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The transition to parenthood: A guide to emotional and relational growth for new parents

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THE TRANSITION TO PARENTHOOD: A GUIDE TO EMOTIONAL AND RELATIONAL GROWTH FOR NEW PARENTS

by

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STATEMENT BY AUTHOR

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This thesis has been approved on the date shown below:

O.C. Christensen — 4-9-90

Oscar C. Christensen, Jr.
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Consumer Resources

Date

To

GEOFF, TREVOR, AND JOEL

who taught me about the
transition to parenthood

To

GLYNN

who was there as
partner, co-parent, and confidant

To

JAMIE

who brought back memories

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ABSTRACT

Many experts support the need for anticipatory socialization to help new parents develop realistic expectations for the transition to parenthood. The purpose of this study was to develop a handbook to help new parents with the emotional and relational changes concurrent with the transition.

Using the historical research method, the handbook was developed. Vignettes were added to illustrate the didactic material. The handbook was evaluated by new parents and professionals involved with new parent education regarding the handbook's value, clarity, length, language level, philosophy, and suggested time for distribution. Also solicited were suggestions for additions and deletions and additional comments.

The conclusion was reached that the handbook seemed useful for helping new parents validate feelings and understand changes concomitant with the transition to parenthood. Some changes in length and language will be made prior to publication. Ideas were presented for additional research and literature for the transition to parenthood.

CHAPTER 1

INTRODUCTION

Bringing a child into the world changes many aspects of a couple's lifestyle. When a helpless infant, requiring round-the-clock care arrives in the home, the couple has to reorganize in order to adapt to the infant's needs (Cox, 1985). "At this time, the marital situation is severely unbalanced. The mother, as well as the father, experience considerable affective lability, a mixture of joy, depression, anxiety, and fatigue. . . . It is also a time when new skills have to be learned fast, and a new lifestyle has to be worked out" (LaPerriere, 1980). No matter now much a baby is planned for and wanted, parents will experience some stress after the baby's arrival until they can successfully adapt themselves to meeting the baby's needs and their own in a reorganized household (Brooks, 1987).

In 1967, Thomas H. Holmes and Richard H. Rahe published a scale for evaluating stress in people's lives. They found that 80% of those whose total scores were above 300 experienced sufficient stress to cause heart attacks, depression, and other serious illnesses within a year. Events associated with pregnancy and birth total 396, a score high enough to predict serious illness (Brooks, 1987). It is therefore not surprising to find that researchers have also determined that new parents (both mothers and fathers) undergo depression (Pitt, 1968; Atkinson and Rickel, 1983; Zaslow et al., 1985) and that a

negative correlation exists between the arrival of the first child and marital quality (Belsky, 1986). Change thus occurs on both intrapersonal and interpersonal levels during the transition to parenthood (Hopkins, Marcus, & Campbell, 1984).

There is an old adage that states: "forewarned, forearmed" (Cervantes, 1605-1615, p. 502). Oakley (1980) believed that the discrepancy that exists between expectations and reality is a cause of depression. Belsky (1985, p. 1043) found the "failure to anticipate accurately the nature of the baby's influence, and especially the tendency to overestimate the positive effects of this event, are associated with negative change in the marital relationship as evaluated by women." Oakley (1980, p. 281) concluded that since a low degree of anticipatory fear is pathogenic because of ineffective inner defenses, "being prepared is beneficial; not being prepared is not." These findings suggest that education aimed at realistic expectations following the birth of the first baby might be helpful in the prevention of depression and in the stability of marital satisfaction.

Entwisle and Doering (1981, p. 256) determined from their study of new parents that most couples give "little thought about what they would be thinking, feeling, or doing once the birth was over." Parents are educated only up to the point of the delivery table (Sollie & Miller, 1980) and while practice in diapering and caretaking may be important, the emotional preparation for parenthood may be "more critical" (Entwisle & Doering, 1981, p. 256). LaPerriere (1980, p. 86) wrote:

> . . . The whole affective experience of early parenthood is somehow not put into words, and does not become public domain. It is not acknowledged, not explored, not validated. The anxieties, the fatigue, and the feelings of entrapment are usually kept silent. The parents who experience them often feel that they are particularly incompetent, particularly guilty, particularly bad.

It appears that a need exists for communicating to new parents what is normative and what is problematic when their first child comes home (Hopkins et al., 1984). "The decrease in family size, increase in mobile, nuclear families and the breakdown of the extended family have minimized the parents' natural opportunities for learning parenting" (Kraus & Redman, 1986, p. 66). When American parents want advice, they turn to books, in contrast to parents of other cultures (Ipsa, 1984). One study about new parents revealed that 100% of the mothers and 77% of the fathers had looked up information in printed material (Wilkie & Ames, 1986). Hence, it appears that a concise book that was readily available to new parents might educate them to appreciate realistically and cope more successfully with the stresses apparent in early parenthood.

Purpose of the Thesis

The purpose of this thesis is to develop a concise handbook for the biological or adoptive parents of a first baby. It will address the emotional and relational needs of both mothers and fathers, either married or in committed relationships. The salient feature of the handbook will be that it will be based on research published in journals or technical books regarding either the transition to parenthood or postpartum depression. It will be

inexpensive to reproduce so that it may be widely distributed at childbirth classes, postpartum support groups, or included in packets prepared by hospitals.

Assumption

There will not be an attempt to explore the cross-cultural aspects of the transition to parenthood because of the unavailability of current research and the limited scope of this thesis. Since research in both the transition to parenthood and in postpartum depression has focused on Anglos or culturally-mixed groups of subjects, the extent to which the findings are generalizable across English-speaking cultures is unknown. In their review of literature on the transition to parenthood, Worthington and Buston (1986, p. 448) concluded: "Almost none of the research is cross-cultural." However, there are suggestions of the universality of aspects of parenthood. One exceptional cross-cultural study regarding the transition to parenthood by black couples (Hobbs & Wimbish, 1977, p. 687) did determine that "black and white parents of both sexes find that interruptions of their life styles to be the single most bothersome aspect of beginning parenthood." Also, in a study of psychological symptoms in postpartum mothers, Watson and Evans (1986) found little difference in psychological symptoms cross-culturally.

Summary

Bringing a first child into a couple's home changes their lifestyle and thereby, adds stress (Brooks, 1987). The couple that

has realistic expectations about the transition to parenthood is better equipped to cope with the stress (Belsky, 1985). A concise handbook, based on research, will be developed. Cross-cultural aspects of the transition to parenthood will not be explored in this study.

CHAPTER 2

REVIEW OF SUPPORTING LITERATURE

Introduction to Chapter 2

The transition to parenthood brings significant personal and marital changes for both mothers and fathers (Harriman, 1983). Personal stressors may result in postpartum depression in varying degrees of severity for either men or women (Pitt, 1968; Atkinson & Rickel, 1983; Zaslow et al., 1985). Marital changes also vary in severity from mild, temporary dissatisfaction to those requiring outside intervention (Worthington & Buston, 1986; Debrovner & Shubin, 1985). The literature review in this chapter will be selected from two areas: postpartum depression and transition to parenthood.

History of Transition to Parenthood Literature

Most studies about the transition to parenthood have been done by two disciplines: developmental psychology and family sociology (Belsky, 1981). The early studies on the subject were cross-sectional in design. LeMasters (1957) hypothesized that the addition of a new member to the family system could force a reorganization of the system and thus constitute a crisis. He incorporated Hill's (1949, p. 51) definition of crisis, "any sharp or decisive change for which old patterns are inadequate," and found that 83% of the 46 couples reported severe crisis on a five-point continuum. Using the same

definition of crisis, Dyer (1963) found 53% of the 32 couples in the extensive and severe crisis categories of his five-point scale. Dyer (p. 201) concluded: "The findings tend to support the hypothesis that the addition of the first child would constitute a crisis event for these middle-class couples to a considerable degree, forcing each couple to reorganize many of their roles and relationships." Both LeMasters and Dyer have been faulted for using "small, unrepresentative samples" (Miller & Sollie, 1980, p. 459). As well, LeMaster's study may have had experimenter effects, because LeMaster helped the 46 couples decide the severity of the crisis they had experienced (Miller & Sollie, 1980).

Hobbs (1965, 1968) related much lower levels of crisis experienced by new parents than either LeMasters or Dyer had encountered. But it should be noted that both LeMasters and Dyer focused on changed behavior patterns, as opposed to feelings and attitudes, and this difference in focus may account for the discrepancy in crisis levels (Miller & Sollie, 1980).

In 1963, Rapoport suggested the term "normal crisis" (Miller & Sollie, 1980). By 1968, Rossi advocated strongly the removal of the words "crisis" and "normal crisis" as concepts in new parenthood since: "There is an uncomfortable incongruity in speaking of any crisis as normal" (p. 28). Rossi recommended that researchers address "the transition to and impact of parenthood" (p. 28). The transition, a normal event, could well be thought of as a developmental task, such as Erikson's task of generativity (Rossi, 1968).

Russell (1974) continued the opposition to the term "crisis" which she thought implied negative outcomes that blind the couple to possible gratifications. Couples in her cross-sectional study checked more gratifications than problems on her checklists, but the gratification items checked were personal in nature, as opposed to those that would benefit the marriage. Hobbs and Cole concurred in 1976, suggesting that: "It is more accurate to think of beginning parenthood as a transition, accompanied by some difficulty, than a crisis of severe proportions" (p. 730).

The early cross-sectional studies had their limitations. At one point in time, it is always difficult to understand how changes are made. The crisis studies were typically retrospective self-reports concerning difficulties of adjustment. They could easily be influenced by social desirability (Cox, 1985). But, the longitudinal studies in more recent years, despite their nonuse of the crisis concept, have suggested a decline in marital satisfaction as couples become parents (Miller & Sollie, 1980; Cowan et al., 1985; Belsky, Lang, & Rovine, 1985). Belsky et al. (1985) summarized the research by stating that most studies revealed modest, negative changes in marital quality across the transition to parenthood which may extend throughout the childbearing and childrearing years of the family life cycle. Furthermore, the changes tended to be greater for wives than for husbands.

The following findings will serve as the basis for information contained in the handbook and are presented in the format of the handbook itself.

RELATED RESEARCH: INTRODUCTION TO HANDBOOK

The arrival of the first child is "one of the critical transition periods in the family life-cycle" (LaPerriere, 1980, p. 87). With this event, the parents are shifted into a different generation with its privileges and responsibilities. No longer do their tasks remain simply taking care of themselves, growing and developing, and separating from their parents. Now they must "attend to and care for another human being" (LaPerriere, p. 87).

Beginning parenthood is a developmental transition in the life cycle. As a developmental transition, it marks a passage from one chronological stage to another. Transitions are "periods of moving from one stable state to another with an interval of uncertainty and change in between" (Williams, 1986, p. 1). But, even though they are normal, transitions are often upsetting life experiences, characterized by emotional lability, confusion, ambivalence, and erratic, unpredictable behavior (Williams, 1986).

High levels of change result in stress for most people, even if the change is anticipated and desirable (Worthington & Buston, 1986). The change and reorganization necessary to the transitional period produce strain on the couple (Hobbs & Cole, 1976). Couples note such changes as declines in romance and increases in partnership in their relationships (Belsky, Spanier, & Rovine, 1983). Marriages

change from egalitarian to traditional, and as an aligning action, couples may change their beliefs in order to compensate for the changes in their behavior (LaRossa & LaRossa, 1981). Individuals discover a change in their identity: "a new baby forces a shift in identity from the self as a child of one's parents, to the self as a parent of one's child" (Cowan et al., 1978, p. 308). The tension also arises from several other causes, including lack of sleep and the resulting fatigue, feelings of immense responsibility, less time for personal and relational activities, and feelings of confinement (Miller & Sollie, 1980).

There appears to be a brief honeymoon period following the birth of the first baby. This concept was introduced by Rossi in 1968. She described the period as a "psychic honeymoon", a "post-childbirth period during which, through intimacy and prolonged contact, an attachment between parent and child is laid down" (p. 30). This is also a time of great interpersonal adjustment and learning. Miller and Sollie (1980) found that personal and marital stress was less evident at 1 month postpartum than at 8 months, giving credence to Rossi's honeymoon theory. Entwisle and Doering (1981) found problems and adjustment were postponed or denied at least for the first few weeks; stresses were more often acknowledged after 4 to 6 weeks.

Structural changes occur with the birth of the first child as the family changes from a dyad to a triad, tripling the number of internal bonds and interpersonal relationships (Belsky & Pensky,

1988). With the husband-wife relationship (H-W), there was only one bond. Now, with the addition of a child (Ch), there are three bonds to be negotiated, correlated, and maintained: H-W, H-Ch, and W-Ch. While the resulting matrix may be stronger, there is also the tendency for every triangle to resolve itself into a pair and an isolate (Broderick, 1984). Initially, the baby may be perceived as an interloper or trespasser by both parents, but as powerful new bonds develop with the baby, one of the spouses may become the isolate and frequently it is the husband who senses the child as a rival (Daniels & Weingarten, 1982).

One of the tasks of a transition is that of grieving losses (Williams, 1986). These losses may involve lifestyles, possessions, practices, relationships, and opportunities enjoyed previously (Zabielski, 1984).

Couples often experience violated expectations after the arrival of the first child (Belsky, 1985). Romanticism (a naive, unrealistic, inflexible, love-oriented attitude toward marriage) and optimism tend to be higher in expectant couples as compared to non-pregnant couples: these attitudes may serve to offset the anxiety and tension apparent in pregnancy (Feldman, 1974). In a survey of married American women who have not yet had children, a question regarding the advantages of having children was asked. The most frequent responses were: (1) stimulation, fun, activity; (2) bring love and affection; and (3) benefit the husband-wife relationship (Fawcett, 1988). Parents, however, often fail to consider the emotional, relational and

financial costs that will also arise. Many do not anticipate the time and attention required to care for an infant (Dyer, 1963). Many do not recognize that initially, a newborn cannot reciprocate in any way (Zabielski, 1984).

When prenatal expectations were compared to postnatal experiences, Belsky (1985) found that the expectations of what the baby would do for the marriage relationship were significantly greater than reported experiences following the baby's birth. "The relationship between violated expectations and marital change is more pronounced in the case of wives than husbands" (p. 1041). Expectant parents thought that the husbands would be more involved in caregiving than they actually were in practice. But husbands do not experience the radical change their wives undergo: they usually continue at work and spend most of their waking hours away from the baby. They experience none of the physical strains of pregnancy and delivery, nor the demands of caring for a baby on a full-time basis (Kach & McGhee, 1982).

RELATED RESEARCH TO SECTION I: THE NORMAL STRESSES OF EARLY PARENTHOOD

Ambivalent Feelings

Many new parents experience a combination of positive and negative feelings towards their newborns in the postpartum period. Both parents experience "considerable affective lability, a mixture of joy, depression, anxiety, and fatigue" (LaPerriere, 1980, p. 88). As a result of perceived social pressure, they may not express the

negative feelings overtly (Rossi, 1968). Because these feelings have not been validated through discussion with others, the new parents often feel "particularly incompetent, particularly guilty, and particularly bad" if they admit the negative feelings even to themselves (LaPerriere, 1980, p. 86). Fawcett (1988, p. 31) suggested that while the nuclear family with children in today's society is an important source of satisfaction, the opportunity costs are also higher, due to "better job prospects for women and expansion of alternatives for leisure time activities. This high satisfaction/high cost situation is a recipe for ambivalence."

In their study of women who were hospitalized during the postpartum period and a control group of new mothers who were not hospitalized, Cohler, Weiss, and Grunebaun (1970) found that the hospitalized women were unable to admit ambivalent feelings about parenting. Instead these mothers viewed the childrearing process in terms of what they believed typical mothers feel or should feel, rather than what they themselves actually felt. "This study suggests that the women who collapsed under the strains of parenthood were clinging rigidly to the images that they had devised or put on and were unable to release. . .," but "images can be the stumbling blocks that stunt and cripple growth" (Galinsky, 1981, p. 95). When feelings are expressed covertly, they are often displaced as irritability or psychosomatic complaints (Rossi, 1968). "Ignoring or bypassing feelings considered unacceptable often creates difficulty" for the marital relationship (Cowan & Cowan, 1987, p. 237). When couples know that

other new parents also experience ambivalent feelings, they may feel reassured. One mother stated, "because an infant is so demanding, there are days when one wishes the baby did not exist. Knowing these feelings are normal, however, makes coping with the day-to-day routine possible" (Miller & Sollie, 1980, p. 463).

It is typical for new parents to experience euphoria and elation shortly after delivery. While some anxiety may also exist, feelings of accomplishment and satisfaction are prevalent initially (Leifer, 1977). Couples often enjoy presenting their parents with a grandchild and the concurrent closeness they feel with extended family (Sollie & Miller, 1980).

However, as the weeks progress, although new parents still feel "excited and invested in the baby," they also feel more "weighed down by a sense of responsibility" and "trapped in the 'foreverness' of the parent role" (Cowan et al., 1985, p. 476). But since it is impossible to revoke the commitment to parenthood (except for placing a child for adoption), psychological withdrawal from the child may be the chosen alternative of a dysfunctional parent (Rossi, 1968).

It is not unusual for parents to actually hate their children at times (LaPerriere, 1980). Infant irritability, crying, colic, and demands can leave the parents feeling depressed, helpless, angry, exhausted and even rejecting of the infant. Crying seems to peak at approximately six weeks postpartum (Wilkie & Ames, 1986). Parents often resent the demands and unpredictableness of their new lifestyle: infants appear to completely take over their life, time and freedom

(Sollie & Miller, 1980). Hostile impulses and thoughts toward the newborn infant are "not unusual and are in fact quite within the normal range of maternal ambivalence" (Asch & Rubin, 1974, p. 870).

During the early postpartum period, it is not unusual for mothers to experience a decrease in self-confidence regarding their maternal abilities. The reality of coping with the new tasks of motherhood appear to evoke feelings of inadequacy, especially in mothers who had feelings of incompetence in early pregnancy (Leifer, 1977). Mothers are often uncertain and anxious about interpreting their baby's cues (Shereshefsky & Yarrow, 1973).

"During the transition to parenthood self-esteem is likely to be in a state of flux" (Cowan et al., 1978, p. 298). Parents have expectations about their roles and how they should be played. When a discrepancy exists between perceived and ideal behavior, the level of self-esteem decreases (McConnell, 1986). As new skills are added to the new parents repertoire and adaptations are made in the parental role, the self may move closer to the ideal, raising the individual's self-esteem (Cowan et al., 1978).

Parents are aware early that society expects them to raise their children to become competent, valued adults (Rossi, 1968). Parents in North America are viewed as highly responsible for their children and what they become (Miller & Myers-Walls, 1983). Most can readily get medical, psychological, and nutritional advice for raising a preschooler, "but adult competency is quite another matter" and parents are anxious about specific ways that they can contribute to

this competency (Rossi, 1968, p. 35). Changing their theories about childrearing is not unusual for new parents (Cowan et al., 1978).

Maternal feelings are not automatic (Entwisle & Blehar, 1979). "You think that all of a sudden there is going to be this motherly surge of love which is not true. . . . I don't think motherly love is automatic as a lot of times you are led to believe," said one new mother (Shereshesky & Yarrow, 1973, p. 175). According to one study, 20% feel maternal during pregnancy or immediately postpartum, and 10% felt maternal at the fifth postpartum month. The average time was approximately 6 weeks. Breastfeeding, the baby's sociability, cuddliness, and ability to engage in social smiling were cited as variables in the onset of maternal feelings (Entwisle & Blehar, 1979).

"Women's unexpected feelings of dependence on their husbands often led them to feel more dissatisfied with the new role arrangements than they had expected to be" (Cowan et al., 1985, p. 464). Because infants have such strong dependency needs and need continuous care, the mother's own dependency needs rise, especially from her spouse. "A new mother needs to receive so that she can give" (Zabielski, 1984, p. 29).

"Fatherhood usually heightens a man's emotions and influences the way he perceives his social status and relationships" (Lewis, 1986, p. 164). Although men may describe their life before the arrival of their child as boring and unfulfilling, their involvement with their infants elicits an intense mixture of ambivalent emotions ranging from fulfillment, wonder, and love, to hostility, pressure,

and worry. As one subject expressed, "It's all the emotions you've ever felt and probably will ever feel--so mixed up you never know when they're going to come" (Lewis, 1986, p. 151). New fathers may resent having less privacy in the home (Entwisle & Blehar, 1979) or the reality that their wives are not as available as previously (Broderick, 1984). New fears arise regarding finances, the child's developmental rate, and the future of the world (Lewis, 1986).

Environmental factors may exacerbate the conflicts experienced by new parents. Distance from family of origin usually results in less support for the new parents (Crnic & Greenberg, 1987). Adjustments to new communities, lack of formal or informal preparation for parenthood, lack of guidelines to successful parenting, lack of cultural support for incorporation of the maternal role--all these things appear to contribute to the emotional stress experienced in the transition to parenthood (Leifer, 1977). As might be expected, single parents, parents of exceptional children, and very young parents experience even greater stress (Miller & Myers-Walls, 1983).

Approximately 25% of today's babies are delivered by Cesarean section (Associated Press, 1989). Pedersen et al. (1981, p. 257) said:

> Those who have had direct contact with women during and after the childbirth process, especially childbirth educators and nurses, have reported that they observe a variety of problems: fear and stress in laboring women who have to adjust to an imminent surgical procedure when a Cesarean delivery was unanticipated; feelings of guilt, failure, and anger in mothers who prepared for a low medication vaginal delivery; separations of mothers and infants rather than the expected immediate contact after birth; difficulty in first feeding and caregiving attempts by mothers who are groggy, in pain, or unable to hold their newborns; and difficulties upon

> returning home from the hospital for mothers who must assume the demands of infant care at a time when they themselves have unusual needs for physical and emotional recovery.

Women who have planned a natural birth but deliver by a Cesarean section have feelings that range from "disappointment at best to post-partum depression reaching psychotic proportions" (Lipson & Tilden, 1980, p. 598). It should be noted, however, that not all women perceive Cesarean births negatively. For some women who have had difficulty conceiving or carrying a child, a Cesarean may be viewed as a necessary safeguard for the baby. Others are aware throughout the pregnancy that a Cesarean is their only alternative (Lipson & Tilden, 1980). But for those women who have already endured an exhausting labor before a Cesarean delivery, "the physical and emotional recovery may be difficult and prolonged in comparison to the woman who has delivered vaginally" (Lipson & Tilden, 1980, p. 599). Whiffen (1988), on her five-point scale measuring delivery complications, places a vaginal delivery at number one and an emergency Cesarean section at number five. In fact, "the effects are not only negative in the short run but far reaching and long lasting in terms of the mother's psychological health" (Entwisle & Blehar, 1979, p. 160).

Husbands of women who have delivered via Cesarean section are also more negative about the birth experience (Entwisle & Blehar, 1979). They express disappointment if they are unable to participate in the birth experience or support their wives as they had anticipated. They experience greater fear for their wives and babies if the surgical procedure was deemed an emergency (Pedersen et al., 1981).

Later, while the mothers experience more difficulty adapting to and interacting with their infants, the fathers reveal more responsiveness to the infant's crying and fussing than fathers of vaginally-delivered babies. Fathers of Cesarean babies are more likely to share initial caregiving responsibilities on an equal basis with the mother, rather than "helping out" as the majority of fathers of vaginally-delivered babies (Pedersen et al., 1981). However, as the fathers involve themselves more in caregiving activities, their interaction shifts away from "playful and purely social interaction" with their infants and soon the infant experiences less positive, less stimulating interaction from either parent (Pedersen et al., 1981, p. 262).

Cesarean support groups serve as catalysts for resolution of negative feelings and memories of the Cesarean experience. They may trigger psychological processes including "catharsis, reconstruction of the birth experience, legitimation (normalizing), and placing her personal experience in a broader context" (Lipson & Tilden, 1980, p. 605). As a result, the parents may feel more acceptance of their experience and be able to place the Cesarean within the perspective of the rest of their lives (Lipson & Tilden, 1980).

Gradually, as parents learn to adapt to the baby's needs, they also adapt to their own emotional reactions (Lewis, 1986). Parents who have learned to acknowledge and express feelings to themselves and to their spouses experience less misinterpretation of each other's behavior and thereby, experience less conflict postpartum (Cowan et al., 1978).

Fatigue

In their study on adjustment in early parenthood, Kach and McGhee (1982) asked parents to list the five most difficult problems since the birth of their children. The problem most frequently mentioned by both mothers and fathers was lack of sleep and energy. Mothers in LeMaster's (1957, p. 353) study reported the same problems and other problems related to them. Specifically, they mentioned "chronic 'tiredness' or exhaustion;" "additional washing and ironing;" "the long hours and seven day (and night) week necessary in caring for an infant;" and "decline in their housekeeping standards." While partners may attribute many of their early difficulties to the presence of the baby and their own inadequacy as new parents, it is more likely that many of the difficulties are either triggered by or aggravated by "their mind-altering state of sleeplessness and fatigue in those first weeks" (Cowan et al., 1978, p. 309).

As mentioned previously, part of the difficulty with fatigue stems from the increased workload (LeMasters, 1957). This increase affects both mothers and fathers, but especially the mothers (McHale & Huston, 1985). Mothers complain more than fathers about the physical demands of the child: perhaps this is because men view their participation in childcare activities as "helping" their wives (Sollie & Miller, 1980). Couples who become parents increase the proportion of joint instrumental activities that center around household tasks and childcare, while their leisure time decreases. Unfortunately,

positive behaviors between spouses also decline resulting in lower marital satisfaction (McHale & Huston, 1985).

Couples need to "sustain between them a process of reciprocal nurturance as they continue to meet each other's emotional needs" (Daniels & Weingarten, 1982, p. 65). Fathers can be sensitive to their wife's recovery process by allowing their wives time for relaxation (Clark & Affonso, 1979). Time management and setting priorities may be effective coping strategies (Worthington & Buston, 1986). Acceptance of instrumental support from family and friends may help with the workload (Zabielski, 1984): if the support is unavailable, the couple may need to seek help from outside agencies in order to cope during the early weeks (Galinsky, 1981).

