Patterns of Proceptive Behavior

In a Non-Clinical Sample

Of Married Couples

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Abstract

The objective of this paper is to describe patterns of proceptive behavior (where the goal is to achieve conception) practiced by husbands and wives in a non-clinical sample. Individual men and women from 401 married couples were interviewed in their homes about any efforts to achieve conception during the previous 12 months and then reinterviewed by telephone 1 and 2 years later. Analyses of covariance indicated that the proportion of respondents reporting each of thirteen specific proceptive behavior varied by sex, parity, and duration of proceptive effort. The proportion of respondents reporting most of the proceptive behaviors tended to increase as their proceptive effort continued without success. Women reported higher levels of some behaviors. Individuals with one child demonstrated a "giving up" effect after two years of unsuccessful proception and, for certain behaviors, a "slow start" effect at the beginning of their proceptive efforts. Cluster analyses indicated three primary clusters of proceptive behaviors. These three clusters appear to represent natural behavioral repertoires that may be used by contemporary U.S. married couples to facilitate the occurrence of conception.
Introduction

Successful species have well developed, redundant mechanisms – or regulatory systems – which ensure that each generation reproduces itself. In higher animals, these systems are by no means entirely biological, containing important behavioral and psychological, dyadic, and social components as well. Among the more complexly organized higher animals, including monkeys, great apes, and humans, these mechanisms depend heavily upon two separate and largely independent systems: sexuality and parental responsiveness. These two systems, which include both motivational and behavioral components, operate in tandem to promote reproduction. First, the sexuality system tends to result in conception. Once that has occurred and been followed by a birth, the parental responsiveness system tends to result in caretaking and protection during the offspring's growth and development. Thus these two systems act in concert to promote and regulate ongoing reproduction.

Humans are almost certainly unique among the higher animals in that they recognize the causal relationship between sexual intercourse and the subsequent occurrence of conception and, ultimately, birth. As a result of this awareness, two new categories of reproductive psychology and behavior commonly become important in human societies. The first category is contraceptive behavior in which the goal is to block the natural link between sexual activity and conception. Literally this is behavior that is "contra" (against) conception. The second category is proceptive behavior in which the goal is to facilitate the natural link between sexual activity and conception. Literally this is behavior that is "pro" (in favor of) conception.
Although a great deal of research has been focused on contraceptive behavior, almost none has been focused on proceptive behavior, an unfortunate fact because both are clearly important for optimum family planning. In previous publications,\textsuperscript{2,3,4} Miller has discussed the conceptualization of proception as an aspect of human reproductive behavior, demonstrated that respondents in a U.S. study readily understand interview questions about it and can provide both reliable and valid data in their responses, and showed empirically that proceptive behavior is a central and critical concept for understanding the link between childbearing motivations, desires, and intentions on the one hand and the occurrence of conception on the other.

This earlier work focused almost entirely on proception as a general category of behavior, the purpose of which is to conceive and bear a child. However, there are a variety of specific proceptive behaviors that people, both individually and as a couple, pursue in order to achieve their goal of achieving pregnancy. This paper will focus on the most commonly reported specific proceptive behaviors, with special emphasis on reporting how each one varies by sex, parity, and the duration of the proceptive effort. Because the respondents studied in this paper were not selected from a medical setting or as a result of some infertility problem but rather represent an area probability sample drawn for a research project focusing on the psychological aspects of human reproduction, the results reported here describe patterns of specific proceptive behaviors as they occur naturally in a non-clinical population.
Methods

We collected the data for this paper during a longitudinal study of childbearing motivation and its effects in 201 parity-zero married couples (i.e., those with no children) and 200 parity-one married couples (i.e., those with one child). All of these couples were residents of Santa Clara County, California, a largely urban and suburban area situated on the southern half of the San Francisco Peninsula and encompassing the city of San Jose. This area includes "Silicon Valley" and is dominated by technology and service industries.

We conducted sampling by identifying residential areas within each of ten cities in the county and selecting socially diverse and geographically dispersed block groups from each of these areas. We then used a reverse telephone directory to screen all residences within each block group for eligible couples. To be eligible a couple had to be currently married and living together and have zero or one child. The wife could not be currently pregnant and had to be age 18 through 39. Neither spouse could be sterilized and both had to speak and read English fluently. Of the 741 couples who were eligible at the initial telephone screening, 18.5% refused to participate at the time of screening, 7.3% were found to be ineligible after both spouses were further screened, and 18.5% refused to participate after both spouses discussed participation.

