FAMILY OF ORIGIN, MARITAL ADJUSTMENT AND THE BIRTH OF THE FIRST CHILD

by

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A thesis submitted in conformity with the requirements for the degree of Doctor of Education
Department of Adult Education, Community Development & Counseling Psychology
Ontario Institute for Studies in Education in the
University of Toronto

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Abstract

This research studied the relationship existing between the differentiation individuals have achieved in their family of origin and their subsequent dyadic relationship after childbirth. Secondary questions examined whether relational patterns between the individual and family of origin would change after the birth and whether the birth would affect the postpartum dyadic relationship.

Standardized questionnaires were administered to 38 individuals in the last months of pregnancy and after the third postpartum month. The Dyadic Adjustment Scale (DAS) assessed the quality of the dyadic relationship, and the Personal Authority in the Family System Questionnaire (PAFSQ) assessed the individual’s relationship with a dyadic partner and with the family of origin.

Hierarchical regression analyses were used to determine which PAFSQ scales, scored antenatally, predicted changes in DAS scores, from the antenatal to postpartum period. The PAFSQ intergenerational intimacy scale correlated with postpartum DAS change
scores. Intergenerational intimacy reflects the mutual vulnerability and trust existing in a relationship, and represents the ability to enter voluntarily into an intimate relationship, a dynamic of individuals with a higher degree of differentiation from the family of origin.

Correlations of PAFSQ scores indicated a significant shift on the intergenerational fusion scale from the antenatal to postpartum period. The higher postpartum scores indicated that individuals were less fused with and more differentiated from the family of origin after the birth. Both the women and men scored significantly higher on the postpartum spousal fusion scale of the PAFSQ, indicating more differentiation from their partner after the birth. The women alone showed a non-significant trend to less spousal intimacy after the birth, suggesting less satisfaction with the expression of affection and sex in the relationship. Correlations of the prenatal and postpartum scores on the DAS indicated that the women alone also showed a non-significant trend to less dyadic cohesion with their partner after the birth.

This study found that differentiation from the family is positively associated with the quality of the postpartum marital relationship, that new parents are less fused with their parents and with each other after the birth, and that women experience negative postpartum changes not experienced by the men.
Dedication

This completed study was accomplished only through the support and encouragement of my husband, Robert, and children, Michael, James and Andrew. I dedicate this work to Robert, the most wonderful partner in the world, who for some reason overlooks all my faults and loves me unconditionally. May his model of being present in a relationship become part of the family script of acceptance that will be an heirloom for our sons.

Although there were many personal and family health obstacles to overcome over the years, and sometimes family chaos and system dysfunction, this study always simmered in the background. I never quit because I never could. I received a family script from my mother, wherein giving up was not an option, and continuing the fight to the end was part of my intergenerational heritage. So I also dedicate this work to my mother, a strong woman who models persistence in the face of adversity.

I also dedicate this work to my sister Patricia, who, sadly, has become a family ghost. She inspired me with her wondrous strength, courage, and tenacity. Is it a coincidence or part of the dance of the family that I completed this work only after her death? Ciao, sister.
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There is no question that this study would never have been completed without the support of David Abbey, my thesis supervisor. I first became interested in family systems theory after attending one of David’s terrific courses. The theory spoke to me, and I was hooked. David became my supervisor, and even though he would not hear from me for months or even years at a time, he was supportive and encouraging when I did reconnect. Many thanks to you, David, for hanging in for so long (no doubt the evidence of a multigenerational family script of loyalty and commitment).

Yves Talbot encouraged me from the beginning and helped me deliver my finished work. He was a good midwife, yet could not prevent me from going through a thesis gestation and labour experience that left me with my own version of the postthesis blues.

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# Table of Contents

Abstract ........................................................................................................ i
Dedication ...................................................................................................... iii
Acknowledgements ....................................................................................... iv
List of Tables ................................................................................................ viii

Chapter I: Introduction

Introduction ..................................................................................................... 1
Overview ........................................................................................................ 2
Purpose of the Study ..................................................................................... 7
Hypothesis and Subproblems ....................................................................... 7
Definition of Terms .................................................................................... 8
Significance of the Study ............................................................................ 12
Assumptions ............................................................................................... 13
Limitations .................................................................................................... 13

Chapter II: Review of the Literature

Stress Theory and New Parenthood
   Coping Skills ........................................................................................... 14
   Social Support .......................................................................................... 15
   Stress Process ......................................................................................... 19
   Family Structure and Stress ................................................................ 21

Crisis Theory and New Parenthood
   Early Research ......................................................................................... 23
   Parenthood as Crisis ............................................................................... 24
   Parenthood as Transition ..................................................................... 25
   Developmental Crises ............................................................................ 27
   Situational Crises .................................................................................... 27
   Crisis and Worry .................................................................................... 29
   Crisis and Identity .................................................................................. 30
   Crisis and the Marital System ............................................................... 31
   Summary .................................................................................................. 32

The Postpartum Experience
   General Overview .................................................................................... 34
   The Work of Pregnancy .......................................................................... 34
   Mother’s Adjustment ............................................................................... 37
   Father’s Adjustment .............................................................................. 40
Family Systems Theory

Overview .......................................................... 57
The Family of Origin ............................................. 58
Differentiation of Self ............................................. 60
Fusion ................................................................. 65
Chronic Anxiety ..................................................... 66
Nuclear Family Emotional Process ............................. 68
Triangulation ......................................................... 69
Emotional Cut-Off .................................................... 71
Multi-Generational Transmission Process .................. 72
Family Projection Process ....................................... 73
Covert Loyalties ...................................................... 74
Intimacy ................................................................. 76
Intergenerational Intimacy ....................................... 77
Personal Authority .................................................. 78
Differentiation and the Marital Relationship .............. 81
Differentiation and Postpartum Transition ................. 87
Summary ............................................................... 92

Chapter III: Methodology

Overview .......................................................... 95
Study Instruments .................................................. 96
Dyadic Adjustment Scale ......................................... 97
  Reliability ......................................................... 97
  Validity .......................................................... 98

Personal Authority in the Family System Questionnaire
  Scales of the PAFSQ ............................................. 99
  Reliability ......................................................... 102
  Validity .......................................................... 102

Hypothesis .......................................................... 104

Subproblems ......................................................... 104

Research Population ............................................. 105

Research Sample .................................................. 105
Sampling Procedure ................................................................. 105
Sample Characteristics
  Demographic Information ....................................................... 107
  Religion and Ethnicity ......................................................... 108
  Scores on Instruments ......................................................... 109
  Discussion ........................................................................... 111
Time Range for Questionnaires ................................................. 112
Statistical Methodology ............................................................ 112
Summary ................................................................................. 113

Chapter IV: Results and Discussion

  Hypothesis ............................................................................. 114
    Analysis ............................................................................... 114
    Discussion ............................................................................ 116
  Subproblem 1 ......................................................................... 117
    Discussion ............................................................................ 118
  Subproblem 2 ......................................................................... 119
    Discussion ............................................................................ 122
Summary ................................................................................. 124

Chapter V: Conclusions, Implications, Future Research, Summation

  Conclusions ............................................................................ 127
  Implications
    Clinical Practice .................................................................... 129
    Marital and Family Therapy ................................................ 130
    Education Issues ................................................................... 131
  Limitations of the Study ......................................................... 133
    Self-Selection of the Sample ................................................ 133
    Violation of Basic Assumption of Independence .................... 134
    Collection of Data ................................................................ 134
    Demographic Characteristics .............................................. 135
    Lack of Generalizability ...................................................... 136
    Difficulty with Measurement of Marital Adjustment ............. 136
    Difficulty with Measurement of Differentiation .................. 137
  Suggestions for Future Research ............................................. 140
  Study Summation ................................................................... 145
Appendixes:

Appendix A: Letter to Respondents .................................................. 169
Appendix B: Consent Form ............................................................... 171
Appendix C: Personal Information Form ........................................... 173
Appendix D: Dyadic Adjustment Scale .............................................. 175
Appendix E: Personal Authority in the Family System Questionnaire .... 177
Appendix F: Postpartum Instructions Letter ....................................... 179
Appendix G: Postpartum Questionnaire for Mothers ....................... 181
Appendix H: Postpartum Questionnaire for Fathers ....................... 184
List of Tables