Lack of Free Time

> When one considers the extensive needs of the newborn infant and young baby, the additional costs incurred in rearing a child, and the fact that many young families today are physically distant from their own parents (who are potential babysitters), it might be expected that the transition to parenthood decreases the amount of time the couple has to engage in recreational activities together and/or alters the way in which spouses spend their time together (Belsky & Pensky, 1988, p. 141).

Couples find that they engage in fewer joint leisure activities (such as watching television or going out to eat) after the arrival of their first child. Studies show a significant decline from the last trimester of pregnancy through the first 3 months postpartum: thereafter, the curve levels off (Belsky et al., 1983; Belsey et al., 1985). Joint activities become centered around childcare and household task responsibilities (McHale & Huston, 1985), making the marriage more of

a partnership and less of a friendship and romance than before the birth of the first child (Belsky et al., 1985).

Harriman (1983) summarized previous research and identified 21 areas of personal and marital impact due to childbirth. Of the 12 personal variables, 7 concerned allocating time; of the 6 marital variables, 3 involved balancing time commitments. Some of the variables identified were: time for oneself, enough time to get everything done, balancing demands on one's time, having time for one's spouse, contact with friends, and leisure activities (Worthington & Buston, 1986). The most negative personal change was having less time for self (Harriman, 1983); the most negative marital change was less time for spouse (Harriman, 1985). Time disruptions and scheduling one's time around the baby are very stressful aspects of new parenthood (Broderick, 1984).

Couples tend to become more family-centered and less interested in activities outside the home (Lewis, 1986). The leisure activities may change to include more entertaining of friends or visiting friends. Activities must be tailored to fit the budget and the lesser amount of free time available. Extended families become a more important part of the couple's social network, especially in the early years of parenting. The quantity of friendships also declines in the childrearing years (Lewis, 1986).

Fewer evenings are spent outside the home for other reasons. First-time parents are reluctant to hire a babysitter because they are uncertain about finding a suitable sitter for the child (Lewis, 1986).

The geographical distance from the family of origin results in decreased availability of potential babysitters who are trusted by the couple (Belsky & Pensky, 1988). Financial constraints because of mother's decreased employment and increased expenses because of the baby are also cited as reasons for staying home. Mothers who are separated from their babies during the day are less desirous of getting out during the evenings as well. Furthermore, parents respond that they have less energy to go out due to meeting the extensive needs of the newborn (Belsky & Pensky, 1988; Lewis, 1986).

Time can easily become a source of conflict in the couple relationship. In their study with a group of new parents, Cowan and associates (1978) found that the couple who were spending the highest number of weekly hours on home and baby care were the most distressed; conversely, the couple spending the fewest number of hours on home and baby care, were more content. In the latter couple's home, each of them worked part time, spent some time pursuing individual activities, and felt some success as parents.

According to LaRossa and LaRossa's (1981) sociological theory, marital conflict often increases following the birth of a child because of the scarcity of free time. Because the dependency of the child requires so much time for childcare, free time is scarce. A basic axiom of conflict orientation suggests that when resources are scarce, people tend to choose themselves over others. One spouse may "win" the time and the other "lose" or relinquish his/her own interests for the sake of the baby. A key variable in the

traditionalization process is the husband's perception of his free time and his decision to withdraw or not to withdraw from childcare based on that perception. If couples have voiced egalitarian beliefs, traditionalization in the home will either result in conflict for the couple or realignment of behavior and thought to justify the change. Couples need to strive for fairness, that is, a similarity of opportunities and constraints for each partner so that resentment does not develop between them.

Confinement

"Confinement to the house and difficulty in getting out" were mentioned by 25% of the women in Kach and McGhee's (1982, p. 385) study as some of the adjustments they had to make in the transition to parenthood. The new mother has to cope with identity problems resulting from quitting a job, as well as less contact with friends and other adults she knew at work. Without continued support from family and friends, the new mother can easily experience feelings of isolation and loneliness. Boredom with routine childcare and emotional constriction may also ensue towards the end of the second month and persist throughout the first year (Leifer, 1977). Breastfeeding may limit a mother's mobility even more (Entwisle & Doering, 1981).

> Parents frequently comment about limitations placed on their social life, particularly on the freedom to travel, or do something on very short notice. Most discover that life is far more complicated than they ever anticipated. For example, the simple desire to go to a movie requires trying to find a babysitter; and going out shopping, especially in cold weather, involves wrapping and unwrapping the baby in suitable clothing (Belsky, 1986, p. 58).

A couple's egalitarian ideals will be challenged by the arrival of an infant. Women who have worked right up till the baby's arrival abruptly discover that they are now housebound, doing large amounts of menial labor without remuneration. Their husbands, on the other hand, continue their daily routine much the same as before (Entwisle & Doering, 1981). "Feelings of loss and nostalgia for more carefree and less demanding periods" were often expressed in Leifer's (1977, p. 81) study.

Men summarize the change in their wives' lifestyles with the word "restricting." In contrast, they use the word "responsibility" to summarize the change in their own lives. Some men also perceive themselves as being restricted by the changes wrought by parenthood. When couples were asked how to cope with the restrictions placed on the wife, they felt that the husband is "required to show sympathy for his wife's current and 'temporary' loss of freedom" (Lewis, 1986, p. 139). Intimate or spousal support (more than support from network members) has been shown repeatedly to have a positive effect on the postpartum adjustment of women (Tietjen & Bradley, 1985).

Financial Concerns

When couples consider the disadvantages of having a first child, financial considerations become salient. Prenatal health care, delivery costs, hospital costs, diapers, clothing, housing, food, medicine, equipment, and childcare (the single most costly item for some families [Heins & Seiden, 1987]) all loom large (Fawcett, 1988). Couples without insurance may accrue family debts. There is often a

need to move to a larger dwelling in order to have a separate room for the baby (Galinsky, 1981). And, couples are frightened by inflation (Plutzik & Laghi, 1983).

It is rare for American children to contribute towards household expenses today. Instead, children become an economic drain of the family for several years:

> A recent estimate for a typical middle-income American family with two children and a mother who works part-time puts the cost of raising a child to age 18 at $82,400 in 1981 prices. If four years at a public college are added, the price of the high quality child rises to $98,000 [Espenshade, 1984]. As much as 50% of the average American family's budget will go toward raising two to three children (Fawcett, 1988, p. 30).

As a general rule of thumb, the direct cost of raising one child from birth to age 18 is three or four times the family's annual income. In addition, parents might also consider the indirect or opportunity costs, that is opportunities lost by women who remain out of the labor market in order to stay home to raise children (Miller & Myers-Walls, 1983).

New fathers appear to be more concerned about finances than their wives. If their incomes have been halved because of their wives quitting work to remain at home with the baby, they may feel an increased need for success in their chosen careers (Sollie & Miller, 1980). Men may try to advance themselves on the "career ladder" as a result (Plutzik & Laghi, 1983). Financial security becomes more important as they consider the responsibility of raising a child (Feldman, 1974).

When couples become parents, men tend to show fewer changes over time than their wives on self-evaluation measures of their roles as parent, partner, and worker. The most salient difference between the sexes is that women become more psychologically and physically involved in the parent role than men do. Women tend to stop work outside the home or cut their hours drastically, while men spend more time at their jobs. Men interpret this change in their work pattern as being good providers for their wives and children, but women sometimes misinterpret that their husbands are pulling away from the home when they are especially needed and had promised to be available to help (Cowan et al., 1985). Career crises for men seem to occur with the transition to parenthood. Men may consider other career directions, question the adequacy of their salaries, or possibly fear of being laid off (Cowan et al., 1978).

Role Confusion: Who Does What?

"In every social organization, there are roles that have to be filled" (Brehm, 1985, p. 186). Traditionally, husbands and wives had more clearly defined roles: the husband had to earn money outside the home and be the authority figure inside the home; the wife had to care for the home and children and maintain social contacts. But no such clarity exists in modern society. Today, the employment of women outside the home has become acceptable and commonplace (Brehm, 1985). Furthermore, the attitudes of women about their roles have changed so dramatically that men can no longer assume that traditional sex roles will go unchallenged (LaRossa & LaRossa, 1981). During times of

transition, couples encounter even further disagreements about who performs various tasks and who makes decisions. Role strain necessarily increases when a couple has a child as they learn to incorporate and manage the additional role of "parent" into their lives (Brehm, 1985).

It is not unusual today for middle-class and even lower-class husbands to take a week off from work immediately after the birth of their children to help with household chores. However, the husbands may assume that these responsibilities are transient since by the second week after delivery, they give approximately the same amount of help as they gave before childbirth, despite the continued, increased workload in the home (Entwisle & Doering, 1981).

Despite the verbalized egalitarian ideals in modern couples, "couples tend to adopt more traditionally-defined and more differentiated roles during times of stressful transition such as around the birth of a first child. . . . The shift appears to be most marked in the household tasks, next in the family decision-making roles, and least in the baby care items" (Cowan et al., 1978, p. 310). Regardless of whether the wives are breastfeeding or employed, they tend to take on such chores as night feedings and calls to the pediatrician (Cowan et al., 1978). In fact, in childcare activities, unemployed women spend about seven times as much time as their husbands and even employed women spend twice as much time as their husbands (Robinson, 1977). The initiation of sex becomes the husband's role, even if both partners had shared this role previously (Cowan et al., 1978).

As a result of the traditionalization of the roles, women become increasingly dissatisfied with the new role arrangements and "who does what" becomes the top issue leading to conflict and disagreement (Cowan et al., 1985). On the other hand, men view the traditionalization of the division of labor positively and this seems to increase their marital happiness (White, Booth, & Edwards, 1986). Of course, satisfaction with roles also depends on the ideal role concepts of each individual couple (Cowan et al., 1978).

Goldberg, Michaels, & Lamb (1985) explored the interdependencies between marriage and parenting subsystems during the postpartum period. They realized, from previous literature, that during the transition to parenthood, women perform most of the household and caregiving activities and men see themselves not as caregivers, but as playmates to their children. Unfortunately, when men do not see themselves as responsible for a task, doing the task becomes optional to them, thereby increasing marital dissatisfaction for their wives. However, in this study, the researchers found that men were less happy with their marriages and baby when they assumed feminine-type household duties. But, when men assumed more active parenting duties and less household tasks, they appeared much happier with their marriages. And so were their wives, who also perceived more support from their husbands.

Body Image

There appears to be a progressive increase in negative feelings regarding body image as pregnancy increases. Even women who

enjoyed their pregnant appearance--the attention of other people and the bodily changes--report dissatisfaction with appearance during the last trimester. They also seem to fear loss of sexual attractiveness and more permanent bodily damage as they observe stretch marks in the skin and increased breast size. But dissatisfaction with appearance becomes even more intense during the postnatal phase than during the pregnancy, perhaps because the compensations of pregnancy are missing. The few women who experience positive body image during the early puerperium are those who feel especially womanly, particularly as a result of nursing. Most women, however, feel either negative or ambivalent at this time and experience more intense fear over loss of sexual attractiveness (Leifer, 1977). The return of the sexual relationship tends to reaffirm a woman's sexuality and her desirability as a sex partner (Clark & Affonso, 1979).

Women are generally unprepared for the delay and difficulty they will experience in returning to their prepregnant clothing size (Cowan et al., 1978). They express disappointment in their large, soft abdomens and their inability to fit into any clothing except but maternity garments (Heins & Seiden, 1987). Breasts may be more pendulous, and because of the extra fat stored during pregnancy, postpartum obesity is problematic (Galinsky, 1981; Reamy and White, 1987). Women have anxieties regarding body intactness (Shereshefsky & Yarrow, 1973): "fears of losing their figures; fears of losing sexual attraction or sexual function through tearing or stretching; fears that

their physical appearance might diminish their husband's affection; fears that nursing would spoil their breasts" (Robin, 1962, p. 134).

Reamy and White (1987, p. 168) recommended that women use a good nursing bra to help support their "increasingly full mammary glands." Women should expect their abdomen to be lax for at least the first 2 weeks postpartum: gradually elasticity will be regained, usually by 6 to 7 weeks. Usually muscle toning exercises can be gradually introduced, beginning in the hospital. "Although early conservative dieting is prudent, it is realistic for the puerpera to set her goal of attaining her prepregnancy weight at 3 to 6 months rather than 6 weeks" (Reamy & White, p. 182).

The Sexual Relationship

The term, the "fourth trimester of pregnancy" has been used to identify the three month transitional period after birth (Kitzinger, 1977). This is a period of "profound biopsychosocial adjustments" (Reamy & White, 1987, p. 166). The psychosocial transition includes the "stresses and demands of the new parental roles and the need to integrate these activities of daily living" causing anxiety and frustration for the new parents (Reamy & White, 1987, p. 165). In addition to the psychological and interpersonal demands, there are significant hormonal changes for the new mother. As a result of the delivery of the baby and the placenta (the primary source of estrogen and progesterone during the second and third trimesters), a state a "steroid starvation" results: this state resembles the postmenopausal state "with consequent vaginal atrophy, decreased vaginal lubrication,

and decreased expansion of the vagina on sexual stimulation" (Reamy & White, 1987, p. 166).

The production of prolactin for lactation also results in decreased estrogen production by the ovaries (Reamy & White, 1987). Yet, low sex drive is not unique to breastfeeding women. Masters and Johnson (1966) reported that women who were bottlefeeding at 3 months postpartum reported low to negligible sexual desire. Other suggested variables which may effect a woman's postpartum sexual response are: loss of breast sensitivity, fatigue, fear of pregnancy, poor communication, saturation of the woman's need for intimate touching (Kayner & Zagar, 1983), weakness, pain with attempted intercourse, an irritating vaginal discharge, fear of permanent physical harm (Masters & Johnson, 1966), and fear of infection (Debrovner & Shubin, 1985).

Other emotional and relational factors may also be involved. "Postpartum depression can significantly lower libido" (Debrovner & Shubin, p. 88). Anger, a frequent component of depression, may lower sexual desire. The husband may feel neglected by his wife. He may resent working all day and coming home to increased work demands in the evenings and throughout the night (Debrovner & Shubin, 1985). It is the husband who is most likely to complain about the changes in sexual activity in the transitional period (Sollie & Miller, 1980). The wife may feel that her body is being overused by others: she may feel that her husband's sexual needs are just one more demand on her body, one that obligates her to perform for the good of the marriage (Debrovner & Shubin, 1985), although women are also usually concerned

about their husband's sexual tensions during the period of postpartum continence (Masters & Johnson, 1966). The couple may also experience some hostility regarding the changing roles in the household (Devrovner & Shubin, 1985). Sexual liaisons cannot be spontaneous, as before the baby's birth, because of the irregularity of the baby's schedule (Sollie & Miller, 1980).

"From a purely physiologic point of view, there is no contra-indication to coition once the postpartum vaginal bleeding has stopped and any incisions or tears in the vaginal outlet have healed" (Masters & Johnson, 1966, p. 167). Debrovner and Shubin (1985) found that the majority of women in their study resumed intercourse between two and three weeks postpartum, even though obstetricians in the United States usually ask couples to refrain from coitus for six to eight weeks (Kitzinger, 1977). Masters and Johnson (1966, p. 163) found that all the women in their study had "returned to full coital activity within six weeks to two months after delivery."

Occasionally breastfeeding interferes with the sexual relationship. The breast may have been symbolic of the previous sexual relationship and is now restored to its teleologic function. The husband may report that "his attitude toward his wife changed from a sexual playmate to a mother--a sort of incest taboo. (This is best treated by more contact with one's real mother)" (Bradt, 1980, p. 127). Men may also avoid approaching their wives because they are fearful of causing physical harm (by tearing stitches) or causing emotional tension for their wives (Masters & Johnson, 1966).

Prior to intromission, the wife can inspect the episiotomy with a hand mirror and can test for soreness and healing by inserting a clean finger or tampon into the introitus. Use of a water-soluble lubricant is helpful to combat any vaginal dryness (Reamy & White, 1987). Automanipulation may be preferable to intercourse initially (Masters & Johnson, 1966). Partial intromission can precede full intromission; passive vaginal containment can precede active thrusting. Side-to-side or female superior positions may minimize soreness. Pillows under the woman's buttocks may relieve pressure on the episiotomy site. Kegel exercises are useful to promote healing, strengthen pubococcygeal muscles and improve vaginal tone, and to increase awareness of vaginal sensation (Reamy & White, 1987).

Couples who have undergone a Cesarean section have concerns about returning to full sexual activity because of the fresh abdominal incision. Since they have no episiotomy or vaginal trauma to interfere, they are usually advised to wait until the abdomen is comfortable. However, the new mothers do not have time to recuperate, as do patients who have other types of abdominal surgery, since they are immediately thrust into the physical activity of childcare. They may be extremely fatigued, as well as having to deal with the emotional consequences (anger, depression, guilt, feelings of inadequacy, etc.) of their surgery. As a result, they may not be psychologically or physically ready for sexual activity as soon as their peers who have delivered vaginally (Debrovner & Shubin, 1985).

Infant Characteristics

> . . . we wish to underscore a very important point, often paid lip service in the past but too frequently neglected in actual research and theory: Not only is the infant or child influenced by its social, political, economic, and biological world, but in fact the child itself influences its world in turn.
>
> Historically, it is true that most emphasis has been placed on the effect of the social and physical environment on the development of the infant and child. For example, the literature is replete with examples of how certain maternal behaviors affect specific infant functions. This emphasis needs to be corrected, lest we conclude that the infant is a passive organism constantly being affected but having no effect, constantly being altered but producing no change itself. Such a model of the developing child in fact is not only false but is on its face illogical (Lewis & Rosenblum, 1974, p. xv).

Most parents recognize that children show strong temperamental characteristics even from their birth. Thomas and Chess, who have studied temperament in children since 1956, termed the children "easy" at one extreme and "difficult" at the other extreme, with a third categorization as well, "children who are slow to warm up." These differences in temperament are well-established by the time a baby is from 2 to 3 months old (Segal & Yahres, 1979).

The parents' earliest perception of their child may be based more on fantasy than on reality. They may expect their children to be better than average since there is great emphasis placed on being better than average in our culture. Gradually the parents begin to form a more precise perception of their child, based on behaviors such as crying, spitting, feeding, elimination, sleeping, and predictability. Parents need to be freed from the stereotypes of what is good or bad in infant behavior and helped to focus on the uniqueness of their

child and his/her responses to the environment (Clark & Affonso, 1979).

Infant calmness or difficulty appears to affect marital adjustment in the transition to parenthood. The parents of calm infants have relatively more time to devote to each other, making the transitional experience more enjoyable. On the other hand, the parents of fussy, difficult infants exert more energy in childcare and experience more frustration. If the father is uninvolved with the fussy infant and the burden of the childcare falls on the mother, resentment may develop between the parents, resulting in lower marital adjustment (Wright, Henggeler, & Craig, 1986).

"An infant's excessive crying affects parents negatively" (Wilkie & Ames, 1986, p. 545). Infant irritability, crying, or colic results in parental feelings of depression, helplessness, anger, exhaustion, and rejection of the infant. In one survey, 80% of the mothers who responded claimed that they had felt like "bashing" their babies and 59% reported that this feeling was due to the baby's crying (Wilkie & Ames, 1986). In Wilkie & Ames' own study (1986), they found that parents' own negative feelings (exasperation, annoyance, depression, ambivalence, incompetence, and anger) correlated positively with the amount their baby cried.

When babies cry, mothers appear to feel most responsible for consoling the child and in general, they seem to be better at coping with the crying infants. At 3 months postpartum, Fleming et al. (1988) found that the infant's state was a significant predictor of

maternal feelings of adequacy. Mothers often blame themselves, thinking that they have mishandled their children in some way (Korner, 1974). When mother's efforts to cope with crying are inadequate, the infant may respond by crying even more, resulting in further withdrawal of the mother (Bell, 1974).

In contrast, the fathers appear to be even less tolerant of the infant's crying (Goldberg et al., 1985). They experience feelings of anxiety and powerlessness, and negative feelings about the changes in their lifestyles. They tend to blame their wives for the excessive crying in the infants when in fact neither parent should be "blamed" for the crying of early infancy (Wilkie & Ames, 1986). There is a substantial reduction in infant crying during the first year (Bell, 1974).

Some parents feel that their infant's crying is willful behavior or a temper tantrum. They need to be reminded that babies need to be held and comforted and that they should not fear "spoiling" them in the early weeks and months when they do comfort them (Shereshefsky & Yarrow, 1973). In moments of frustration, when parents feel overwhelmed, abuse of the child is a very real danger (Wilkie & Ames, 1986). In her case study of a mother of twins, Zabielski (1984) found that under the pressure of the constant infant demands, the mother attributed a force and purpose to the behavior of the infants of which they were completely incapable. She saw additional demands as an assault on her resources. However, Zabielski (p. 38) also "searched the infants for any personal response to herself and these responses

tended to reinforce her mothering efforts," suggesting that mothers may also ascribe positive attributions to the infant's behavior when they need encouragement.

"Developmental psychologists have long recognized that the effect the infant has is likely to be a function of his/her unique characteristics" such as temperament, health, physical appearance, responsiveness, and attractiveness (Belsky, 1981, p. 11). For instance, Russell (1974) recounted that the parents of infants who were more demanding (i.e., cried frequently, often "on the move," had feeding problems) experienced more crisis. Babies with serious health problems, premature babies, and "special" needs babies all complicate the transitional period for their parents (Belsky, 1981). "Bearing a special child might disrupt a vulnerable marriage or enhance a spousal relationship that already has a firm foundation" (Belsky, p. 12).

For various reasons, adopted children often experience more prenatal and birth complications which may result in more difficult temperament patterns and early developmental delays, possibly affecting their parents transitional period negatively.

> A growing body of research suggests that adopted children are more likely than nonadopted children to be born to adults who manifest various psychopathological conditions thought to have some genetic component. . . . Furthermore, adopted children more often experience prenatal and birth complications than their nonadopted counterparts. . . . Both types of biological vulnerabilities could produce more difficult temperament patterns and early developmental delays in young adopted children, which in turn, could adversely affect the early parent-child relationships and the couple's attributions concerning parenthood (Brodzinsky & Huffman, 1988, p. 273).

The timing of the placement may also affect the transitional period for the parents because of attachment bonds between the child and other caregivers. Children who have experienced disruptive early caregiving (i.e., multiple foster placements in the first year or so) are likely to exhibit acute distress reactions which can possibly lead to more insidious forms of maladjustment since they have not been able to form secure and trusting relationships with any caregiver. These socioemotional difficulties usually occur in cases where the infants are separated from biological and/or foster mothers after 6 to 7 months of age (Brodzinsky & Huffman, 1988).

Relationships with Grandparents

> We believe that partners' perceptions of their families of origin do begin to shift after they become parents. One parent begins to reinterpret his or her growing up years as more supportive now that he or she sees how difficult it is to raise a child; another becomes more resentful about the endless bickering he or she was exposed to as a child (Cowan et al., 1985, p. 466).

Couples often tackle parenthood with high ideals for raising their children better than their parents, determined not to make the same mistakes. Yet, despite their best intentions, they are likely to find themselves either repeating the same mistakes or making new ones. In doing so, they reappraise their own growing-up years with more humility and understanding, realizing that their parents may have been more conscientious and well-meaning than they had originally thought. This is a growth-producing experience, one in which the new parents stop attributing their difficulties to their parents and start taking responsibility for their own lives. It can result in greater

closeness between the generations, perhaps for the first time in years (LaPerriere, 1980). No longer are they simply the children of their parents, but now they are the parents of their children (Cowan et al., 1978).

"Strengthened relationships with extended families are . . . reported routinely" (Belsky, Ward, & Rovine, 1986, p. 122). Young adults often experience parenthood as their rite of passage into full adulthood, giving them increased identification with another generation (Leifer, 1977). Some new parents experience a much closer relationship with their parents after years of distancing; others experience being allowed to participate in family discussions which were formerly open only to the "grown-ups" of the family (Cowan & Cowan, 1987).

Tinsley and Parke (1987, p. 271) reported that geographically close grandparents appear to be "involved, appreciated, and active members of the support network of parents with young infants." As many as 60% of grandparents see their children once a week. By providing support to their adult children, grandparents can partially relieve parents of their responsibilities which, in turn, may indirectly alter the parents' attitudes and/or behavior toward their children and modify the quality of the marital relationship (Tinsley & Parke, 1987). For some couples, "including their families of origin into their nuclear family system allows a greater variety of triadic relationships to form and relieves stress on the parent system"

(Okun, 1984, p. 101). Usually the maternal grandparents are more involved with the new family (Tinsley & Parke, 1984).

However, too much contact from grandparents may be perceived as "aversive and intrusive" by the younger generation (Tinsley & Parke, 1987, p. 272). Moderate levels of contact have been found to be more helpful than the more extreme high or low levels. Contact is said to be satisfactory when it is enough to satisfy needs without eliciting resentment (Tinsley & Parke, 1984).

Advice from grandparents may be devalued by new parents who want to evolve their own childrearing styles (Entwisle & Blehar, 1979). Russell (1974) reported that a significant problem for new fathers was the suggestions from in-laws about the baby. When grandparents are critical, the new parents experience additional stress; when grandparents are supportive and respect the new parents uniqueness, new parents experience a great source of encouragement (Galinsky, 1981). Interference from grandparents may cause unfinished business from the family of origin to resurface (Okun, 1984). "Conflicts are activated and rivalries stirred. Issues of social class, religious affiliation, and family customs, often are sharpened" (LaPerriere, 1980, p. 91).

"Parents, in effect, serve as 'gatekeepers' between their own children and the grandparents" (Tinsley & Parke, 1984, p. 177). The recipient of support likes to maintain some control over the frequency and timing of the contact (Tinsley & Parke, 1984). Negotiating boundaries with the grandparents can sometimes be stressful, but the couple

needs to decide how much to include or exclude them in their lives (Okun, 1984). Parents, who at one time kept a low profile, may be motivated by the birth of a grandchild to become involved with their children again; therefore, the new parents may need to renegotiate boundaries to maintain their sense of privacy (Broderick, 1984).