Each spouse was interviewed separately and privately during an initial face-to-face interview and then again one and two years later during two telephone follow-up interviews. Additional information about the purpose, design, and methodology of this study is available in other publications.\textsuperscript{5,6}
For our purposes here, we will limit our focus to a set of questions asked during the initial and two follow-up interviews about whether and, if so, how the respondent had tried to achieve conception during the previous 12 months (initial interview) or since the last interview (two follow-up interviews). Because each interview was separated by approximately 12 months, these questions covered about a three year span in each respondent’s life.

During the three years covered by our inquiries, 420 individuals from 227 couples answered "yes" on at least one interview occasion to the question "Have you and your husband/wife tried to get pregnant in the last 12 months/since the last interview?" If they answered "yes," individuals were then asked a series of questions (see Results section for specific wording) about how they had started procepting, their state of mind while procepting, how long they had been procepting, whether they had used certain behaviors while procepting, and what the outcome of their proceptive effort had been. Twelve of the 13 behaviors we asked about were derived from earlier research. The thirteenth was added after the initial interview as a result of responses to an open-ended question about "other" proceptive behaviors.

Many of our respondents reported having procepted at more than one of the three interviews. Sometimes this was because the period during which they were trying to conceive extended beyond the period covered by one interview. Other times it was because they stopped trying and started again later or because they procepted, conceived, had a full term pregnancy and then subsequently started procepting again. Because of these complexities, it was necessary to define specifically what would count as a proceptive interval
that period of time during which an individual was trying to achieve a pregnancy. After carefully reviewing all our data, we decided to count as a single proceptive interval any of the following: 1. an interval of proception followed by a conception and full-term pregnancy; 2. an interval of proception followed by a conception, miscarriage, and a resumption of proception; 3. an interval of proception voluntarily discontinued but then resumed after a brief period of abstinence, contraception, or using no method; and 4. an open-ended interval of proception (i.e., on-going at the most recent interview). In practice, 2. and 3. were frequently combined in that couples often followed a miscarriage by a brief period of abstinence and/or contraception before resuming proception. In most instances the "brief periods" lasted 2 to 4 months but 6 months seemed to be the natural cutting point in our data, so we included one case with 6 months and two with 5 months. If a respondent reported a resumption of proception after a full-term pregnancy or a period of abstinence and/or contraception lasting more than 6 months, the second period of proception was counted as a separate proceptive interval.

As might be expected, some proceptive intervals spanned the initial or first follow-up interview, i.e., began before the interview and continued for some period of time afterwards. A few intervals even spanned both interviews. When interviews were spanned in this way, respondents were asked twice (three times if two interviews were spanned) about their behavior during the interval: once (twice) during the spanned interview(s) and once during the subsequent interview. By treating the data collected at each (all three) of these interviews as separate intervals, we were able to expand the number of intervals available for study and thus increase the power of our
data analysis. The final count was 342 husband proceptive intervals reported and 335 wife proceptive intervals reported. In 15 (4.4%) instances a husband did not report a proceptive interval when his wife did. The reverse occurred 22 (6.6%) times. Often the spouse not reporting proception in these cases did so at a later interview but some of these spouses simply had a different perception or recollection of what they were trying to achieve vis-a-vis conception.

The goal of data analysis was to characterize the patterns of specific proceptive behaviors and then understand the basis for those patterns. First, we calculated the percentage of proceptive intervals during which each of the 13 specific behaviors were reported, compared husbands' and wives' reporting of each behavior, and calculated two indices of agreement between spouses. Next, we used analysis of covariance to construct and test for each type of proceptive behavior the goodness of fit to our data of a linear model in which sex, parity, and duration of the proceptive interval were the predictor variables. Finally, we conducted several special analyses in order to clarify interpretation of the results of our linear modeling.

**Results**

At the initial interview the demographic characteristics of the 227 males and 227 females who provided data for this study were as follows. The average age of the males was 32.0 years and of the females was 29.9 years. The average number of years of education was 16.5 for males and 15.9 for females. Nineteen percent of both sexes were non-white. Fifty-seven percent of the respondents began the study with one child and 43% began with no children.
Religious affiliation for the males/females was Protestant 42/47%, Roman Catholic 23/26%, and None 24/19%. The average income reported by couples was 69.3 thousand dollars. Approximately 76% of the women were currently employed.