Table 1 Range of Possible Subscales on the PAFSQ 101
Table 2 Demographics of Pretest Sample Compared to Pre- and Posttest Sample 108
Table 3 Religion and Ethnicity of Pretest Only Sample Compared to Pre- and Posttest Sample 109
Table 4 Differences in DAS and PAFSQ Scores of the Pretest Only Sample Compared to the Pre- and Posttest Sample 110
Table 5 Hierarchical Regression of Antenatal PAFSQ Subscales Related to Changes in Postpartum DAS Scores 116
Table 6 Antenatal and Postpartum Scores on Subscales of the PAFSQ 118
Table 7 Antenatal and Postpartum Scores on Subscales of the DAS and PAFSQ for Women 120
Table 8 Antenatal and Postpartum Scores on Subscales of the DAS and PAFSQ for Men 121
Table 9 Differences Between Women and Men on the Spousal Fusion Scale 122
Table 10 Differences in Scores for Women and Men on the DAS both at Time 1 and at Time 2 122
CHAPTER I

Introduction

Childbirth and its impact on the lives of new parents has been the subject of much study in North America. Developmental theorists, family theorists, marital theorists, and others have attempted to define and articulate the experiences of men and women as they become new parents.¹ There is a large body of literature addressing the changes young couples experience after childbirth, and each subset of literature is framed from the reference points of the specialized perspectives of the diverse authors. However, there is concurrence that the birth of a first child does impose changes on the marital dyad and that the new parents carry to this time of change their unique experiences from being parented in their family of origin.

This study sharpens the focus on these widely acknowledged postpartum changes and examines the relationship between family of origin and marital adjustment after the birth of a first child. Two large bodies of literature are reviewed to provide the background for this study: parenting adjustment literature and family of origin literature. In light of the continuing debate about whether birth is a transition or crisis, the literature on stress theory and crisis theory and parenthood are also reviewed. Stress theorists focus on the importance of coping skills, social support, and family structure when dealing with life stresses, while crisis theorists examine developmental and situational crises, the impact of worry on crisis resolution, and the impact of crisis on the marital system.

The literature on the physical and psychosocial experience of new parents is also reviewed, and includes studies on the mother’s adjustment, the father’s adjustment, the

¹ For the most part, these studies, often built on the experiences and input from convenience samples, have focused on new parents who share similar demographics, that is, who are predominantly Caucasian, middle-class, married and educated. Although the generalizability of the information culled from the studies of this homogeneous group is somewhat limited and narrow, this window on the experiences of one group within the larger culture has provided a rich perspective on how some young families experience parenthood. This present study will be framed within this socio-cultural context, with the understanding that comments and discussions will relate specifically to some Canadian families and only partially to others.
realignment of roles, economic concerns, postpartum sexuality, marital adjustment, and infant parent attachment.

Overview

Change in Family Homeostasis

The birth of a first baby is a challenge to the homeostasis, or balance, of a family as the child is integrated into the family system and the roles and responsibilities of parenthood are assumed by the new mother and father. While developmental stage theorists regard birth as a "marker", or life event, that can threaten or strengthen the family unit (Gould, 1978; Levinson, 1978; Neugarten, 1976; Sheehy, 1976), many family life theorists view the first experience of parenthood as a crisis (Dyer, 1963; LeMasters, 1957; Lewis, Owen & Cox, 1988) or major life transition (Erikson, 1965; Hobbs, 1965; Hobbs & Cole, 1976; Russell, 1974). The "role gain" experienced by new parents often results in "role strain" as new behaviours are integrated into existing repertoires, marital and family communication processes are adapted, and relationships are renegotiated (Brouse, 1988; Dix, 1985; Midmer & Clemmens, 1991; Sheehan, 1981).

Adaptation and Reorganization

Adaptation and reorganization are required within the family system in order to accommodate the new family member and to allow the family to continue in its psychosocial development. Inability to navigate this transition or crisis will prevent the family from accomplishing future tasks and may hold its members in a state of arrested development (Midmer & Talbot, 1988). Relationships within the multigenerational family system and between the members of the marital dyad may be significantly impacted on by the process of resolution of the birth experience. The ability of a family to cope with life transitions or crises is a reflection of their adaptive processes as well as their capacity to tolerate stressful situations. Rigid role assignment, poor communication, control issues, and poor conflict resolution strategies decrease flexibility during times of crises and exacerbate the stress the family is experiencing (Shonkoff, Jarman, Kohlenberg, 1987).
Importance of Social Support

Lack of social support or the unrealistic estimation of the amount of support that will be forthcoming may lead to a process of "support deterioration". This often increases the psychological distress of new mothers who may have overestimated the amount of postpartum support they would receive from their partners, family, and friends (Barrera, 1986). A lack of support from her partner will often increase a woman's sense of dissatisfaction, lead to marital relationship strain, and augment the risk for an adverse birth outcome (Williamson, Jr., LeFevre, Hector, Jr., 1989). In addition, there is a good association between lack of support during pregnancy and the poor postpartum outcomes of child abuse and woman abuse, and a fair association with postpartum depression and physical illness (Wilson, Reid, Midmer, Biringer, Carroll, & Stewart, 1996).

Accomplishment of Developmental Tasks

A new mother must accomplish discrete developmental tasks as she moves through the pregnancy. These include the acceptance of the pregnancy in the first trimester, identification with the motherhood role and reflection on her own relationship with her mother during the second trimester, and acknowledgment of the separate existence of the baby and relinquishment of the pregnancy during the third trimester (Rubin, 1952). Pregnancy wantedness and intendedness are associated with marital satisfaction and have been found to be predictive of marital satisfaction after the baby is born (Snowden, Schott, Awalt, & Gillis-Knox, 1988). However, continued ambivalence about the pregnancy after 20 weeks has been found to be associated with an increased risk for child abuse and woman abuse in the postpartum period (Wilson et al., 1996).

Postpartum Mood and Anxiety Disorders

New mothers are at risk for mood and anxiety disorders during the postpartum period. Postpartum depression, occurring in 10-15% of new mothers, has been found to be associated with a lack of psychosocial assets (Nuckolls, Cassel, & Kaplan, 1972) and a poor marital
relationship (O’Hare, Schlechte, Lewis, & Varner, 1991; O’Hara, 1985; O’Hara, Neunaber, & Zekowski, 1984). New fathers are also psychologically stressed after the birth, and may experience a wide range of psychosomatic complaints (Clinton, 1987) as well as a depressed mood (Zaslow, 1985). Sleep deprivation and changes in postpartum sexuality, as well as financial and economic concerns resulting from the woman’s move from the workplace to the home, are additional challenges and stresses on the postpartum marital relationship.

Changes in the Postpartum Marital Relationship

Of singular consequence is the effect of the birth of the first child on the marital relationship. The new parents’ ability to maintain a healthy marital relationship during the period of rapid change in the postpartum period is often predicated on the structure of their own parents’ marital relationship (Lewis, 1988a). Couples who rank their parents’ marriage as strong and happy tend to use this relationship as a model for their own marital relationship in the postpartum period.

Those couples who describe their relationship as strong and happy during the last trimester of pregnancy are also better able to transcend the chaos of the postpartum period, and experience significantly less disturbance and strain in their marriage (Lewis, 1989, 1988a). However, women in postpartum relationships that become more, or very, traditional2 after the birth of the baby often experience a decrease in marital satisfaction and affectional expression in the postpartum period (Belsky, Lang, & Huston, 1986). Traditional shifts in the marital relationship are usually related to the woman’s increased financial and emotional dependence on her partner. Located in the home by choice or during maternity leave, the marital partners often begin to assume sex-role expectations about the division of labour.

The more traditional structure of the family that is common during the postpartum period (Belsky, et al., 1986; LaRossa & LaRossa, 1981; Tomlinson, 1987) may be rooted in societal behavioural expectations and cultural imperatives for the new mother and father. For example,

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2 The word traditional is used in this context to refer to the family structure wherein the father’s principal role is to be the breadwinner and the mother’s principal role is to be the homemaker. This family structure, which places the woman in the home and the man in the work-place, often results in a gendered-division of labour.
the socially defined character of infant care as women's work (Chodorow, 1978; Giminez, 1984; Kitzinger, 1978) may challenge a new mother's autonomy and self-identity (Lederman, 1984; Midmer & Clemmens, 1991; Sheehan, 1981).

