REPORTS AND MEMORANDA

A Pilot Study of Child-Rearing Practices among Mothers of Young Children in Dublin.

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Our pilot survey was prompted by an earlier study of infant rearing carried out by John and Elizabeth Newson in Nottingham in 1963[1], and by a desire to undertake a comparable investigation in Dublin. Work was limited by both time and facilities; but our questionnaire was fairly comprehensive, and we obtained satisfactory co-operation from the mothers we interviewed.

The Sample

The collection of the sample posed considerable problems. The Nottingham survey covered 709 mothers within two weeks of their child's first birthday; and this was made possible through access to the records of the city health department. However, similar records are not kept in Dublin. It seemed possible, on the other hand, that the Registrar-General's records might be used to obtain the names and addresses of 100 children drawn at random from the registry of births for a particular week or month about a year previously; but these records were not made available to us. We then approached the Medical Social Worker at the Rotunda Hospital, knowing that 85 per cent of all births in Dublin take place in the four main maternity hospitals. The Master of the Rotunda agreed to let us draw on their records, providing we obtained the mother's prior consent to an interview at her home. This could be done either by seeing the mothers at the ante-natal clinic, or by approaching them in the post-natal wards. It was decided that the latter would yield a more representative sample, though realising that this would entail abandoning our original aim of interviewing mothers of one-year-olds.

We, therefore, made a complete round of the hospital post-natal wards on two separate occasions. There are 96 post-natal beds, and from the charts in each ward we discovered which mothers (i) had at least one other living child under the age of four and a half years ,(ii) were married and (iii) were living in Dublin City. We explained to each mother the purpose of the survey, and asked if we might visit them at home within the next few weeks to administer a questionnaire. We stressed that we were seeking advice, not offering it. Of 68 mothers approached (62 public patients, 6 private), 65 agreed, giving a refusal rate of 4·4 per cent. Two of those refusing gave inadequate accommodation as their reason; one said she would not have time to be interviewed. One address subsequently proved to be incorrect; while, on completion of the inter-

1. John and Elizabeth Newson: *Patterns of Infant care in an Urban Community*, London, 1963.

views, four were found to be unsuitable for our survey as not having another child in the family under the age of four and a half. The number of interviews completed, therefore, was 60 (88 per cent of the original sample).

The questions asked in the course of the interview referred to the child next in age from the new baby; and in the sample the age of this child varied from one year to four and a half years approximately. We have tried to indicate the effect of age differences in the results. The fact that each mother when interviewed had a new baby of between one and four weeks old may have influenced replies to certain questions (for example, several mothers reported instances of temper tantrums in their elder child since the arrival of the new baby); but we do not feel that the results are invalidated as a consequence: most children are brought up with brothers and sisters, and the jealousies, disobedience and other difficulties arising from the presence of siblings are part of normal behaviour.

The Interviewing

This was spread over three weeks of February, 1971. A total of 92 visits had been paid before the 60 interviews were completed, making an average of 1·53 visits per completed interview. A total of 273 miles was travelled, an average of 4·55 miles per completed interview.

	Number of interviews completed	%
One call	41	68·3
Two calls	12	20·0
Three calls	5	8·3
Four calls	2	3·3

(Total number of visits 88, plus 4 found later to be invalid).

Each interview took between 15 and 25 minutes to complete. It was not difficult to obtain the mothers' interest or cooperation, more particularly because all of them had already agreed to take part; but some mothers answered all the questions fairly briefly while feeding the baby, or doing some other task, while others expanded at length on each question. Some questions merely involved ticking the appropriate answer, while others called for greater description and expansion; and in the latter case we tried to record the mother's actual words as far as possible.

Distribution of sample by social class

Classification was by father's occupation, using the following method of classification:

I and II: Professional and managerial: Doctors, solicitors, clergymen, teachers, nurses, company directors, shopkeepers (own business), policemen, etc.

III WC: White collar: Clerical workers, shop assistants, etc., tradesmen in one-man business, foremen and supervisors in industry.

III Man.: Skilled Manual: Skilled tradesmen in industry, drivers, etc.

IV: Semi-skilled: Machine operators, bus conductors, window-cleaners, driver's mates, porters, etc.

V: Unskilled: Labourers, refuse collectors, cleaners in industry, messengers, persistently unemployed, etc.

The distributions resulting from the classification were as follows:

Social Class	*Number*	*Percentage*	*Nottingham sample (per cent)*
I and II	9	15	14·2
III WC	12	20	13·0
III Man.	19	32	50·8
IV	8	13	14·4
V	12	20	7·6
Total:	60	100	100·0 (N=709)

TABLE 1: *Average age of mothers at time of interviews (year), by social class*

	I and II	*III WC*	*III Man.*	*IV*	*V*
Dublin:	28·9	26·4	29·2	27·1	31·2
Nottingham	28·9	29·0	28·3	29·6	28·6

It should be noted that some mothers in the English sample had only one child, while all the mothers in our sample had at least two children.