When asked "Which of the following statements best expresses how you and your husband first started trying to get pregnant?", 52% said they "had abruptly discontinued their regular method of contraception," 18% said they "had switched to a less effective method and then stopped using anything," 12% said they "were not using contraception very regularly and gradually stopped using it altogether," 16% said they "were not using contraception and decided to make a real effort to get pregnant," and 2% said they "were alternatively procepting and not procepting" (quotation marks indicate the wording of response options offered the respondents). Husbands and wives agreed 67% of the time on these categories, the main area of disagreement being whether they had abruptly discontinued their regular method or had switched to a less effective method first.

When asked "Which of the following statements best expresses your own state of mind while trying to get pregnant?", 54% of the respondents said they "intended to get pregnant and were actively trying to make it happen," 41% said they "intended to get pregnant but were letting it happen naturally and without any special efforts," and 5% said they "did not really intend to get pregnant but did not feel...(they)...would mind getting pregnant." There was 64% agreement between spouses on their state of mind while procepting, with wives (60%) reporting "actively trying" more frequently than husbands (45%). A case can be made that the 5% who said they "did not really intend to
get pregnant" were not actually procepting because of their lack of intent. However, we found that some of these individuals, while not completely comfortable acknowledging intent, readily reported using certain behaviors to achieve conception. Therefore, we elected to retain this small subgroup in our analyses.

We calculated two different measures of duration since the start of proception. The first included only the time during which the respondent was actually procepting and excluded any time during which there was a pregnancy followed by a miscarriage and/or a brief period of abstinence or contraception (M = 9.30 months, SD = 13.96 months). The second included both the time during which the respondent was procepting and the time taken by other activities – pregnancy, abstinence, contraception – during a proceptive interval (M = 13.88 months, SD = 13.96 months). In those results reported below where duration of proception is included as an independent variable, we used the first of these two definitions. Separate analyses (not reported) showed that the results obtained with the second definition were closely similar.

Respondents reported that a proceptive interval had ended in pregnancy 48% of the time. In 47% of the intervals the respondents reported that they were still procepting and in 5% they reported that they had stopped trying. Spouses agreed on proceptive interval outcome 98% of the time.

In Table 1 we list in Column 1 the 13 specific proceptive behaviors about which each respondent was asked. The meaning of most of these is self-evident but the spontaneous comments of our respondents regarding certain behaviors is illustrative and clarifying. The position most frequently
mentioned for item 3 involved placing a pillow under the woman's hips. A number of respondents believed that this could influence the sex of the child. The most frequently cited changes in eating habits were losing weight, eating more fruits and vegetables, and stopping wine or coffee. Some men said they reduced the amount of exercise they practiced, especially long distance running. The most frequently cited change in sleep habits was to get more rest. Finally, women mentioned quitting work as the main change in work pattern and they mentioned reducing work hours, delegating more responsibility at work, and not bringing work home as ways of either changing work patterns or avoiding stress.

Columns 2 and 3 in Table 1 show the percentage of time that husbands and wives reported that they had used the specific proceptive behavior listed in Column 1 during a proceptive interval. The most frequently reported types of proceptive behavior include timing sexual intercourse, increasing its frequency, purchasing an ovulation kit, and having the wife stay flat in bed after intercourse. The least frequently reported types of proceptive behavior include changing sleep habits, changing work patterns and changing the pattern of exercise.

Columns 4 and 5 in Table 1 show two different ways of calculating the percentage of times couples agree that they used a specific proceptive behavior. In column 4 (Agree I) agreement occurs when both members of a couple agree either that they did or that they did not use a specific behavior. In column 5 (Agree II) agreement occurs when both members agree that they did use a specific behavior. Agree I tends to overstate agreement where the
Table 1. Percent of Time that Husbands and Wives Report Specific Proceptive Behaviors and Percent of Time that Couples Agree, During 357 Proceptive Intervals.