In some cases, couples may turn to their parents for help during the transition to parenthood, only to find that the parents may be unavailable or unable to help. In other cases, because of the late-timing of parenthood, the new parents may already be caring for their own parents; in these instances, the direction of support is reversed, that is, from parent to grandparent (Tinsley & Parke, 1984). In other cases, the two families of origin may provide unequal support. One family may be preferable to the couple for reasons of affluence, attractiveness, warmth, and/or less trouble ridden: the couple may choose to limit their loyalty to that family. However, this allegiance to one family over the other skews the balance of power within the new family and "the parent with the less favored family may feel inferior, less entitled, less worthy, less powerful" (LaPerriere, 1980, p. 91).

Mother's Return to Work

New mothers need to learn to resolve the balance between their own needs and those of their family (DeMeis, Hock, & McBride, 1986). Women who are well educated and have had satisfying careers usually experience some conflict between their careers and motherhood, and most of these women accommodate their careers to their new role as

mother, rather than the reverse (Daniels & Weingarten, 1982). However, the economic need of the family is the main reason that most women go to work (Gordon & Kammeyer, 1980), despite the fact that many of these women actually prefer to stay home (DeMeis et al., 1986).

The belief system of women appears to affect how much separation anxiety mothers experience when they leave their infants to return to work. When mothers believe that exclusive maternal care is very important, that their children prefer and are better off with their care, and that their children will not adjust well to another caregiver, they are likely to experience more worry, sadness, and guilt if they have to return to work. When mothers perceive that mother-child separation has benefits for the child (e.g., the child learns more interpersonal skills and becomes aware of diverse values, perspectives and beliefs through interaction with other caregivers) they have less difficulty with separating from their children. In sum, when mothers return to work because they had planned to and want to, they will experience less separation anxiety than those who want to stay home but have to work (DeMeis et al., 1986).

Making the decision between staying home and returning to their careers is very difficult for some new mothers. They may feel pulled between their desire to nurture their infants and the desire to continue a career (Sollie & Miller, 1980). One mother in Sollie & Miller's (1980, pp. 163-164) study expressed her frustrations and discontents as follows:

> My baby is a new individual in my life whom I love dearly, but at this point in my life I am not personally fulfilled in simply being a mother. I am finding it difficult to cope

> with the boredom and lack of intellectual stimulation in my life. I gave up my career of teaching because I felt it would be unfair to take my baby to a day care center or babysitter. I'm very undecided as to what I should do.

More distress and discontent over being full-time homemakers was expressed by mothers who previously had careers; however, these women also expressed anxiety about how returning to work would effect their children (Sollie & Miller, 1980). Fulltime homemakers appear to be "at risk for stresses related to the monotony, fragmentation of tasks, and pressures for speed in performance associated with fulltime housework" (Miller & Myers-Walls, 1983, p. 66). Entwisle and Doering (1980, p. 259) reasoned that the mothers who did return to work might experience less burden in the mother role "because women who work outside the home have a change of scene and a refreshing relief from baby care."

DeMeis et al. (1986, p. 630) found that all the mothers in their study (i.e., those who preferred to stay at home and those who preferred to be employed) responded to the "salience of the maternal role and their perceptions of their young babies as being fragile and vulnerable." In other words, they exhibited a greater need to nurture their infants and experienced their employment as interference with their maternal roles.

Belsky, Perry-Jenkins, & Crouter (1985) found that if women find their jobs unsatisfying, they report more work-family interference: this is reflected at home with less maintenance behavior in their marriage, increased conflict, declines in marital communication,

household patterns need to be rearranged and the parents also experience a reduction in sleep. If work interferes with family life and vice versa, the patience and sensitivity of each partner to the spouse is likely to be reduced. Along with the renegotiation of many aspects of family life, stress will result, making marital communication more difficult and generating more conflict. For men, low job status has the same effect of work-family interference. The more stressed and fatigued the husband when he returns home, the more negative interactions occur: the wife also experiences more household tasks that day.

Women are likely to encounter four distinct types of conflicts related to their five different roles (parent, spouse, employee, friend, and homemaker) when they have infants and are employed outside the home (Myers-Walls, 1984). These conflicts are: time conflicts (there is not enough time to accomplish all responsibilities); locations conflicts (it is not possible to be in two places at once); energy conflicts (supplies of physical, emotional, and mental energy are limited); and expectation conflicts (a person is expected to act differently in different roles). For instance, employment and social life roles may conflict with parenthood due to location conflicts; "time and energy conflicts may be the basis for difficulties in balancing housekeeping and being a spouse with parenthood" (Myers-Walls, p. 270).

Poloma (1972) identified four strategies that women use to successfully integrate their maternal roles with employment. First,

they define their situation positively. Examples of positive cognitions might be: "I spend more actual time with my children than my nonworking neighbors who are very active in volunteer work" or "I am a better mother because I work and can expend my energies on something other than the overmothering of my children" (Poloma, p. 196). Second, they establish a salient role, so that if a conflict situation occurs between family and career responsibilities, the family demands are first on the priority list. Third, they compartmentalize: they keep their home and employment roles as separate as possible. Fourth, they compromise their own careers to fit in with such factors as the husband's job, his attitude toward her job, the children's ages, the amount of energy she has, and her personal philosophy of motherhood. And, "when one or more of these factors is out of kilter, the wife makes the necessary adjustment to manage role strain. She generally expects little and asks nothing of the family to better enable her to adjust to family and career demands" (Poloma, p. 196). However, Paloma also found that the use of the four strategies was not successful in balancing the parenthood and housekeeping roles (Miller & Myers-Walls, 1983). But when their jobs are satisfying and the women well-organized, the women can usually be very satisfied with multiple roles and can usually manage conflict without internalizing it (Poloma, 1972).

RELATED RESEARCH TO SECTION II: INDIVIDUAL AND MARITAL PROBLEMS

Postpartum Depression

Each year thousands of women (10% to 15% of new mothers) suffer mild to moderate postpartum depression (Cox, Holden, & Sagovsky, 1987). At a time when society tells women that they are supposed to be happy, new mothers may find themselves engulfed in despondency that they simply cannot comprehend (Kraus & Redman, 1986). Guilt and shame often keep them from asking for help. Lack of available support prevents most of them from finding help (Dix, 1985; Handford, 1985). Many doctors are not prepared to handle the problem; significant others hope they will simply "snap out of it" with some reassurance and a little extra instrumental help (Kraus & Redman, 1986).

Today's new parents are facing a world that is very different from what they experienced in their families of origin. Couples are less prepared to become parents since the decrease in family size, increase in mobility, and the breakdown in the extended family have minimized the parents natural opportunities for learning parenting (Kraus & Redman, 1986). Furthermore, the traditional role of women has been devalued and many women feel that they are obligated to set aside "important" work for the tasks of mothering (Kraus & Redman, 1986).

In some cases, without help, postpartum depression will subside spontaneously (Yalom et al., 1968; Handford, 1985; Searle, 1987). But often it continues well past 1 year, leaving mothers

feeling confused, inadequate, overwhelmed, and trapped, with low self-esteem and a crushed identity (Dix, 1985; Searle, 1987). Studies have led us to believe that the probable consequences of untreated post-partum depression are the following:

1. deterioration of the mother's physical and mental health (Handford, 1985; Cox et al., 1987)
2. self-destructive behaviors on the part of the woman (e.g., alcoholism, drug addiction, suicide attempts) (Handford, 1985)
3. dysfunctional parent/child relationships (e.g., scapegoating, masked emotional rejection, attachment problems, etc.) (Handford, 1985; Searle, 1987)
4. marital breakdown
5. child abuse (Robertson, 1976; Searle, 1987)
6. child neglect (Handford, 1985)
7. long-term negative impact on the family (Cox et al., 1987; Searle, 1987).

Clearly new parents need to be educated before delivery, if possible, so that they can do everything possible to prevent destruction from postpartum depression in their lives (Gordon, Kapostins, & Gordon, 1965).

Researchers generally agree that there are three types of postpartum depression: postpartum blues, postpartum depression (per se), and postpartum psychosis (Murray & Gallahue, 1987; Kraus & Redman, 1986; O'Hara, 1987; Searle, 1987). O'Hara (1987, p. 206) stated, however, that "it should be noted that there is little evidence that

they actually represent 3 distinct states." Murray and Gallahue's (1987) research seems to confirm this belief. The types appear to exist along a continuum of severity ranging from very mild to very severe; they will be discussed in that order.

The mildest and most frequently experienced type of postpartum depression is postpartum blues. Anywhere from 50% to 80% of new mothers experience this type from the 3rd day after the birth (Yalom et al., 1968) until 8 weeks postpartum (O'Hara, 1987). Emotional lability is typical: patients describe themselves as "excited," "giggly," "oversensitive," and "upset by little things." Garrulousness is also a tendency. Impairment of abstract or conceptual thought may be apparent; Thematic Apperception Test picture projections resemble those found in depressives (Robin, 1962). Insomnia is rarely a problem (Hamilton, 1962).

Episodes of crying may last for over 2 hours at a time. The reasons for the crying are many and varied; for some, it is sadness or hopelessness, while for others, the reasons may be environmental changes and threats (especially in relationship to the husband), low self-esteem (doubts regarding competence as a mother), illegitimate pregnancy, postpartum pain or illness, dissatisfaction with the baby, relief at the conclusion of a difficult labor, difficulty with parents who have not accepted the marriage, and difficult interaction with the obstetrician (Yalom et al., 1968). The tears may even be blamed on the "back-to-school" [controlled] atmosphere of the hospital (Robin, 1962). Many women express anger, usually directed at their husbands

for their lack of consideration or unwillingness to help; many regress to wanting to be mothered themselves (Yalom et al., 1968). "Any indication of personal slight or rejection precipitates transient depressive swings" (Yalom et al., p. 24). Mothers often complain of feeling physically and emotionally drained from both pregnancy and the birth (Searle, 1987).

Because the blues are such a transient mood disturbance and because the majority of women apparently experience them, they may well be considered a "normal concomitant of postpartum adjustment" (Hopkins et al., 1984, p. 501). However, O'Hara (1987) believed that the postpartum blues may be a precursor to postpartum depression. If the blues persist or become more severe, they may indeed become early warnings of postpartum depression (Searle, 1987).

The depressive symptoms of postpartum depression (per se) usually appear insidiously after the return home (Pitt, 1968) in the early postpartum weeks and months and may persist for more than a year (Kraus & Redman, 1986). Symptoms reported include tearfulness, despondency, labile mood, feelings of inadequacy, inability to cope (particularly with the baby) (Hopkins et al., 1984), overwhelming feel-ings of guilt, shame, often isolation, and a sense of loss of self (Handford, 1985). Guilt often involves "self-reproach over not loving or caring enough for the baby" (Pitt, 1968, p. 1327). Somatic symp-toms abound; irritability, fatigue, and exhaustion are frequently complaints (Pitt, 1968). Suicidal ideation is relatively infrequent (Hopkins et al., 1984).

Mothers with postpartum depression differ in their response towards the baby. Some have an unwarranted anxiety over the baby, especially in regards to feeding (Pitt, 1968). Others feel ambivalent towards the child: feelings vacillate "between love and actual desires to hurt the child, refusal to feed or see the infant, and a general lack of interest" (Searle, 1987). Fleming et al. (1988) found that mild postpartum depression does not interfere with the instrumental activities between mother and child, but it does have a negative effect on the affective social relationship between the mother and infant.

Researchers are undecided as to whether postpartum depression is a distinct entity in itself. In his study of 305 postpartum women, Pitt (1968) found no correlation between previous mental illness and postpartum depression: in fact, he called it "atypical" depression, that is unique to the postpartum period. As well, Cutrona (1982, p. 490) believed that "the symptoms of nonpsychotic postpartum depression are somewhat different from those of Major Depression as specified in the DSM-III." Searle (1987) noted that postpartum depression can be distinguished from other depression by the thought content: the new mother feels unable to meet the enormous demands on her love from her family, resulting in the self-derogatory feelings of depression.

A depressive mood change that extends beyond 10 days is likely to persist and may even persist for more than 1 year; therefore, women who experience this type of postpartum depression need to receive appropriate professional help (Cogan, 1980).

Although postpartum psychosis is the most infrequent form of postpartum depression (between 1 and 4 per 1000 childbearing women), it is the most severe, with symptoms usually occurring 2 or 3 weeks after childbirth (Cogan, 1980; Murray & Gallahue, 1987). Postpartum psychosis is characterized by deep depression, suicidal thoughts or attempts, threats of violence, and actual physical violence towards or complete rejection of the infant (Searle, 1987). Symptoms may also include confusion, hallucinations or delusions, and gross impairment in the ability to function (O'Hara, 1987). Current opinion suggests that there is little difference between puerperal and nonpuerperal psychoses (O'Hara, 1987). "The majority of the puerperal psychoses fulfill the research and diagnostic criteria for mania disorder or major depressive disorder and are judged to be psychotic reactions associated with childbirth" (Murray & Gallahue, 1987, p. 197).

The etiology of postpartum depression remains unclear. Researchers have examined at least three different paths in their search for its origin: physiological, psychological and interpersonal.

Many doctors believe that there are physiological causes, specifically hormonal changes resulting from childbirth that trigger depression. Katharina Dalton (cited in O'Hara, 1987) posited that during pregnancy there is an exaggerated hormonal output to hold the fetus in the uterus and nurture its survival. By the time of delivery, the mother's estrogen and progesterone level are 50 times higher than before pregnancy. Between 24 and 36 hours after childbirth, the

estrogen and progesterone levels fall from these high levels to levels that are below prepregnancy levels. This sudden drop in hormones is similar to drug withdrawal, with related symptoms (Dix, 1985; O'Hara, 1987). However, other studies have been inconclusive regarding the role played by estrogen, progesterone, or prolactin in any of the post- partum depressions (O'Hara, 1987: Murray & Gallahue, 1987).

Results from studies on the roles of cortisol, dexamethasone, and tryptophan have been mixed and inconclusive (O'Hara, 1987). O'Hara (1987, p. 209) believed, however, that the "continued exploration of the role of tryptophan and its effect on serotonin in the blues may be profitable." After reviewing the literature, Murray and Gallahue (1987, p. 200) believed that "the biogenic amines, norepinephrine and serotonin, together with changes in gonadal hormones in connection with menstrual cycle, pregnancy, and puerperium may be involved in a susceptibility to affective disorders." There also appears to be a correlation between premenstrual tension and postpartum blues (Cutrona, 1982).

O'Hara (1987) reviewed the research linking postpartum depression with gynecological and obstetrical factors. Studies attempting to link the depression with menstrual problems, previous abortion or miscarriage, or obstetrical complications were all inconclusive. Breastfeeding and bottle-feeding appear to have no relationship to postpartum depression (Murray & Gallahue, 1987).

It is likely that there are psychological causes to postpartum depression since both adopting mothers and new fathers may experience

postpartum depression (Kraus & Redman, 1986; Atkinson & Rickel, 1984). All social classes appear to be susceptible: no significant relationship exists between socioeconomic status and postpartum depression (Cutrona, 1982).

"Depressions are characteristically associated with the experience of loss, and childbirth encapsulates a combination of many losses" (Kraus & Redman, 1986, p. 67). Losses include loss of sleep (Kach & McGhee, 1982), loss of free time (Belsky & Pensky, 1988), loss of self-image (Roth, 1975), loss of freedom (Tietjen & Bradley, 1985), and loss of role in the workplace (Kraus & Redman, 1986). Handford (1985) found that significant loss (e.g., miscarriage, death of a significant other, etc.) during the 2 years before the birth and life changes involving loss (e.g., loss of employment or even job promotion) were associated with postpartum depression.

A stress theory of postpartum depression has been proposed by many researchers (Murray & Gallahue, 1987). Besides the somatic stresses of pregnancy and delivery, there are the everyday stresses of being on continuous, 24-hour call for the very dependent infant (LaRossa & LaRossa, 1981). There also appears to be a consistent relationship between undesirable stressful events or circumstances around the time of childbirth and postpartum depression (Cutrona, 1982).

Personality may be a factor contributing to postpartum depression. Some studies have reported, for instance, that the attributional style of women, measured in pregnancy, could predict

postpartum depression (O'Hara, 1987; Cutrona, 1982) while others found that attributional style did not give strong support, at least to a sense of guilt, as the explanation for postpartum depression (Murray & Gallahue, 1987). Attitudes about self-control may also be related to postpartum depression level (O'Hara, 1987). Anger, hostility, and anxiety have also been linked to it (Murray & Gallahue, 1987; Yalom et al., 1968).

"Most studies have found a significant relationship between prior history of psychiatric symptoms and postpartum depression" (Cutrona, 1982, p. 496). Many women experience the onset of symptoms during the pregnancy. Thus it appears, that "a higher proportion of women who develop postpartum depression have a history of previous psychiatric problems than women who do not become depressed following childbirth" (Cutrona, p. 496).

There are likely interpersonal causes for postpartum depression, as well. The birth of a new baby constitutes a developmental crisis for a couple or family (Kraus & Redman, 1986). In order to successfully meet the crisis, the couple must complete some tasks: make room for the new member in the system, establish a hierarchy for the parents, and continue to replenish the couple system, as well as their individual needs (Okun, 1984). Boundaries and relationships among friends, business associates, and extended family members need to be renegotiated (Okun, 1984; Kraus & Redman, 1986).

Most families perpetuate myths about the joys of parenthood and do not confirm the difficulties and new stresses that an infant

brings to a family. When a mother's experience deviates from the family expectation, anxiety and guilt may result (Kraus & Redman, 1986).

Usually a full maternal bond does not develop between mother and child until between 3 weeks and 3 months postpartum (Kraus & Redman, 1986). The infant's dependency, self-centeredness, and inability to relate initially make the mother-child relationship very one-sided (Zabielski, 1984). In addition, potential mismatches in temperament may further contribute to the delay in development of maternal feelings (Kraus & Redman, 1986).

The marital relationship appears to have a bearing on the development of postpartum depression. Couples with low scores in self-disclosure (indicating communication problems), for instance, were more likely to be depressed postpartum (Atkinson & Rickel, 1983). However, couples, whose relationships were characterized by mutuality, were less likely to develop postpartum stress problems (Shereshefsky & Yarrow, 1973). Whiffen (1988) found low marital adjustment scores predictive of postpartum depression. When men report depressed mood following the birth of their first child, spousal relationships are consistently an area of concern (Zaslow et al., 1985).

"Postnatal depression frequently occurs after the withdrawal of support systems, for example, on return home from hospital or after father returns to work" (Searle, 1987, p. 81). Lack of social support (eg. helping with household tasks, acting as confidant) from the spouse, family, and friends has been correlated with levels of

postpartum depressive symptoms (O'Hara, 1987). Yalom et al. (1968) found that anger directed toward the husbands for lack of consideration or unwillingness to help was associated with postpartum blues.

Morris (1987, p. 280) reported that depressed mothers used constructs describing themselves and their mothers as "negative and closely linked." These new mothers needed to go through a process of differentiation from their mothers before their depression subsided (Morris, 1987; Okun, 1984).

Lomas (1959) observed that, in cases of puerperal breakdown, the emotional, geographic, and emotional links between new parents and their families of origin were weak. The family consisted only of mother, father, and baby as an independent unit.

"None of the potential causal factors in postpartum depression have been supported unambiguously in the literature" (O'Hara, 1987, p. 214). However, several researchers do agree that the single best predictor appears to be the prenatal depression level (Cogan, 1980; O'Hara, 1987; Handford, 1985). A history of family psychopathology seems to be strongly related to the development of postpartum depression (O'Hara, 1987). Women who experience high levels of stress during pregnancy and who lack supportive spouses also appear to be particularly vulnerable.

Cogan's (1980) review of the literature on postpartum depression reveals that women who experienced depression tended to be more neurotic, more anxious, less extroverted, more often married for less than three years, and somewhat older. She (p. 3) also found that "the

amount of reinforcement which the new parents experienced during the postpartum period was also related to prediction of postpartum depression." Women who did well during the postpartum period had more friends with young children, gave less emphasis to tidiness in the home, obtained more experienced help with the baby, had husbands who reduced their outside activities in order to become more available in the home, continued to socialize outside the home (although less frequently), and continued outside interests (although with more limited responsibilities).

The treatments for postpartum depression are many and varied. It would appear that if a woman presents her problems to a physician, she will be treated with drugs. If she goes to a psychologist, she will receive psychotherapy. No one treatment of choice is evident in the literature. Research continues in both treatment and prevention (O'Hara, 1987; Dix, 1985; Murray & Gallahue, 1987).

Gordon and Gordon (Cogan, 1980) successfully explored the value of adding preparation for parenthood information to the content of prenatal baby classes to prevent postpartum depression. The mothers were taught to get educated about the responsibilities of motherhood; to get help from their husbands and dependable friends or relatives; to make friends with other couples with children; to set priorities; to get plenty of rest; to discuss feelings and plans with their husbands; to have limited outside interests, to arrange for babysitters early; and to get a family physician early. "Where husbands received special instruction with their wives, less than half as

many women developed emotional problems as did wives who participated alone" (Gordon et al., 1965, p. 160).

Relaxation training in combination with exposure to possible postpartum stressors has also been used successfully as a method of reducing postpartum emotional distress (O'Hara, 1987). In another effort towards prevention, Dalton (O'Hara, 1987) treated 27 women who had at least one previous episode of postpartum depression with progesterone. She reported no cases of depression within 6 months of delivery; however, she used no control group for her study.

Not surprisingly, tranquilizers, antidepressants, and antipsychotic medications have been used as intervention for postpartum depression. Tricyclic antidepressants, monoamine oxidase inhibitors, and lithium have all been used successfully (Murray & Gallahue, 1987; O'Hara, 1987). Generally breastfeeding will have to be discontinued once medications are started, and often the mother is rendered incapable of caring for the baby because of the side effects of the drugs (Handford, 1985).

Handford outlined a nonmedical treatment program for mothers suffering from postpartum depression, offered by the British Columbia Ministry of Human Resources as one of its services to families. Initial assessment is handled over the telephone because of the anonymity which it provides and the difficulty many women experience in trying to get away from home. The assessment involves a description of what the woman is experiencing plus giving her information which helps her feel "less alone and different" (Handford, p. 32). Then, a telephone

counselor, who has herself experienced postpartum depression, is assigned to call the depressed mother at least 2 or 3 times per week. Lastly, a weekly support group is available. The goal of the treatment is to help the mother "regain a sense of herself and take control of her life" (Handford, p. 33).

Morris (1987) used group therapy to help mothers who had been depressed for over a year from their baby's birth. Although the members were uncommunicative initially, in time they shared openly and became good friends, leading Morris to conclude that these women needed confiding relationships to end their loneliness and depression.

Kraus and Redman (1986, p. 67) saw postpartum depression as the result of faulty interactions: "If a depressive spiral develops, it is a result of the interaction between the person and her environment." They proposed a seven-stage intervention to reorganize the maladaptive relationships that have developed. The model (p. 68) includes:

1. accepting and normalizing conflicting complaints of each family member,
2. involving significant others as customers for change,
3. reframing depression as positive but costly,
4. deriving adaptive behavior from maladaptive premises,
5. regulating involvement of others in childrearing,
6. restraining the new mother from too-rapid resumption of the responsibilities of motherhood, and
7. predicting and prescribing relapse.

The authors described a case study but as yet have not researched their use of the circular model with postpartum depression.

Strasburger (1980) described a case study in which he was "stuck" when working only with the depressed mother. When her husband was included in the therapy and family systems techniques (reframing, doubling or coaching, prescribing the symptom, etc.) were used, the new mother became "aware that she had been expecting satisfaction and happiness from another person, though it was her responsibility to achieve these things for herself" (Strasburger, p. 45). Strasburger (p. 48) concluded that although postpartum depression can be successfully treated with individuals, "seeing the symptoms in the context of a couple's dynamics permits an alteration of the system with which the individual interacts" which may contribute to intrapsychic change as well as more satisfactory outcomes.

Researchers appear to agree on the types of depression, yet even in this area the trichotomy is unclear. Much disagreement exists in the areas of etiology and treatment. While treatment has generally been successful, education and prevention techniques appear to be capable of eliminating a substantial portion of postpartum depression in new mothers (Cogan, 1980).

Marital Satisfaction

Studies have shown that there seems to be a curvilinear pattern in marital happiness over the marital life cycle (Feldman, 1974; Brehm, 1985). "The U-shaped pattern appears to be closely associated with the arrival and departure of children: with marital

satisfaction declining as children are born and grow up, but then increasing as the children mature and leave home" (Brehm, 1985, p. 284). The points of least satisfaction in the marriage seem to be when the last child goes to school and when the family has teenagers. One hypothesis for the rise in marital satisfaction in the latter years is a decrease in expectations and a growing acceptance of imperfections in the spouse as the couple grows older (Feldman, 1974). The decrease in marital satisfaction is experienced first by the wife (Waldron & Routh, 1981; Ryder, 1973; Cowan et al., 1985). Various reasons for this decrease have been suggested: postpartum depression, confinement, fewer social interactions, and receiving less reinforcement than before the baby's birth (Waldron & Routh, 1981). "Disagreements on the solutions to problems" was another problem cited by wives in Waldron & Routh's (p. 787) study. If the wife was depressed, it is possible that she might become apathetic to solutions and capitulate to her husband. It is also possible that disagreements arise more frequently because of the increased range of topics the couples now discuss. Also, it appears possible that the wives may nag their husbands when they perceive insufficient support but in the end capitulate (Waldron & Routh, 1981).

Ryder (1973, p. 605) found that wives with a child were more likely to complain "that their husbands were not paying enough attention to them" than when they were childless or pregnant. He suggested two possible hypotheses for this outcome: either the husbands were

less attentive to their wives after a child is born, or wives want more attention from their husbands after the birth of their child.

