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Social Factors Associated With the Decision to Relinquish a Baby For Adoption

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Abstract

Little is known about the characteristics, social circumstances and mental health of women who give a child up for adoption. This paper reports data from a longitudinal study of 8556 women interviewed initially at their first obstetrical visit. In total, 7668 proceeded to give birth to a live singleton baby, of which 64 then relinquished the baby for adoption.

Relinquishing mothers were predominantly 18 years of age or younger, in the lowest family income group, single, having an unplanned and/or unwanted baby and reported that they were not living with a partner. These women were somewhat more likely to manifest symptoms of anxiety and depression both prior, and subsequent to, the adoption, but the majority of relinquishing mothers were of 'normal' mental health. The decision to relinquish a baby appears to be a consequence of an unwanted pregnancy experienced by an economically deprived single mother rather than the result of emotional or psychological/psychiatric considerations. These findings document a particular dimension of the impact of poverty on health.

Introduction

Despite recently expressed concerns about the health needs and mental status of mothers who give up a child for adoption^{1,2} there is a remarkable absence of community data which would enable us to understand the social factors underlying the mother's decision or its likely consequences. The factors influencing a mother to give up her child are likely to have changed in recent times, with a decline in adoptions in Australia from over 5000 in 1977 to 2294 for the year ended June 1985³. Of all Australian babies adopted, the majority are adopted well after the child has left hospital. Most of these post-hospital adoptions involve an adopting parent who is a relative of the parent relinquishing the child.⁴ Consequently, relinquishing a baby almost immediately after birth represents a special case and is the result of a unique combination of factors. It is probable that many mothers not wishing to have a child would terminate an unwanted pregnancy, while those proceeding with the pregnancy and adoption may do so for one or more of a number of reasons. Firstly, they may have religious beliefs which deny the option of an abortion. Secondly, they may vacillate over the decision to terminate or not realise they are pregnant until it is too late. This might be a consequence of a confused emotional state occasioned perhaps by marital or related difficulties. Thirdly, they may find their circumstances have changed since they first became pregnant (for example they have separated from their partner) and they no longer wish to have a child. Fourthly, they may be unaware of agencies or clinics offering terminations.

While the above possibilities are interesting, little is known about their relevance for the majority of women who give up their babies for adoption. The data available also suggest that these women have a high risk of subsequent emotional problems^{5,6} which may continue for decades after the original decision.² This paper only considers the economic and social characteristics and short-term mental health changes experienced by such mothers. This report takes data from the Mater-University of Queensland Study of Pregnancy (MUSP) to identify the demographic and social circumstances of mothers relinquishing a child at a large Brisbane

public hospital. Using longitudinal data it also examines the mental status of these mothers prior, and subsequent to, the adoption procedure.

Background

A computer search of the previous literature has identified only two prior Australian studies^{1,2} and several overseas studies. None of these studies enable us to understand the combination of factors which lead a woman, in a contemporary western industrial society, with reasonable social service benefits, to give up her child.

Previous studies have concentrated on the mental health^{1,2,6} and demographic characteristics of relinquishing mothers^{1,7,8} and are characterised by small, unrepresentative samples. Most report cross sectional data with a reliance on retrospective reports by mothers of their prior mental health and feeling about becoming pregnant. Such reports are likely to be of uncertain validity.

Demographic Trends

Australia, like many other developed countries, has experienced a number of demographic changes which may be pertinent to understanding the factors influencing a mother to relinquish a child. Thus there has been a steady decline in the fertility rate at all ages, but particularly in the youngest age groups. Despite this the proportion of all births which are classified as ex-nuptial has increased dramatically.⁹ The median age of mothers giving birth to their first child has also steadily increased since the beginning of the 1970s.³ Indeed since 1976 in Australia the rate of reproduction has been below that needed to replace the population, and has continued to fall.³

Reasons for Relinquishing a Child

Despite the numbers involved in the adoption process in Australia, data on the correlates of adoption are almost non-existent, perhaps because such mothers are not normally identifiable. There are, however, some American and British studies which are suggestive. The pertinent factors they identify fall into two categories, those focusing on socio-demographic factors and those which are situational and reflect a specific social and/or psychological process.

Pertinent socio-demographic factors influencing relinquishment include the mother's age, marital status and religion. Thus a Los Angeles study suggests that 41 per cent of mothers giving up a child were 19 years of age or younger⁷, while two other U.S. studies simply identify youth as a factor.^{8,10} Similarly, these studies note that single mothers are over-represented in such groups. Here, of course, it is difficult to know whether age and marital status are themselves important in the decision making process or whether a third variable (for example, poverty) contributes to or determines the final decision. Thus it would not be unreasonable to suggest that young, single mothers are generally poor and that such mothers may choose to relinquish a child for largely economic reasons. Not surprisingly, Catholic¹⁰ and Baptist¹¹ women appear to more often relinquish, perhaps because they feel more compelled to proceed with a pregnancy which other women might have terminated.