However, the traditionalization and patriarchal construction of the postpartum marriage, with the husband as breadwinner and wife as homemaker, may also be a replication of the marriage the new parent witnessed as a child between his/her parents (Belsky & Isabella, 1985; Lamb, 1978; LaRossa, 1977), and may impact on the marital system as both partners examine their new roles as parents within the context of the parenting they received in their family of origin.

Birth of the Nuclear Family Triangle

As the couple moves from dyad to triad, the nuclear family triangle is created. The newborn can be a powerful member of the nuclear family triangle, existing as a symbol of the intergenerativity of the family, which relates to the structure, shared meaning, and connectedness of the family system (Doherty & Colangelo, 1984; Doherty, Colangelo & Hovander, 1987; Doherty, Colangelo, Green & Hoffman, 1985).

This intergenerativity reflects the influence of the family of origin of each parent on the newly established family of procreation. The family of origin, itself subject to manifold influences from previous generations, may become a potent determinant of the ease with which the new parents weather the postpartum transition. The degree of differentiation of self from the family of origin of each parent may also be an important factor in the resolution of the crisis or transition of birth (Bowen, 1981; Bray & Williamson, 1987; Colarusso, 1990; Kerr, 1981; 1985; 1988).

Differentiation, or individuation, relates to the ability to think, feel, and act as an individual and as an emotionally independent and separate human being during relational interactions (Bowen, 1972; 1978; 1981; Kerr, 1981; 1985; 1988; Kerr & Bowen, 1988). Complete differentiation occurs when an individual has attained emotional maturity, and is able
to interact with others with dispassionate objectivity rather than reactive subjectivity (Kerr, 1988), whereas a lack of differentiation, or fusion, refers to how "emotionally stuck" individuals are in relationships with others (Bowen, 1978; Kerr, 1981).

**Personal Authority**

Of particular interest is the impact of the birth of the first child on the personal authority the new mother or father experiences within the family of origin. Personal authority, based on the degree of differentiation an individual has attained in her or his family of origin, relates to a young person’s development of a peerhood relationship with her/his parents through the termination of the hierarchical power structure in the intergenerational relationship (Bray & Williamson, 1987, Bray, Williamson, & Malone, 1986; Williamson, 1982a; 1982b; 1981). If a lack of personal authority exists, it is often accompanied by a proportionate decrease in intergenerational intimacy and an increase in intergenerational intimidation (Williamson, 1981).

**Impact of Differentiation on the Marital Relationship**

Individuals tend to select marital partners who have achieved similar levels of differentiation (Bowen, 1976; 1978; Framo 1976). If marital partners are poorly differentiated, they may experience relationship disharmony as they reconstruct the scenes and replay the scripts from difficult relationships in their family of origin (Framo, 1976). The important and long-standing influence of the family of origin can impact directly on the dynamics of the family of procreation, and couples who perceive their family of origin to be similar to their partner’s have better marital adjustment (Wilcoxen & Hovestadt, 1983). Higher marital satisfaction is also achieved if the individuals in the relationship perceive that their parent’s marriage was happy when they were children living with the family of origin (Lewis & Spanier, 1979).

In sum, the birth of a first child challenges the marital relationship simply because of the profound nature of the event in the lives of the new parents. The dyadic relationship may be further challenged by the physical and emotional adjustments that accompany new parenthood. How differentiated the new parents are from their family of origin and how much personal
authority they command with their family of origin will also impact on the health of their marital relationship. How these two factors interplay will be the purpose of the study.

**Purpose of the Study**

The main purpose of this study was to examine the relationships that exist between differentiation of self and the relational patterns of new parents with their family of origin, their dyadic relationship, and their marital adjustment in the postpartum period, (i.e., within the first months after the birth of a first child). More specifically, this study focuses on whether different levels of differentiation of self and the experience of being reared in a particular family of origin, when tempered with the crisis of birth, will affect the change marital relationship after the birth of a first child.

Two measurement scales were administered to a sample population of individuals who attended prepared childbirth classes in a large urban hospital. These two scales were administered before the baby was born, in the last three months of pregnancy, and after the baby was born, within the first 6 months of parenthood.

The Dyadic Adjustment Scale (DAS) (Spanier, 1976) was used to measure marital adjustment and the Personal Authority in the Family System Questionnaire (PAFSQ) (Bray, Williamson & Malone, 1984) was used to assess the degree of personal authority, or differentiation, each individual experienced in his/her family of origin.

**Hypothesis**

The research hypothesis in this study is that:

Higher levels of differentiation from the family of origin, as measured by the Personal Authority in the Family System Questionnaire in the antenatal period, are associated with a smaller decline in the level of marital adjustment, as measured by the Dyadic Adjustment Scale, from the antenatal to the postpartum period.
Subproblems

Of secondary importance is the exploration of the following subproblems:

1. Does the antenatal pattern of relational functioning within the family of origin, as measured by the PAFSQ, change after the birth of the first baby?

2. Is the rapid reorganization of the childless dyad into a three-party family system associated with a change in their marital system, as measured by the DAS?

Definition of Terms

There are three major concepts in this study that require definition: social support and crises, marital adjustment, and differentiation of self. These terms, as they are used in this study, are defined as follows.

1. Crises

The concepts of coping skills, social support, and stress process are subsumed into crisis theory. Coping skills relate to the behaviours undertaken by individuals when encountering stressful events to help them restore and maintain the homeostasis of the family system (Pearlin & Schooler, 1978; Shonkoff, Jarman, & Kohlenberg, 1987). Social support, or psychosocial assets (Nuckolls et al., 1972), principally relates to the perceived support, or tangible assistance, identified by the individual (Barrera, 1986; Wandersman, Wandersman, & Kahn, 1980; Williamson, Jr., & LeFevre, 1992). The stress process is described as a complex, varied, and intellectually challenging activity that individuals undergo as they mobilize themselves and their resources in response to stressful life events (Pearlin, Menaghan, Lieberman, & Mullan, 1981).

Crises can be classified into two categories: either as developmental (maturational) or situational (accidental). Developmental crises, such as leaving home, entering into a spousal or
marital relationship, retirement from the workforce, and so on, are normal and expected occurrences in the process of an individual's psychosocial development. Situational crises are precipitated by an external event or stress such as illness or death in the family, usually occur suddenly or without advance notice, and require an immediate crisis resolution response from the individual (Erikson, 1965; Weiss, 1976).

Crises can be further categorized into three distinct forms. The first is a severely upsetting situation of limited duration that requires immediate mobilization of the individual's resources. This crisis may end with a return to a balanced state, or may become a transition state resulting in a change in the individual's sense of self, a disruption of the pre-existing social equilibrium, and relational and personal changes. The transition state may end with the establishment of a new stable life organization, or may result in a "deficit" situation, whereby some of the individual's needs are not being adequately met on an on-going basis (Weiss, 1976).

In this study, the birth of a baby is considered a normal developmental crisis that may be precipitated into a situational crisis if the pregnancy outcome is not favorable to either the mother or the baby (Midmer & Talbot, 1988). The birth of a first child may advance from a short-term crisis, to a more prolonged transition state, may not resolve optimally, and may result in a deficit situation wherein the needs of either or both parents are left unmet.

The ability of the new parents to withstand the stressors of pregnancy is influenced by their real and perceived social support (Barrera, 1986), their ability to muster mediating resources to use to cope with the stress (Pearlin et al., 1981), and their family's organizational structure (Lewis, 1986). How the new parents handle issues of commitment, or inclusion; power, or control; and closeness, or intimacy (Lewis, 1986; Midmer & Talbot, 1988) will also impact on their crisis resolution efficacy.

2. Marital Adjustment

Marital, or dyadic, adjustment consists, for the purposes of this study, of four components: dyadic satisfaction, dyadic cohesion, dyadic consensus, and affectional expression
(Spanier, 1976). Marital/dyadic adjustment is not a static occurrence but a process of movement along a continuum which can be evaluated in terms of proximity to anchors of either good or poor adjustment. This definition embraces adjustment as a component of all primary relationships, whether marital or non-marital, and focuses on the qualitative evaluation of an ever-changing process which can be measured at any point in time on a dimension from well-adjusted to maladjusted. Marital adjustment is measured by the Dyadic Adjustment Scale (Spanier, 1976).