TABLE 2: *Average age of child referred to in interview, at time of interview (months)*

I and II	*III WC*	*III Man.*	*IV*	*V*
29·8	26·3	25·3	25·3	31·5

The comparatively high age of the children in social class V may be partly explained by a higher incidence of miscarriage in this group; but we have no direct evidence of this.

TABLE 3: *Average number of children in family at interview, by social class*

	I and II	*III WC*	*III Man.*	*IV*	*V*
Dublin:	3·2	2·6	3·3	3·6	5·3
Nottingham	2·1	2·1	2·6	2·7	3·4

Again it should be noted that all the mothers in our sample had at least two children.

TABLE 4: *Average age of mothers at birth of first child (years), by social class*

	I and II	*III WC*	*III Man.*	*IV*	*V*
Dublin:	24·1	23·3	24·5	22·0	22·3
Nottingham:	24·4	24·1	23·0	23·0	22·6

TABLE 5: *Proportion of families with three or more children (percentages), by social class*

	I and II	*III WC*	*III Man.*	*IV*	*V*
Dublin:	66	33	68	50	75
Nottingham:	28	27	40	44	64

TABLE 6: *Proportion of mothers aged 21 or less at the birth of their first child (percentages)*

	I and II	*III WC*	*III Man.*	*IV*	*V*
Dublin:	11	33	26	25	50
Nottingham:	24	25	40	46	53

Most of the children we were concerned with had been born in hospital: 83 per cent, close to the figure for Dublin as a whole, but considerably higher than the corresponding English figure. Social classes I, II and III WC did not appear in the figure for home births. In only three cases were people other than the doctor or midwife present at the birth; but in one hospital birth the husband was with his wife until the second stage of labour (in a private ward). Several mothers remarked that husbands were not permitted in the labour ward. At one home birth a neighbour was present, and in another the mother's mother was present.

TABLE 7: *Proportion of mothers attending ante-natal relaxation classes (per cent)*

	I and II	*III WC*	*III Man.*	*IV*	*V*	*All*
Dublin:	44	25	20	12	8	18
Nottingham:	32		17			21

A number of mothers said that they had attended relaxation classes for their first confinement, but not for the later ones; others that when they had had their first baby (anything up to 20 years ago) these classes had not been available. It seems likely, then, that the numbers attending the classes are increasing. The majority of those who did attend remarked on how useful they had been. There was special mention of the value of the controlled breathing taught at these classes. In general, mothers seemed resigned to the process of child-birth; their own experience of it was commonly described as "fairly reasonable", "not too bad", "it wasn't that bad", and "you soon get over it". Occasionally mothers described their feelings more explicitly: "It wasn't very easy. I wanted to die. The Sister was very abrupt; and when I had the twins (last birth) the staff were really very nice which makes all the difference". (*Casual docker's wife*). "I intended to have the baby in a disciplined frame of mind; but it was too difficult" (*technician's wife*). "I was disappointed I didn't feel the birth" (*charge-hand's wife*). "I don't enjoy it: it's just an ordeal. I bear with it, and the sooner it's over, the better" (*labourer's wife* who had had ten children). "It was difficult enough but I suppose they're all difficult enough. I don't think they give you very much help. It should be easier in this day and age" (*tube-winder's wife*). "It's worth it when you see them afterwards" (*linesman's wife*). Some of the mothers showed definite negative feelings towards the birth: "I hated it". The baby was 8 days overdue and had to be induced" (*chartered accountant's wife*). "I was absolutely terrified" (*assistant supervisor's wife*). "I was a difficult patient. I thought it was pretty bad" (*farm labourer's wife*). "It was very bad, that moment. That's why I went private this time" (*foreman's wife*).

We classified their responses as Positive, Negative, Indifferent and Concerned (which meant that they seemed interested by what was going on, but were not really positive towards it); and percentage distributions by class were as follows:

TABLE 8

	I and II	*III WC*	*III Man.*	*IV*	*V*	*All*
Positive	33	42	36	25	33	35
Negative	11	8	0	0	25	8
Indifferent	22	25	42	50	25	33
Concerned	33	25	21	25	17	23
N=	9	12	19	8	12	60

Feeding

The information we gathered about feeding practices must be examined while bearing in mind that the children were not all of the same age, and that differences in feeding habits were, therefore, to be foreseen. Nevertheless, some of our results were unexpected.

