income fell in the last tax year.

	SELF	COMBINED
1. Less than \$10,000/ less than \$191 per week		
2. \$10,000 - \$19,999 pa / \$192 - \$394 per week		
3. \$20,000 – \$29,999 pa/ \$395 - \$576 per week		
4. \$30,000 – \$39,999 pa/ \$577 - \$769 per week		
5. \$40,000 – \$49,999 pa/ \$770 - \$961 per week		
6. \$50,000 – \$79,999 pa/ \$962 – \$1,539 per week		
7. \$80,000 – \$99,999 pa/ \$1,540 - \$1,929 per week		
8. Over \$100,000pa / Over \$1,930 per week		

THANK YOU VERY MUCH FOR ANSWERING THIS QUESTIONNAIRE. WE HOPE IT HAS BEEN USEFUL TO HELP YOU WORK THROUGH YOUR THOUGHTS.

If you would like to receive a copy of the results at a later date, please indicate on the end sheet.

If you would be willing to participate in a follow-up survey in around 18 months time, please also indicate on the end sheet.

**PLEASE RETURN THIS QUESTIONNAIRE TO:**

**Lareen Newman**

**Dept of Geographical & Environmental Studies**

**University of Adelaide SA 5005**

**AN ENVELOPE IS PROVIDED FOR YOUR CONVENIENCE**

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