3. Differentiation of Self

Differentiation of self, or individuation, requires two processes: one within the individual, and one within the context of his/her relationships with significant others, most particularly, the family of origin (Bowen, 1978; Kerr, 1981). The family of origin is defined as the family in which a person had her/his beginnings - physiologically, psychically, and emotionally (Hovestadt, Anderson, Piercy, Cochran, & Fine, 1985). Poorly differentiated parents tend to rear children who are differentiated to the same approximate level as themselves. When adults, these individuals tend to partner with others who are differentiated to a comparable level, thereby perpetuating intergenerational and multigenerational differentiation patterns and problems (Bowen, 1978; Kerr, 1981).

Within an individual, differentiation of self is the degree to which the individual is able to discriminate between thoughts and emotions, control his/her own thoughts and feelings, consider her/his own judgment as an adequate basis for action, and take full responsibility for the consequences of these actions (Anonymous, 1972; Bowen, 1978; Bray & Williamson, 1987; Kerr, 1981; 1984; 1985). Intense emotional attachment in relationships is replaced with an ability to claim one's own identity and autonomy, and to function in an objective and emotionally independent fashion (Hovestadt et al., 1985).

Within the context of family relationships, either in the family of origin, the nuclear family, or the dyadic relationship, other key concepts are called into play. These include: fusion, triangulation, intimacy, isolation, personal authority, and intergenerational intimidation.
Fusion is the opposite pole of differentiation of self, or individuation, and refers to a particular type of relationship between two people wherein individuals are "stuck together", do not have a clear sense of self as individuals, and function in a dependent, emotionally reflexive, semiautomatic manner. Fused individuals view the world subjectively rather than objectively, and abrogate responsibility for their actions to others rather than assuming accountability themselves. For example, such an individual, tripping and falling over a cliff to certain death, would blame the stumble on the new shoes purchased for them by their partner and see their partner’s failings as the reason for their imminent demise. The level of fusion in the relationship reflects the degree of unresolved emotional attachment the individual has with the family of origin (Anonymous, 1972; Bray & Williamson, 1987; Kerr, 1984; Kerr & Bowen, 1988).

Triangulation refers to a certain type of relationship among three people. Because of the anxiety inherent in a fused dyadic relationship, a third party is "triangulated", or drawn, into the relationship to diffuse tension (Bowen, 1978). For example, consider a father who is disciplining his teenage son for some behaviour infraction. If the tension and anxiety in this two-party system gets too high, his wife may begin to interject for leniency in the punishment. At this point the dynamic moves between the husband and wife as the father admonishes her to stay out of the argument. This new argument between the mother and father allows the son to move to the outside position of relative non-involvement in the triangle. The wife has become triangulated into the argument in order to dissipate the high anxiety in the father-son interaction.

Intimacy is defined as voluntary closeness between individuals with distinct boundaries to the self while isolation is viewed as the opposite pole on the continuum with intimacy (Williamson, 1981; 1982a; 1982b). Intergenerational intimidation refers to the degree of personal intimidation experienced by an individual in relation to his/her parents, or other powerful family members, and it exists as the opposite to the concept of personal authority (Bray et al., 1984; Williamson, 1982b). For example, those individuals who continue to make important life decisions based on concern for the approval of their parents and not their own needs and desires are experiencing intergenerational intimidation.
In this study, the Personal Authority in the Family System Questionnaire (Bray et al., 1984) is used to measure differentiation.

**Significance of the Study**

Much of the literature pertaining to the relationship changes experienced by couples adjusting to parenthood focuses on the vulnerability of the dyadic relationship. Health care providers who interact with childbearing couples are in an ideal position to provide anticipatory guidance about postpartum marital difficulties. By working directly with the couples, health care workers, given effective implementation procedures, can facilitate better communication within the dyad and assist new parents to develop problem identification and problem solving techniques.

Research that focuses directly on the transition process that occurs after birth and the factors that influence this process, such as family of origin issues, is needed to provide more data on how to minimize postpartum marital adjustment difficulties. This research study will explore these issues and pose important questions concerning some of the causes of postpartum transition problems.

If a significant relationship is found to exist between differentiation of self and postpartum marital adjustment difficulties, specific prenatal intervention strategies could be developed. The answers to the research questions may well provide obstetrical healthcare workers with increased opportunities to meet the needs of new parents at this critical stage of their lives and to help the family regain organizational balance and family coherence after the major crisis of birth has occurred. Furthermore, couples who are considering becoming parents, and who are in troubled relationships, would benefit from proactive exploration of family of origin issues and their relationship to parenting and postpartum dyadic relationship changes.
**Assumptions**

With reference to the hypothesis, there are several assumptions inherent in the study:

1. The birth of a first child results in significant changes in the lives of new parents.

2. The birth of a first child impacts on the marital adjustment of new parents.

3. The birth of a first child has more impact on the marital relationship of individuals with lower levels of differentiation.

4. The birth of a first child affects the relational processes within the family of origin.

**Limitations**

The following limitations may apply to this research:

1. The research sample is only representative of the population of individuals who attend prenatal classes at one large, urban hospital. The results of this study will not be generalizable to the larger childbearing population. It must be noted, however, that the instruments used in this study were developed and tested on populations with similar demographics to the study sample.

2. The scores the individuals achieve on the Dyadic Adjustment Scale at either of the two administration times can only be a valid measure of their marital adjustment at that particular time. The scores have no predictive value for their future dyadic relationship.
CHAPTER II

Review of the Literature

Stress Theory and New Parenthood

Coping Skills

All families experience transitions and crises over their life span. Many of these occurrences, such as the first day of school or the beginning of retirement, are predictable, while others, such as the early death of a family member, are unexpected and tragic. Since families have different coping strategies and resources, adaptation can vary dramatically. Age, gender, intellectual resources, temperament, and overall problem-solving skills of family members all impact on adaptation processes. How a family copes with sudden or expected change reflects their family style, their store of adaptive processes, and their ability to tolerate stressful situations (Shonkoff, et al., 1987).

Shonkoff et al. write that

[c]oping behaviours help restore and maintain the dynamic balance of the family system, promoting growth and development. The adaptive process may actively change the nature of the stressor or may simply modify the way in which stress is perceived . . . . Families . . . vary in their coping styles . . . those with the least adaptive abilities are characterized by rigidly assigned roles, increased interpersonal distance among members, poor communication, and difficulty in sharing power. The most adaptive systems . . . generally demonstrate a substantial degree of flexibility in their role definition, greater interpersonal closeness, clear patterns of communication, and comfortable sharing of power that facilitates problem solving by negotiation. (p. 511)

Individual members of a family unit may react differently to family stress. Pearlin and Schooler (1978) studied 2,300 individuals aged 18-65 to determine the efficacy of different coping behaviours. They identified coping as "the things that people do to avoid being harmed by life experiences" (p. 2), basing this definition on the fundamental assumption that people actively rally their resources when dealing with different stressors. They write that
[The protective function of coping behaviour can be exercised in three ways: by eliminating or modifying conditions giving rise to problems; by perceptually controlling the meaning of experience in a manner that neutralizes its problematic character; and by keeping the emotional consequences of problems within manageable bounds. (p. 2)]

They continue that these efficacious coping strategies are not equally distributed in the general population and are more likely to be used by men, and by educated and affluent men and women. For individuals making the transition to new parenthood, these findings suggest that new fathers and educated and/or affluent new parents may be able to mediate and cope with postpartum stressors more effectively than new mothers or those couples of lower socioeconomic status.