The Nottingham survey reports a common "practice for a doctor or midwife to encourage a mother to put her infant to the breast as soon as possible after the birth". Nearly half the mothers interviewed in England were breast-feeding their babies at one month, dropping to around ten per cent at six months. In our sample, only 18 per cent had breast-fed their baby at some time; 10 per cent were still doing so at four weeks. The English survey reported 83 per cent of mothers either breast-feeding, or making some attempt to do so, four days after birth. Only one mother in our sample continued breast-feeding after 6 months and weaned her baby without using bottle feeding at all.

Of the children in our sample, 40 per cent were first babies; but of those who had been breast-fed 45 per cent were first babies, suggesting a slight tendency for more mothers to try breast-feeding their first baby. For example, 6 mothers who said that they breast-fed their first baby, had not done so for the child with which the questionnaire was concerned. We gained the impression that breast-feeding was not actively encouraged at the maternity hospital, and that many mothers did not receive the continued support and encouragement often required to persevere with breast-feeding. Nevertheless, of those who had breast-fed, most said that they had enjoyed it. However, the majority of mothers did not comment further, and it appears that breast-feeding is out of fashion among Dublin mothers at the moment. While the average age of the mothers in the sample as a whole was 28·9 years, the average age of mothers who had breast-fed their children at some time was 31, despite there being a greater proportion of first children in the latter group, and mothers more likely (one might have expected) to be younger. The average age of mothers still breast-feeding at four weeks rose to 32 years, and to 33 years among women still breast-feeding at six weeks, thus supporting our belief that breast-feeding is currently unfashionable among younger mothers. It is known that such fashions occur in England also, although the fact that the English survey was undertaken eight years ago makes direct comparison of results in this instance difficult, since fashions in that country may have changed in the meantime.

Feeding schedules

In general, mothers planned their feeding schedules instinctively and were not greatly influenced by the advice of medical staff, or by experts in baby care writing in books, journals or magazines. We classified their feeding schedules as "Rigid", "Flexible" and "Demand":

TABLE 9: *Over-all classification of feeding schedules (percentages)*

	Rigid	*Flexible*	*Demand*
Dublin:	32	28	40
Nottingham:	25	22	53

While mothers remained in hospital a fairly strict routine was adhered to; but, as the table shows, over two-thirds abandoned this when they went home. The Nottingham survey found a slight but consistent trend for mothers to become more flexible, and less routine-conscious, with second and later babies. We found a similar trend (Table 10):

TABLE 10: *Feeding schedules for first and later children (percentages)*

	Rigid	*Flexible*	*Demand*
First babies	42	38	20
Later babies	25	22	53
All babies	32	28	40

TABLE 11: *Feeding schedules by class (percentages)*

	I and II	*III WC*	*III Man.*	*IV*	*V*	*All*
Rigid	11	42	42	13	33	32
Flexible	22	33	11	62	33	28
Demand	67	25	47	25	33	40

Social class appears to influence feeding schedules. Although it is not usual for mothers to allow demand feeding for their first baby, there is no doubt that it is more time-consuming because the day cannot be planned in advance. Mothers in social class I and II perhaps have more time to practice demand feeding. Strangely, class III Man. do not seem attracted to a flexible feeding schedule, unlike class IV, who favour it more than any other. A few mothers adhering to a rigid feeding schedule had adopted the practice of giving the baby a small amount of sweetened water if the baby cried before the feed was due.

Reactions to refusal to eat

We obtained some information regarding mothers' reactions to a child's refusing to eat; and we classified them according to the degree of "concern" they seemed to display. A typical answer of a mother classified as "very" concerned was: "She often won't eat, and it upsets me very much. I put it in the bin and we try again". An example of a "mildly" concerned mother: "I try to make him eat it, but never force him"; and of an unconcerned mother: "He can leave it if he doesn't want it". The resulting percentage distribution was as follows:

Very concerned	*Mildly concerned*	*Unconcerned*
8	38	63

Several of the mothers classified as "unconcerned" told us that the situation did not arise. Comments such as "He's a terrific eater", and "She eats everything", were common. The attitude held very generally seemed to be that the child would not starve himself, and could be depended upon to ask for food when he was ready for it. Few mothers said they would consult the doctor if their child would not eat, and few seemed worried that indulgence over food would result in a spoilt child.

Weaning

We found considerable variations in weaning patterns, our sample including a baby who was completely weaned by two months, and another of three-and-a-half years who was still having two bottles a day. Several mothers reported that their child had either regressed to, or was asking more often for, a bottle since the arrival of the new baby. In many instances the bottle was filled with milky tea. It seems that the bottle continued to provide for the child the type of comfort associated with dummies and thumb-sucking, even when he was quite used to joining in with adult meals. (For example, 27 per cent of mothers reported that they gave a bottle or dummy, or a teddy, to the child to get him off to sleep).