Cowan et al. (1985) found that men's perceptions of marital satisfaction did not change significantly from pregnancy through 6 months postpartum. However, between 6 and 18 months, "the new fathers' satisfaction with the couple relationship took a steep plunge" (Cowan et al., p. 469). Men spend more hours on the job becoming "good providers" (Cowan et al., p. 467): their wives perceive them as pulling away when they especially want support (Cowan et al., 1985) and they resent their continued participation in outside activities as well (Sollie & Miller, 1980). Men often distance themselves from the parental role--they "help" their wives with the baby--and conflict results, especially if they expect a repayment for the "help" and their wives are not willing to give it (LaRossa & LaRossa, 1981).

The drop in marital satisfaction for both spouses appears to be related to increased conflict, with role conflict at the top of the list of issues leading to conflict and disagreement (Cowan et al., 1985). There are linear declines in positive behavior and maintenance behavior. Feelings and expressions of love for the spouse decline, while feelings of ambivalence increase (Belsky et al., 1985). Communication declines in quantity and quality. Couples show greater differences in opinions, ideas, perceptions, and satisfactions as their roles become more differentiated (Cowan et al., 1985).

Marriages typically become more patriarchal during the transition to parenthood (LaRossa & LaRossa, 1981). The power structure in the marriage changes as women quit work and rely more on their husbands for finances. A woman's dependence on her husband for help with childcare also puts her in a less powerful position. In order to rectify the situation, couples use more coercive strategies with each other--power plays, guilt induction, disparagement. The result for some couples could be "a cycle of mutual coercion escalating ultimately to the use of physical force" (LaRossa & LaRossa, p. 62). Husbands seem more satisfied with the amount of influence they exert after the birth of their children (McHale & Huston, 1985).

Yet, where childcare is concerned, the wife becomes the expert and holds the power in that area, while the husband remains the secondary caregiver. "This 'deference' to the mother is significant since it may both influence the distribution of 'power' within the marital relationship and distance the father psychologically from his wife" (Lewis, 1986, p. 141). The different statuses of the spouses as childrearers can make parents compete for the baby's attention. Women may feel let down by their husbands' aloofness, but at the same time, men feel that their contributions are unrecognized and that they are being excluded by their wives (Lewis, 1986).

Despite the negative changes in the marital relationship during the transition to parenthood, "parents make it clear that their relationship with the child is the most satisfying aspect of their lives during this period" (Cowan et al., 1985, p. 469). In other

lives during this period" (Cowan et al., 1985, p. 469). In other words, they do not blame the baby for their difficulties (Cowan et al., 1985).

Wright et al. (1986, p. 278) sought "to identify the key systemic variables that predict good marital adjustment following the transition to parenthood." They found three predictor variables for each spouse. Wives were likely to relate higher levels of marital adjustment when their husbands were highly satisfied with the marriage. It is likely that husbands who are satisfied with the marriage are also more helpful and supportive of their wives post-birth, resulting in the wives' better evaluation of the marriage. Planned pregnancies were also found to be predictive of higher marital adjustment, probably since the husband is more supportive and involved in parenting than if the pregnancy was unplanned. The third predictor of wives' marital adjustment was lower levels of infant fussiness/ difficulty, since infant demands are met primarily by the mothers.

High postbirth marital adjustment for husbands was predicted by "husbands' low social nonconformity and high psychological discomfort" (Wright et al., 1986, p. 277). Men with high levels of social nonconformity appear to be less able to adapt to conventional social standards and are likely more self-centered and less flexible. It would appear that these men have difficulty assuming traditional roles during the transition to parenthood period. The high levels of psychological discomfort concomitant with high postbirth marital adjustment likely refer to higher levels of anxiety before the birth

which are typical of men who are more strongly invested in the marriage and family than husbands who are not anxious. Husbands of older wives also experienced higher marital adjustment. Wright and associates suggested several reasons for this finding: the wives' greater maturity and capacity to deal with problems; the wives' established friendships with other women who have children; and the relative financial security of older couples. Prebirth marital cohesion reported by wives was the third predictor of marital adjustment for the husbands. It is possible that well-adjusted couples continue spending time in joint activities, including childcare, after the birth of their child.

As a result of their findings, Wright et al. (1986) recommended that therapists dealing with couples who are having problems in the transition to parenthood and who want to build successful marriages help the spouses to make the family the first priority. They also need to agree on arrangements regarding household and childcare responsibilities, and their relations with friends. In order to build their relationship, the couple needs to spend time solely devoted to one another. "In essence, the therapist helps the couple shift from a relationship that was based largely on mutually enjoyed activities to one that is based on commitment, sharing, reciprocity, and the development of family. The latter relationship requires much more maturity, responsibility, and understanding" (Wright et al., p. 290).

RELATED RESEARCH TO SECTION III: SUGGESTIONS FOR IMPROVING THE TRANSITION TO PARENTHOOD

Couple Priority

Minuchin (1974) claimed that it is not unusual for temporary enmeshment to occur between mother and child in the early postpartum months (Okun, 1984). This enmeshment frequently results in the husband's feelings of being neglected by his wife and the wife's feelings of restriction to one family member and the boundaries of the family while the husband is free to come and go at will. The husband's response to the temporary distancing of his wife may depend on his preparation and motivation for parenthood and the state of development in the couple system prior to the onset of parenthood. If the couple has established clear boundaries previously, they are likely capable of establishing clear boundaries between themselves and their child. This parent hierarchy or subsystem naturally has more power and authority in the family than the child or sibling subsystems (Okun, 1984).

Couples with children have significantly less verbal communication. When they do interact, these couples converse more about their children and less about themselves and their relationship. They feel more distant than couples without children and are more vulnerable to conflict and thus, experience lower marital satisfaction (White et al., 1986).

Studies have shown that social support during the postpartum period affects life satisfaction, satisfaction with parenting, and the quality of behavioral interactions with infants (Crnic & Greenberg,

1987). Yet, the mothers' perceived satisfaction with the amount and availability of support is also important. Having a large support network may not necessarily be better since it may create its own stressors, such as increased demands on the parents' time and obligations to be supportive of others (Crnic & Greenberg, 1987). Women are more likely to turn to their network members more frequently when their marriage is poor (Tietjen & Bradley, 1985). But, intimate or spousal support is more effective than friendship or community support. High levels of instrumental and emotional support from husbands act as buffers against stress and depression for mothers in early parenthood (Crnic & Greenberg, 1987).

Couples need to find ways "to replenish the couple system" during the transition to parenthood (Okun, 1984, p. 100). Husbands and wives experience an increasing desire for positively-toned interactions (Belsky & Pensky, 1988). Intimacy is the ideal (Bradt, 1980). Regarding intimacy, Bradt (1980, p. 126) said:

> Somewhere in the midrange of the spectrum between distance (when a family has no space for the child) and overcloseness (when the family uses the child to fill a vacuum) is the favorable space of intimacy. Intimacy involves a caring relationship without pretense, and revelation without risk of loss or gain from one or the other. It is giving and receiving, an exchange that enhances because it facilitates the awareness of selves, of their differences and sameness. It is discriminant, encouraging elaboration of facets of each person. It creates and sustains belonging, while appreciating each individual's uniqueness.

When two parents sustain intimacy in their relationship, they create a favorable environment for their children to flourish (Bradt, 1980).

In their study, Daniels and Weingarten (1982) found that couples adopted one of two ways to cope with the impact of having a child. In the first strategy, the couple makes their own relationship "the fulcrum of intimacy and emotional intensity within the family" (Daniels & Weingarten, p. 88). They refuel the energy of the marriage and give it top priority. In the second strategy, the entire family is the focus of intimacy. "Here the couple concentrate their energies on the family as a whole and their own relationship is no more central or governing than any other relationship in the family" (Daniels & Weingarten, p. 89). Although the couple may go out alone and conserve an adult life together, group activity is the priority in the home. The second strategy is often adopted by young adults who have not had time to establish a strong sense of their "coupleness." (Rossi [1968] claimed that the early years of a marriage when the wife worked gave the marriage a greater egalitarian base, which affected the couple's decision-making, commonality of experience, and sharing of household responsibilities. This base later helps the couple establish some barriers between themselves and their children.) But, unless the marriage is given top priority, it suffers (Daniels & Weingarten, 1982). "Although marital intimacy can be sustained without making it the central feature of family life, the fires burn brighter longer when they are carefully tended" (Daniels & Weingarten, p. 94). Couples may need outside help to negotiate more private time together to nurture their marriage (Cowan & Cowan, 1987).

The National Institute of Mental Health (NIMH) (1985, p. 1) asked the following question of 50 parents who had raised their children to become productive, well-adjusted adults: "Based on your personal experiences with your own children, what is the best advice you could give new parents about raising children?" Their responses were classified into ten basic principles, one of which they titled, "Tend to Personal and Marital Needs" (NIMH, p. 2). The parents suggested that when there is love, respect, and faithfulness between the spouses, the entire family experiences more security. One parent contended:

> A husband and wife are apt to be successful parents when they give their marriage the first priority. It may seem that the children are getting 'second best' from this approach but they rarely are. A happy mother and father are most apt to have happy children when the children's roles are clearly and lovingly defined. Child-centered households produce neither happy marriages nor happy children (NIMH, p. 2).

Without a stable marital relationship, the couple may be driven irreparably apart by the physical, financial, social and emotional challenges of parenthood. Indeed a pregnancy and the arrival of a new child may act as a wedge to further estrange the spouses (Reamy & White, 1987).

In their study of the positive and negative effects experienced by new parents, Sollie and Miller (1980) devised some implications for parent education. They determined that emphasis needed to be placed on the husband-wife relationship and that new parents needed to be "encouraged to spend time together, away from the baby" (p.

167). This "time away" from the baby can also be beneficial to the infant, who is given the opportunity to develop trust in other caregivers. Parents in support groups can develop cooperative arrangements for babysitting, enabling some parents, who might otherwise be unable to afford babysitting, to have time alone.

Individual Time

Alexander's functional family theory assumes that people "strive to balance needs for intimacy with those for psychological, psychosocial, and physical distance through allocating the 24 hours of the day into activities" (Worthington & Buston, 1987, p. 460). Each of the three types of activities chosen by the individual has the function of contributing to the intimacy-distance balance. The first, intimacy-promoting activities, are those involving sharing positively valued experiences with another person. Sexual contact, pleasant reminiscences, or conversation about important topics are examples of intimacy-promoting activities. The second, distance-promoting activities require people to be either psychologically or physically alone. Examples of these activities are reading, studying, daydreaming, sleeping, and even the vegetative withdrawal in depression. The third category of activities involves coaction but not intimacy. For example, discussing events of the day, watching television together, or playing games with someone are coactive events which generally do not promote intimacy. When one of these three types is absent or in profusion, the person feels unbalanced and dissatisfied.

Mothers especially need to be reminded to balance their own needs with the needs of the family (DeMeis et al., 1986). The husband may need to assume major responsibility for seeing that his wife has some social relaxation (Clark & Affonso, 1979). When mothers interrupt careers, they often experience both intellectual and social voids in their lives (Miller & Sollie, 1980). Zabielski (1984, p. 28) reported that a "sustained one-way giving and receiving transaction is created, 'trapping' the mother into repetitive, monotonous chores and a socially isolated, unchanging, demanding environment. Physical and emotional fatigue mounts and can lead to a profound state of depletion."

Parents need to get out, go somewhere, and have contact with others for their own good and also to prevent hostility toward the child (Zabielski, 1984). Without "time outs," burnout may occur. The symptoms of burnout include physical and emotional exhaustion, and social exhaustion, which involves a loss of concern for significant others and the assumption of cynical, dehumanized perceptions of these people. Ironically, it is the superparents, the parents who can't do enough for their children, that are most likely to experience burnout (LaRossa & LaRossa, 1981).

"The ability to balance a social life with mothering is correlated with better total adjustment, more freedom from changes, more acceptance of changes, higher marital satisfactions and harmony, and greater freedom from parental responsibilities and restrictions (Myers-Walls, 1984, p. 269). Daniels and Weingarten (1982) found that

when women lacked a compelling interest other than their children they usually experienced loneliness. Having a hobby or an absorbing activity is often a fundamental part of a person's identity. Personally gratifying activities can be a source of vitality to the self, while they provide a break from the home and children.

"The overriding task in a long-term couple relationship is establishing a balance between individuality and coupleness" (Cowan et al., 1978, p. 298), or what Rossi (1968, p. 31) called "the balance between individual autonomy and couple mutuality." Unfortunately, when a new baby arrives, the individual needs and couple needs tend to be shelved in order to meet the constant needs of the baby (Cowan & Cowan, 1987). Therefore, the couple needs to clarify roles. In the parental role, they need to negotiate "who will do what, when, and where"; in their individual roles, they also need to negotiate "who will have free time when, where, and how" (Okun, 1984, p. 101). Families that can strike a balance between separateness and connectedness are best able to absorb a newborn child (LaRossa & LaRossa, 1981).

Shared Parenting

There is a very high proportion of instrumentality in the parental role and "women carry the major burden of the instrumental dimension of parenting" (Rossi, 1968, p. 39). Goldberg et al. (1985, p. 498) recounted that in their group of parental subjects, "mothers usually performed baby care activities over 75% of the time whereas fathers engaged in baby care only 25% of the time." The higher the mother's participation in baby care tasks, the lower their reported

marital adjustment, "particularly cohesion (togetherness) and consensus (agreement). Interestingly, wives' marital satisfaction did not vary with household task participation, which suggests that wives expected to perform the majority of daily chores and tasks" (Goldberg et al., p. 500).

Women may experience less enjoyment with their maternal role as time progresses (Rossi, 1968). While older homemakers are more skillful in their domestic tasks, they seem to experience less enjoyment in them. Maternity seems to deprive women of opportunities for personal growth and development. For many women, "the personal outcome of experience in the parent role is not a higher level of maturation but the negative outcome of a depressed sense of self-worth, if not actual personality deterioration" (Rossi, p. 34). Furthermore, multiparous women may have more emotional difficulty and lower levels of maturation than primaparous women.

The father who refuses to do anything for the new baby is "the exception, not the rule" (LaRossa & LaRossa, 1981, p. 57). However, new fathers tend not to assume full responsibility for childcare. They will occasionally move to the role of the primary caretaker, but, "when they do take over, they almost always assume that they are 'helping' their wives rather than 'sharing' the parental responsibilities" (LaRossa & LaRossa, p. 57). The LaRossas reported that not once in their interviews with couples did a couple refer to the wife as "helping" her husband with the baby! When the word "help" denotes the father's perception of his caregiving, he may believe that he has done

his wife a favor and expect a favor in return. Wives may not wish to "pay the price" involved in returning the favor: "They may not be comfortable with the deferential stance they are expected to take to offset their husband's gratuities" (LaRossa & LaRossa, p. 61).

Many theories exist about why fathers do not involve themselves more in the parenting of infants. Zaslow et al. (1985) observed new parents in home visits in order to see how the behavior of fathers who reported depressed mood over eight days differed from new fathers who experienced no blues. The depressed mood fathers showed diminished proximity and less caregiving with their babies, while their wives showed heightened proximity. Zaslow et al. (p. 148) suggested that the early attempts of the depressed men left them feeling frustrated and helpless: then, as they withdrew support, their wives "simply picked up the slack." An alternate hypothesis was that the wives of these men are "less likely to share the parenting or encourage and support father participation" (Zaslow et al., p. 148).

Galinsky (1981) believed that some women appear to be very unsatisfied with the way their husbands care for the babies: when mothers must maintain the role of the family expert in childcare, the fathers become discouraged and take little initiative in the parenting process. Parke and Tinsley (1987) believed that the mother has a gatekeeper function, in which she may determine or control the access of others to caregiving: they may, in fact, limit the degree of father involvement. LaRossa and LaRossa (1981, p. 59) suggested that "women have a psychological investment in their family roles, and

become threatened if they cannot count on housework and baby care as their domain." Thus, the fathers "distance" themselves from the parental role, while the mothers "embrace" the role (LaRossa & LaRossa, p. 58).

Shared activities that caring for a child often creates (e.g., taking pictures, bathing, playing with the child) can provide the opportunity for enjoyable marital interaction (Belsky, 1981). In his study of new fathers, Lewis (1986) found the couples who felt closer attributed the closeness to their joint involvement with the baby. They claimed that the baby "bonds" them together, giving meaning to their relationship. The fathers claimed that their daily caregiving experiences were both rewarding and enjoyable. Sollie and Miller (1980) observed personal and marital qualities in couples from mid-pregnancy until eight months postpartum and made several implications for parenthood education. Among them is:

> There is a need to foster an attitude of mutuality in caring for the child. Both parents can be actively involved in preparation for parenthood classes, childbirth, and care of the child. In fact, when both parents are involved, a feeling of family unity may be more likely to develop. Marital relationships may also benefit from the feeling of "we-ness" which can develop from shared responsibility. Also, the father gains satisfaction from participating more actively in his child's life (Sollie & Miller, p. 167).

When fathers become very involved in parenting and very attached to the infant (i.e., engrossment), they are unlikely to feel excluded from the family triad, as many new fathers do. Sharing childcare with their wives can "strengthen family unity and reduce the physical and emotional tensions and stress" (Clark & Affonso, 1979, p.

522). Zaslow et al. (1985) found that fathers who were more involved in caregiving reported significantly greater marital satisfaction and more spouse communication concerning the baby. Reduced anxiety and greater satisfaction for the father may also be the result of his greater involvement in childcare (Cordell, Parke, & Sawin, 1980). Another significant byproduct of father involvement with infants is that "nurturant parental behavior leads to greater identification with the parent on the part of the child" (Cordell et al., p. 336).

While many parent intervention programs may press for an egalitarian arrangement for new parents, their goal should not be to shift all families in that direction (Parke & Tinsley, 1987). "The goal should be to provide the quality and quantity of support that will enable each family to enact their roles competently within their own ideological framework" (Parke & Tinsley, p. 106). For some families, this may mean minimal father participation; in others, it means shared responsibility. In some families, increased father participation may result in conflict and disruption, resulting from a threat to well-established role definitions. In sum, the dynamics and ideology of the individual families need to be considered.

Flexibility

Miller and Sollie (1980, p. 462)) found that a recurring theme in the comments of first-time parents was the "change from an orderly, predictable life to a relatively disorderly and unpredictable one." For these parents, adaptability became a major coping strategy for coping with the stresses they experienced. Other related coping

strategies included learning patience, being more organized, and becoming more flexible.

New mothers have to deal with "new concepts of time, a different organization of self, and a changed coordination of routine" (Shereshefsky & Yarrow, 1973, p. 173). For some women who have had to adhere to tight time schedules in their occupations, this change is difficult. Now, instead of yielding to the clock, they need to be responsive to the demands of the infant and those within themselves.

> Keeping one's self ready for feeding on demand, or awakening from sound sleep to determine the basis for an infant's discomfort (or one's own discomfort, from too-full breasts), trying to take advantage of the infant's hours of sleep either to gain much-needed rest, meet other obligations, or undertake a cherished outing--all this requires a new organization of one's time and energies, and the women reacted with greatly varying capacity for flexibility and readiness to find satisfaction in their different rhythm (Shereshefsky & Yarrow, p. 173).

Women who seek active control may be especially frustrated with care for an infant whose demands are unpredictable: they may chafe at the constant caregiving that infants require when they yearn to do other things as well (Entwisle & Doering, 1981).

"Babies change over time and, in the process, place different demands on their caregivers" (LaRossa, 1986, p. 97). Parents of infants, for instance, are not required to be with the baby every moment: they may be halfway accessible (on call) at some times and completely accessible (on duty) at others. But when the baby gets older, the level of coverage increases and the parents need to adapt to these changes. Older babies sleep less and are more mobile when

they are awake. Parents will need to spend more time interacting with them, even if their home is "baby-proofed".

During the transition to parenthood, new parents may need to adjust previously set goals in order to cope (Worthington & Buston, 1986). Setting priorities is effective for alleviating the stress that results from limited time. Compromising standards (i.e., "being willing to accept lower performance in a role that conflicts with the more highly valued role" [p. 456]) is frequently a helpful strategy in order to maintain flexibility.

Other Suggestions

In an attempt "to help new mothers to manage their new responsibilities successfully, and thus to reduce postpartum emotional distress," Gordon et al. (1965, p. 158) investigated the use of prenatal instruction, "which included social psychologic preparation for the 'motherhood role'." They (p. 160) found that women who took the advice given in the classes "underwent significantly less subsequent emotional upset" than did the controls. The outline for this section, "Other Suggestions," is taken from the "points that were stressed" with the experimental group in this study (Gordon et al., p. 159). Many of these "points" were also repeated in Searle's (1987) article (which, incidentally makes no reference to Gordon et al.'s study) as suggestions for mothers working through postpartum depression.

1. Receive and use information. "The responsibilities of motherhood are learned: hence get informed" (Gordon et al., 1965, p. 159). Myths regarding the "impact of childbirth and the

role of mothering" need to be eradicated (Searle, 1987, p. 84). Couples need to appropriate books, parent education classes, discussion groups, and community and social resources to gain information about the changes inherent to the transition to parenthood. Parents should also participate in child-rearing classes, and it is wise for them to participate together since "differences in child rearing attitudes between husband and wife appear to have a marked effect on marital happiness" (Feldman, 1974, p. 224). Parent education and exploration of attitudes regarding childrearing before and after the birth of the child may minimize the influence of differences of opinion between the spouses and help reduce decreases in marital satisfaction.

2. Get extra help from relatives and friends. "Get help from husband and dependable friends and relatives" (Gordon et al., 1965, p. 159). Searle (1987, p. 84) added neighbors and professionals to the list and emphasized the importance of "paternal attitude and involvement" as a significant variable in postpartum depression. Miller and Sollie (1980) concurred by stressing husband support, along with available help (advice, information, and caretaking) from friends and neighbors. Zabielski (1984, p. 29) listed three types of support mothers need to supply their "psychic energy for a mother's act of giving": "practical gifts of help, time, and support; expressive gifts of interest, concern, and acknowledgement; and

material gifts", probably food, clothing, equipment, etc. Searle (1987) recommended that the practical help needs to be used to develop and reinforce competence, as opposed to "taking over."

3. Deliberately make friends with couples who are experienced parents. "Make friends of other couples who are experienced with child-rearing" (Gordon et al., 1965, p. 159). Peer support systems are especially important if the new parents are geographically distant from extended families (Okun, 1984). Friends with children can serve as parenting mentors for each other. They also act as sounding boards for airing frustrations and as resources for babysitting and carpooling. Galinsky (1981) added that friends can understand and validate feelings, help parents deal with fears of inadequacy, plus give specific help and advice to problems. She warned, however, that if competition among the friends becomes a problem, these relationships can become undermining rather than supportive. Cohler et al. (1970) found that the mothers in their study who were hospitalized as a result of postpartum emotional difficulties had withdrawn from social relationships before the baby's arrival.

Interest in and previous experience with children are predictive of adaptation for new mothers (Shereshefsky & Yarrow, 1973). Professional experience with children or babysitting experience may alter the stress associated with

early parenthood (Fleming et al., 1988). Mothers who have had previous experience with infants tend to have higher self-confidence as they begin parenting (Myers-Walls & Coward, 1979). Therefore, if expectant couples have not had previous experience with children, babysitting for friends with children may give them some experience that will increase their confidence later during the transition to parenthood.

4. Maintain a stable environment. "Don't move too soon after the baby arrives" (Gordon et al., 1965, p. 159). Searle (1987) simply refers to this as "maintaining a stable environment."
5. Maintain your outside interests. "Don't give up outside interests, but cut down on responsibilities and rearrange schedules" (Gordon et al., 1965, p. 159). Miller and Sollie (1980) concurred: couples in their study also mentioned continuing in prebirth activities as an important coping strategy.
6. Don't be overly concerned about keeping up appearances or doing unnecessary tasks. "Don't be overconcerned with keeping up appearances" (Gordon et al., 1965, p. 159). Searle (1987) suggested that new parents should restrict unimportant tasks or delegate them to others. In her study on role-sharing couples, Haas (1980, p. 296) found that the most common strategy employed by the couples in her study was "to cut down on housework or at least to give it a very low priority." The next most common strategy was to keep a regular schedule of housework so that it never got out of hand.

7. Maintain open communication with your spouse. "Confer and consult with husband . . . and discuss your plans and worries" (Gordon et al., 1965, p. 159). Harriman (1985) related implications from her research for parent education: she felt it was appropriate to teach parents ways to nurture the marital relationship and make time for one another. In addition, in order to empathize with one another, couples need to be able to recognize sexual differences in their perceptions of the change that occurs in early parenthood. Ignoring or bypassing feelings that are considered unacceptable often creates or exacerbates difficulty for the partner or couple (Cowan & Cowan, 1987). "Positive verbal reinforcement of nonconde-scending type" can serve to encourage partners in the many new skills they are attempting as new parents (Haas, 1980, p. 295).

8. Make use of babysitters (or friends or family) even in the early months so that you can get a break from childcare. "Arrange for baby-sitters early" (Gordon et al., 1965, p. 160). Searle (1987, p. 84) encouraged:

> Myths about 'bonding,' which obligate the mother to be continuously near and responsible for the infant, must be exposed as false. The first 2-3 months are times of adjustment, stress and upheaval and are best coped with by sharing the tasks of caregiving with sensitive, significant others.

9. Do not be a nurse to relatives or others during the early months of parenting (Gordon et al., 1965). New parents need

plenty of rest and sleep themselves in order to cope with the stresses inherent to parenting infants.

10. Seek professional help early if you are having problems (Searle, 1987). Marital tension during pregnancy is considered a predictor of postpartum depression (Whiffen, 1988). Therefore, professional help is recommended before delivery in order to prevent postpartum difficulties. Couples might consider individual or conjoint counseling, group counseling, and/or parent support groups. Informal, community services, such as Parents Anonymous, are potentially useful methods for intervening with stressed parents: advantages of such services may be less cost, greater credibility of the helpers, availability to isolated populations, and lack of abrupt termination of the services (Miller & Myers-Walls, 1983).

Worthington and Buston (1987) recommended that couples with high conflict prior to delivery are good candidates for marriage therapy. A crisis intervention approach with communication or problem-solving training might be appropriate with these couples. Other couples with low initial conflict might benefit from "information and enrichment interventions" (Worthington & Buston, p. 465). For instance, couples who experience high disruptions in time schedules may benefit from time management seminars. Couples who face multiple decisions might benefit from reading books about conflict resolution.