Social Support

With respect to psychosocial issues, coping skills in new parents have often been related to their degree of psychosocial assets, or social support (Nuckolls et al., 1972). A global concept of social support is often used in the literature, with little analysis or breakdown of the factors subsumed into the theory. Barrera (1986) argues that there are three broad categories of support that need to be considered: social embeddedness, perceived support, and enacted support. He writes that

[**Social embeddedness** is that social support concept that refers to the connections that individuals have to significant others in their social environments. Being socially connected is a central element in one’s “psychological sense of community” and constitutes the flip side of social isolation and alienation. (p. 415)]

**Perceived social support** has emerged as a prominent concept that characterizes social support as the cognitive appraisal of being reliably connected to others . . . measures of perceived social support incorporate two dimensions, perceived *availability* and *adequacy* of supportive ties. (p. 416)

Social support can also be conceptualized as actions that others perform when they render assistance to a focal person . . . Measures of *enacted social support* complement other measures by assessing what individuals actually do when they provide support . . . the helping behaviours that constitute enacted support are likely to be provided when individuals face adversity, particularly acute stressors. (p.417)
After reviewing the social support literature, Barrera (1986) found that perceived social support was the most frequently assessed social support concept reported in the literature, and that measures of perceived support consistently showed negative relationships to distress and to measures of life stress and strain. He stated that this negative relationship exemplified the "support deterioration model in which life stress results in the deterioration of perceived support which, in turn, is related to increased psychological distress" (p. 438).

These concepts of perceived support and support deterioration are important when considering the early postpartum period. Antenatally, mothers often over-estimate the amount of support they will receive from their partner, and couples often over-estimate the amount of social support they will receive from their family and friends (Belsky, 1985; Rankin, Campbell, & Soeken, 1985). The postpartum reality is often quite different from their romanticized antenatal expectations. The intense support given in the first postpartum weeks, for example, when a grandmother stays with the new parents to help them over the immediate transition, often ends abruptly with the departure of the support person, leaving the new parents feeling unsupported and vulnerable. In other instances, new parents report that they thought they would have received more support, and this sense of violated expectations, or support deterioration, can compound their stress experience.

In a study focusing on differing expectations of social supports, Rankin et al. (1985) found that factors promoting satisfactory postpartum marital satisfaction were different for new mothers and new fathers. Volunteer couples expecting their first child (n = 246) were recruited from prenatal classes. Although fathers anticipated fewer sources of support than mothers, the couples disagreed on the social support they anticipated, with greatest disagreement about whether friends should be used for support. In addition, the expectant women overestimated their husband’s future involvement with household tasks. For some women, this disparity between individual expectations, or perceived support, and the eventual postpartum reality led to dissatisfaction and marital relationship strain. This exemplifies the "support deterioration" theory previously described by Barrera (1986).
However, Hackel and Ruble (1992) comment that some women who ascribe to a more traditional, gender-specific distribution of labour in their marital relationship may experience positive feelings when their postpartum work contributions are, in fact, greater than expected. These women may view their higher proportion of housework as validation of their values concerning the traditional nature of their marital relationship. This finding is in contrast to the theses of other marital researchers (Belsky et al., 1986; Belsky & Isabella, 1985; Lamb, 1978; LaRossa, 1975) who argue that the increased home workload of the new mother may be disadvantageous to the marital relationship, since it places her into a gendered division of labour which may be far different from her preconceptual and pregnancy workload experience.

In a cohort of 513 rural pregnant women being screened for serious perinatal complications, including neonatal death, severe neonatal morbidity, and low birth-weight (Williamson, Jr., LeFevre, & Hector, Jr., 1989), an increase in stressful life events during pregnancy was associated with a 2.3 times higher incidence of adverse birth outcomes, although high stress scores alone at 20 and 34 weeks of pregnancy were not associated with an increase in adverse outcomes. In a later study with this same cohort of women, Williamson, Jr. and LeFevre (1992) used a single-item measure in the antenatal period to identify tangible assistance, or perceived support. Simply by asking about the availability of supportive companions, women at increased risk for serious obstetrical outcomes could be identified. Those women who answered that there was no supportive companion available were also found to be of particularly high socioeconomic risk (under 18, no male partner, less than high school education).

This study did not follow the women into the postpartum period to observe whether the support was simply perceived and eventually deteriorated or whether it was real and long-standing. It is important to note, however, that the thought that there was at least one immediate and trustworthy support person available appeared to mediate positively in the obstetrical outcomes of some of the women, perhaps by reducing anxiety and the concomitant fears of being uncared for, isolated, and alone.

Lack of social support during pregnancy has also been found to have a good association with the poor postpartum outcomes of child abuse and woman abuse and a fair association with
postpartum depression and physical illness (Wilson, et al., 1996). Lack of social support was characterized by: isolation; lack of help when dealing with daily tasks; stressful events, or crises; and lack of social, instrumental, and/or emotional support from a spouse, close friend, or family member.

In an attempt to study the effects of different types of social support on the adjustment of new parents, Wandersman et al. (1980) studied two cohorts of postpartum couples at three months and nine months postpartum. One group (n = 18 fathers, 23 mothers) attended postpartum parenting groups and the control group (n = 24 fathers, 23 mothers) did not. Four types of early postpartum social support, classified as parenting group, marital instrumental, marital emotional, and network, were related to more positive postpartum adjustment (well-being, marital interaction, and parental sense of competence). This study indicated that there were gender differences with respect to the different types of support. Whereas parenting group support was significant for fathers in predicting postpartum adjustment, network support was significant for mothers. However, the study did not show that membership in the postpartum parenting groups played a major role in mediating overall postpartum adjustment difficulties.

This finding is in contrast to research on the effect of antenatal education, which focused on the impact of teaching about parenting skills and communication strategies, on postpartum anxiety, the postpartum marital relationship, and postpartum adjustment. Midmer, Wilson, and Cummings (1995) conducted a randomized controlled trial with 70 primiparous, low risk obstetrical couples. The experimental group received two parenting skills and communication classes in addition to regular prenatal classes, while the control group only attended regular prenatal classes.

Anxiety and the dyadic relationship were measured antenatally in the middle trimester, and remeasured along with postpartum adjustment at six weeks postpartum and six months postpartum. Although the data were not analyzed with respect to gender, the analyses revealed that the intervention group experienced significantly less anxiety, more positive dyadic relationships, and better postpartum adjustment than the control group. Through the provision of anticipatory guidance and cognitive rehearsal strategies, the intervention classes appeared to
mediate the stress of the early postpartum period, resulting in less manifestations of postpartum distress symptoms.

In sum, these studies all emphasize the huge need the newly delivered mother and father have for support during the postpartum period. Social support in all its manifestations appears to be a crucial component of the successful segue into parenthood. Without such support, the transition into parenthood may become a crisis, and support deterioration may compound postpartum marital difficulties. This subset of literature supports the first assumption inherent in this study, that the birth of a first child results in significant changes in the lives of new parents.

**Stress Process**

In 1967, Holmes and Rahe published their widely used scale to assess social readjustment. This scale purported to determine an individual’s composite stress score based on his/her rating of individual life events, under a possibly mistaken assumption that events in the same category, such as births or deaths, were of equivalent stress. No consideration was taken of context or individual circumstances. The sum total of the values of all the stressful events experienced over the previous year yielded a ranking on a continuum from low stress to high stress. However, the scale did not take into account the psychosocial resources an individual could muster to alter the experience and perception of a stressful event, changing its stress value measure.

Challenging this limited perspective on stress and its antecedents, Pearlin et al. (1981) described social stress not as a series of single events, but as a complex, varied, and intellectually challenging process. Expanding on an earlier study (Pearlin & Schooler, 1978), Pearlin et al. conducted a longitudinal study over four years with 2,300 adults between 18 and 65 years of age from an urbanized area of Chicago. They outlined a process of social stress comprised of three conceptual domains: the sources of stress, including life events and chronic life strains; the mediators of stress, including self-concepts and coping skills; and the manifestations of stress. The authors proposed that “life events can lead to negative changes in
peoples' roles, changes whose persistence wears away desired elements of self-concept, and that, through this set of linkages, stress is aroused. Coping and social supports, for their part, can intervene at different points along this process, thereby mediating the outcomes.” (p.342).

In an attempt to determine the psychosocial stressors perceived by childbearing women, Arizmendi and Affonso (1987) studied a convenience sample of 221 women representing three groups: first trimester, n = 81; third trimester, n = 80; and postpartum, n = 60. The results of this study indicated that anxiety appeared to be a powerful mediator in the interpretation of stressful events. Anxiety levels generated by stressful events varied across the childbearing period. High anxiety was related to internal events such as anticipatory fears of labour and delivery and the health and welfare of the infant. The one category of external events that proved to be stressful was mate/spouse interactions. Furthermore, the anxiety they experienced was consistent across the three time periods.