TABLE 12: *Proportion of babies whose weaning was completed by 6 and by 12 months according to social class (percentages)*

		I and II	*III WC*	*III Man.*	*IV*	*V*	*All*
6 months	Dublin	11	8	5	—	8	7
	Nottingham	10	9	4	1	1	5
12 months	Dublin	56	50	47	50	50	50
	Nottingham	50	47	29	21	15	31

It will be seen that there are no significant class differences in weaning in our sample, unlike Nottingham, where the middle classes tended to wean their babies earlier than the working classes. As 30 per cent of the babies in our sample were not yet weaned it is difficult to complete the picture. The follow-up study by John and Elizabeth Newson made when the children in their sample had reached four years was still unable to provide a final age limit for bottle-sucking. Unlike the English study, we did not find mothers apologetic or embarrassed when admitting that their child still used a bottle at the age of two or three: there seems no stigma attached to prolonged use of the bottle.

Dummies

Nor did we find mothers embarrassed when admitting that their child had used a dummy. Rather, it was generally assumed a normal part of the baby's equipment; and we rarely met a mother who openly disapproved of them. We did find wide class differences, but no definite pattern; and over-all fewer of the mothers provided dummies

in our sample than did so in Nottingham. (We did not include mothers who said they had tried to give their baby a dummy, but that he refused it. If these are taken into

TABLE 13: *Proportion of babies who have had a dummy at some time, by social class (percentages)*

	I and II	*III WC*	*III Man.*	*IV*	*V*	*All*
Dublin	11	83	57	37	58	53
Nottingham	39	53	71	75	74	65

account the overall percentage rises from 53 to 58.) It seemed to be entirely a matter for individual preference whether the child was given a dummy: it was not dictated by social pressures or class differences. A minority of mothers indicated that they put up with the sight of them because they were so effective; but apart from the few who definitely disapproved of dummies, the general attitude was one of permissiveness.

Diet

It was here that we found the widest, and most disturbing, discrepancies between our survey and that in Nottingham, where the Newson's reported that "on the whole, infants today are very well fed." They found 7 per cent of diets to be deficient in vitamin C, and a similar proportion deficient in protein. Only 0·5 per cent were deficient in both.

From the answers to our questions we felt we had a reasonable guide to the general components in Dublin of children's diets. All mothers were well able to remember clearly the previous day's diet, and this seemed a more reliable guide to the child's actual diet than what the mother would call a 'typical day's diet'. On the basis of the information given in their replies, we classified diets as deficient in quantity, in protein, in vitamin C, or as totally inadequate; and from this classification we found three-quarters of all diets to be deficient in some way. We were generous in our classification, taking into account the age of the child, and even the smallest amount of protein or vitamin C (as indicating the mother's appreciation of its importance).

A typically *inadequate* diet, we judged to be:

Breakfast: Porridge, tea, fried bread.
Dinner: Stew (usually potatoes and gravy), tea.
Tea: Bread, jam, tea.
Other: Biscuits. No vitamin supplement. Girl, four and a half years old.

A typical example of a diet *deficient in quantity*, we judged to be:

Breakfast: Weetabix, milk.
Dinner: Soup, potatoes, milk.
Tea: Egg, milk.
Other: Apple, ice lolly, bread. No vitamin supplement. Girl, two years old.

A typical example of a diet *deficient in vitamin C* we judged to be:

Breakfast: Cornflakes, tea, bread and butter.
Dinner: Stew.
Tea: Liver, baked beans, toast.
Other: Bread and butter. No vitamin supplement. Girl, three years and nine months.

A typical example of a diet *deficient in protein* we judged to be:

Breakfast: Weetabix, tea, bread.
Dinner: Soup, stew, tea, bread.
Tea: Cheese sandwich, tea.
Other: Apples. No vitamin supplement. Girl, almost three years old.

There is not a great deal of difference between these diets, but it is clear that they are inadequate for a child of that age. A diet we judged *adequate* was:

Breakfast: Cornflakes, toast, milk.
Dinner: Soup, chop, potatoes, milk.
Tea: Scrambled egg, yoghurt, milk.
Other: Fruit (to make up for the fact that he won't eat vegetables). No vitamin supplement. Boy, three and a half years old.