Situational factors influencing relinquishment also involve a variety of potentially interacting variables. Presumably the most important of these is likely to be unplanned and/or unwanted pregnancy¹⁰, although it has been argued that relinquishing mothers may be emotionally or psychiatrically disturbed.¹² Unfortunately previous studies examining the above possibilities have not specified the magnitude of effect attributable to situational factors.

In sum, a relatively small and diminishing proportion of women are choosing to give up their babies for adoption. While young, unmarried mothers proceeding with an unwanted

pregnancy appear to have the greatest likelihood of relinquishing a child, such Australian community data have not been previously available and are therefore the subject of the following analysis.

Methods

This analysis was based upon the Mater- University of Queensland Study of Pregnancy (MUSP), details of which have appeared elsewhere.¹³ The details of 8556 consecutive pregnancies presenting at a large public hospital in Brisbane were obtained. The criteria for the inclusion of cases in this analysis were:

- that the mother gave birth to a single child which left the hospital in a live state; and
- that data was available for some (but not necessarily all) variables. Some women thus may have declined to answer some questions, or in a few instances, refused to respond to a whole questionnaire — but participated and provided other data. Cell frequencies will consequently vary marginally from table to table.

Overall there were 8556 women invited to participate in the study. Of these there were 83 who declined to participate at their first clinic visit, a further 13 who returned an uncompleted enrolment questionnaire and 2 whose language skills were inadequate. Altogether 781 women did not give birth to a singleton child at the hospital (some of the above are refusals and multiple births). Of the 781 women 342 were cases transferred elsewhere and a further 143 were lost to follow-up. There were 171 recorded miscarriages and 60 multiple births, 40 cancellations and 25 others lost to follow-up.

Excluding stillbirths and neo-natal deaths, there remained 7691 children known to be alive one month after the birth. The decision to exclude neo-natal deaths follows the observation that these children may have been moved to intensive care and, in some cases, were not able to be adopted or taken home by parents.

In total 64 children were adopted out, 61 before leaving hospital and another three subsequent to their hospital discharge. Of the 7691 children for whom data or disability/handicap data was available, there were five adoptions (out of 64) in the handicapped group (7.8 per 100) and 59 adoptions (out of 7691) in the 'normal' group (0.8 per 100). Data were obtained on five separate occasions. Firstly, mothers were invited to complete a questionnaire at their first clinic visit, then a second questionnaire a few days after the birth and a third some six months later. A fourth questionnaire and child health assessment was administered at the five year follow-up. Details of the mothers' medical and obstetric history were extracted from the medical record and comprised the fifth data source. As adoption status is derived from the hospital record, and mothers giving a child up for adoption were excluded from post-hospital follow-up, the data are necessarily limited to the first two questionnaires and the medical record.

Measures Used

To determine the size and strength of social networks, a shortened modified version of the ISSI^{14,15} was used. Eight items of the type "flow many of your relatives do you see regularly?" comprised the size-of-network scale, with a .8 Cronbach alpha reliability coefficient. A similarly derived four item adequacy of social network scale, for example, "Do you wish that you could see your relatives more often than you do?" had a .66 alpha reliability coefficient.

Dyadic or marital, adjustment was assessed using a modified subscale of the Spanier^{16,17} Dyadic Adjustment Scale. This Spanier scale has been found to have criterion and construct validity, correlates well with other similar scales, and the version used in this study had a .89 Cronbach alpha reliability coefficient. Typically these items seek information about

the perceived adequacy of the dyadic relationship, whether partners fight with each other, confide in each other, quarrel or “get on each other’s nerves”.

Two indicators of the wantedness of the child were used. The first resulted from a four item scale developed by us which sought responses to how the mother reacted to the news when she first learnt she was pregnant (for example, “I would have preferred not to become pregnant”). This scale produced a .85 alpha. The second indicator was also developed by us and was a four-item index (reduced from 5) which sought information about whether the pregnancy was planned or wanted or resulted from a failure of contraception. For these two measures the sample was divided into three groups:

- those women who reacted negatively or positively (or fell in between) to the news they were pregnant;
- those women who had an unplanned/unwanted pregnancy and were unsure about whether it was wanted; or
- had planned/wanted the current baby.