This study reinforces the importance of intervention strategies for use in the antenatal period that will impact on the anxiety that is aroused from contemplation of postpartum marital relationship changes. As has been previously noted, a psychoeducational intervention in the form of parenting communication classes has been found to be efficacious in reducing postpartum anxiety and improving postpartum marital satisfaction and adjustment (Midmer et al., 1995).

This conceptualization of a multi-faceted stress process has strong implications with respect to the postpartum period and speaks to a central assumption in this study, that the birth of the first child has a significant impact on the lives of new parents. Those new parents with poor self-concepts and a paucity of coping skills to mediate the stress process may experience the postpartum transition period with less equanimity and more distress, less adjustment and more anxiety. As Pearlin and Schooler (1978) indicated, this experience of distress may be exacerbated among new mothers and those individuals who are less educated and less affluent, and when coupled with the deleterious effects of anxiety, may compromise further the postpartum marital relationship.
Family Structure and Stress

Defining the family as a large system with subsystems that include health status at the individual level, marital relationship at the dyad level, and family functioning at the system level, Mercer et al. (1986; 1988; 1990) postulate a theoretical model for studying the effect of antepartum stress on family functions during pregnancy and during postpartum, in the eight months following birth. In these studies, 153 high-risk women and 75 male partners of high-risk women, and 218 low-risk women and 147 male partners of low-risk women were interviewed during the twenty-fourth and thirty-fourth weeks of the woman’s pregnancy to determine the effects of antepartum stress on family functioning.

As was hypothesized, antepartum stress in the form of negative life events had indirect effects on the family functioning of all the men and women. “Postpartum functioning at 8 months, although somewhat less optimal among high-risk parents, did not differ significantly from pregnancy levels. However, family functioning was significantly less optimal at 8 months from both the low-risk women’s and low-risk men’s perspectives, indicating that the disorganization following birth and the incorporation of an infant into the family is unresolved among obstetrical low-risk families” (1990, p.80).

One can speculate that the high-risk couples had developed coping strategies for stress during the pregnancy, and that these strategies allowed them to maintain a consistent level of family functioning in the postpartum period. The low-risk couples, however, suddenly faced with the crisis of parenthood, may have been less experienced at handling stress and/or deficient in coping strategies. Alternatively, the experience of having a high risk pregnancy, may, despite the high anxiety it provokes, serve to bond the expectant couple more closely together, uniting them in their desire for a successful resolution of the pregnancy. The exigencies of dealing with a high risk situation may have changed the course of their pregnancy and postpartum experience, such that the common ups and downs in the marital relationship did not occur.

Focusing on the family structure and stress, Lewis (1986) observes that families are distributed into four basic organizational structures: competent, dominant-submissive,
chronically conflicted, and severely disturbed. He defines structure as repetitive patterns of interaction that operate without the family’s awareness, and maintains that stress must be considered in light of the family’s pre-stress organizational structure because of its significant impact on the outcome, or resolution of stress. The organizational structure of the family is established early in the new parents’ relationship and relates to the way the couple handles issues of commitment, power, and closeness.

The Family FIRO (Fundamental Interpersonal Relationship Orientation) Model (Doherty & Colangelo, 1984; Doherty, Colangelo, Green, & Hoffman, 1985) is premised on the belief that family and marital relationships are built around three main interpersonal constructs: inclusion (commitment), control (power), and intimacy (closeness). The addition of a new baby effects a shift in the homeostasis of the couple relationship and challenges the marital system with respect to these three relationship dynamics (Midmer & Talbot, 1988). The couple is required to examine inclusion issues, such as the depth of their commitment to their marital relationship, (who is in or out); control issues, such as the sharing of power and control through mutual or unilateral decision-making, (who is top or bottom); and intimacy issues, such as the degree of vulnerability or closeness/intimacy permitted in the relationship, (who is near or far). The ability of the couple to withstand the stressors of new parenthood may be predicated on their successful resolution of relationship issues based these three constructs (Midmer & Talbot, 1988).

This subset of literature also relates to the assumptions inherent in the study hypothesis, that birth will result in major changes in the lives of new parents. The works by Mercer et al. (1986; 1988; 1990), focusing on the differences between low-risk and high-risk couples, are particularly salient for this study. Only individuals with low obstetrical risk were recruited into the study, and those individuals who delivered an infant before full-term were eliminated from the study. This ensured that all the subjects in the study would enter into parenthood with similar obstetrical histories, and that all the subjects would experience the onset of new parenthood without the prior or urgent need to develop and utilize coping strategies.
**Crisis Theory and New Parenthood**

**Early Research**

The very early theorists on the relationship between the marital relationship and parenthood provided the basis for the large body of literature that now exists. At the turn of the century, Simmel (1902) conceptualized the consequences of the change from dyad to triad, and Hill (1949) studied families under stress. These early researchers into family development theory and crisis theory began to lay the groundwork for contemporary definitions of crisis and transition.

Beginning in 1949, Nuckolls et al. (1972) began to study systematically the quality and quantity of life events observed to cluster around illness in the family. These events included widespread family system changes - changes in family structure, marriage, occupations, friendship groups, etc. They coined the term "life crisis" to describe the many life changes, taking place over several years, that appeared to cluster around each original stressful event.

Further research revealed that "the higher the quantitative estimate of life crisis, the greater the probability of an associated major health change occurring within the two succeeding years" (p.432). Pregnancy and childbirth were considered a life crisis and a woman's ability to deal with stress was found to be related to her "psychosocial assets", the psychological or social factors that would contribute to her ability to adapt to her pregnancy.

The citation of these works serves to outline the views of the original theorists on the impact of birth of a first child on the family. Much of this early work still withstands academic scrutiny and continues to form the cornerstones of more modern theoretical constructs on the family.
**Parenthood as Crisis**

In the 1950s, LeMasters (1957) began to study whether parenthood precipitated a crisis for the new parents. He focused his work on the crisis of accession, that is, the crisis that occurs in a family system when a new family member is incorporated. His principal question was "If the family is conceptualized as a small social system, would it not follow that the adding of a new member to the system could force a reorganization of the system as drastic (or nearly so) as the removal of a member?" (p. 112). In his qualitative study of 48 middle-class couples in stable marriages and economic situations, 83% of the couples reported "extensive" or "severe" crisis adjusting to the birth of the first child. This finding was partly explained by the romanticized views these couples held about parenthood, and their lack of any real preparation for the realities of parenthood.

In 1963, Dyer (1963) endeavored to answer the same question posed earlier by LeMasters, "Is parenthood a crisis?" In an attempt to identify and measure crisis objectively, Dyer devised a questionnaire with a Likert-type scale, and obtained a crisis score for each couple based upon their responses. As in LeMasters' study, Dyer discovered that adding the first child to the urban, middle-class married couple did constitute a crisis event to a considerable degree. Of the 32 couples studied by Dyer, 53% were reported to be in the "extensive" or "severe" crisis category. He also found that only five of the 17 couples in these categories had planned their pregnancy.

As well as with other variables, a significant relationship was found between crisis and the marital adjustment of the couple after the birth of the child. Dyer concluded that he concurred with LeMasters' findings that many couples had unrealistic expectations about parenthood. He foresaw that educational programs preparing couples for parenthood would make an important contribution to the adjustment of new parents, providing them with anticipatory guidance and parenting coping strategies.
These studies, which described parenthood as a crisis, predominated family theory during the 1950s and early 1960s, until further research offered an alternative interpretation for the experiences of new parents during the early postpartum months.

**Parenthood as Transition**

In 1965, Hobbs reported results quite different from those of LeMasters and Dyer. Hobbs drew his random sample of 53 couples from public birth records of first-time parents who were white, urban, and whose first baby was under one year old. The sample couples varied considerably with regards to age, education, and occupation. Analysis of the data from Hobbs' checklist of 23 items on postpartum adjustment revealed that 87% of the couples were classified in the "slight" crisis category, and that there were no couples in the "extensive" or "severe" crisis categories. Women had significantly higher mean crisis scores than their partners. These results suggest that, although the transition to parenthood might not be as difficult as indicated by the studies of LeMasters (1957) and Dyer (1963), nevertheless, most couples experienced some crisis symptomatology and women experienced more distress than men.