TABLE 14: *Percentage of children receiving adequate diets, by social class.*

I and II	*III WC*	*III Man.*	*IV*	*V*
78	58	42	25	8

There were significant class differences, although it is difficult to know how far the low incidence of adequate nutrition below social classes I and II is due to shortage of money, and how far to lack of knowledge of the essential components of an adequate diet for a growing child. Since two-thirds of the mothers in our sample had given some kind of vitamin supplement to their children, it is possible that many mothers providing inadequate diets did so simply because they could not afford to do otherwise. At the same time, however, we did not feel that mothers sensed the importance of a good diet. They did not hesitate or apologise when describing them. There is no doubt that, in England, the provision of Welfare orange juice and cod liver oil at reduced prices has helped to bring the importance of a balanced diet to English mothers' attention; and the high proportion of English mothers providing vitamin supplements (over 80 per cent) supports this. However, the families in our sample were larger, and we had fewer skilled workers as fathers: that is, the families in our sample had to make less money go further. Family allowances in Ireland are about a quarter of the British rate, and it is understandable that the mothers in our sample had less money available to buy nutritious food. There is no doubt that meat and vegetables are considerably more expensive than

baked beans and bread. Nevertheless, the fact remains that many of the children in our sample were not being fed properly, and in some cases were seriously malnourished. Of those mothers currently giving vitamin supplements to their children, two-fifths gave additional vitamin C (*Del Rosa, Haliborange,* etc.); a fifth gave what was described as "tonic" which seems to be a multi-vitamin preparation; a quarter gave some form of cod liver oil, and one in six gave other preparations, such as malt extract, *Invite*, etc.

In general, then, such differences between Irish and English mothers as our results so far reveal, appear to arise from a tendency for the former to bring up their children on lines suggested by convention or "instinct", rather than theory. The attitude was one of, "I do what I think is best", rather than adherence to the "right" and "wrong" of books on baby care. Mothers in Ireland seemed generally more relaxed, less influenced by the opinions of others, and less interested in what other mothers did. We saw only one copy of Dr. Spock's guide to child care; and this might partially account for smaller class differences among our sample than were found in the Nottingham study. When baby care books are read at all, middle class mothers are more likely to read them; but when less attention is paid to "expert" advice, all classes are on a more equal footing. It appears also that in Ireland there are fewer fashions or trends in principles of child rearing. The next sections, dealing with sleeping and behaviour, seem to bear this out.

II

We decided to investigate the number of hours that each child spent asleep during the 24-hour period prior to the interview, since we felt this would yield more reliable information than asking mothers for theoretical estimates. The mothers were, therefore, questioned as to the time their child had gone to bed the previous evening, and the time he had wakened in the morning. In each case the time of sleeping and waking was recorded. We supplemented this information by check questions, such as: how long it took the child to go to sleep? had he woken in the night, and for how long? and the amount of time he had spent sleeping (as distinct from "resting"), during the day. Some children had wakened early (for example, when father had gone to work, or older children to school), and were given a bottle or taken into their mother's bed to sleep again for a further few hours. In such cases the time they finally wakened was recorded.

Average Hours of Sleep

We added the number of hours each child had spent asleep in the preceding 24-hours. Dividing the ages into three groups we found a small decrease, by age, in the average number of hours of sleep required by the children.

TABLE 15: *Average Hours Sleep by Age*

Age (months)	*N*	*Average Hours Sleep*	*Maximum (hours)*	*Minimum (hours)*
12—24	30	13·7	17·0	10·0
25—36	19	13·0	17·5	11·0
37+	11	12·0	14·5	10·0

The results show wide variations in individual requirements at all ages (we assumed that the number of hours sleep any individual baby needed was identical with the number of hours he actually spent asleep). A very small proportion of the total hours sleep in 24 hours is taken during the daytime. Only 20 per cent of our children had had day-time naps compared with 95 per cent in the Nottingham survey: even in our youngest age group (12–24 months) only quarter had day-time sleeps. Three-quarters of all these naps were less than 15 minutes in duration. Our figures seem consistent, therefore, with the results of the Nottingham study, in that young children not only spend less time asleep than is generally supposed, but also a great deal less than the "normal sleep requirements" laid down by handbooks of baby care. The Nottingham study also found, like ourselves, large individual differences in sleep requirements.

Although the proportion of children in Dublin who had day-time naps, compared with that in Nottingham, is strikingly small, we did not feel this difference to be entirely due to the higher mean age of our sample, since only slightly more children (27 per cent as compared with 20 per cent of the total) in the youngest age-group had naps. All naps were shorter than half-an-hour, except for one 28-month-old boy, whose nap was 90 minutes. We therefore gained the impression that mothers in Dublin did not regard day-time naps as an essential part of a young child's routine in the way most Nottingham mothers did.

We suspect that the children in our sample were often dressed late, and not brought downstairs until late morning. We often found that the children were still in bed, and their mothers in dressing-gowns, after mid-day, even though they may have been actually awake for some time. Also, as all our mothers had given birth to another child only two or three weeks before we called, their routine was centred mainly on the new baby: if they had to feed the baby during the night they, doubtlessly, welcomed an opportunity to sleep late in the morning, and did not encourage their two and three-year-olds to rise earlier, either. The change of routine due to the arrival of a new baby may account for the fact that our children got up late, and were not often put to bed again in the afternoon for a nap.