<table>
<thead>
<tr>
<th>Specific Proceptive Behaviors</th>
<th>Percent Time Husbands*</th>
<th>Percent Time Wives*</th>
<th>Percent Time Agree I*</th>
<th>Percent Time Agree II*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Increase Frequency of SI**</td>
<td>51.5</td>
<td>54.9</td>
<td>70.3</td>
<td>56.8</td>
</tr>
<tr>
<td>2. Timed SI**</td>
<td>61.7</td>
<td>66.6</td>
<td>84.1</td>
<td>78.5</td>
</tr>
<tr>
<td>3. Used Certain Position for SI**</td>
<td>16.7</td>
<td>14.9</td>
<td>82.2</td>
<td>28.8</td>
</tr>
<tr>
<td>4. Wife Stayed Flat After SI**</td>
<td>45.9</td>
<td>47.5</td>
<td>76.9</td>
<td>61.3</td>
</tr>
<tr>
<td>5. Changed Eating Habits</td>
<td>6.7</td>
<td>21.2</td>
<td>81.3</td>
<td>18.9</td>
</tr>
<tr>
<td>6. Changed Pattern of Exercise</td>
<td>5.6</td>
<td>10.7</td>
<td>88.1</td>
<td>13.6</td>
</tr>
<tr>
<td>7. Changed Sleep Habits</td>
<td>2.6</td>
<td>1.2</td>
<td>98.1</td>
<td>33.3</td>
</tr>
<tr>
<td>8. Changed Work Pattern</td>
<td>3.5</td>
<td>7.5</td>
<td>90.9</td>
<td>9.4</td>
</tr>
<tr>
<td>9. Avoided Stress</td>
<td>10.4</td>
<td>17.5</td>
<td>81.6</td>
<td>21.3</td>
</tr>
<tr>
<td>10. Got Info. on Fertile Period</td>
<td>49.1</td>
<td>54.3</td>
<td>79.7</td>
<td>68.0</td>
</tr>
<tr>
<td>11. Purchased Ovulation Kit</td>
<td>25.5</td>
<td>24.9</td>
<td>88.0</td>
<td>62.8</td>
</tr>
<tr>
<td>12. Sought Medical Help</td>
<td>26.3</td>
<td>32.8</td>
<td>87.2</td>
<td>65.3</td>
</tr>
<tr>
<td>13. Used Medication</td>
<td>10.8</td>
<td>12.8</td>
<td>93.1</td>
<td>56.9</td>
</tr>
</tbody>
</table>

*Denominators for Percent Time Husbands and Percent Time Wives are 342 and 335, respectively (259 and 253 for item 11). These represent the number of intervals during which each spouse group reported procepting. The denominator for Percent Time Agree I is based on the 320 intervals (242 for item 11) during which both spouses of a couple reported procepting and the numerator equals the number of couples agreeing either that they did or did not practice the specific proceptive behavior listed in the left hand column. Percent Time Agree II is based on the number of proceptive intervals during which at least one spouse of a couple reported the specific behavior and the numerator equals the number of couples where both spouses reported the behavior.

**SI = "Sexual Intercourse"
behavior is infrequently reported (e.g., items 6, 7, and 8). On the other hand, Agree II tends to understate agreement where the behavior is frequently reported (e.g., items 2, 4, and 10). Taking into account both types of calculations, there appears to be relatively high agreement on just over half of the specific behaviors (viz., items 1, 2, 4, 10, 11, 12, 13). Those behaviors about which there was relatively low agreement (viz., items 3, 5, 6, 7, 8, and 9) tend to be ones that are readily adopted by one member of the couple only.

In Figure 1 we show in graphic form the results of modeling seven specific proceptive behaviors using analyses of covariance. These seven behaviors demonstrate the most significant predictor variable differences and illustrate all the important types of findings obtained through all the covariance analyses. The results of modeling the remaining six proceptive behaviors are presented descriptively below. In each model the percentage of respondents reporting use of a specific proceptive behavior was calculated by sex, parity, and five categories of duration. A linear model was then fitted to the data, with differences allowed across categories of predictor variables whenever so doing improved model fit. Each model produced a non-significant goodness of fit, meaning that the model as shown (or described) did not deviate significantly from the data.