RELATED RESEARCH: SECTION IV
A WORD OF ENCOURAGEMENT

"Besides providing an information base to expand the horizons of teachers and students, research can help to correct myths and misconceptions which constantly arise" (Miller, Schvaneveldt, & Jenson, 1981, p. 628). For instance, several years ago Ann Landers asked her readers to determine whether or not they would have children if they could live their lives again and make that choice. Seventy percent of the parents in her sample replied that they would not choose to have children again. It is likely that the public was led astray by the figures in her biased sample. Fortunately, the same research question was asked again by more objective, systematic research conducted by General Mills (1977). Using a representative sample, General Mills showed that 90% of parents would choose to have children again. Other more recent studies have since replicated the results obtained by General Mills, indicating that the majority of parents find parenting to be very rewarding (Miller et al., 1981).

After listing four general classes of problems experienced by new parents, Belsky et al. (1986, p. 121) stated that "it would be a mistake to conclude . . . that there are no gratifications and rewards associated with parenthood." Sollie and Miller (1980) identified four positive themes experienced by new parents. The first included the emotional benefits: comments frequently mentioned love, joy, happiness, and fun. One mother stated: "The rewards for all the efforts and hard work are well worth the trouble" (Sollie & Miller, p. 150).

The second positive theme was self-enrichment and development: this included "being viewed as an adult, becoming more mature and responsible, thinking and planning for the future, becoming less selfish, and experiencing self-fulfillment" (Sollie & Miller, p. 152). The third theme suggested a feeling of family cohesiveness: the parents experienced a stronger bond between themselves. When the marriage is good already, the parents appear to respect each other more and feel greater commitment towards the marriage. The fourth positive theme revealed "a sense of identification with the child and pleasure from watching the child's growth and development" (p. 155): anticipations about the child's future growth, development, and accomplishments were also frequently reported. In another study, regarding what parents were least prepared for in new parenthood, "the thing most commonly mentioned by mothers (67%) was the love and attachment that they had come to feel for the baby" (Kach & McGhee, 1982, p.282).

The parent-child relationship becomes increasingly more reciprocal somewhere between 2.5 to 5 months (Galinsky, 1981). The baby's first social smile may be a milestone that signals the beginning of this period of reciprocal exchange. Babies begin to recognize their parents and reach out for them. Zabielski (1984, p. 44) called this reciprocity a "two-way giving and receiving exchange": the baby frequently and regularly responds to the mother's care and the mother no longer has to search the baby for a personal response to her mothering. When there is less disparity between what the mother

gives and what she receives, a balance is finally achieved in the social system.

Parenting seems to have a maturing effect (Belsky, 1981, 1986). Parents report self-enrichment and personal development as benefits. They consider themselves less selfish, and find that they are thinking more about the future (Belsky, 1986). New fathers report that they are more responsible and moderate, and less selfish; new mothers report becoming less moody, selfish, and egocentric (Belsky, 1981). Although the new mothers in Leifer's (1977, p. 90) study were still experiencing stress, they felt that the demands and challenges of parenthood gave them "a sense of greater completeness or wholeness as a person."

Parenthood may be a marker that allows young adults to hold adult status and identify with the older generation (Leifer, 1977). Belsky (1986, p. 59) reported: "Parents often report that they feel more adult. . . ." Parenthood appears to be implicit in adult roles as they are defined by society (Sollie & Miller, 1980). Strengthened relationships with extended families are concomitant to new parenthood (Belsky, 1986; Sollie & Miller, 1980).

Early parenthood may be the most stressful stage in the life cycle (Campbell, Converse, & Rogers, 1976). For some new parents, the early weeks or months are extremely trying. However, the deleterious effects of the child on the parents seem to diminish as the child grows older (Sollie & Miller, 1980). The early physical stressors decline as the child matures (Miller & Myers-Walls, 1983).

Joint-leisure activities, which experience a decline from pregnancy through 3 months postpartum, appear to stabilize between 3 and 9 months postpartum (Belsky et al., 1983). Even Dyer (1963, p. 201), who concluded that the addition of a first child was a crisis event, found that "the large majority [of new parents] made a quite satisfactory recovery from the crisis, although this often followed a difficult period of several months." Eighty-one percent made recovery scores of "excellent" or "fair to good." Among the comments and advice offered to other new parents by one of the participants in Dyer's study (p. 201) was: "Realize your life will be different because of addition of the baby, but it will be a better and more complete life."

Summary of Chapter 2

Transition to parenthood literature reveals that the first child apparently has some negative effect on the marriage relationship, especially for the wife. Although some couples, usually those with more satisfactory marriages prepartum, appear to be unaffected greatly by the transition, others find the impact of the first child extensive, requiring a "new balance among work, home life, social life, and married life, which may be resolved in different ways by different couples" (Worthington & Buston, 1986, p. 448).

Postpartum depression literature reveals three types of postpartum depression: the blues, postpartum depression, and postpartum psy2chosis. The blues appear to be common (50-80%) but transient, in contrast to postpartum psychosis, which is relatively

rare. Postpartum depression, per se, occurs in 10% to 20% of postpartum women, making it clinically significant. The etiology of postpartum depression remains unclear currently (Hopkins et al., 1984).

CHAPTER 3

METHODS AND PROCEDURES

"The major goal of research in any field is to produce or discover knowledge. . . ." (Miller et al., 1981, p. 625). Studies may be based on original data or based entirely upon documentary sources (Goode & Hatt, 1952). In either type of research, ". . . the investigator uncovers facts and then formulates a generalization based on the interpretation of facts" (Tuckman, 1988, p. 3).

This study was based on a review of the research literature, making it, in effect, a historical study (Best & Kahn, 1989). While some historical studies involve themselves with "the conflicts among nations," others focus on "domestic battles within a family" (Shulman, 1988, p. 21).

Historical investigation has many of the characteristics of scientific research activity. It involves delimiting a problem; formulating hypotheses or raising questions: gathering an analyzing data; testing the hypothesis to determine its correspondence with the evidence; and the formation of conclusions. While the investigator does not directly gather data or observe events, he/she does use the testimony of many witnesses who have observed the event from various vantage points. The observations may be either qualitative or quantitative. As a result of the investigation, a synthesis and

presentation of facts will be produced in a logical, organized format (Best & Kahn, 1989).

Survey of Need

Several steps were taken to determine what popular literature on the emotional and relational changes of new parenthood is currently available. A survey of local bookstores revealed many books on pregnancy, baby care, and parenting. Some of the baby care books incorporated either into the text or in separate chapters the needs of new parents. One book (Lewis, 1989, cover) was studied since it addressed "the emotional and physical needs of the mother, and the changes, choices and challenges she faces in the year following her baby's birth." A careful search was made of the bibliography and end notes to determine other recent publications of a similar nature and the empirical basis of the book. Several recently written books were then ordered either through the public library or through inter-library loan to survey the availability of literature for new parents in the emotional/relational area. Most of the publications addressed only the needs of the mothers, as opposed to both parents, and few used journal articles from the areas of transition to parenthood or postpartum depression as their basis.

In addition, the August, 1989, International Childbirth Education Association catalog (Predmore, 1989) was searched for the availability of materials relating to the emotional/relational needs of new parents. Among the hundreds of books, booklets, and pamphlets

described, few addressed the psychological changes in the transition to parenthood for both parents.

Local obstetricians, midwives, and childbirth educators were contacted to determine what pamphlets or booklets they might know of and be distributing to their patients in this specialized area of parent-hood. They knew of none.

A descriptive outline for a possible handbook for new parents was then drafted. It was sent to selected local experts and national organizations to ascertain a need for such a publication and to obtain suggestions of topics that were pertinent for new parents. One section was added to the outline as a result of this survey: Mother's Return to Work.

A presentation was then made to local healthcare experts at an organization called Healthy Mothers/Healthy Babies. This group included obstetrical nurses, childbirth educators, a nursing instructor, and public health administrators. They were given copies of the outline plus a description of the format and asked for an evaluation of need and suggestions in creating such a handbook (Table 1).

Table 1. Response of members of Healthy Mothers/Healthy Babies to need for proposed handbook

Yes	8
No	0
Don't Know	1

Handbook Development

"A major purpose of education is the dissemination of what is known" (Miller et al., 1981, p. 625). Social scientists have been criticized by the lay public for not disseminating the surplus of knowledge that is now available in language which most people can understand (Miller et al., 1981). Examples of the dissemination of information are: A Parents Guide to Healthy Emotional Development for Children with Arthritis (Ziebell, 1976) and Healthy Emotional Development for Hearing Impaired Children: A Guide for Parents (Perry, 1986). One of the main values of education for families involves clarifying realistic expectations by providing accurate scientific information which can help to correct the misconceptions people now possess (Miller et al., 1981).

Using the method of historical research, a handbook was developed answering the following questions: what stressors can couples expect to encounter during their transition to parenthood; what specific problems may arise; and what helps make the transitional period proceed more smoothly. An outline of the handbook appears in Figure 1.

Evaluation Procedures

Following the development of the first draft of the handbook, it was submitted to a panel of four experts to judge the content for accuracy and value. The experts are all professionals involved in some aspect of new parent education. The panel members included:

WHEN COUPLES BECOME PARENTS:
A GUIDE TO EMOTIONAL AND RELATIONAL ADJUSTMENT
FOR NEW PARENTS

Introduction

The Normal Stresses of Early Parenthood

- Ambivalent Feelings
- Fatigue
- Lack of Free Time
- Confinement
- Financial Concerns
- Role Confusion: Who Does What?
- Body Image
- The Sexual Relationship
- Infant Characteristics
- Relationships with Grandparents
- Mother's Return to Work

Individual and Marital Problems

- Postpartum Depression
- Marital Satisfaction

Suggestions for Improving the Transition to Parenthood

- Couple Priority
- Individual Time
- Shared Parenting
- Flexibility
- Other Suggestions

A Word of Encouragement

Suggested Additional Readings

Figure 1. Outline to handbook

1. a psychologist who has worked with families (parents and children), who is currently sponsoring a parent support group;
2. a registered neonatal nurse;
3. a clinical instructor in obstetrical nursing; and
4. an obstetrical nurse, who is also currently teaching childbirth education classes.

A copy of the handbook (Appendix A), a cover letter (Appendix B), and an evaluation form (Appendix C) was given to each panel member in order to carry out the evaluation process (Ziebell, 1976; Perry, 1986). They were asked to judge the material for accuracy and value.

Simultaneously, the first draft of the handbook, a cover letter (Appendix B), and an evaluation form (Appendix C) were given to a selected sample of six couples expecting their first child and four couples whose first child was less than 15 months of age. The couples were asked to evaluate the readability and apparent value of the content. All participants were asked to return the manuscripts and evaluation forms within approximately 2 weeks after they were received.

Summary

A survey of need for a handbook on the emotional and relational needs of new parents was conducted. Using the historical research method, a handbook was developed. Following this development, it was submitted to a panel of experts and a group of new parents for evaluation.

CHAPTER 4

EVALUATION RESULTS

The handbook was submitted for evaluation to four professionals involved with new parent education and six couples expecting their first child and four couples whose first child was less than 15 months of age. The evaluation was returned by all four professionals and by nine of the couples. (One of the expectant couples did not return the evaluation.)

Evaluation Results

The results of the evaluation were encouraging, but revealed that some editing of the manuscript is still necessary. In addition to the specific questions answered, several constructive comments were made that should prove to be helpful in writing a final revision before publication for distribution. The results of each specific question posed will be discussed separately with the responses shown for both parents and professionals.

1. Do you feel the need for help with the emotional and relational changes you will experience (or have experienced) with the arrival of your new baby (in your area of professional practice)?

	Often	Sometimes	Never
Parent Responses	6 (33%)	12 (67%)	0
Professional Responses	4 (100%)	0	0

All the professionals expressed a need for assistance with new parents' emotional and relational problems often. Two thirds of the parents reported feeling the need for assistance sometimes and one third reported the need frequently.

2. Do you think this handbook adequately discusses the emotional and relational changes that occur when you become new parents (encountered by new parents)?

	Very Adequately	Adequately	Very Inadequately
Parent Responses	9 (53%)	7 (41%)	1 (6%)
Professional Responses	3 (75%)	1 (25%)	0

Three quarters of the professionals believed that the handbook very adequately discusses the emotional and relational changes encountered by new parents; one quarter believed the subject was covered adequately. Over half of the new parents concluded that the subject was covered very adequately, whereas 41% believed that it was covered adequately. One parent responded in the inadequate category; one parent did not respond to this question.

3. Do you agree with the basic philosophy of this book (i.e., realistic expectations [either positive or negative] promote a smoother transition period)?

	Strongly Agree	Agree	Disagree
Parent Responses	17 (94%)	1 (6%)	0
Professional Responses	3 (75%)	1 (25%)	0

An overwhelming majority of the parents and three quarters of the professionals strongly agreed with the basic philosophy of the

handbook. The remainder, one parent and one professional agreed with the philosophy, and no one disagreed. Should the sample population in this study be representative of the majority of future readers, the potential for compliance with the suggestions and ideas offered is enhanced.

4. Would you recommend this handbook to (other) new parents?

	Frequently	Occasionally	Never
Parent Responses	11 (61%)	6 (33%)	1 (6%)
Professional Responses	1 (25%)	3 (75%)	0

The majority of the new parents reported that they would recommend the handbook frequently to other new parents, whereas the majority of the professionals related that they would recommend it occasionally. One parent claimed that he/she would never recommend the handbook. The professionals were not told when given the handbook that the target audience was couples in committed relationships, perhaps accounting for some of their reluctance to recommend it routinely. One professional related that only 25% of the population with whom she worked were married or in committed relationships.

5. Does this book seem clear and easy to understand?

	Very Clear	Usually Clear	Not Clear
Parent Responses	12 (67%)	6 (33%)	0
Professional Responses	3 (75%)	1 (25%)	0

The majority of parents and professionals found the handbook very clear and easy to understand. The remainder found it usually clear; no one reported that it was not clear.

6. How do you feel about the length of this handbook?

	Too Long	Just Right	Too Short
Parent Responses	3 (17%)	13 (72%)	2 (11%)
Professional Responses	2 (67%)	1 (33%)	0

The majority of the parents believed that the length of the handbook was just right, whereas the majority of the professionals believed that it was too long. (One professional was eliminated from the tally since she responded to two categories: she believed that Section I was too long, but the remainder of the handbook was just right.) None of the professionals found it too short, whereas two of the parents thought it was too short. The professionals may have believed that most parents would not take time to read such a long document, but the parents may be eager for information that would validate feelings and help them with relationships.

7. How do you feel about the number of topics covered?

	Too Many	Just Right	Too Few
Parent Responses	1 (6%)	16 (88%)	1 (6%)
Professional Responses	2 (50%)	2 (50%)	0

The professionals were evenly divided between "too many" and "just right" regarding the number of topics covered in the handbook.

The great majority of parents, however, believed that the number of topics was just right. One parents reported too many topics; one parent reported too few.

8. How do you feel about the language used in this book?

	Too Sophisticated	Just Right	Too Simple
Parent Responses	4 (22%)	14 (78%)	0
Professional Responses	2 (50%)	2 (50%)	0

Again, the professionals were evenly divided regarding the difficulty of the language in the handbook: half believed it to be just right and half believed that it was too sophisticated. The majority of the parents, however, reported that the language was just right. However, four parents found it too sophisticated.

9. When would you most appreciate receiving this handbook? (do you feel that the contents of this handbook would be most meaningful to new parents?)

	Before the Baby's Birth	In the Hospital	After Return Home
Parent Responses	15 (83%)	2 (11%)	1 (6%)
Professional Responses	3 (100%)	0	0

The great majority of parents and professionals reported that the handbook would be most useful to new parents before delivery of the baby. (One professional was not included in the tally since she indicated that the handbook could be distributed either before the baby's birth or when the parents return home.) Two parents related

that they would appreciate receiving the handbook in the hospital and one parent would appreciate receiving it after returning home.

10. How do you feel about the number of examples given in the book?

	Too Many	Just Right	Too Few
Parent Responses	2 (11%)	12 (67%)	4 (22%)
Professional Responses	0	4 (100%)	0

All the professionals agreed that there were just the right number of examples in the handbook. Two-thirds of the parents reported the number of examples just right, but two parents concluded there were too many and four believed there were too few.

In sum, the majority of the evaluators responded that the handbook meets a need for assistance with the emotional and relational changes of new parents, adequately covers the subject, is correct in its basic philosophy, would be recommended to others at least occasionally, seems clear and easy to understand, is an appropriate length, covers the right number of topics, contains the right number of examples, generally uses an appropriate level of language, and would be most meaningful to parents before the baby's birth.

In addition to the 10 specific questions on the evaluation form, parents and professionals were asked to include suggestions for additions and deletions and make other pertinent comments.

Recommendations from the Evaluation

The following suggestions were made for additions by parents:

> Write a section on how to respond to the expectations of friends and relatives who have no children and expect us to be as spontaneous as we were before our baby's birth. "I wish they could read this too!"
>
> "The examples given help me to relate to what was being discussed in each section. Possibly add a few to the postpartum depression section--an example of the blues, postpartum depression and postpartum psychosis."
>
> "Possibly a section on how to deal with unwanted outside help and suggestions."
>
> "You might include a section on how fathers can understand what their wives are going through. What can they do to help most?"
>
> Write "a special section for fathers that narrows in on how to handle a wife's emotional/physical changes and the change in the role of the father that has come about. (There was mention made of these things, but I feel a special section just for them would be helpful.)"
>
> "The suggestions on how to deal with problems was helpful. (Perhaps an even more detailed guideline for facing these problems could be included.)"
>
> "Maybe more on dealing with family members and friends and how to relay your appreciation and yet keep the distance."

Two of the professionals recommended expanding on ideas already presented. One requested more information on the treatment of postpartum depression; the other wanted an elaboration on the suggestion, "maintain a stable environment."

Under "suggestions for deletions," two of the professionals believed that some of the topics could be "combined" or "blended" to avoid overwhelming the reader. They felt that the first section in particular was too long. One new father complained that the

"manuscript reflects a bias toward the adjustment required of mothers" and that "only cursory attention is paid to the adjustments required of fathers." One expectant parent expressed that the overall tone of the handbook was "somewhat depressing": he recommended "that positive aspects of the child-rearing [be] interspersed with the negative."

One professional had "some reservation about the use of 'husband and wife' as there are so many unmarried couples today." This is a difficult problem since there appear to be no single words in English which differentiate gender and also suggest a committed relationship other than "husband" and "wife." Words such as "partner," "mate," or "spouse" do not distinguish gender, which is necessary for understanding the meaning intended in the content. She continued, "It is a dilemma and no really easy answer [is apparent]."

The parents had few suggestions for deletions. One parent wrote, "Keep everything!" Three parents spoke of the need for simplifying the language. Specific words or phrases which presented some difficulty for them were: "ambivalence," "vignettes," "psychosomatic complaints," and "environmental and situational." One suggested deleting mention of researchers "Alexander Thomas and Stella Chess."

Under "other comments," the evaluators expressed several opinions and ideas. One couple expressed their opinion that the handbook read too much like a textbook. Even though the topics were interesting, they believed that the tone of the handbook was too clinical and impersonal. One of the professionals suggested that there was an abrupt change from "the third-person research style to

the advice-giving second-person [style]": she found this "abrupt and jarring at times." Several evaluators mentioned that the handbook "flows well." Another professional thought the handbook would be equally valuable for parents expecting their second or third child. One expectant parent recommended marketing the handbook "to OB/GYN's who can give to patients who are thinking of getting pregnant!" Four of the couples requested keeping the handbook for future reference.

Several of the evaluators commented on the vignettes. Some of their comments are:

> "The personal examples are excellent."
>
> "I especially like the use of vignettes at the beginning of each section of normal stresses. These add a touch of reality and really help ground the concepts in daily life."
>
> "I liked [the] examples. Is it possible to carry them further . . . to Ellen's solution to [her] dilemma?"
>
> "Examples given helped make the book more applicable and readable. It help to hear 'real life' situations in addition to the facts."

There were also many other positive comments from the parents, including:

> "Good advice on accepting help from others . . . good information relative to C-sections. . . . Advice dealing with sex is understandable and practical. This is good. . . . The last section was excellent! This information is encouraging to me."
>
> "Very interesting and insightful. I feel that I will be better prepared now to deal with the stress when our baby is born. Thank you for including us in your study."
>
> "Wow! What an eye opener!"
>
> "The book was very informative about what can happen to a marital relationship. It was also very easy to read."

"Many of the other materials I've read so far have dealt only with the physical needs of mother and child. I appreciate the thorough discussion of emotional changes prospective parents face!"

"It was so thought provoking, bringing to mind those things I need to make [a] priority, like my marriage, even now. [It helped me realize] that our marriage is the center and that is OK! It also gave me a more realistic view of how much of my time will be spent around the home . . . . Thanks, this was a great encouragement."

"The one thing I found myself doing was applying each section to my life. . . . I really enjoyed reading this handbook. It really encourages me; it has emphasized the importance of open, honest communication between spouses."

"I can really relate to a lot of these thoughts and feelings of the fathers. I would have liked to have read this before our child was born. This book made me realize that there are a lot more changes to foresee in my life as a parent (both good and bad)."

"I got a lot out of reading the booklet and <u>will</u> recommend it to other couples having children."

"Wonderful job--definitely a realistic "to the point" piece of reading material. The shortness of the booklet was appreciated since time is so valuable once the child has arrived."

Among the positive comments from the professionals were:

"This is a fine, scholarly paper. As a research project, it is comprehensive and well documented."

"There has been excellent gathering of information. . . . From a professional point [of view], I felt the area of marital satisfaction was done very well."

"Very good reading! Excellent content!"

"The concept of this booklet is terrific. . . . I found the practical hints at the end very helpful and the information informative and reassuring."

Projected Changes Prior to Publication

Many of the suggestions made by the evaluators will be honored in order to make the handbook as meaningful as possible to new parents. For instance, additional research will be done regarding the problems experienced by new fathers and how they can best relate to their wives' emotional stresses. The couples were also interested in learning about how to deal effectively with extended family and friends at this difficult time. A brief explanation of the treatments available for postpartum depression will also be added. Substitutions will be made of all the specific words and phrases mentioned previously that gave the parents difficulty. The "Lack of Free Time" and "Confinement" segments in Section I could easily be combined to shorten the handbook slightly. In general, much of the handbook will be rewritten in a lighter, more conversational style.

Simple illustrations, cartoons, or photographs will be interspersed with the text in the handbook to add interest. These might also clarify some of the written material. References included in the handbook for the purpose of the thesis will be omitted. Direct quotations will be acknowledged in footnotes. All references will be listed alphabetically at the end of the handbook.

Summary

Parent and professional responses were tabulated and discussed. Recommendations for additions and deletions to the handbook were provided; opinions, suggestions, and positive comments were presented. Projected changes prior to publication were introduced.

CHAPTER 5

USES AND IMPLICATIONS

Possible Handbook Uses

"Didactic and imaginative literature can be used in the contexts of preventing possible future maladjustment and providing remediation for existing problems" (Zaccaria & Moses, 1968, p. 13). Reading can furnish glimpses of self-understanding, lead to changes in our attitudes, and be a stimulus for identification with fictional characters, "thereby offering suggestions for solving our own problems" (Lester, 1977, p. 76). Reading may also stimulate the person to verbalize problems associated with shame and doubt, since he/she may see that others have similar problems. Reading may also reinforce social values and behavior by presenting positive examples (Lester, 1977). "Reading meets great needs in us for self-understanding, for understanding others, or the events and situations that confront and baffle us" (Coomaraswamy, 1988).

There are two basic types of bibliotherapy: reading bibliotherapy and interactive bibliotherapy (Hynes & Hynes-Berry, 1986). The former may be used either to help with an individual's emotional growth or to offer insight into a personal crisis. It is a process of dynamic interaction between the personality of the reader and the literature (Haldeman & Idstein, 1977). Self-knowledge, gained by reading, "is the key that can unlock our minds from the stranglehold

of our long-established false assumptions upon which our unhappiness rests" to give us new beginnings (Coomaraswamy, 1988, p. 80). Furthermore, "behavior change that is attributed to oneself is more likely to be maintained than behavior change where an individual believes it has been caused by external factors such as his therapist, medication, or the mere passage of time" (Hunt, 1988, p. 86). The latter, interactive bibliotherapy, as a process of growth and healing, is centered not as much in the act of reading as in the guided dialogue about the material with a facilitator or therapist, usually in a group (Hynes & Hynes-Berry, 1986). The handbook developed in this project could be used for either reading or interactive bibliotherapy.

The most obvious use of this handbook would be for distribution to couples in childbirth education classes. Large numbers of couples voluntarily enroll in these community or hospital sponsored programs. Unfortunately, most of these classes are devoted entirely to the birth event itself. However, by adding one or two extra classes, some anticipatory socialization might take place. Couples might read the handbook at home. In the group, they could talk about their expectations in small groups: they could focus on salient issues such as the division of labor, feelings about when to respond to a crying baby, and the involvement of grandparents. In so doing, they would learn what their spouses are thinking and also what other expectant couples are anticipating in order to develop more realistic expectations (Belsky & Pensky, 1988).

The handbook could also be distributed in the offices of obstetricians or in hospital information packets for new parents. Where postpartum support groups or groups for mothers experiencing postpartum depression exist, the handbook could be used to stimulate discussion. Participants in such groups might develop an awareness of their feelings as universal. They might also experience some existential realities, such as: "life is at times unfair and unjust"; or, "I must take responsibility for the way I live my life, regardless of the support and guidance I get from others" (Hynes & Hynes-Berry, 1986, p. 10). If on-going personal or marital therapy is indicated, the counselor could ask the client(s) to read the handbook as background material for areas to be discussed (Ziebell, 1976).