As in Nottingham, the most usual time for going to bed in the evening was around seven o'clock—although this may be, on average, slightly earlier for Dublin children, bearing in mind that our children were somewhat older. Of the total we found that 22 per cent went after 9.00 p.m., compared with only 5 per cent in Nottingham; and none were in bed before 6.30 p.m., compared with 31 per cent in Nottingham. It is possible that these differences relate to age differences. (In these figures for late-bed-times we did not include a proportion of children who started their night's sleep in the living room and were transferred to their cot some hours later.) We found no statistical correlation between bed-time and age of child; nor, correlating bed-times with social class, did we find a statistically significant relationship.

On the whole, then, our children, age for age may have gone to bed slightly earlier than their equivalents in Nottingham; but the proportion of our children going to bed late was greater than in Nottingham, perhaps partly because our sample contained more older children.

Sleeping Accommodation

We found two-fifths of the children still sleeping in their parents' bedroom (in Nottingham, three-fifths were still sleeping in their parents' bedroom at a year old). About the same proportion shared a room, either with a brother or sister, or with sevéra

siblings. Only a fifth slept alone. In Nottingham only 14 per cent shared a room with some other person; 26 per cent were sleeping in a room alone. Such differences, of course, are not entirely the outcome of lower housing standards in Dublin, where average family size is also higher: sleeping arrangements are determined by a combination of family size and amount of accommodation. As a consequence, we found the proportion of children sleeping alone decreasing directly with descent in social class. None slept alone in the lowest social class (class V).

In some families it is customary to have a young child in the parents' room for convenience during the night, even when separate accommodation is available. It is true that the children in our sample, being older, may have had less need for comfort or attention during the night: we found some relationship between type of sleeping accommodation and age of child, showing that children sleeping with their parents were younger. Of those sleeping with brothers, two-thirds were in the younger age group; whereas of those sleeping with sisters, the same proportion were in the intermediate group (25–36 months). However, the majority of those sleeping alone were young (12–24 months); and it seems clear that factors other than age determine whether or not the child sleeps alone. In particular, it seemed likely that conventions varied with social class—partly, no doubt, because of variations in the amount of accommodation available.

Getting the Baby to Sleep

Mothers either left the child to go to sleep by himself, or stayed with him until he had settled down, or gave him some kind of comforter such as a bottle, dummy or teddy. We found that a majority, 60 per cent, just put the child to bed and left him. Only 8 per cent stayed with the child, and only 16 per cent gave him a comforter. These findings contrast strongly with those from the Nottingham survey, where, the Newsons concluded, mothers who do nothing more than just put their baby to bed and leave him are in a minority. Many authorities on baby care deprecate staying with the child, or giving him a bottle or toy to soothe him, on the grounds that it may "spoil" him. Mothers may be aware of this and may have under-reported the extent to which they give comfort and company to their children at bed-time. However, we found many examples of mothers who adhered strictly to advised practice.

Although the age of the child influenced them to some extent, we were given the impression that mothers had a casual attitude to bed-time procedure. Some were genuinely surprised when we asked probing questions about soothers, etc. Their response was typified by one mother who said, "Ah no, I just leave him, that's all." A few had a more positive attitude to bed-time, which they regarded as an important event, especially as the father could often be present; and they took pains to make sure that the child would sleep quickly and with a minimum of fuss.

Widely differing procedures were adopted when the child failed to sleep after being put to bed; but we were able to distinguish three main types: mothers who go up to the child, those who bring him down, and those who ignore him. About a quarter of the mothers said that the problem did not arise. In all classes the most common way of dealing with the problem was to bring the child down to the living room; the second was to go up to him, least favoured in social class I and II. The Nottingham researchers distinguished between rigid and permissive mothers in this respect. The rigid mother leaves the child to cry himself to sleep, come what may. Indulgent mothers soothe the child to sleep as described; but if he really cannot sleep they bring him down to rejoin the family. The practice recommended by "experts" is to take a firm line; and some

mothers also see the situation as a clash of wills in which they must be victorious if the child is not to become spoiled. It is for this reason that they prefer to go up to the child, rather than "give in" by allowing him to come down.

Most parents with young children experienced some disturbed nights. We found that 20 per cent of our children had wakened in the night prior to the interview, mainly for 15 minutes or less; few were awake for longer than half an hour. It is impossible to compare our figures directly with those of the Nottingham survey; but of our children aged between 12–24 months, 23 per cent wakened during the night, compared with 35 per cent of one-year-olds in Nottingham.