In 1972, in an attempt to study both the positive and the negative components of parenthood, Russell (1974) administered the Locke-Wallace (Locke & Wallace, 1959) marital adjustment questionnaire and the Hobbs' (Hobbs, 1965) checklist to measure the degree of crisis experienced in parenthood to a random sample of 511 urban couples, including working-class as well as middle-class parents. Results indicated that respondents perceived their first year of parenthood as only moderately stressful but also found the experience rewarding. These conclusions appeared to parallel the findings of the earlier study by Hobbs (1965).

Russell concluded that the interview method employed by LeMasters was associated with higher crisis scores than the questionnaire method. As well, studies that used exclusively middle class respondents and which included babies up to two years of age (Dyer, 1963; LeMasters, 1957) reported higher crisis scores than studies, including her own, which drew upon a more representative sample and which included babies under one year of age (Russell, 1974).
The finding that parents with older babies may experience more marital dissatisfaction was reinforced by a more recent study by Heaton (1990). He suggests that "there appears to be a sort of 'honeymoon' effect after the birth of each child. That is, the [marital] dissolution is low immediately after birth and increases within a year or two thereafter" (p. 59). Dalgas-Pelish (1993) reports similar results in her study of 185 men and women who were either childless (n = 25 women, 22 men), expecting a first child (n = 25 women, 24 men), had 5-month-old children (n = 25 women, 20 men) or had a 24-month-old child. Her results indicate that while individuals with five-month-old babies had lower marital satisfaction than those who were pregnant, individuals with 24-month-old babies had lower scores than those who had five-month-old babies. Data also indicated that pregnant individuals had greater marital happiness than childless couples, and childless couples had greater happiness than parents of 24-month-olds.

In 1975, replicating the original study in 1965, Hobbs and Cole (1976) again focused on the transition to parenthood. Using a random sample of couples from the same geographic area and nearly identical methods as in the initial study, they confirmed the results of the original study: couples experienced only slight amounts of difficulty in adjusting to parenthood, and women reported significantly greater amounts of difficulty than fathers. The authors conclude that, in light of this evidence, it would be more accurate to refer to the beginning of parenthood as a transition rather than a crisis (Hobbs & Cole, 1976).

It must be noted, however, that as Cox (1985) suggests, these studies demonstrating a decline in marital satisfaction after the birth of the first child must be interpreted with some caution. The studies were limited by conceptual and methodological problems, including: the families were studied after the birth of the child; retrospective self-reports of marital satisfaction before birth were used; and the concept of crisis was defined differently, poorly, or not at all by the researchers.

Lewis (1989) argues that the decline the couples experienced may reflect the difference between their pregnancy euphoria and their postpartum reality, rather than a real difference in their postpartum marital relationship compared to their preconceptual relationship. He further maintains that the greater decline in marital satisfaction noted in the women may be a reflection
of their adjustment to the role of motherhood and/or their experience of postpartum mood and anxiety disorders.

This set of literature also speaks to the assumptions in the study, that the birth of the baby will impact on the marital relationship. In addition, the last critical comments from Lewis (1989) have relevance for this study. If pregnancy is a life situation that is unique and time-limited, can it be compared with the early postpartum months, another unique and time-limited experience? The perspective taken in this study is that the somewhat rarefied experience during the third trimester of pregnancy, when both the expectant mother and father are full of the excitement of the impending birth, is in many ways comparable to the rarefied experience of the first three months of parenthood, when the new mother and father are full of the excitement and wonder of the infant. Although these are contextually-different life experiences, nevertheless, the marital system may resonate to them in a similar fashion.

**Developmental Crises**

In spite of the large number of studies addressing the postpartum period, there continues to be semantic debate over whether birth is a crisis or transition, a developmental task or a marker event. Erikson (1965) classified crises into two categories: either developmental (maturational) that are normal and expected occurrences in the process of an individual's psychosocial development, or situational (accidental) that are precipitated by an external event. The birth of a baby can be an accidental crisis if the pregnancy is unplanned, but, in most cases, would be considered a developmental crisis, a normal expected event in the lives of a young family.

**Situational Crises**

Weiss (1976) considered crises from a situational perspective, maintaining that a crisis may be considered a state of situational distress that produces emotional reactions in almost everyone involved in the actual situation. Within this definition, it is usual to consider crises associated with negative events, (e.g., bereavement, marital separation or divorce, sudden
unemployment, etc.). Such crises often begin with a brief period in which the individual's emotions seem to be suspended as he/she perceives the situation to be intensely threatening. This is accompanied by a mobilization of energy in response to the situation, and an intense focus of attention on the crisis until some resolution has taken place.

These crises may end in one of two ways: by a return to a pre-existing situation or by a persistent disruption of the situation, resulting in emotional and relational change. The period of relational and personal change may also be called a "transition" or "transition state". This transition state ends with the establishment of a new, stable life organization, accompanied by a new, stable identity (Weiss, 1976). If the new life organization is inadequate, lacking, or insufficient for the individual, she/he may be in a "deficit" situation, perceiving that her/his needs are not being adequately met.

In transition states, usual patterns of managing have been disrupted, and individuals, confronted by difficulties for which they have no solution, may feel confused, frustrated, and isolated. This may not be the case for individuals in deficit situations. Although they perceive some aspect of their life to be lacking, these individuals have stabilized again around the deficiency. They are no longer confused; they know the conditions under which they live (Weiss, 1976).

Wynne (1984) proposes a model that incorporates both predictable and unpredictable change in families. He suggests that four relational processes appear to unfold epigenetically to form the basis for understanding family development: attachment and caregiving, communicating, joint problem-solving, and mutuality. These relational processes exist on a continuum with positive and negative anchors. Anchoring at the negative pole can lead to distancing, divergence, or relational failure. Although the specific processes are presumed to unfold in an orderly sequence that is predictable, periods of discontinuous destabilization may occur with the random introduction of new relational issues into the family's development.

Terkelsen (1980) suggests that transitions are characterized by a destabilization of the system from which new family structures emerge. These destabilizations may be characterized
by conflict, frustration, and anxiety within the family, and may result from the primary need-attainment of one family member. Challenges to the family's homeostasis that are resistant to the usual stabilizing mechanisms within the family system can result in crises characterized by inconsistencies, confusion, and paradoxical injunctions, all of which are necessary prerequisites for creative change within the family structure (Carter & McGoldrick, 1980). This provides validation for the argument by Lewis (1986; 1989) that competent families will be more able to resolve major transitions and crises better than more conflicted or dysfunctional families.

In a study of 90 fathers and 115 mothers, Harriman (1986) found that the amount of change and the quality of change (positive or negative) that parents perceive to be occurring is related to their marital adjustment. The birth of the baby resulted in a higher degree of positive change in the lives of parents who scored high on marital adjustment than in couples who scored low. Harriman suggests that the happiness the parents are experiencing with their new infant helps them view the other changes in their lives as positive.

In sum, the adaptation to bearing a first born infant conforms to all three definitions of crisis outlined above. It is rarely a short-lived experience that is easily resolved. More commonly, the experience of childbirth is a situational crisis that results in a transition state characterized by some experience of confusion, frustration, and isolation. The experience may also result in a deficit situation wherein parents stabilize at a new level where some of their needs are not being met. However it is construed, the birth of a first child does have a significant impact on the lives of new parents.

**Crisis and Worry**

Levy and McGee (1975), maintaining that "childbearing, as a significant maturational period in a woman's life, provides a natural experiment in crisis resolution" (p. 171), tested Janis's Theory of "Communication and Stress Resolution" in a sample of sixty first-time mothers. According to Janis (1958; 1965), psychological stress was defined as the reaction to a physically dangerous event in which pain, bodily injury, or death is anticipated. The way an individual
handles the impending crisis during the preimpact period can affect the actual outcome of the event.

Study results indicated that the "work of worry", as described by Janis, was essential for successful resolution of childbirth crisis. Women who had engaged in rehearsal strategies and who had positive expectations of their birth experience based on their mother's report of her birth experience fared better than women who had not. Levy and McGee concluded that realistic expectations were important in crisis resolution and that pre-stress communication impacted on crisis outcome either positively or negatively.