Subjective stress was assessed using the Subjective Stress Scale¹⁸ developed initially as part of the international cooperative study of heart disease. It is claimed to have face validity and measure subjective aspects of stress. It also correlates highly with other indicators of psychosomatic stress. It comprised items like “My daily activities are extremely trying and stressful” and had a .84 Cronbach alpha reliability coefficient.

Mental health was addressed using a measure developed by other researchers, namely the Delusions -Symptoms-States-Inventory of Bedford and Foulds¹⁹ (also see Foulds)²⁰. This scale was developed by psychiatrists whose conception of mental illness is based upon the extent to which such symptoms interfere with, or limit, day-to-day functioning. Validation studies of a number of types have been conducted including, comparisons of experts’ ranking of symptoms, the demonstrated capacity of the scale to distinguish between institutionalised and normal samples and the hierarchical/metric properties of the scale²¹⁻²⁴

Findings

Table 1 presents the rate of relinquishment for women with varying socio-demographic characteristics. Young women (under 18 years of age), lowest income women, single women (either at first clinic visit or after the birth), have the highest rates of relinquishment. The mothers’ educational level and religion appear to be unrelated to the rate of giving a baby up for adoption.

The factor (Table 2) which has the strongest association with relinquishment is the mother’s report (early in pregnancy) that she had no partner (both early in pregnancy and shortly after the birth). This latter finding is partly a reflection of the mothers’ marital status, although it appears to identify a sub-group of unmarried (single) women who are living alone. Of the 64 mothers who gave up a child, 53 described themselves (at the first clinic visit) as not living with a partner, while 45 so described themselves after the birth.

Table 3 examines a number of stress and mental health problems as these relate to the decision to relinquish a child. Women whose first reaction to the news of their pregnancy was negative had a particularly high rate of subsequently relinquishing their child (between 33 times and 150 times more likely to relinquish — 95% confidence limits). Women who were stressed or anxious or depressed at the first clinic visit were more likely to relinquish, though these effects were relatively minor.

Table 4 presents the results of a seven variable logistic regression model which includes the mothers’ age, family income, marital status, first reaction to the news of the

pregnancy, whether the pregnancy was planned/wanted and dyadic adjustment and depression of the partners at the first clinic visit. The two factors which provide the strongest independent prediction of subsequent relinquishment are, the mother's report, early in pregnancy, that her first reaction to the news she was pregnant was negative and, her marital status.

Table 5 examines the association between the mothers' mental state (anxiety and depression) and relinquishment. While mothers who are anxious and depressed at the first clinic visit do manifest higher rates of relinquishment, it is clear that these effects are relatively modest and that the vast majority of relinquishing mothers are neither anxious nor depressed. Further, when the respondents are assessed after the decision to give up the baby, they appear overwhelmingly normal, Only 10 of [he relinquishing mothers scored moderate or high on the anxiety scale, and 6 mothers scored moderate or high on the depression scale after relinquishing the child. On the basis of these findings it appears that mental illness is neither a precursor nor consequence of the decision to relinquish a. baby, for the vast majority of women making such a decision.

TABLE 1

Rate of children given up for adoption by demographic characteristics of mother
(Rate per 1000 Pregnancies)

	Rate (Total pregnancies)		Odds of giving baby up for adoption (95% Confidence Limits)
Age (in Years)*			
18 or less	48	(608)	(4.4 - 13.1)
19 to 25	6	(3833)	1.0
26 to 34	3	(2764)	(0.2 - 1.0)
35 or more	5	(397)	(0.2 - 3.4)
Family Income*			
\$5199 or less	46	(538)	(7.3 - 28.2)
\$5200 - 10399	7	(1942)	(0.9 - 4.3)
\$10400 - 20799	3	(3837)	1.0
\$20800 or more	5	(755)	(0.5 - 4.8)
Mother's Education**			
Less than Grade 10	5	(1413)	(0.3 - 1.3)
Grade 10 or 12 completed	8	(4816)	1.0
College/Business etc	9	(1117)	(0.5 - 2.1)
University	16	(190)	(0.6 - 6.1)
Mother's Religion**			
Roman Catholic	10	(2123)	(0.6 - 2.1)
Church of England	9	(2241)	1.0
Agnostic or Atheist	8	(1038)	(0.4 - 2.0)
Other Christian	6	(1656)	(0.3 - 1.4)

* Chi square $p < .001$

** Not significant

TABLE 2

Rate of children given up for adoption by social network affiliations reported by the mother
(Rate per 1000 Pregnancies)