Crying

Crying is an important form of expression for young children and it may provoke strong maternal reaction. Many mothers, who had at first said it did no harm to leave their child to cry, added that it would not be for long because that they "could not stand the sound". We felt that the first reaction to be mere repetition of current medical advice, whereas the second was a statement of what they actually did, and a reflection of their true feelings. But we felt it necessary to obtain a definite indication of the maximum amount of time each mother would leave her baby. We also added (like the Nottingham researchers) the phrase, . . . "if you thought there was nothing wrong," in order to give hard-hearted mothers an opportunity to tell the truth, and the soft-hearted an opportunity to say that children do not cry without a reason. Restrictive mothers tend to interpret crying as a child's bid for attention which should not be indulged. Permissive mothers regard crying as an important form of communication which needs to be responded to.

We found that nearly 60 per cent of the mothers said that it did no harm to leave a baby to cry; the remainder said it was harmful. However, at least two-thirds do not leave their own children to cry for more than fifteen minutes.

TABLE 16: *Length of time mothers left their babies to cry*

Time	*N*	*%*
Up to 15 minutes	36	60
Over 15–20 minutes	10	7
Over 30 minutes	3	5
No time—do not leave	5	8
Until stops crying	6	10
Total	60	100

The majority of mothers in all social classes do not leave their children to cry for long, although mothers who left the children until they stopped were roughly three times as common in class I and II as in the classes below this. This class also showed a tendency, if the child were ultimately picked up, to leave them crying for longer periods before this was done. In short, it seems that most mothers left their children for 30 minutes or

less, and that proportionately more do this in the lower than in the upper social classes. Upper class mothers are perhaps more conscious of the advice on the subject offered by handbooks of childcare, and other sources of expert guidance, and wish to follow it. It was commonly believed by our mothers, as among those in Nottingham, that it is more harmful to leave boys to cry than girls, the former being liable to rupture. However, we found no difference in the actual practice of mothers: boys and girls appear to be treated similarly. Some mothers felt that it was positively good for children to have a good cry: "It airs their lungs," one of them said.

The reactions of mothers to their children's crying were classified into four groups: mothers either took them up, left them, fed them or gave them a dummy. Where the crying was judged to be serious, only 2 per cent would ignore it. Nearly nine mothers out of ten would take up their children, 10 per cent gave him a feed, and about 2 per cent a dummy. Some mothers distinguished between crying in temper (which they said should be ignored), and crying in distress (which needs comforting).

Temper Tantrums

By one year children are becoming mobile and beginning to explore their environment. In doing so they frequently meet frustrations, and express their resentment and anger through tantrums. In all social classes in Dublin more boys than girls have tantrums; and there may be a greater overall incidence of them in social class V. Only a quarter of our mothers reported no tantrums at all, compared with approximately half the Nottingham mothers. Methods of dealing with tantrums (as reported by our informants) were readily grouped into six categories: slap, ignore, remove, admonish, deprive, give in. Slapping is common in all classes, but perhaps especially so in the middle and upper, and in social class V. Ignoring is a more popular punishment with the higher classes than with classes IV and V. Admonishment appears to be particularly common in class V. If it is permissible to generalise from our limited data, therefore, it seems that social class V mothers prefer to slap or scold their children when they have a tantrum; while upper class and class III mothers on the other hand, as well as favouring slapping, try to ignore tantrums. Possibly these mothers are more influenced by expert advice (which recommends ignoring) and have more energy and time to tolerate tantrums. On the other hand, the only mothers in our sample who capitulated to tantrums were from social class III, white collar and manual.

The most common circumstance provoking tantrums was one in which the child failed to have his own way. Several mothers noted that tantrums had been more frequent than usual since she had returned from hospital. Tantrums also occurred frequently when older children returned from school—a situation often provoking jealousy and anger in a younger child.

Punishment and Naughtiness

Some mothers believed that a child of a year or so cannot be "naughty"; others consider as "naughty" an act of deliberate misbehaviour. The former were more permissive generally in their methods of upbringing, compared with those mothers who believed a child capable of "naughtiness" at any age, given the opportunity (about two-thirds of our sample).

We asked mothers what kind of punishments they administered to their children when they were "naughty", classifying their answers according to whether they

slapped, deprived, removed, admonished or gave no punishment. The commonest form of deprivation was of food. Removal simply meant putting the child in another room, or otherwise away from the "scene" of the offence. The distribution of types of punishment given was highly scattered, the only striking feature being that slapping was common and popular in all classes. Apart from punishment for "naughtiness", four mothers out of five reported slapping their child frequently, although slapping usually meant a tap: we had the impression that few mothers beat their children. One unemployed labourer's wife said that slapping only made them worse; but in general very few mothers thought slapping within reason harmful. A few said they occasionally lost their temper if their child had persistently annoyed them and precipitated a crisis (such as spilling a bag of flour); and in these circumstances they might slap hard, more to relieve their own feelings than to help the child.