Need for Further Research

As mentioned previously, very little research has been done in the transition to parenthood from a cross-cultural standpoint. Only one article is available on the transition to parenthood for blacks (Hobbs & Wimbish, 1977). No articles were available regarding the transition to parenthood for Hispanics or Asians residing in English-speaking countries or native Americans.

Belsky (1981, p. 17) has suggested a need for the use of interdisciplinary efforts in research for understanding the transition to parenthood, specifically the need to "build bridges between the disciplines of developmental psychology and family sociology." Yet, to date, the literature on postpartum depression and transition to parenthood has not been integrated. Many of those who have researched

the transition to parenthood (Brehm, 1985; Cowan et al., 1985; Belsky, Lang & Rovine, 1985) believe that there is a drop in marital satisfaction following the birth of the first child, and this drop in satisfaction is experienced first by the wives (Cowan et al., 1985; Ryder, 1973; Waldron & Routh, 1981). Several researchers in postpartum depression (Atkinson & Rickel, 1983; Shereshefsky & Yarrow, 1973; Whiffen, 1988; Zaslow et al., 1985; Kraus & Redman, 1986; and Strasburger, 1980) suggest that marital problems are related to and/or are predictive of postpartum depression. It would appear then that postpartum depression might be an individual manifestation of marital dissatisfaction. Interdisciplinary collaboration might advance understanding of the relationships between postpartum depression and the drop in marital satisfaction.

Implications

This present work has a number of implications for research and further literature in the area of the emotional and relational aspects of the transition to parenthood.

Implications for Research

A study could be designed to test a change in anxiety levels from the use of the handbook. The value of the handbook could be further assessed by testing anxiety levels at various times pre- and postpartum using a group of new parents who read the handbook alone, a group who were also involved in a discussion group, and a control group who had not read the book. Specific items measured on a

continuum could include anxiety levels about: ambivalent feelings, lack of free time, financial concerns, roles, fatigue, the sexual relationship, confinement, body image, relationship with grandparents, and marital satisfaction.

Implications for Further Literature

Handbooks could also be developed for parents who have experienced a Cesarean section and single parents. One of the professionals who evaluated the handbook recommended a handbook written to new grandparents. Although the format of other handbooks might be very similar, the vignettes would reflect the specific audience of the handbook.

Summary

There is evidence from the handbook evaluation that many parents need assistance with the changes occurring in their lives as a result of becoming parents. They seem to need to have validation for their feelings and the adjustments that are being made during the transition to parenthood. Reading the handbook appeared to help some new parents understand themselves better and free them to accept the changes concomitant with the transition to parenthood.

APPENDIX A

HANDBOOK: WHEN COUPLES BECOME PARENTS: A GUIDE TO EMOTIONAL AND RELATIONAL ADJUSTMENT FOR NEW PARENTS

WHEN COUPLES BECOME PARENTS:

A GUIDE TO EMOTIONAL AND RELATIONAL ADJUSTMENT

FOR NEW PARENTS

by

Lorraine Evalyn Morris Laing

FOREWORD

This is not another book about
pregnancy
childrearing
baby care
or breastfeeding.

This is a book about YOU
the parents of a new baby.

It is written to help you understand what
problems
concerns
and feelings
many new parents experience when they bring home a new baby.

The information in it has been gathered from dozens of books and journals which social scientists and doctors have written after
observing
interviewing
and testing
other new parents
sometimes over several weeks and months.

You might say, with Charles Dickens,
that when couples become parents
"It was the best of times,
It was the worst of times. . . ." (1)

It is this author's sincere wish that knowing what other couples have experienced will add more joy to the
best of times
and hope to the worst of times.

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INTRODUCTION

The soft light of dawn crept through the ruffled white curtains of the nursery window. Ellen listened to the rhythmical squeak of the rocker as she cuddled her new daughter to her breast. Sandy was almost a week old already and Ellen was relieved that all had gone so well in the hospital. And Sandy was healthy: she had the lungs to prove it!

But Ellen was exhausted. It seemed as if her head had hardly touched the pillow all night. Maybe now she could catch up on some sleep. She eased out of the rocker so that she would neither jar her incision nor waken her daughter. She sniffed Sandy's sweet-smelling head once more, kissed her soft, brown locks, and lay her gently in the bassinet.

Ellen thought of the dishes lying in the sink from last evening. She knew Tom's alarm would ring in less than an hour. Should she stay up to do the dishes and get him some breakfast, or crawl back into bed for another cat nap? With a twinge of guilt, she opted to crawl back into bed quietly. She rolled over, half listening for Tom's alarm and half ready for Sandy's next cry.

Beginning parenthood is a transition that couples often find difficult. They are sometimes apprehensive about the enormous responsibility of caring for a new life. No longer are they the young gengeneration whose major concern is to grow and develop, to separate from their parents, and to look after themselves (1). Now they must accept total responsibility for a completely helpless, totally dependent human being. Initially this experience can be totally overwhelming!

Transitions are periods of "moving from one stable state to another, with an interval of uncertainty and change in between." Although transitions are normal occurrences in the life cycle, they can be upsetting: they may be like emotional roller coasters, full of confusion, ambivalence, and unpredictable behavior (2). Beginning parenthood is a transition known to cause some distress in most people (3).

High levels of change are considered stressful for most people, even if the change is anticipated and desirable (4).

Bringing an infant into the home for the first time requires change and reorganization which often produces strain on the couple (5). The tension arises from several causes, including lack of sleep and the resulting fatigue, feelings of immense responsibility, less time for yourself and your spouse, and feeling confined (6).

Besides the lifestyle changes, transitional periods often involve losses to grieve. New parents may experience loss of career opportunities, free time, sleep, time for leisure pursuits and personal care, adequate finances, and perhaps even some relationships (7).

When a new child enters the home, the relationships in that home become more complex. Two-person groups are the easiest to manage. The addition of a third person can often result in a pair and an outsider (8). At first the baby may be perceived as an intruder by both parents, but as powerful new bonds develop with the baby, someone may soon feel left out (9). That "someone" could be either the father, the mother, or the baby. Most often it is the father who feels neglected: because his wife is so involved with caring for the baby, he misses the attention she previously gave him and he may feel jealous of the new child (10). The wife in turn may sense her husband's feelings yet be unable to meet his needs because of the demands of the baby. Indeed, she may very well be longing for his care and attention: new mothers have increased needs for support and assistance, especially from their husbands (11). This is only one example of a situation in which marital conflict can easily arise as a result of the transition.

New parents often anticipate only the positive benefits of having a baby. They believe that the baby will enhance their relationship as a couple, bring them closer together, provide them with something in common (12). While a new baby can do all these things, the parents often fail to consider the costs (emotional, relational, and financial) that will also arise. Most do not anticipate the time and attention required by the baby (13). New parents often fail to recognize that parenting a newborn requires one-way giving to a dependent who is initially incapable of reciprocating in any way. This can be an emotionally draining experience (14)!

The stresses of parenting a new baby can begin almost immediately but tend to be recognized at about four to six weeks after delivery (15). While both parents are aware of the strain, generally it is the mother that senses more pressure, both on a personal level and in the marriage (16). The impact of the baby is probably felt more keenly by the mother since she usually does the greater portion

of the routine baby care, and she may still be physically exhausted from the pregnancy, delivery, and the night wakings, especially if she is nursing the baby (17).

A Personal Note

While much of this publication discusses the negative aspects of new parenthood, it is written with the strong belief that when you know about the stresses commonly associated with the transition to parenthood, you can also know that you are neither unusual nor inadequate in your own experience. It may help you to feel some control over your otherwise hectic lives and may also help you avoid unnecessary marital stress (18)(19).

Please keep in mind as you are reading this handbook that it is based on research. Notice the use of words like "many", "some", "a few". What may be typical of the experience of "many" may not be true for you. The more we learn about the transition to parenthood, the more we realize what we have to learn. There are gaps in the research thus far and so there will be gaps in this book. Please also note that the vignettes are fictional but representative of couples' personal feelings at this time.

This handbook represents the author's perception of the research. While every effort was made to interpret accurately, the information depicts a second-hand sharing of the knowledge, which is never quite the same as obtaining it directly from the source.

Section I of this handbook deals with the normal stresses that new parents feel, along with some suggestions to help with specific problems; Section II discusses personal and marital problems in the transition; Section III contains more suggestions to make the transition easier; and Section IV is intended to encourage, to help you focus on the many positive aspects of new parenthood.

SECTION I

THE NORMAL STRESSES OF EARLY PARENTHOOD

Ambivalent Feelings

When Wayne picked up the phone at noon to make his daily call home, he had no idea what he was in for. Suzanne outlined for him the horrors of the previous night and that morning--a sick baby, vomiting, diarrhea, mounds of laundry. He knew that she had been up with Jesse several times during the night, but she was asleep when he left for work and all seemed well then.

But obviously his assumption was incorrect. While the worst was over, Jesse had remained fussy all morning and Suzanne had spent most of the morning rocking him. Even now, Wayne could hear Jesse fussing in the background.

What surprised Wayne the most was Suzanne's comment: "Maybe this has all been a mistake, Wayne. I just don't think I'm cut out for this." And then he heard her gently sob.

Wayne felt helpless. He wanted to be there for her. He felt guilty that he hadn't awakened during the night. What could he do or say now that would help Suzanne? Finally, he stammered, "I'll try to get home early today, honey. I'll ask the boss if I can take some work home. Just try to hang on a little longer. You're gonna be a great mom: I just know it!"

Most new parents feel a combination of positive and negative feelings towards their newborns. Usually new parents do not verbalize these negative feelings to their friends and they may not even admit them to themselves because of the painful guilt they might experience. So, as a result of not knowing that these emotions are common, you may feel particularly incompetent, guilty, and even "bad" if you experience them (1). When you acknowledge only the acceptable feelings that you think you "should" feel, you are likely to experience psychosomatic complaints, irritability, and difficulty in your relationships (2)(3)(4). Ambivalent feelings are most likely to arise when you

honestly assess the costs versus the values of having a baby (5). But knowing that ambivalent feelings are normal can make coping easier (6).

Initially new parents are likely to experience both elation and euphoria at the time of the birth of their baby. Feelings of accomplishment and satisfaction prevail (7). They are proud of their newborn and enjoy seeing the pride and joy evident in the baby's grandparents (8).

However, as the weeks progress, they become very aware of the heavy responsibilities of parenthood and the helplessness of their child. They may feel trapped in the "foreverness" of the parent role (9). Since parenthood is irrevocable, and you cannot divorce a child as you might a spouse, the danger here can be psychological withdrawal from the infant (10).

Infants can be so demanding and unpredictable that there are days when new parents may wish that their children didn't exist (11). Some hostile impulses and thoughts about newborns are not unusual and are very much within the normal range of postpartum feelings (12). But however normal the impulses are, actual emotional or physical abuse of the child is never considered normal. If a parent feels unable to control his/her actions, immediate help must be obtained to protect the baby and help the parent deal with his/her emotions! Parent hotlines are available in many communities to direct you to the necessary help.

Most new parents feel at least somewhat inadequate about caring for their newborns. Mothers have difficulty dealing with the baby's cues and their meanings (13). Parents are aware that society expects them to raise children who will be competent adults: they wonder how (14)(15)! It is not unusual for them to change their ideas and theories about child-raising after the child is born (16). They often feel as if they are not living up to their potential as parents and the discrepancy between what they are and what they think they should be, lowers their self-esteem (17).

New mothers may take an average of six weeks to even feel like mothers. Feelings of love and affection for the baby are not always immediate: sometimes they take time to grow (18).

New mothers are often disturbed by their new feelings of dependence on their husbands (19). But the more a new baby depends on her, the more she needs to receive emotional support and assistance, especially from her spouse (20).

New fathers have found that parenthood heightens their emotions and influences the ways that they perceive their social status and relationships. They may describe their life before the baby's birth as boring and unfulfilling. Their involvement with their babies elicits an intense mixture of positive and negative emotions: fulfillment, wonder, love, anger, despair, hostility, pressure, worry (21). They resent the fact that their wives are not as available as previously. They may resent a temporary lack of privacy in the home (22). They express fears about finances, the rate of the child's development, about the future of the world. They are often surprised by the depth of involvement they feel as parents (23).

Many environmental and situational factors influence how new parents feel. Among these are distance from extended families, adjustments to new communities, amount of preparation for successful parenthood, and amount and quality of support from family and friends (24)(25). Needless to say, parenting stressors are greater for single parents, very young parents, parents of handicapped children, and parents who experience many other things, including the particular situation of the family, the values and characteristics of the parents, and the characteristics of the children (26).

Today around 25% of babies are delivered by Cesarean section (27). A whole range of negative emotions surrounds Cesarean births, including disappointment, failure, anger, envy, and guilt (28)(29). Mothers take longer to "feel like mothers" (30) possibly because of their initial separation from the baby and/or their difficulties with the first feedings. They also encounter problems caring for a new baby at home while they are recovering physically and emotionally from the surgery.

Fathers too experience intense emotions after Cesarean sections: disappointment that the delivery did not go as planned or that they were excluded from participation in the birth, and fear for their wives and infants, especially if the surgical procedure was considered an emergency. It is typical for fathers of Cesarean babies to assume more responsibility for caregiving (31). Support groups for Cesarean parents have proven very helpful for resolving many of the negative feelings (32).

When you acknowledge and express your feelings to yourself and to your spouse, you will be less likely to misinterpret each other's behavior and you should, therefore, experience less conflict (33). Gradually, as you learn to adapt to your baby's needs, you will also learn to adapt to your own emotional reactions (34).

Fatigue

Susan's whole body ached. She had just fed and bathed her new daughter and had put her down for another nap. As she cleaned up the bathtub and hung up the towel, she knew that all she wanted to do was rest herself. But it was only eleven a.m. and she had not gotten up until nine that morning. She had been up with Sarah only once during the night, but somehow seven hours sleep was just not enough these days.

Susan had so much to do. All around her lay unfinished tasks from previous days. Yet the bed beckoned her like a gigantic magnet pulls a scrap of metal. So Susan bargained with herself to get the laundry started, water the plants, and pull meat from the freezer for dinner before she would once again succumb to the cries of her tired body.

Many new parents complain that lack of sleep and the resulting lack of energy are the most difficult problems they face after the birth of their babies (1). Parents are literally "on call" for their infants seven days and nights per week (2). The baby's night wakings result in interrupted sleep for both parents with ensuing fatigue, exhaustion, and, what one study called "the mind-altering state of sleeplessness" (3).

Besides the night wakings, new parents also face an additional workload and its physical demands. The workload seems to be especially increased for the mothers (4), who are simultaneously recovering from the pregnancy and birth. Research shows that usually mothers view themselves as the primary caretakers, while fathers see themselves merely as "helpers" (5).

What can you do to help yourselves through the early days when fatigue is such a problem?

1. You can care for each other (6). You can negotiate taking turns at caring for the baby so that each gets a reasonable amount of sleep. The husband needs to see that his wife gets some relaxation (7).

2. You can set priorities. Baby care and self care are very important priorities, but you may have to compromise your standards with lower priority items such as housecleaning, at least temporarily (8).

3. You need to accept the practical and expressive gifts of help and support offered to you by friends and relatives (9). If help is not offered, you may need to seek help from other outside sources in order to cope with your increased needs at this time (10).

Lack of Free Time

"Janie, guess what?" hollered Paul enthusiastically as he slammed the front door. "Max gave us two tickets to tomorrow night's game at the stadium. I can't believe it! We're going to get to see the game!"

Janie looked less than enthusiastic. In fact, she looked tired and even annoyed. "Now how are we going to pull this off?" she snapped. "We certainly can't take a month-old baby to a football game. It'll be cold and noisy and..."

"Look. We'll get a sitter. Max knows this kid who sits for them. He says she's only fourteen but she does okay. It won't cost that much and the tickets are free. Besides, it'll do us both good. It seems like forever since we've had a night out. 'A change is as good as a rest.' That's what Dad used to say. Here's the number. Why don't you give her a call?"

New parents find that the amount of time that they spend in leisure activities, either together or individually, usually decreases significantly (1). Most frequently couples find that they spend more time together in household or childcare tasks rather than the fun activities they once enjoyed (2). Their marriage becomes more of a working partnership and less of a friendship and romance (3)(4).

New parents list the following difficulties regarding time:

* lack of time for one's self
* lack of time for their spouse
* not enough time to get everything done
* interruptions of routines, plans, and goals
* balancing the demands on their time
* decreased leisure activities
* fewer contacts with friends (5)
* scheduling one's time around the baby (6).

Couples find that their leisure activities change as well. For instance, they may eat out less and visit with close friends more. Relatives become more important in their social network and their number of acquaintances may actually decrease (7).

New parents spend fewer evenings out for several reasons. They frequently have definite ideas about finding a suitable sitter (8). If grandparents are not geographically close enough to babysit, couples are less likely to choose someone else, especially someone that needs to be paid since money is frequently a limited resource for new parents (9)(10). As well, the extensive needs of a newborn leave parents with less time and energy for leisure pursuits, especially if mother has returned to work (11). As a result, couples become more family-centered in their leisure pursuits (12).

When a valued resource, such as time, is scarce, conflict can easily arise for the couple. Because infants are so helpless and completely dependent, they require round-the-clock care resulting in a scarcity of free time. This may cause conflict in the relationship, especially if one partner "wins" the time and the other partner "loses" or relinquishes his/her own interests for the sake of the baby. Couples need to strive for fairness, that is, a similarity of opportunities and constraints for each partner (13) so that resentment does not develop between them.

Confinement

Cheryl watched the trail of exhaust from the family car as her husband drove off to work. It was seven a.m. A powdering of new-fallen snow covered the yard. Across the street, she noticed the frosty breath of three teens who chattered as they awaited their bus to school. The sky looked gray, as if it were full of more snow. "Bleak!" That's how to describe it. "Dismal" might be equally as good. "What to do? What to do on a day like this?" she pondered. "I feel trapped!"

Cheryl looked around inside. The living room was cluttered, dirty dishes lay in the sink, and upstairs, the bed was disheveled. It's not that she had nothing to do. Cheryl and Bill had only been here two months and there was still unpacking to do. They had moved in order to be closer to Bill's work and have another bedroom for Billy, now one month old. Cheryl missed her jogging buddy, Judy, who was still on the other side of town. Maybe this would be a good

day to call Judy to see how she was getting along. But it was too early for that yet. In the meantime, she'd have a second cup of coffee, find some cheerful music on the radio, and begin the morning chores.

"Confinement to the house" and "difficulty in getting out" are frequently mentioned by new mothers as typical problems in the transition to parenthood. Since women often quit a job outside the home, they have less contact with friends and other adults they knew when they worked (1). This may result in feelings of isolation and loneliness, unless they have sufficient support from friends and family (2).

When occasions do arise for social interaction with friends, mothers report that getting out is far more complicated since arrangements have to be made for the baby. Spontaneity appears to be a thing of the past; more planning must be done each time to meet the needs of the baby (3). Breastfeeding may limit a mother's mobility even more (4).

Wives complain that they are surprised to find themselves doing so much manual labor, which is, of course, unpaid (5). Because of the repetitiveness of their household and childcare chores, and without the social and intellectual stimulation of their jobs, they are likely to feel bored (6). They may have "feelings of loss and nostalgia for more carefree times" (7).

New fathers also experience a loss of freedom, but they usually recognize that their wives are more tied down than they. Empathizing with their wife's temporary period of confinement (8) and providing them with emotional support (9) as well as sharing the childcare and household responsibilities are all conducive to the wife's emotional adjustment during the transitional period.

Financial Concerns

LaVerne lay in bed listening to the lighthearted music on his clock radio and the rain on the roof. It was 6:35 a.m. already and he knew he had to get up. Since Vanessa had stopped working to have the baby, he could sense the pressure of an ever-shrinking savings account. It was all up to him now. He had to be the man of the family. He had to do it: no one else could do it for him. Maybe if he continued to push himself and his sales record improved, the

boss would notice and give him a promotion. That would certainly ease the family finances. Did he even want to remain in sales? No time for such thoughts now. "Another day, another dollar," he muttered to himself as he slid out of bed and made his way to the bathroom.

When a first child is born into a family, many new parents feel that they are not financially ready for the additional responsibility, even though the child is wanted (1). New mothers often quit their jobs, take a leave of absence, or cut their working hours, leaving the family with less income at least temporarily (2). Depending on their medical insurance, couples may be left with debts to doctors and the hospital. Then there are the added expenses in caring for a baby: food, clothing, equipment, medical care, and sometimes, childcare, the single most costly item for some families (3). Many couples move to larger (and usually more expensive) dwellings in order to make room for their infants (4). Experts say that, as a general rule of thumb, the direct cost of raising one child from birth to age 18 is three or four times the family's annual income (5).

Fathers appear to be the ones most concerned about finances. Because of the reduced family income, they complain there is no extra money to spend (6). Financial security becomes more important (7). Husbands may put more energy into climbing the career ladder as they experience an increased need to be successful(8)(9). They often spend more time at their jobs and their wives are likely to misinterpret their absence as pulling away from the family just when they are needed for support, especially if they had previously suggested that they would be available to share the care of the baby (10).

Role Confusion: Who Does What?

Anita had seemed particularly peeved lately. Jack could feel the tension in the air. But when he asked her about it, all she would say is, "You've got eyes! Just look around you!" Sure he had eyes and he could see that she had plenty to do. But why should she stay so downright irritable these days? If she would just look around, she would see that he had plenty to do too: his garden, work from the office. Why, he had even started building his new son a bed frame, one that would look just like a little sports car. That's what fathers were supposed to do, wasn't it? That's what he remembered his father doing!

In social organizations, there are roles which must be filled for the normal functioning of the organization. In a marriage, both the husband and the wife have roles. Traditionally, the husband's role was the wage-earner outside the home and the authority figure inside the home; the wife's role was to care for the home environment, raise the children, and sustain appropriate friendships (1). Today, however, the attitudes of women about their roles have changed so dramatically that men can no longer assume that traditional sex roles will go unchallenged (2).

Typically husbands take off from work about one week after the birth of their babies to help their wives with the babies. By the end of the second week, the husbands give about the same amount of help as before the birth, despite the increased workload in the home (3). As time goes on, a shift toward more traditional roles occurs, even if the household chores were shared before the birth of the baby (4)(5). The change is most apparent in household tasks, but it also occurs in decision-making power (6). As well, in childcare activities, unemployed women spend about seven times as much time as their husbands and even employed women spend twice as much time as their husbands (7).

The shift in roles can become a very significant source of conflict (8). Although men appear to be more satisfied with the traditional role arrangement, women frequently become resentful and the marriage is weakened by the added tension (9). Of course, satisfaction with roles also depends on the ideal concepts of each individual couple (10).

When men assume more household tasks that they consider "feminine" while their wives assume the greater proportion of the childcare tasks, neither men nor women report high satisfaction with their marriage. However, when men focus more on active parenting and less on household tasks, they appear much happier with their marriages. When men and women share childcare tasks, women feel supported by their husbands and are generally happier in the marriage (11).

Body Image

> When Gail left the hospital, she wore the maternity clothes she had arrived in three days earlier. She marvelled at how loose they appeared and dreamed about how good it would feel to wear her regular clothes "with a waist" again.

At home, Gail picked what she remembered was her loosest pair of jeans. And to her surprise, she couldn't button them--by at least two inches. She rooted around in the closet until she found an old pair of pull-on pants. They fit, but they made her tummy look huge. With a sigh of disappointment, she resurrected one of her long maternity tops and determined to faithfully do the exercises that she had been given in the hospital. "This is going to be more work than I thought," she muttered. "But I will get into those jeans again."

Generally, women have negative feelings about how their bodies change during pregnancy. (If a woman is dissatisfied with her body before pregnancy, she may feel even worse.) But even the few women who enjoy their pregnant appearance often feel dissatisfied with their bodies after the baby is delivered (1). They may be disappointed that their abdomen is still soft and large because the muscles have been stretched. They may be discouraged to find that only their maternity clothes fit initially (2). Many are still heavier than before pregnancy and also notice their breasts are full and large. And, to make matters worse, many new mothers feel that they don't have either the time or energy to work on their appearance during the early days and weeks following delivery (3).

These body changes may result in fears for many new mothers. They fear that they have lost their sexual attractiveness and thus may lose their husband's affections. They fear that nursing will spoil their breasts (4). They fear that their bodies will never be the same again (5).

While still in the hospital, ask your doctor for suitable exercises to help tone your abdominal muscles. The abdomen is usually lax for the first couple of weeks after delivery, but it usually returns to close to its prepregnant size within 6 to 7 weeks (6). A good nursing bra can help support your increasingly full breasts (7). Early dieting needs to be approached with caution. Realistic goals for attaining prepregnant weight are three to six months (8). Making love again with your husband will also help to reaffirm your femininity and your desirability as a sex partner (9).

The Sexual Relationship

Ever since Daniel was born, David had missed the wonderful sexual relationship that he had previously enjoyed with Debra. Not that Daniel was to blame, mind you: Daniel

was the apple of their eye. They both loved him deeply, but David longed for the good old days as well, the days when he and Debra could just unplug the phone and savor the whole evening for themselves. But you sure couldn't unplug Daniel. He was there to stay.

David was not sure just how to approach Debra this time. Somehow it seemed awkward. The time was right: even the doctor had said it was okay. But Debra seemed so tired these days and so preoccupied with Daniel. But as awkward as it was, he knew he would somehow have to broach the subject and today was the day!

The return to a sexual relationship is very unique for each couple. While many doctors still recommend waiting six weeks after the baby's arrival, many are now shortening this waiting period, according to the individual needs of the couple (1).

But while many new mothers may be physically ready for intercourse, they may not be psychologically or emotionally ready at the prescribed time. They give several reasons for this:

* fatigue
* weakness
* pain with attempted intercourse
* an irritating vaginal discharge
* fear of permanent physical harm (2)
* fear of infection
* fear of pregnancy (3)
* feeling "touched-out" (since the baby has been touching them so frequently)
* vaginal dryness with sexual arousal (noticed particularly by wives who are breastfeeding)
* poor communication with their husbands regarding their level of sexual interest (4).