In Figure 1 we have grouped and presented the seven graphs according to their similarity and complexity and represented the four sex-by-parity groups and their various combinations as indicated in the legends. The first (upper left) panel shows models of two proceptive behaviors – getting an ovulation kit and using certain positions for sexual intercourse – that have a
marked temporal trend and a parity-by-duration interaction. As the duration of proception continues without success, respondents tend to increase the use of these two behaviors until at least two years have passed, at which time those with one child decrease their use, while those with no children continue their increase. The second (upper right) panel shows models of three behaviors – timing sexual intercourse, getting information about the fertile period, and staying flat in bed after sexual intercourse – that also have a temporal trend and a parity-by-duration interaction, the main difference being that the interaction occurs at both the beginning and end of the duration. Thus those respondents with one child manifest lower use of these three behaviors relative to those with no children both when proception is first initiated and after at least two years have passed.

The third (lower left) and fourth (lower right) panels show models of one behavior each – seeking medical help and using medication – both of which manifest some of the same features as the previous panels, but with more complex interactions. Seeking medical help not only shows a marked duration effect but also a sex-by-parity interaction effect during the first four duration intervals, followed by a complex sex-by-parity-by-duration interaction effect. Respondents sharply increase the use of this behavior over time, with parity-zero women consistently reporting greater use of this behavior. After at least two years have passed, however, parity-one respondents manifest a decreased use of this behavior, while parity-zero respondents level off their use, with the women continuing to report greater use. Using medication shows a moderate duration effect among women and no such effect among men, until at least two years have passed at which time
the parity-one women decrease to the baseline male use and the parity-zero men increase to the level of the steadily increasing female use.

The models for the remaining six proceptive behaviors reveal either no or comparatively smaller predictor variable effects and those effects that are present correspond closely to the ones already described. Increasing the frequency of sexual intercourse and changing sleep habits manifest no effects. Changing the pattern of exercise and changing the work pattern manifest a minimal duration effect, with parity-zero females using these behaviors slightly more than all other groups. Changing eating habits shows no effects for the first four duration intervals except that parity-zero women use the behavior at a consistently higher level. When at least two years have passed, all groups except parity-zero men show a modest increase. Finally, avoiding stress generally manifests a moderate increase across the five duration intervals.

In order to further our understanding of the 13 specific proceptive behaviors, we conducted two additional sets of analysis. In the first, we examined the degree to which each behavior was associated with each of the others, using oblique principal component cluster analysis (SAS PROC VARCLUS). Three primary clusters were identified: a Sexual Intercourse Cluster (items 1, 2, 3, and 4; proportion of variation explained = 0.578), a Behavioral Cluster (items 5, 6, 7, 8, and 9; proportion of variation explained = 0.394), and a Medical Cluster (items 10, 11, 12, and 13; proportion of variation explained = 0.455). There was a marginally significant tendency for the Behavioral Cluster to divide into two parts, one composed of items 5, 6, and 7 (proportion of variation explained = 0.505) and one composed of items 8 and 9
(proportion of variation explained = 0.713). When the cluster analyses were conducted separately by sex, this division occurred only among females and was significant.

Although the individual items in each cluster generally failed to demonstrate similar sex, parity, and duration covariance models, there are certain common features of these models for the items in each cluster. For example, the items in the Sexual Intercourse Cluster tend to have a relatively high frequency, a moderate upward temporal trend, and a lower start and lower finish for parity-one respondents. The items in the Behavioral Cluster tend to have a low frequency and either no temporal increase or only a small one. Finally, the items in the Medical Cluster tend to start off with a low frequency and rise markedly over time to a relatively high frequency, with the parity-one respondents dropping off dramatically at the final duration point.

In the second set of additional analyses, we conducted cross-tabulations between the specific proceptive behaviors reported by respondents at one duration point and those reported at the subsequent duration point if the interval remained open and the same behaviors were reported. These analyses allowed us to determine what type of reporting consistency occurred across duration points and thus helped in the interpretation of the patterns formed in Figures 1 and 2. In particular, by examining for consistency across duration points 0-5 and 6-11 and across duration points 18-23 and 24+, we could evaluate whether some of the sharp differences across those two pairs of points (e.g., Figure 1, panel 4) were primarily artifacts of individual memory. The results (not shown) did not support that hypothesis.
Discussion

Proceptive behavior occurs when individuals or couples modify their behavior in order to enhance the possibility of conception. Perhaps the best example of this is when individuals stop contracepting or otherwise change their contraceptive practices for the purpose of initiating procreation. Associated with these behavioral changes are states of mind in which individuals feel that they are actively trying to make a pregnancy occur (what may be called active proception) or that they are letting a pregnancy occur without any special efforts (what may be called passive proception).