There was no dominant reason for "naughtiness" reported by our sample: destructiveness, inquisitiveness, selfishness, rudeness and disobedience were all fairly equally mentioned. No doubt problems of definition had something to do with this. Such class differences as appeared were small and statistically dubious; but there appeared to be some tendency for "destructiveness" to be reported more often in class I and II, while "inquisitiveness" was never mentioned by class V mothers. Our data are too few, however, to justify any generalisation on the subject.

It was evident, then, that practically all the children were subjected to controls and character training from an early age. Restrictive mothers thought some "pain" inevitable in childhood for the child's own good: a child should not be allowed to "get away with things"; otherwise he will become unmanageable and spoilt. Permissive mothers, on the other hand, tried to avoid circumstances in which trouble was likely to arise. They "coaxed him out of situations", and blamed themselves when things went wrong, feeling that a child cannot understand punishment at an early age. We gained the impression that, in general, our mothers were fairly permissive. This characteristic seemed a natural one, perhaps passed down from grandparents, rather than learnt from the advice of contemporary baby-care handbooks and other sources of liberal child-guidance.

Toilet Training

We asked mothers whether they were taking particular trouble to get their child toilet-trained at the period of the interview; and we rated them accordingly as very or mildly concerned, and unconcerned. (Some children were reported to be completely trained already.) The resulting distribution may be seen in Table 17. Analyses by social

TABLE 17: *Mothers' concern with toilet training*

	N	%
Very concerned	10	17
Mildly concerned	17	28
Unconcerned	18	30
Trained	15	25
Total	60	100

class, and by the child's age, were somewhat inconclusive, owing to the small sample; yet they suggested that concern is greater among the middle classes than among the lower, even though toilet-training appears to be completed, on an average, later among the middle classes—as, indeed, among class V, the lowest social class. Possibly mothers in the latter class, having larger families, have less time and energy to conform exactly to prescribed recommendations on toilet training, even if they are aware of them. On the other hand, upper class mothers may be more liberal in executing these recommendations.

The general consensus was that children should ideally be trained between the ages of $1\frac{1}{2}$–2 years. The mean age of toilet training in our sample was, in fact, 1 year 11 months. The Newsons warn that reports of children's milestone achievements are likely to be remembered in a favourable light. However, we felt that the warning might apply less strongly in our survey. Irish mothers appeared less conscious of a norm in this respect, and are certainly less concerned about adhering to one.

Fathers' Participation

It is commonly believed that Irish fathers are uncooperative in the home, because their upbringing in large, matriarchal, often rural families differentiates sharply between sexual roles, and emphasises a division of labour based largely upon sex. It is, therefore, to be expected that men will view their role in family life as exclusively that of bread-winner, and will prefer the company of male companions in the pub to an evening at home.

We found no evidence to support this view. Indeed, we were impressed by the extent to which the husbands in our sample participated in domestic activities and family life. One mother (a sheet metal worker's wife), summarises our findings in commenting: "A lot of girls I know around here say they want to marry Englishmen, but I didn't—Irishmen are good with the children. . . ." In slightly less than 20 per cent of our cases could it be said that fathers participated very little, or not at all, in domestic matters; and this appeared to be the case in all social classes.

TABLE 18: *Proportion of fathers undertaking various activities in the care of their children (percentage)*

	Feed him	*Change nappy*	*Play with him*	*Bath him*	*Get to sleep*	*Attend in the night*	*Take out alone*
Frequently	63	40	83	36	72	58	62
Sometime	12	23	10	59	22	25	20
Never	25	37	7	5	7	17	18

It is true that activities like playing with the child or getting him to sleep are most popular amongst fathers, who participate less in changing nappies, in feeding, in bathing or even attending to them at night. Nevertheless, the proportions doing these things remain considerable. The number of fathers taking out children alone is striking in view

of the belief that men do not like being seen walking with a pram. Apparently they are less concerned about this than is imagined.

Going Out

About half the sample of mothers went out at least once a week; slightly less than 10 per cent claimed they never went out at all for relaxation with their husbands, the majority of these from class V. Otherwise there was little apparent class differentiation in the frequency.

No clear-cut reasons emerged why some couples went out and others did not. In a few cases financial hardship was undoubtedly a cause preventing it; in several, the mother said that she could not be bothered, and preferred staying at home. If middle class mothers value the opportunity to accompany their husbands on social and cultural occasions, working-class mothers may be equally content to watch television, and indeed may find the role of motherhood satisfying in itself to the extent that they do not look beyond to other interests. In Nottingham the Newsons concluded that working-class mothers are also likely to be more distrustful of babysitters. In Dublin relatives are greatly preferred to paid babysitters in all social classes.