As well, many may also feel anger or resentment towards their husbands if they feel otherwise neglected or if the husbands are not involved in caring for the baby and in doing necessary household chores. They may feel coerced into performing sexual favors only for the good of the marriage, rather than as a way of meeting their own needs (5). Yet, despite these difficulties, most wives are also concerned about the sexual needs of their husbands (6).

New fathers frequently feel displaced after their babies' arrival. They may feel either ambivalence or resentment towards the infant because the many demands of the baby take priority over their own needs (7). It is the fathers who are most likely to complain about the sexual changes that occur in the postpartum period (8). Many have already been asked to delay sexual activity during the latter part of the pregnancy and it is difficult to understand why further delay has been imposed (9). On the other hand, they may be fearful of causing physical harm (perhaps by breaking some stitches) or causing emotional tension for their wives (10).

Occasionally, breastfeeding interferes with the sexual relationship. Husbands may report that their attitude towards their wives has changed from that of a sexual playmate to that of a madonna, a sort of incest taboo. Curiously, visits from the husband's mother help him regain perspective and bring reality into clearer focus (11).

Women who are nursing and have not yet started their periods may experience lower levels of sexual desire than they did in their prepregnant state. This is a normal, natural aspect of the reproductive cycle. It is important to know about all these aspects so that partners can better understand each other (12).

You might think that those who had Cesarean sections may be able to attempt love-making sooner since they do not have to contend with an episiotomy. However, this is not true. Their recuperation time from major abdominal surgery is slowed down by caring for the baby. Moreover they may be dealing with the added emotional trauma discussed earlier (13).

There are many things that you might try to make your first attempts at love-making more pleasant:

1. Before leaving the hospital, get instructions from the doctor about how long to wait and what birth control measures to use. If at all possible, the husband should also be there to hear the instructions and understand them. Ask the doctor about beginning the Kegel exercises to tone the muscles surrounding the vagina. These exercises involve tightening and relaxing the muscles in the vaginal or pelvic floor area which may have been weakened by childbirth.

2. Your sexual needs can be met in ways other than intercourse. Touching, caressing, massaging, and holding are all ways to show you care. Manual partner stimulation or masturbation may be temporary options for sexual pleasure.

3. Before the first intercourse, you may want to inspect the episiotomy incision with a hand mirror. Inserting a clean finger or tampon into the vagina to test for soreness might also be helpful.

4. Partial entrance into the vagina by the penis with very little movement may be necessary with initial sexual contact. A generous amount of water-soluble lubricant makes insertion more comfortable, especially for nursing mothers. Experiment to find positions that will minimize the soreness of the incision. Pillows under the woman's buttocks may help redirect the pressure to avoid the tender spot.

5. Rest and relaxation, physical and emotional support, and a nutritious diet are all important for reviving the sexual energy which has been diminished since childbirth (14).

6. Because of the baby's irregular schedule early in life, you may have to plan your sexual liaisons for a while rather than simply being spontaneous (15).

Infant Characteristics

Luis Perez Garcia had allergies, or so the doctor thought. His little button nose was constantly running and oh, how he hated it when either Miguel or Isabella wiped it! You would never guess that only fifteen pounds and twenty-two inches could make such a fuss!

If only the nose-wiping were the biggest problem that Miguel and Isabella encountered with their son, all would be well. But Luis' allergies also caused him to awaken frequently in the night when he had difficulty breathing. Isabella would aspirate his nose and have to feed him each time he awakened. It seemed as if Luis even had trouble sucking with his stuffy nose and he never had a "full meal" before he would fall asleep. At four months, Isabella was still feeding him at least six times per day and sometimes more. Both she and Miguel felt weary and discouraged but what scared them the most was the subtle change in their feelings toward Luis. Why couldn't he be like other babies his age?

Research on the behavior of infants shows that children show strong differences in temperament, almost from birth. Alexander Thomas and Stella Chess believe that children may fall into extreme categories: at one extreme are the "easy" children, while at the

other extreme there are the "difficult" children. A third group of children are "slow to warm up": these children adapt to new situations more slowly (1). While many parents expect their babies to be "better than average", in reality the infants each have their unique style of responding to the world (2).

Infant calmness or difficulty appears to affect marital adjustment in the transition period. Parents with calm infants have more time to spend with each other and they, therefore, find parenting more enjoyable. On the other hand, parents with fussy babies have more difficulty with their marriage since they spend so much energy attending to their infants (3).

Parents with crying, irritable, or colicky babies often feel helpless, depressed, angry, exhausted, and even feel rejection towards the baby (4). While mothers are more apt to be the ones who console the crying infants, they tend to cope somewhat better with the difficulty than do fathers. Yet even mothers blame themselves and feel inadequate when they can't console a crying baby. They think that in some unknown way they have mishandled their children to cause the problem (5)(6).

Fathers seem to have even more frustrations with difficult babies: they experience anxiety, feelings of powerlessness, and negative feelings about changes in their lifestyles, all for which they tend to blame their wives. But usually neither parent should be "blamed" for the stressful crying in early infancy (7).

Some parents feel that their infant's crying is willful behavior. They determine that the baby is having a temper tantrum, and may take measures to discipline him or her (8). For instance, a mother may think that her child consciously decided to cry every time she tries to relax just to be mean. In the heat of the moment, parents may accuse their babies of deliberate, planned behavior and may be tempted to abuse them. But babies are completely incapable of such complex thinking at this stage (9). It may be encouraging to realize as well that babies' crying decreases substantially in the first year of life (10).

In the past, psychology has focused on how parents' treatment of their children has had lasting effects on their children. While there is much truth to this teaching, we now know that infants and children also influence the behavior of their parents (11). Certain characteristics of infants' individuality do exert some influence on parental behavior.

Besides temperament, developmental psychologists also recognize that the infant's responsiveness, physical characteristics, attractiveness, and health have an impact on the transitional period (12). For various reasons, adopted children often experience more prenatal and birth complications which may result in more difficult temperament patterns and early developmental delays, possibly affecting their parents' transitional period negatively. If infants have had several successive foster parents in their first year or so, they have experienced many separations and losses, and may have difficulty forming a secure and trusting relationship with any new caregiver (13).

Babies with feeding problems, babies who sleep less than most their age, babies with serious health problems, premature babies, and "special" needs babies, all complicate the transitional period further for their parents. While an abnormal child can bring some couples closer, couples who already have an unsteady marriage or who have a low tolerance for stress might experience serious difficulties with the added stress of a child who is demanding in some way (14)(15).

Relationships with Grandparents

Jan's mom and dad had been just great. They were there in the waiting room when Amy was born. And when it was time to come home from the hospital, it was they who picked her up so that Brad didn't have to take time off work.

Mom and sometimes Dad came over every day for the next two weeks to help Jan with Amy. Mom taught Jan how to arrange the nursery, how to bathe the baby, and even how to know what Amy wanted and when she wanted it. She shopped for Jan, cleaned for Jan, washed and ironed for Jan, and even prepared all her meals. Often she and Dad would stay on for dinner and well into the evening.

This was all fine for a while. But it was beginning to get to Brad. While he appreciated all their extra help, he resented the intrusion on his family's privacy. And both he and Jan were beginning to feel that they wanted to do some things for Amy in their own special way rather than how Mom said it "should" be done. After talking it over, they decided that Jan would ask her mother to cut back to two or three days per week and leave them to manage by themselves on weekends. Jan needed to feel that she was capable of handling Amy by herself and Brad was looking forward to having more moments alone with Jan and with Amy.

When couples become parents, their ideas about their own families begin to shift. Once they realize how difficult it is to raise a child, they can become more appreciative of the care they received from their own parents. Others may become more resentful of the conditions in their homes in their growing-up years and realize the abuse or neglect they received as children (1). These parents, although their ideas about childraising might be vague, might be very determined not to make the same mistakes as their parents. While most new parents want to raise their children better than their own parents, sooner or later they are likely to find themselves either making the same mistakes or making new ones (2).

Many couples experience a change in the relationship with their parents. For some the contacts become closer, more frequent, and stronger. Some couples report being allowed into conversations which were previously reserved only for the "grown-ups" of the family (3)(4). Becoming parents may give a couple the privileges of full adulthood for the first time: it helps them to identify with the older generation, as well (5). No longer are they the children of their parents, but now they are the parents of their children (6).

Many grandparents live geographically close enough to their children that they can become very actively involved in supporting them during the transition period. The caregiving and play that grandparents give to their grandchildren can relieve parents of much stress and responsibility. Usually the maternal grandparents give more help (7). Grandparents also may give information, reassurance, emotional support, and even financial aid to the new parents. And this is usually very much appreciated (8)!

However, too much contact from the grandparents may be interpreted as intrusive and undesirable (9). The parents may decide that it is inappropriate and unwanted (10). They may resent frequent suggestions about how to care for the baby (11) and feel that they need to determine their own style of raising children (12). If grandparents are critical of their children's parenting, this can become another source of tension in the new family (13). In general, support from grandparents is considered "just right" when it satisfies needs without evoking resentment (14).

Couples need to act as "gatekeepers" between the grandparents and grandchildren. They are the ones who need to establish some type of control over the frequency and timing of the contacts (15). They need to determine how much to include and exclude them (16). Too much

closeness can reactivate old conflicts, rivalries, and issues of social class, religious affiliation, and family customs (17).

Sometimes grandparents are either not available (because of geography or other commitments) or not willing or able to help (18). Sometimes the new parents may be in the position of actively caring for their elderly parents (19). Sometimes, only one set of grandparents accepts the baby or is able to help. When there is some inequality in the involvement of the two sets of grandparents, the parent whose family is least involved may feel less worthy, less powerful, and more inferior (20).

Mother's Return to Work

> It was Tuesday, which meant that Betty had only six days left before returning to work. The thought scared her: she had no idea how she was going to manage being a wife and mother and a grocery clerk too! But she had to do it. There were all those hospital and doctor bills yet to pay off, and Chuck's wages just weren't enough.
>
> Probably what scared Betty the most was leaving Angela with her mother's neighbor. Mom thought she was a nice lady, but Mom really didn't know her all that well. And how could little Angie tell her if she hated it there?
>
> But it was the best that Betty could do. At least Angie wouldn't be exposed to other children during the flu season. Mrs. Nicolaus seemed friendly, she kept her house clean, and, most important, she didn't charge too much.

After their baby's birth, some women want to return to work, some want to stay home, some have to return to work (for financial reasons or other commitments), and some are undecided. Some mothers believe very strongly that they can care for their children better than anyone else and that their children much prefer their care to that of others. These mothers are likely to experience sadness and guilt if they have to return to work. Other mothers believe their children develop better interpersonal skills and become more aware of and accepting of others' values, perspectives, and beliefs when they are cared for by others. These mothers tend to experience less anxiety about leaving their children to the care of others (1).

Making the decision between staying home and returning to their careers is very difficult for some new mothers. They may feel an obligation or desire to care for the child, yet they encounter

boredom, lack of intellectual stimulation, and social voids at home. Women who have had enjoyable careers seem to experience more discontent over assuming traditional homemaker roles if they decide to remain at home (2). The burden of the new mother role may be less when mothers are employed outside the home since they experience a change of scene and relief from the stress of baby care (3).

Yet most working mothers will see their jobs as somehow interfering with their top-priority roles as mothers (4). If their jobs are unsatisfying, they are also likely to experience more marital stress at home. If their husbands are also stressed and fatigued when they arrive home, the wives are likely to report more negative interactions with them and are more likely to do the majority of the household tasks that day (5).

Women are likely to encounter four distinct types of conflicts when they have infants and work outside the home. They will experience time conflicts, that is, insufficient time to accomplish all their responsibilities. There are location conflicts, the dilemma of being in two places at once. There are energy conflicts since their physical, emotional and mental energy supplies are limited. Finally, there are conflicts in expectations since they are expected to behave so differently in the conflicting roles (6).

How do women successfully manage the conflicts between home and work if they choose to return to work? First, they define their situations as positive. They strongly believe that they are better mothers because of their outside interests. They feel convinced that their children's needs are all being met somehow. Second, they establish their roles as wives and mothers as most important, so that when a conflict situation occurs (eg. a child is sick), they are comfortable with giving their home needs top priority. Third, they keep their home and work roles as separate as possible so that they can concentrate on one role at a time. Fourth, any compromise between home and job roles is made in favor of home role demands. These compromises are dependent on several factors: their husband's attitude toward their career and the demands of his profession, the ages of the children, the wife's personal philosophy on her role as mother, and the amount of energy she can gather to withstand the demands of her two roles. When their jobs are satisfying and the women well-organized, some women can manage home and work roles very nicely (7)(8).

SECTION II

INDIVIDUAL AND MARITAL PROBLEMS

Postpartum Depression

Nancy thought she had it made. She'd given birth to a healthy, gorgeous baby girl, just what she'd wanted! Her labor had gone beautifully and lasted only six hours--not bad for a first! Eric had been with her, coaching and encouraging her, throughout labor and delivery just as they had planned. And she would never forget that first time she snuggled Kathy to her breast. Both she and Eric would cherish that moment forever.

That was only four days ago. Why did Nancy feel so differently today at home? Why was she fighting tears all day? Eric was home just as he'd promised--doing dishes, laundry, shopping, vacuuming--all those necessary chores.

It all started when she couldn't find a potholder this morning to pull her oatmeal from the microwave and she burned her finger, ever so slightly, on the hot cereal. Eric came into the kitchen soon after and kissed her finger, just like her mother had done years ago. They both snickered about the incident. Later on, when Kathy woke up, Nancy lost control again and cried off and on for the remainder of the morning.

Nancy felt so stupid to be carrying on this way. She had so much to be thankful for: so, why, oh, why couldn't she show it now?! Why couldn't she stop this foolish crying?

Each year thousands of new mothers (at least 10-15%) will suffer from mild to moderate postpartum depression (1). At a time when society tells women that they are supposed to celebrate a joyous event, these new mothers find themselves engulfed in despondency that they cannot understand (2). Guilt and shame often keep them from asking for help. Lack of available support prevents many of them from

finding help (3). Many doctors are not prepared to handle the problem; family and friends hope they will simply "snap out of it" with some reassurance and a little extra help (4).

In some cases, without professional help, postpartum depression will disappear (5). But often it continues more than one year, leaving mothers feeling inadequate, lonely and isolated, resentful of the demands made by their babies, and highly negative about themselves (6). Even new fathers and adoptive parents have depressive reactions following the arrival of a new baby (7). One informal pilot study has led researchers to believe that the probable consequences of untreated postpartum depression are the following:

* breakdowns of the mothers' physical and mental health
* destructive behaviors initiated by the mothers toward themselves (eg. drinking, drug addiction, suicide attempts)
* unsatisfactory relationships with husbands and babies
* child abuse, and
* child neglect (8).

Clearly, new parents need to be aware of the symptoms of postpartum depression so that they can get help when necessary to prevent its destruction in their lives.

While researchers seem to disagree about many aspects of postpartum depression, they generally agree that there are three different types: the blues, postpartum depression, and postpartum psychosis. Yet, in reality, these types seem to overlap.

While the blues are the mildest form of postpartum depression, they are also the most frequently experienced. Anywhere from 50 to 80% of new mothers experience the blues from the early days in the hospital (9) till eight weeks postpartum (10). Postpartum blues are characterized by episodes of crying, sometimes lasting for over two hours at a time. New mothers may cry seemingly without reason. For instance, a husband may arrive late for his hospital visit or a nurse may suggest that the baby is still hungry. It seems that any words or actions from another person which they interpret as thoughtless or uncaring can cause this exaggerated reaction. Other causes of the crying might be:

* changes and threats in the environment (especially changes in the relationship with the husband),
* anger toward the husband for his lack of consideration or unwillingness to help

* doubts about competence as a mother
* pain or illness after delivery
* dissatisfaction with the baby
* relief at the conclusion of a difficult pregnancy and/or delivery
* difficulty with parents who have not accepted the marriage
* an unsatisfactory visit from the doctor.

In general, it appears that often new mothers desperately want to be cared for and mothered themselves (11).

The good news is that the blues are considered a normal part of the postpartum adjustment period. Usually no outside medical or psychological help is required to deal with them and with time and rest, they disappear. However, if the depressed mood lasts for several days, it may represent the beginning of postpartum depression, which often does require appropriate professional help (12).

The symptoms of the second type of postpartum depression can range from mild to moderately severe. Postpartum depression usually begins slowly within a few weeks of delivery and can last a year or more (11). Various studies show that anywhere from 8 to 23% of new mothers experience this type of depression (14).

Symptoms of postpartum depression may include feelings of sadness, anxiety, hopelessness, irritability, lack of energy, and inability to cope (especially with the baby). As well, physical symptoms such as constant tiredness, delayed return of menstrual periods, swelling, weight gain, hair loss, insomnia, and lack of sexual interest may exist (15).

Since postpartum depression may impair a woman's ability to function in her many roles, it should be taken seriously and necessary help should be obtained (16).

Postpartum psychosis, the third type, is extremely rare: only one or two cases are diagnosed in every 1000 new mothers. The psychotic reactions usually start 2 or 3 weeks after childbirth (17). Postpartum psychosis is characterized by loss of touch with reality: inability to function, confusion, hallucinations or delusions, great excitement, extreme changes in moods, and fears of harming the baby are some of its symptoms(18)(19). This is a serious illness that always requires professional help and often requires hospitalization (20).

What causes postpartum depression? No one seems to know for sure. "Changes in body chemistry" would seem to be a very logical response: for instance, estrogen and progesterone levels fall drastically after the birth of a baby. Yet studies trying to relate biochemical changes with postpartum depression have been either negative or inconclusive so far (21)(22).

Researchers have observed that even adopting mothers and new fathers may experience depression following the arrival of a new baby (23). This has led them to believe that there may be psychological causes to postpartum depression. As mentioned previously, there are many losses to be grieved in the transition to parenthood: sleep, free time, freedom, self-image, job, etc. (24). Some think that postpartum depression is caused by the many stresses, both physical and emotional, that accompany the postpartum period (25). Others think that it is caused by the person's thoughts and attitudes (26)(27)(28).

Changes in interpersonal relationships during the postpartum period are also possible causes of the depression. As mentioned previously, new parents must make adjustments in their relationship with each other. They must adjust to the characteristics of their new child. And they must adjust relationships with relatives and friends. Some women may also need to adjust a "too close", dependent relationship with their own mothers to alleviate the depression (29).

Who is at risk? While this also remains unclear, many researchers agree that women who were depressed before the birth of their babies or who have a family history of depression seem particularly vulnerable (30). Women having their first child appear to be more susceptible (31). Women who have cesarean sections when they had planned a natural birth often become depressed (32). Other stressful events or situations during the pregnancy or during or after delivery increase the danger. Women of all social classes are at risk (33).

Lack of social support outside the marriage and dissatisfaction with the marriage are other factors which increase the probability of depression (34). When the wife is confined to the home and her energy is drained by the demands of childcare, she may not have time to cultivate friendships, making her relationship with her husband especially significant. A marriage in which the husband and wife confide in one another seems particularly meaningful in the postpartum period (35).

There are several ways that postpartum depression has been treated. Sometimes medications are used, but often, breastfeeding must be stopped and sometimes the mother is not able to look after her baby while taking these drugs (36). Counseling may be very helpful, especially if it is done with both parents together (37). In some locales there are weekly support groups for new parents or therapy groups for new mothers (34)(35). Ask your doctor, hospital, or community mental health services for information and referral to individual therapists or groups.

Marital Satisfaction

April couldn't remember one single evening in the last two months when both she and Ted had eaten a whole meal together. Even now she had Casey in her arms, giving him another bottle while Ted was rinsing off his plate at the sink. "Would you take Casey for a while, so that I can eat?" she asked with annoyance. Why was Ted so insensitive to her needs?

Ted took Casey who fussed ever so slightly when he was disturbed in the middle of his feeding. Holding the bottle upright under his chin, Ted adjusted the TV to his favorite evening quiz show and then retreated to the couch where he sat down with his back to April and his feet propped up. Meanwhile, April reheated her fish sticks and fries and returned to the table to eat alone.

Something was wrong with this picture! Had life deteriorated so much that they resorted to fish sticks, quiz shows, and their own separate ways? Where were the gourmet meals by candlelight, the soft background music, and the intimate conversations they once enjoyed at the end of the workday? This certainly wasn't the "happily ever after" that April had in mind when she married Ted three years ago.

Studies of marriages have shown that there seems to be a decrease in marital satisfaction over the years. When couples are first married they have high expectations of each other: when these expectations are not met, early feelings of love are replaced by disillusionment. Then, when children come along, they seem to add to the difficulties in the marriage. Finally, as the children begin to leave home, the couple may begin to feel more acceptance of each other and thus, more satisfaction with the marriage. In their later years,

couples appear to be as happy as they were in the early stage of their marriage. The points of least satisfaction in the marriage appear to be when the last child goes to school and when the family has teenagers (1).

After the birth of the first child, this decrease in satisfaction in the marriage is initially felt by the wife. She may be experiencing some postpartum depression. She may be feeling tied down to the house. She probably has had fewer contacts with her friends and is feeling less supported than she did before the baby's arrival (2).

New mothers often complain that their husbands don't pay enough attention to them. This could be interpreted two different ways: either the husbands are less attentive than they were previously, or the wives feel they need more attention now (3).

New fathers appear to be content with the marriage until between 6 and 18 months after the baby's arrival. Men do not seem to become as involved in the parental role as women. They may pride themselves in being good providers for their wives and children, leaving their wives with the bulk of the parenting role (4).

The drop in marital satisfaction for both men and women appears to be related to increased conflict in the marriage (5). Couples also report fewer positive behaviors towards each other and are less expressive of their feelings of love for each other (6). This would suggest that they do fewer favors for each other to show that they care. Couples tend to talk less to each other. They show greater differences in opinions, ideas, perceptions, and satisfactions (7). They are likely to apply more pressure to each other: for instance, a wife may use guilt in order to manipulate her husband to do household chores (8).

There appear to be changes in the power structure of the marriage during the transition to parenthood. When women quit work or cut down on the amount of work they do outside the home, they become more dependent on their husbands for money (9). The homes become more traditional, more patriarchal, that is with father as the head. Wives may become more indifferent about solving problems and simply give in and allow their husbands to make the decisions (10). And husbands seem more satisfied with the increased influence they now have (11).

And yet, where childcare is involved, the wife becomes the expert, while the husband remains the helper and playmate. In this area, the wife may well hold the power and in so doing she may

distance her husband from her. He may feel that his contributions are not appreciated. In the end, both husband and wife may end up competing for the baby's attentions (12).

Parents usually don't blame their babies for the decrease in satisfaction in their marriage. In fact, they claim that the babies are the most satisfying part of their lives during this period (13).

So, how can you help restore some of the contentment you once enjoyed into this difficult period of your lives? First, each of you needs to make the family your first priority. Second, you must be able to agree on arrangements about household and childcare responsibilities and relationships with friends and relatives. Third, you must take time by yourselves to build your couple relationship, a new type of relationship founded on commitment, sharing, and mutual "give and take" in order to develop a healthy family life. This requires much more maturity, responsibility, and understanding than you ever needed as singles or newlyweds. If you cannot successfully build these three components into your marriage, you may need the services of a marriage and family counselor to help you change your marriage to its previously satisfying condition (14).

SECTION III

SUGGESTIONS FOR IMPROVING YOUR TRANSITION TO PARENTHOOD

Couple Priority

In the early weeks and months of life, mothers and babies are necessarily very close. Initially the father may feel somewhat alienated from his wife, while the wife feels confined by the needs of the baby. Eventually, if all goes well, the father, too, will have developed strong bonds with the baby (1), but the couple may find that they are talking to each other less, especially about themselves. When they do converse, much of the conversation centers around the child, leaving the couple feeling less close and more vulnerable to conflict (2).

Many studies have shown that support from friends and relatives can help couples cope with the stresses which occur during the transition to parenthood. But too much outside support can create its own problems for the couple: outside support may also include increased demands on the couple's time and obligations to be supportive of others (3). If the husband is not supportive and the marriage relationship is poor, new mothers often ask for outside support which may separate the couple even more (4). On the other hand, if the husband is emotionally supportive and shares in the workload, even mothers who feel a great deal of stress in their lives report greater satisfaction with their lives in general and with their roles as parents (5).

Another task that new parents face is to create some boundaries around themselves so that their roles as parents do not interfere with their roles as spouses (6). They need to set aside time in order to talk about themselves. This intimate relationship involves caring for one another and sharing feelings and dreams without risk of criticism from each other. And as each person shares, he/she becomes more aware of self, while the other person learns to appreciate facets of his/her uniqueness or sameness. No pretense is necessary. True belonging involves acceptance of each person as he/she is. When two parents are highly committed to each other, the environment they create will likely be favorable for the growth of their children (7).

There are two different ways that couples can choose to cope with the impact of having a child. In the first, the couple can make their own relationship the hub of closeness in the family. They maintain a healthy sense of themselves as a couple. In the second family type, the entire family is central. The interests of the entire family take precedence over the couple relationship. Group needs and activities become top priority. The parents see themselves simply as family members. Couples who become parents early in their marriage often adopt the family-first strategy simply because they have not had time to establish themselves firmly as a couple. But their marriage relationship is likely to suffer (8).

You will probably want to strike a balance in your home between togetherness as a couple and as a family. Although the intimacy in marriage can be preserved without making it the central feature of family life, the marriage thrives better longer when it is sensitively nurtured (9). Couples who want to be good parents need to make their marriages a priority so that they can grow and thrive (10). Without a solid, stable marriage, a child can act like a wedge to drive the couple apart (11). Child-centered homes yield neither happy marriages nor happy children (12).

Therefore, one of the best things that you can do as couples is spend time together away from the baby, building your relationship. Although this takes more planning after the baby's arrival, it is well worth the effort. It can also be beneficial to your baby since it allows the infant to develop trust in someone other than you. Often parents work out a cooperative babysitting arrangement with other parents so that their "time outs" from parenting can be less expensive (12).