	Rate (Total pregnancies)	Odds of giving baby up for adoption (95 % Confidence Limits)
Marital Status at FCV***		
Single	64 (825)	(34.7 - 266.4)
Living Together	4 (883)	(1.6 - 25.5)
Married	1 (5607)	1.0
Separated/Divorced/Widowed	10 (210)	(2.4 - 73.9)
Marital Status at Child's Birth***		
Single	66 (677)	(47.6 - 813.2)
Living Together	4 (842)	(1.6 - 59.2)
Married	0.4 (5530)	1.0
Separated/Divorced/Widowed	30 (168)	(16.3 - 440.3)
Size of Social Network**		
Large Social Network	4 (2401)	(0.2 - 1.1)
Some Friends/Relatives	8 (2760)	1.0
Few Friends/Relatives	10 (1736)	(0.8 - 2.0)
No Friends/Relatives	13 (380)	(0.7 - 3.1)
Perceived Adequacy of Network**		
Networks Adequate	4 (2081)	(0.2 - 1.1)
Partly Adequate	8 (4334)	1.0
Networks Inadequate	11 (818)	(0.6 - 2.8)
Dyadic Adjustment at FCV***		
No Partner	94 (342)	(19.0 - 59.6)
Poor Adjustment	32 (124)	(3.7 - 32.3)
Moderate Adjustment	6 (517)	(0.6 - 6.4)
Good Adjustment	3 (6549)	1.0
Dyadic Adjustment at Birth***		
No Partner	94 (427)	(26.3 - 93.4)
Poor Adjustment	0 (54)	-
Moderate Adjustment	4 (518)	(0.4 - 8.3)
Good Adjustment	2 (6243)	1.0

*** Chi square $p < .001$

** Chi square $p < .01$

* Chi square $p < .05$

FCV= First Clinic Visit

** = Not significant

TABLE 3

Rate of children given up for adoption by stress and mood problems reported by the mother
(Rate per 1000 Pregnancies)

	Rate (Total pregnancies)	Odds of giving baby up for adoption (95% Confidence Limits)
First Reaction to Pregnancy***		
Negative	92 (304)	(32.9 - 150.4)
Equivocal	26 (1016)	(8.5 - 38.9)
Positive	1 (6244)	1.0
Pregnancy Planned/Wanted***		
Unplanned/Unwanted	23 (1468)	(9.7 - 102.7)
Unsure	12 (1956)	(5.0 - 54.9)
Planned/Wanted	1 (3988)	1.0
Subjective Stress at FCV**		
No Stress	8 (5068)	1.0
Mild Stress	8 (1936)	(0.7 - 1.6)
Moderate/Lot Stress	8 (488)	*
Subjective Stress at Birth™		
No Stress	7 (5646)	1.0
Mild Stress	7 (1380)	*
Moderate/Lot Stress	19 (270)	(1.0 - 6.9)
Anxiety at FCV**		
Nil/Mild	7 (6690)	1.0
Some/Lot	15 (857)	(1.1 - 3.9)
Depression at FCV***		
Nil/Mild	7 (7154)	1.0
Some/Lot	28 (363)	(2.0 - 7.8)
Anxiety at Birth**		
Nil/Mild	7 (6602)	1.0
Some/Lot	14 (705)	(1.0 - 4.2)
Depression at Birth***		
Nil/Mild	7 (7066)	1.0
Some/Lot	25 238	(1.6 - 8.7)

*** Chi square $p < .01$

** Chi square $p < .05$

* Unable to calculate

FCV= First Clinic Visit

™ = Not significant

TABLE 4

**Prediction model of factors influencing mothers to offer their children for adoption
(Catmod Analysis)**

	Chi-Square	(df)	p-Value
Age of Mother	0.8	(1)	.38
Family Income	1.2	(1)	.28
Marital Status at Birth	22.8	(3)	.01
First Reaction to Pregnancy	31.2	(2)	.01
Whether Pregnancy Planned/Wanted	3.0	(2)	.23
Dyadic Adjustment at First Clinic Visit	4.6	(3)	.20
Depression at First Clinic Visit	0.2	(1)	.64

TABLE 5

Mental state of mothers at first clinic visit (FCV) and shortly after the birth by adoption State
Mental health was assessed using the short form of the DSSI of Bedford and Fouids, 1983.

	Percent of all Adoptions	Percent of all Births
Anxiety at FCV		
Nil/Some	79	89
Moderate/High	21	11
Depression at FCV		
Nil/Some	84	95
Moderate/High	16	5
Anxiety at Birth		
Nil/Some	82	90
Moderate/High	18	10
Depression at Birth		
Nil/Some	89	97
Moderate/High	11	3

FCV = First Clinic Visit

Discussion

In a world experiencing what some have labelled “rapid social change”, it is interesting to focus on one specific behaviour — the decision to proceed with a pregnancy but then immediately relinquish the baby for adoption. Prevalent social trends show that an increasing proportion of births are ex-nuptial. Further, social service benefits are available to mothers in such circumstances thus apparently limiting their economic need to give up the child for adoption. There has consequently been a decline in the availability for babies for adoption.