Once proceptive behavior is initiated, there are a number of specific behaviors that individuals may pursue in order to help achieve conception. We have identified and described thirteen of those behaviors and examined how they vary by sex, parity, and duration of proceptive effort. There is considerable overall variation in the frequency with which these behaviors occur, timing sexual intercourse being reported by almost two-thirds of the married couples in our sample and changing sleep habits being reported by less than 2%.

There are definite patterns in the pursuit of these thirteen proceptive behaviors according to the sex and parity of the individual and the duration of the proceptive effort. The pattern of each specific behavior is described, but certain general patterns, depicted in Figure 1 with respect to seven specific proceptive behaviors, are apparent and warrant further comment. For example, there is a common sex pattern, which is actually a sex-by-parity interaction effect, in which wives with no children report using a specific
proceptive behavior more often than any other sex-by-parity group. This probably reflects a greater interest in and concern about getting pregnant among women who have yet to have a child. There is also a common parity pattern, which is actually a parity-by-duration interaction effect, in which parity-one individuals report a substantial drop in frequency of various proceptive behaviors once they have been procepting for two years or more.* Parity-one individuals also report a lower frequency of certain proceptive behaviors during the first six months of proceptive effort. The first pattern looks like a "giving-up" effect and the second looks like a "slow start" effect. Both of these patterns probably represent a relatively reduced concern about achieving conception among those who have already had a first child. Finally, there is one common duration pattern, namely that almost all specific proceptive behaviors increase with the duration of the proceptive effort. This probably reflects an increasing determination on the part of individuals to achieve conception as time passes without their achieving success.

The thirteen proceptive behaviors that we have identified tend to be associated in three broad clusters. In other words, individuals reporting one of the behaviors in a cluster also tend to report the others. The Sexual Intercourse Cluster includes increasing the frequency of sexual intercourse, timing sexual intercourse, using certain positions during sexual intercourse, and having the wife stay flat in bed after sexual intercourse. These are among the most commonly reported items and tend to be used increasingly over time. As such, they appear to represent the primary repertoire of behaviors that individuals and couples tend to use in their own efforts to conceive.
The Behavioral Cluster includes changing eating habits, patterns of exercise, sleep habits, and work patterns and avoiding stress. These items are relatively infrequently reported and tend to show no or a minimal time trend. They are also much more frequently reported by one spouse and not the other. Thus they would seem to represent a secondary, less critical repertoire of behaviors that individuals believe they can use on their own to facilitate conception. It is of interest that among women this cluster can be further divided into two parts, one of which involves work-related behaviors. This finding together with the fact that so many women in the study were employed outside the home suggests that the possible effect of employment-related stress on the chance of conception is an important area of concern for women.

The Medical Cluster includes getting information on the fertile period, purchasing an ovulation kit, seeking medical help, and using medication. These behaviors tend to be infrequently used at the beginning of proception but demonstrate a substantial increase after a year or a year and a half of proceptive effort. This suggests that they represent an important back-up repertoire that individuals may use in conjunction with the medical community when their primary proceptive efforts have failed.

One of the most important features of the findings reported in this study is that the sample was not clinic or hospital based but rather was selected on a probability basis from a large geographic area. This means that the specific proceptive behaviors and patterns of their occurrence described here represent what occurs naturally in the contemporary U.S., or, at least, in a U.S. population demographically similar to our sample. Our findings provide
clinicians and service providers with a baseline knowledge of what many
couples are, in fact, doing to achieve conception. This baseline in turn suggests
areas where more information and instruction may be useful for the general
population.
Footnote

*This drop in frequency below levels achieved at shorter durations seems paradoxical unless these respondents are not reporting behaviors that they used earlier. Although we demonstrated in a special analysis that memory was not a factor as respondents moved from one 6 month duration to the next, many of those in the 24+ month category were already procepting for 24+ months at the beginning of the study and were, therefore, not part of that analysis. Some of these respondents had been procepting for 36, 48, or even more months and it is likely that their responses only represent their behaviors for the most recent 6, 12, or 18 months. This most likely accounts for the frequency drop seen in parity-one respondents. The absence of this pattern in parity-zero respondents suggests that they are still using those behaviors, even out to 36 and 48 months after the initiation of proception.
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