Individual Time

One theory of family functioning suggests that people endeavor to balance their needs for intimacy with those for distance each day with three types of activities. Intimacy-promoting activities are those that involve sharing valued experiences with someone. For example, they might share memories, have stimulating conversation, or sexual involvement. Distance-promoting activities are those in which people are alone, either physically or psychologically, doing things like reading, studying, fantasizing, or sleeping. The third type of activity involves coaction but not intimacy, that is, activities done jointly such as playing a game, watching TV, or discussing your plans for the day. When these three types of activities are balanced to a

person's liking, he/she feels satisfied, but when one or more of the activities is missing or in profusion, the person may feel unbalanced and dissatisfied (1).

Mothers especially need to be reminded of their requirement for free time. They ought to be encouraged to be aware of their own needs and to balance their needs with those of their family (2).

Women who have abandoned satisfying careers to stay at home with their infants may have an especially difficult time adjusting to their new lives. They may feel bored, tied down: they miss the stimulation they once experienced on the job (3).

Because of the constant demands of parenting, new mothers often feel trapped by the monotonous, tedious chores and the social isolation of an unchanging environment. They can literally work themselves into a state of physical and emotional depletion (4). This condition is called burnout. It results in cynicism or a lack of concern for the family for whom they are most concerned. Ironically, it is the "superparents", the ones who are trying the hardest to be "good" parents who are most likely to undergo burnout (5). Mothers need to get out and go somewhere, to have contact with others, without their children so that they can in the long run be more effective parents (6).

Women who have learned to balance a social life with their mothering avoid loneliness and usually experience a better adjustment to being parents (7). Having an outside interest, a hobby, or leisure pursuit is another way that parents can either physically and psychologically experience some individual time. These outside interests become essential to a healthy identity (8).

One of the most significant tasks that newlywed couples have is to establish a balance between their individuality and togetherness (9). However, when a new baby enters a couple's life, their individual needs and couple needs are often set aside in order to care for the baby's needs (10). But couples still need this individual and couple time, and, in order to get it, they need to support each other. They need to decide who will have free time, when, where, and how (11). And they need to take it!

Shared Parenting

When couples become parents, their workload is increased enormously. But usually this workload is carried by the wife, resulting eventually in her decreased satisfaction with the marriage and possibly even lower self-esteem and a decline in her personal development (1)(2).

Usually new fathers do not refuse to share in the workload. However, when they do tend to their children, they are likely to assume that they are helping their wives rather than sharing the parenting responsibility. They may even expect a repayment of some type from their wives for their help: wives are then likely to refrain from asking for more help, further compounding their dissatisfaction with the marriage (3).

It is possible that men do try parenting initially but feel frustrated and helpless with their lack of effectiveness. They may give up and their wives simply pick up the slack (4). Some women appear to be very unsatisfied with the way their husbands care for the babies: when mothers must maintain the role of "family expert in childcare", fathers can become very discouraged and take little initiative in the parenting process (5).

Studies have shown that when both spouses are actively involved in parenting, pleasurable interaction is likely to be the result (6). The couple is likely to feel closer: their joint involvement with the baby bonds them together, giving meaning to their relationship (7). An attitude of mutuality in childcare often results in a feeling of family unity and increased satisfaction with the marriage (8).

Fathers who are more involved in the baby's caregiving report many positive benefits from this commitment. Their marriages appear to be much more satisfying: they are less likely to feel excluded in the family (9)(10). They experience less anxiety and generally experience greater satisfaction in their role as father (11). And, they are likely as well to become attached to their children, paving the way for enhanced parent-child relationships in the future (12).

Equal, 50/50 sharing in childcare by both parents is probably unrealistic for most couples. The goal of new parents should rather be to support each other so that each of you can function competently and feel satisfaction with your roles (13).

Flexibility

When couples become parents, they report that their lives are changed from orderly and predictable to disorderly and unpredictable (1). Parents must adapt to the needs of their infant, and in order to adapt, they must be flexible, that is, willing to change to accommodate their child.

For some, this can be very difficult. Women, for instance, who have been accustomed to following tight time schedules have to unlearn this behavior and instead, adjust to following the demands from the baby or from within the self. They must learn to sleep when the baby sleeps so that they can be available when they are needed by the infant and remain somewhat rested themselves. This different rhythm is more difficult for some mothers to assume than for others (2).

Some women want to actively control their environment. They may become very frustrated in trying to meet the unpredictable demands of a helpless infant since they cannot plan their time as precisely as before. They are likely to become very upset when they have days in which they are doing nothing but caring for the infant (3).

As infants grow and change, their parents have to change with them. When they are very young, infants can be confined to a crib or infant seat. But as they get older, children become more mobile and require more active tending and watchfulness. The parents' lives are more chaotic (even if their home is "baby-proofed") because they must always keep an eye on the child (4).

Couples have found that being patient, organized, and more flexible were helpful ways of coping with their child's unpredictability (5). Some of your former goals may have to be shelved or adjusted temporarily. Setting priorities is also beneficial for the family's well-being. Then, when there is a conflict, you must be willing to accept lower performance in areas which are not considered top priority (6).

Other Suggestions

Many of the coping techniques used successfully by new parents have already been discussed, but a few remain that are well worth considering:

1. Receive and use information. The appropriate responsibilities of parenthood are primarily learned rather than intuitive. Therefore, you need to become informed. Myths abound about what new parents "should" do for themselves and for their children. Good books, discussion groups, and classes are available to help you find the reliable information you need to be a competent, confident parent (1)(2). It is helpful for couples to learn together about child-rearing since differences in attitudes about raising children can be another source of conflict in the marriage (3). (A list of other books on the emotional/relational aspects of parenthood may be found at the back of this handbook.)

2. Get extra help from relatives and friends (4)(5). Couples need three types of support:

* practical gifts of help, time, support
* expressive gifts of interest, concern, acknowledgement
* material gifts of food, clothing, equipment (6).

When these gifts are offered, new parents need to actively accept and use them, knowing that sometime in the future they will likely be able to encourage others.

3. Deliberately make friends with couples you respect who are also experienced parents (7)(8). These friends can act as models from which you can learn parenting skills, styles, etc. (9). They can be good sources of advice and through observing their family situation, you may be able to establish what's normal for the various stages of child development (10). If you have not yet had your baby, babysitting for friends can give you the hands-on experience that is so important for building your confidence about caring for infants and young children (11)(12).

4. Maintain a stable environment. Avoid moving soon after the baby arrives (13)(14).

5. Maintain your outside interests. However, you will probably need to reduce your responsibilities for a while, delegating them to others (15)(16).

6. Don't be overly concerned about keeping up appearances or doing unnecessary tasks (17). Couples find it helpful to cut down on housework or at least make it a lower priority. Scheduling some of the chores so that they don't get out of control or negotiating who does what day by day can assure that the necessary chores get done (18).

7. Maintain open communication with your spouse. Take time to listen and understand each other's feelings and perceptions of the changes you are experiencing (19). Determine each other's needs and try to negotiate how these needs can be met (20). Verbally encourage each other about the new skills you are learning (21).

8. Make use of babysitters (or friends or family) even in the early months so that you can get a break from childcare. Some parents believe the myth that they must be with their infants continuously in order for bonding to occur (22).

9. Don't be a nurse to relatives or others during the early months of parenting. You need plenty of rest and care yourself in order to adequately care for your infant, yourself, and your spouse (23).

10. Seek professional help early if you are having problems. You might consider individual counseling, marriage counseling, parent support groups, or group therapy.

If, before delivery, you feel depressed or are having marital problems, seek help before the baby arrives because you are likely to have even more difficulty after the baby's arrival (24). If, after delivery you are having difficulty coping with the baby, feeling indifferent towards him/her after several weeks, neglecting, or abusing your child, you need to seek help immediately (25). If you are uncertain about seeking professional help for either your marriage or your response to your child, be reassured that asking for help is never inappropriate.

SECTION IV

A WORD OF ENCOURAGEMENT

Several years ago Ann Landers asked her readers to determine whether or not they would have children if they could live their lives again and make that choice. Seventy per cent replied that they would not choose to have children. Many people misread into this biased sample, thinking that it was fairly representative of parents in general.

In 1977, General Mills commissioned a survey asking the same question, but this time the research was conducted in a more objective, systematic way. This time 90% of the parents replied that they would choose to have children again if they could relive their lives (1). Other studies done since that time have also revealed that couples have found parenting to be very rewarding and that they consider their families the most rewarding part of their lives (2).

It would indeed be a mistake to conclude that there are no benefits or rewards to having children. In fact, most parents believe that these benefits far outweigh whatever costs they experience (3). They claim that their rewards are well worth all their efforts (4).

Parents believe that there are many emotional benefits derived from having a child: they use words such as "love", "joy", "happiness", and "fun" regularly when talking about their children (5). Many are pleasantly surprised by the strong feelings of love and attachment that they have for their offspring (6).

Some feel even more enjoyment of a baby as time goes by. They enjoy watching him or her grow and change. As a baby begins to respond --to smile, to reach out--their feelings of pleasure and delight grow even stronger. Parents receive fulfillment from their child's loving reaction to them and his/her dependent idealization of them (7).

Couples also find that parenting is an enriching, maturing process (8)(9). As time goes on, mothers may feel an increased sense of self-esteem, perhaps feeling that they are much closer to their

ideal self than they had been. Although they may still be experiencing stress, meeting the demands and challenges of raising a child may result in a greater sense of wholeness and completeness as a person (10).

Parenthood means being recognized as an adult, perhaps for the first time. New parents are able to identify with a different generation (11). Relationships with extended families are often strengthened (12).

Many couples feel that their babies have brought them closer together. If their marriage was good initially, the child may act as a strong, uniting force. The parents may feel greater personal commitment towards the marriage and new respect for each other (13).

Although early parenthood is said to be one of the most stressful stages in the life cycle (14), parents generally find that as their child grows older, many of the detrimental effects of the earlier stages disappear (15). The early physical stressors decline significantly (16). As the baby begins to sleep through the night, parents become more rested and able to cope with daily activity. Many find that by nine months postpartum, they have been able to resume many of their old leisure activities (17).

The transition to parenthood has many stressors which indeed make life seem unmanageable for a few months. In time, parents describe life as better and more complete, but different than it had been previously (18).

SUGGESTED ADDITIONAL READINGS

Bolton, R. (1979). People skills: How to assert yourself, listen to others, and resolve conflicts. New York: Simon & Schuster, Inc.

Although this book is not written especially for new parents, it does contain the basic elements for getting along with people: your spouse, your boss and fellow employees, friends, etc. Topics include: assertiveness, listening skills, barriers to communication, reading body language, conflict prevention and resolution, and problem solving.

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DelliQuadri, L., & Breckenridge, K. (1984). Mother care: Helping yourself through the emotional and physical transitions of new motherhood. Los Angeles: J. P. Tarcher, Inc.

A sensitive book that discusses emotional, relational, and physical changes that women experience after the birth of their first baby. One section deals with complications such as Cesarean sections, premature birth, handicapped babies, and child abuse.

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Dix, C. (1985). The new mother syndrome: Coping with postpartum stress and depression. New York: Pocket Books.

A full, sympathetic description of postpartum depression. The appendix contains an impressive listing of support groups, doctors, and self-help clearing houses across the U.S.A.

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Dorman, M., & Klein, D. (1984). How to stay two when baby makes three. New York: Ballantine Books.

This book focuses on the needs of the husband-wife relationship during the traumatic period following delivery. Included are such topics as: the "nursing couple", parents who bottle-feed, renewing the relationship, postpartum exercises, and Kegel's exercises.

Galinsky, E. (1981). Between generations: The six stages of parenthood. New York: Times Books.

Galinsky divided parenthood into six stages--from pregnancy to launching. Her second stage, "the nurturing stage", deals with the relational and emotional changes that new parents experience. This is a well-researched, informative, interesting book.

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Harrison, B. (1986). The shock of motherhood: The unexpected challenge for the new generation of mothers. New York: Charles Scribner's Sons.

A well-written book that focuses on the changing roles of parents and with the struggles and conflicts that accompany those changes. Homes today are compared with the traditional ones of yesteryear, the ones that parents experienced when they were children.

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Hotchner, T. (1988). Childbirth and marriage: The transition to parenthood. New York: Avon Books.

This excellent book deals with many of the issues you have read about in this handbook and more, but in more depth. Chapter titles include: "Changing Expectations", "The Father's Needs and Problems", "Your Identity as a Mother", "Practical Concerns in the Early Weeks", "Shared Care", and "Outside Relationships". Also important for new parents: it is written in short sections so that you don't need to spend large chunks of time understanding the content.

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Kanter, C. N. (1983). And baby makes three: Your feelings and needs as new parents. Minneapolis: Winston Press, Inc.

While this book deals with feelings and needs of new parents, it also focuses on other important aspects, including myths of motherhood and fatherhood, role models, self-understanding, labor and delivery experiences, and conflict negotiation. Five couples (all new parents) share their varied experiences to illustrate the content of the book.

Lewis, C. C. (1989). Mother's first year: A coping guide for recent and prospective mothers. White Hall, VA: Betterway Publications, Inc.

Besides an expansion of the information given in this publication, this book also has chapters on mothering twins, the adoptive mother, single motherhood, older mothers, mothering a premature baby, and mothering a handicapped baby. Packed with outside resources.

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Plutzik, R., & Laghi, M. (1983). The private life of parents: How to take care of yourself and your partner while raising happy, healthy children--a complete survival manual. New York: Everest House Publishers.

A sensitive, warm book, involved with parent care. Contains many personal accounts of parenting experiences plus advice from those who've "been there".

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Wilson, C. C., & Hovey, W. R. (1980). Cesarean childbirth: A handbook for parents. Garden City, NY: Doubleday and Company, Inc.

Chapter 10 of this helpful book addresses the emotional responses to Cesarean childbirth. The remainder of the book contains practical information and advice aimed specifically at parents who have experienced Cesarean childbirth.

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7. Leifer, 1977, p. 81
8. Lewis, 1986
9. Tietjen & Bradley, 1985

Financial Concerns

1. Shereshefsky & Yarrow, 1973
2. Cowan & Cowan, 1985
3. Heins & Seiden, 1987
4. Galinsky, 1981
5. Miller & Myers-Walls, 1983
6. Sollie & Miller, 1980
7. Feldman, 1974
8. Plutzik & Laghi, 1983
9. Miller & Sollie, 1980
10. Cowan et al., 1985

Role Confusion: Who Does What?

1. Brehm, 1985
2. LaRossa & LaRossa, 1981
3. Entwisle & Doering, 1981

4. Cowan et al., 1978
5. Worthington & Buston, 1987
6. Cowan et al, 1978
7. Robinson, 1977
8. Cowan et al, 1978
9. White, Booth, & Edwards, 1986
10. Cowan et al., 1978
11. Goldberg, Michaels, & Lamb, 1985

Body Image

1. Leifer, 1977
2. Heins & Seiden, 1987
3. Galinsky, 1981
4. Robin, 1962
5. Shereshefsky & Yarrow, 1973
6. Reamy & White, 1987
7. Reamy & White, 1987
8. Reamy & White, 1987
9. Clark & Affonso, 1979

Sexual Relationship

1. Reamy & White, 1987
2. Masters & Johnson, 1966
3. Debrovner & Shubin, 1985
4. Kayner & Zagar, 1983
5. Debrovner & Shubin, 1985
6. Masters & Johnson, 1966
7. Reamy & White, 1987
8. Sollie & Miller, 1980
9. Masters & Johnson, 1966
10. Masters & Johnson, 1966
11. Bradt, 1980
12. Debrovner & Shubin, 1985
13. Debrovner & Shubin, 1985
14. Reamy & White, 1987
15. Sollie & Miller, 1980

Infant Characteristics

1. Segal & Yahres, 1979
2. Clark & Affonso, 1979
3. Wright, Henggeler, & Craig, 1986
4. Wilkie & Ames, 1986
5. Fleming, Ruble, Flett, & Shaul, 1988
6. Korner, 1974
7. Wilkie & Ames, 1986
8. Shereshefsky & Yarrow, 1973
9. Zabielski, 1984
10. Bell, 1974
11. Bell, 1974
12. Belsky, 1981
13. Brodzinsky & Huffman, 1988
14. Belsky, 1981
15. Russell, 1974

Relationships with Grandparents

1. Cowan et al., 1985
2. LaPerriere, 1980
3. Belsky, Ward, & Rovine, 1986
4. Cowan & Cowan, 1987
5. Leifer, 1977
6. Cowan et al., 1978
7. Tinsley & Parke, 1984
8. Tinsley & Parke, 1987
9. Tinsley & Parke, 1987
10. Tinsley & Parke, 1984
11. Russell, 1974
12. Entwisle & Blehar, 1979
13. Galinsky, 1981
14. Tinsley & Parke, 1984
15. Tinsley & Parke, 1984
16. Okun, 1984
17. LaPerriere, 1980
18. Sollie & Miller, 1980
19. Tinsley & Parke, 1984
20. LaPerriere, 1980

Mother's Return to Work

1. DeMeis, Hock, & McBride, 1986
2. Sollie & Miller, 1980
3. Entwisle & Doering, 1980
4. DeMeis et al., 1986
5. Belsky, Perry-Jenkins, & Crouter, 1985
6. Myers-Walls, 1984
7. Poloma, 1972
8. Miller & Myers-Walls, 1983

Section II

Postpartum Depression

1. Cox, Holden, & Sagovsky, 1987
2. Cutrona, 1982
3. Handford, 1985
4. Kraus & Redman, 1986
5. Yalom, Lunde, Moos, & Hamburg, 1968
6. Morris, 1987
7. Atkinson & Rickel, 1984
8. Handford, 1985
9. Yalom et al., 1966
10. O'Hara, 1987
11. Yalom et al., 1966
12. Hopkins, Marcus, & Campbell, 1984
13. Murray & Gallahue, 1987
14. O'Hara, 1987
15. Kraus & Redman, 1986
16. O'Hara, 1987
17. Murray & Gallahue, 1987
18. O'Hara, 1987
19. Hopkins, Marcus, & Campbell, 1984
20. O'Hara, 1987
21. O'Hara, 1987
22. Murray & Gallahue, 1987
23. Kraus & Redman, 1986
24. Kraus & Redman, 1986
25. Murray & Gallahue, 1987
26. O'Hara, 1987
27. Murray & Gallahue, 1987
28. Searle, 1987

29. Morris, 1987
30. O'Hara, 1987
31. Atkinson & Rickel, 1984
32. Lipson & Tilden, 1980
33. Cutrona, 1982
34. Cutrona, 1982
35. Hopkins, Marcus, & Campbell, 1984
36. Handford, 1985
37. Kraus & Redman, 1986
38. Handford, 1985
39. Morris, 1987

Marital Satisfaction

1. Feldman, 1974
2. Waldron & Routh, 1981
3. Ryder, 1973
4. Cowan et al., 1985
5. Cowan et al., 1985
6. Belsky, Lang, & Rovine, 1985
7. Cowan et al., 1985
8. LaRossa & LaRossa, 1981
9. Sollie & Miller, 1980
10. Waldron & Routh, 1981
11. McHale & Huston, 1985
12. Lewis, 1986
13. Cowan et al., 1985
14. Wright et al., 1986

Section III

Couple Priority

1. Okun, 1984
2. White et al., 1986
3. Crnic & Greenberg, 1987
4. Tietjen & Bradley, 1985
5. Crnic & Greenberg, 1987
6. Okun, 1984
7. Bradt, 1980
8. Daniels & Weingarten, 1982
9. Daniels & Weingarten, 1982

10. NIHM, 1985
11. Reamy & White, 1987
12. NIHM, 1985
13. Sollie & Miller, 1980

Individual Time

1. Worthington & Buston, 1987
2. DeMeis et al., 1986
3. Miller & Sollie, 1980
4. Zabielski, 1984
5. LaRossa & LaRossa, 1981
6. Zabielski, 1984
7. Myers-Walls, 1984
8. Daniels & Weingarten, 1982
9. Cowan et al., 1978
10. Cowan & Cowan, 1987
11. Okun, 1984

Shared Parenting

1. Goldberg, Michaels, & Lamb, 1985
2. Rossi, 1968
3. LaRossa & LaRossa, 1981
4. Zaslow, Pedersen, Cain, & Suwalsky, 1985
5. Galinsky, 1981
6. Belsky, 1979, 1981
7. Lewis, 1986
8. Sollie & Miller, 1980
9. Zaslow et al., 1985
10. Clark & Affonso, 1979
11. Cordell, Parke, & Sawin, 1980
12. Clark & Affonso, 1979
13. Parke & Tinsley, 1987

Flexibility

1. Miller & Sollie, 1980
2. Shereshefsky & Yarrow, 1973
3. Entwisle & Doering, 1981
4. LaRossa, 1986
5. Miller & Sollie, 1980
6. Worthington & Buston, 1987

Other Suggestions

1. Gordon, Kapostins, & Gordon, 1965
2. Searle, 1987
3. Feldman, 1974
4. Gordon et al., 1965
5. Searle, 1987
6. Zabielski, 1984
7. Gordon et al., 1965
8. Searle, 1987
9. Okun, 1984
10. Galinsky, 1981
11. Fleming et al., 1988
12. Meyer-Walls & Coward, 1979
13. Searle, 1987
14. Gordon et al., 1965
15. Searle, 1987
16. Gordon et al., 1965
17. Gordon et al., 1965
18. Haas, 1980
19. Harriman, 1985
20. Daniels & Weingarten, 1982
21. Haas, 1980
22. Searle, 1987
23. Gordon et al., 1965
24. Whiffen, 1988
25. Miller & Myers-Walls, 1983

Section IV

A Word of Encouragement

1. General Mills, 1977
2. Miller, Schvaneveldt, & Jenson, 1981
3. Belsky, Ward, & Rovine, 1986
4. Sollie & Miller, 1980
5. Sollie & Miller, 1980
6. Kach & McGhee, 1982
7. Zabielski, 1984
8. Belsky, 1981, 1986
9. Belsky, 1986
10. Leifer, 1977
11. Leifer, 1977

12. Belsky, 1986
13. Sollie & Miller, 1980
14. Campbell, Converse, & Rogers, 1976
15. Sollie & Miller, 1980
16. Miller & Myers-Walls, 1983
17. Belsky, Spanier, & Rovine, 1983
18. Dyer, 1963

APPENDIX B

COVER LETTER TO PROFESSIONALS AND PARENTS

761 S. Calle Escondido
Tucson, AZ 85748
March 8, 1990

Dear

I need your help!

I am preparing a handbook for parents who are about to have or have just had their first child. This is part of my thesis for a Master of Arts Degree in Counseling and Guidance at The University of Arizona.

I have proposed to have this book evaluated by a group of new parents and professionals who are interested in the transition to parenthood.

This handbook is designed to help new parents form realistic expectations about the first few months of parenting. Research has shown that when parents have realistic expectations they can cope better with the stresses present during the transitional period. Your opinions and comments about the handbook will help shape the final draft. Eventually, I hope to have the handbook published by a corporation so that it may be distributed to new parents.

I am asking you to read through the accompanying manuscript and then complete the enclosed evaluation form. This may take up to two hours, depending on how quickly you read. Your participation is voluntary; therefore, you may discontinue any time you wish. Please return both the manuscript and the evaluation form by March 22, 1990.

It is my hope that the evaluation form is self-explanatory. If you have any questions, please feel free to call me at 298-3758.

Thank you for your time and effort.

Sincerely,

Lorraine E. Laing

APPENDIX C

EVALUATION FORMS

Handbook Evaluation for Professionals

N.B. By filling out this evaluation form, the assumption will be made that you have:

(1) read the accompanying cover letter, and

(2) given your consent to participate in this study.

1. In your area of professional practice, do you feel the need for assistance with new parents' emotional and relational problems?

Often _____
Sometimes _____
Never _____

2. How adequately does this handbook cover the subject of the emotional and relational changes encountered by new parents?

Very adequately _____
Adequately _____
Very inadequately _____

3. Do you agree with the basic philosophy of this book? (i.e. Realistic expectations promote a smoother transition period for new parents.)

Strongly agree _____
Agree _____
Disagree _____

4. Would you recommend this handbook to new parents?

Routinely _____
Occasionally _____
Never _____

5. Does the book seem clear and easy to understand?

Very clear _____
Usually clear _____
Not clear _____

6. How do you feel about the length of this handbook?

Too long _____
Just right _____
Too short _____

7. How do you feel about the number of topics covered?

Too many _____
Just right _____
Too few _____

8. How do you feel about the language used in this book?

Too sophisticated _____
Just right _____
Too simple _____

9. When do you feel that the content of this handbook would be most meaningful to new parents?

Before the baby's birth _____
In the hospital _____
When parents return home _____

10. How do you feel about the number of examples given in the book?

Too many _____
Just right _____
Too few _____

Suggestions for additional topics/issues:

Suggestions for deletions:

Other comments:

Handbook Evaluation for Parents

N.B. By filling out this evaluation form, the assumption will be made that you have:

(1) read the accompanying cover letter, and

(2) given your consent to participate in this study.

1. Do you feel the need for help with the changes you will experience (or have experienced) with the arrival of your new baby?

   Often _____
   Sometimes _____
   Never _____

2. Do you think this handbook adequately discusses the changes that occur when you become new parents?

   Very adequately _____
   Adequately _____
   Very inadequately _____

3. Do you think it is helpful to understand the negative (as well as the positive) changes that new parents often experience?

   Very helpful _____
   Somewhat helpful _____
   Not helpful _____

4. Would you recommend this handbook to other new parents?

   Frequently _____
   Occasionally _____
   Never _____

5. Does this book seem clear and easy to understand?

   Very clear _____
   Usually clear _____
   Not clear _____

6. How do you feel about the length of this handbook?

   Too long _____
   Just right _____
   Too short _____

7. How do you feel about the number of topics covered?

Too many _____
Just right _____
Too few _____

8. How do you feel about the language used in this book?

Too sophisticated _____
Just right _____
Too simple _____

9. When would you most appreciate receiving this handbook?

Before the baby's birth _____
In the hospital _____
After the baby comes home _____

10. How do you feel about the number of examples given in the book?

Too many _____
Just right _____
Too few _____

Suggestions for additional topics/issues:

Suggestions for deletions:

Other comments:

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