Mothers who proceed with the pregnancy and give up their babies for adoption after the birth are disproportionately young (under 19 years of age), poor, without a partner and comprise women who predominantly reacted negatively to the news that they were pregnant. Interestingly they are not more likely to report their religion as Catholic, perhaps reflecting the general decline in the influence of the major religious groups in contemporary society.

In interpreting these findings a number of qualifications and caveats should be considered. Firstly, our sample is not representative of all pregnancies but is limited to that approximately 50 per cent of pregnancies in Brisbane which are delivered in a public hospital facility. It is possible to speculate about whether similar results might have been obtained had the study included patients of private obstetricians. One could reasonably suggest that such women would find it easier than their public counterparts to obtain a termination for an unwanted pregnancy (such terminations are not permitted in public hospitals in Queensland). Further, private patients are wealthier and are likely to have better control of their fertility (probably fewer unwanted pregnancies). Clearly our results cannot be generalised beyond that sector of the obstetrical population which obtains its care from public hospital facilities. Despite this qualification it would seem reasonable to suggest that, in view of our findings, relatively few patients of private obstetricians are likely to give up their babies for adoption.

Secondly, it is pertinent to reflect on the possibility that factors other than those we have measured may influence the decision to relinquish a baby. It is likely that a variety of interpersonal, social and cultural factors, not included in this study, might further contribute to our understanding of the decision to relinquish a baby.

We have noted that relinquishing mothers are younger, poorer and less often in a continuing relationship with the father. Other data we have suggests that relinquishing mothers more often manifest a lifestyle which is likely to negatively impact on the health of the baby. Thus 45.3 per cent of relinquishing mothers have their first clinic visit in the third trimester (compared to 11.1 per cent of non-relinquishing mothers). Differences in substance abuse and other lifestyle variables are also apparent. Despite these differences our results suggest that while relinquishing mothers share certain characteristics, there are many mothers with these same characteristics who do not give up their babies for adoption. While we have identified the common features of relinquishing mothers it remains for other studies to document the more detailed multifaceted nature of the decision- making process.

Thirdly, the results relating to the mental health of relinquishing mothers warrants some elaboration. It could be suggested that well known endocrine changes occasioned by childbirth (for example, leading to post-natal depression) raise questions about the appropriateness of measuring the mental health status of the mother a few days after the birth of her child. While there is some substance to this argument our results show that, for our sample as a whole, mental health changes over the period from first clinic visit until after the birth and from after the birth until the six month follow-up, are minor. In general the mental health of women remains more or less similar for the one year period from first clinic visit until the six month follow-up. Thus any changes occasioned by the decision to relinquish could be expected to produce a significant shift in mood. Such a shift is simply not observed.

While our data confirm the suggestion in earlier papers that a proportion of relinquishing mothers are more emotionally disturbed, such an observation has limited clinical relevance because only a small proportion of relinquishing mothers manifest symptoms of mental illness and mothers who were more emotionally disturbed prior to the relinquishment, were more likely to subsequently give up their babies. There is little evidence that mothers relinquishing a baby are mentally or emotionally disturbed around the time the baby is relinquished.

Conclusion

Many women are in social categories or report circumstances which are likely to increase their willingness to give up a child for adoption. Clearly extreme youth, poverty, an absence of a partner and an unwanted/unplanned pregnancy may all contribute to a decision to relinquish a child. Yet the data indicate that the vast majority of women reporting these 'disadvantages' proceed to keep the child at least until after they have left hospital. Indeed the majority of the small group of women who manifest any or even all these disadvantages together do not relinquish the child.

The data provide two practical implications and raise one interesting question for those concerned with issues of adoption and its consequences. Firstly, the mothers who give up a child for adoption appear to be responding rationally to the problems they are likely to face if they keep the child. Secondly, some of the possibilities raised in the literature (the importance of religious beliefs, mental and emotional causes and consequences of relinquishment) appear to be relatively unimportant when compared to other basic economic and social disadvantages.

Of interest however is the finding that despite the accumulated impact of a number of disadvantages, the majority of even the extreme group proceed to leave hospital with the child. Do these mothers subsequently relinquish? If they keep the child, how effective are they as childbearers? Do these children subsequently disproportionately experience neglect and manifest antisocial behaviours? While this paper has been limited to factors influencing the decision to relinquish, it is apparent that the longer term consequences of such factors may be of considerable interest as well.

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