One might argue, therefore, that the communication of accurate information about childbirth and postpartum adjustment to prenatal couples would allow them to indulge in the work of worry and cognitively rehearse the crisis and its resolution. As has been previously mentioned, these findings were tested through the provision of anticipatory guidance on postpartum adjustment to prenatal couples and found to be valid (Midmer et al., 1995).

Again, these citations serve to support the thesis assumption that the birth of a firstborn child is a significant event in the lives of new parents, necessitating anticipatory psychological preparation.

**Crisis and Identity**

Sheehan (1981) explored postpartum as a time when a woman's identity and self-confidence are in crisis. Utilizing crisis theory, the stages of growth and development, and a theory of role transition and enactment, Sheehan developed three questionnaires, or attitudinal survey sheets, as clinical tools to study postpartum transition. The surveys were administered during a series of interviews to a sample of six young (20-30 years of age), married, healthy women, chosen from prepared childbirth classes.

This small study substantiated the argument that the maternal adjustment period during the first six postpartum weeks did constitute a crisis in a woman's life. For women, postpartum is a
critical period of identity reformation and role transition. A woman's ability to achieve a sense of being a mother and to articulate a philosophy of motherhood is based on her perception of the role of mother and its resonance or dissonance with her way of life.

The sample in this study were women who had strong self-concepts, planned pregnancies, and available support systems. Although the results of this study are not generalizable to a wider population, the author argues that women who are in less advantageous psychosocial positions may more frequently experience postpartum as a crisis and may encounter more difficulties in identity reformation and role transition (Sheehan, 1981).

**Crisis and the Marital System**

This developmental crisis perspective is also articulated by Lewis (1988a; 1988b; 1989). Lewis writes that "A common model of family development includes the construct of periodic family transitions of a crisis nature that necessitate structural change within the family" (1988a, p.149). The transition to parenthood is a family transition of a crisis nature that necessitates adaptive structural change within the family. If structural change does not occur, the family is considered "stuck" and family members may begin to behave in a dysfunctional manner (Lewis, 1988a). In addition, those families that show organizational competence cope with crises and transitions more effectively (Lewis, 1986; 1989).

This research by Lewis (1988a; 1988b; 1989) and Lewis et al. (1988) focused on a sample of 38 young married couples who were studied intensively as individuals, dyads, and triads in both the prenatal and postpartum periods. This longitudinal research explored whether prenatal marital structures were changed by the transition to parenthood, and which prenatal marital structures influence the process of incorporation of the infant into the family system.

At one year postpartum, 22 of 38 couples demonstrated the same level of marital competence as they had prenatally, 14 couples demonstrated deterioration in their marital relationship, and two couples were improved. These results supported the hypothesis that couples with high levels of marital competence prenatally would maintain their high levels of
marital competence in the postpartum period (Lewis, 1988a; 1989). Furthermore, "the basic template for the total family structure was derived from the structure of the parents' marital relationship" (1988a, p.151).

**Summary**

When encountering an event perceived as stressful, individuals call into play stress resolution resources, including their repertoire of coping skills and their social support systems. Coping behaviours in individuals with good levels of adaptation may modify the perception of stress and neutralize its distressing components.

The expectations and perceptions of anticipated postpartum support are often inaccurate. If the quality and quantity of perceived support is not valid in reality, new parents may feel a sense of violated expectations and some degree of support deterioration. Antenatal identification of tangible assistance in the form of trustworthy support persons has been found to act as arbiter in the obstetrical outcomes of some high-risk women. Antenatal parenting skills and communication classes have been found to decrease postpartum anxiety, increase marital relationship functioning, and increase postpartum adjustment. Postpartum parenting support groups have not yet been found to play a major role in mediating postpartum adjustment difficulties.

Family structures that are highly competent appear to cope with stress more effectively than more dysfunctional or conflicted families. Because of the role gain and role strain that exemplify the postpartum period, new parents are required to examine the issues of inclusion, control, and intimacy in the postpartum period as they reorganize their expanded family system into a new “normal” structure.

Various authors argue for different terminology with respect to whether birth is a crisis or transition. All the authors cited maintain that the incorporation of a first child into a dyadic relationship will challenge the system to a lesser or greater degree. It appears that those couples who have the least romanticized views about parenthood, the most realistic information about
postpartum adjustment, and who are in the most competent marital relationships will experience the least postpartum adjustment difficulties. Although women consistently scored higher negatively on postpartum adjustment checklists and anxiety questionnaires in the postpartum period, those women with planned pregnancies who had begun to embrace the role of mother in the prenatal period appeared to experience less identity crisis and role transition after the birth of the baby.

This section of the literature review supports the perspective that birth is at least a transition and at most a crisis in the lives of new parents. The sudden shift in the family system with the addition of the child results in a move from homeostasis to heterostasis. Both the family of origin and the family of procreation are involved in the integration of the new member into the family. This period of transition or crisis, the resultant heterostasis, and the final integration of the infant in the family provides a unique opportunity to study the shifts, if any, in differentiation and relationship processes within the family. These issues form the backbone of the study, and are directly related to the study hypothesis and subproblems.
The Postpartum Experience

General Overview

In order to understand and appreciate the postpartum experience more fully, it is essential to become aware of the many different aspects of the transition to parenthood. Although the focus of this study is on marital adjustment after childbirth, many other variables influence the experience of new parenthood and the marital system of the new parents both during the pregnancy and in the early weeks and months after the baby is born. The marital relationship does not exist in a vacuum but is directly affected by the emotional, physical, and psychological health of the mother, father, and infant.

Traditionally, antenatal psychosocial health assessment has been neglected by many health care providers who continue to place their emphasis on biomedical obstetrical surveillance (Elbourne, Oakley, & Chalmers, 1989). In contrast to medical concerns, psychosocial issues rarely present as discrete entities. The complexity of these psychosocial problems and the lack of guaranteed efficacious intervention strategies have exacerbated the anxiety and feelings of incompetence that health care providers experience when dealing with family system problems.

However, there is increasing recognition of the importance of psychosocial issues in the health of the new family, and the identification of antenatal psychosocial factors associated with adverse postpartum family outcomes is becoming a standard of practice (Wilson et al., 1996). The identification, through this study, of antenatal differentiation issues that impact on the health of the postpartum family will add to the momentum urging all obstetrical providers to look beyond anatomy to a biopsychosocial model of care for childbearing women and their families.

The Work of Pregnancy

According to Lederman (1984), pregnancy is a transition between two lifestyles or states-of-being: the woman-without-child and the woman-with-child. Transition between these two
lifestyles can be regarded as a paradigm shift necessitating a change in the woman's current self-image, beliefs, values, priorities, behaviours, and relationships. The new paradigm that emerges with birth involves major shifts in perception as the woman begins to incorporate the child into her lifestyle. Some women, realizing that there is no return to their former state-of-being, experience resistance and conflict as they navigate this developmental process.

Pregnancy serves as an apprenticeship to this fundamental paradigm shift and involves the expectant mother in the completion of distinct developmental tasks. Rubin (1952) outlined a developmental schema for pregnancy that includes three discrete phases, or developmental tasks, that need to be achieved by the pregnant woman. Rubin argued that the successful transition to motherhood could not occur if these tasks were left unaccomplished.

According to Rubin, the task of the first trimester is to accept the pregnancy as a reality. Many women experience some initial ambivalence and confusion in the early stages of pregnancy if their joy and happiness conflict with their doubts and fears about the effects of pregnancy and motherhood on their lifestyles and/or careers. Pregnancy wantedness and intendedness are issues for many women. However, prolonged ambivalence is a red flag for concern (Wilson et al., 1996). If the pregnancy is unwanted and unaccepted after 20 weeks, there is an increased risk for child abuse after the infant is born (Altemeier et al., 1982; Seagull, 1987; Shearman, 1987; Strass, 1980) and a strong association with antenatal and postpartum woman assault (Amaro et al., 1990; Bland, & Orn, 1988; Hilliard, 1985).

Pregnancy wantedness and intendedness, studied by Snowden et al. (1988), were related to marital satisfaction both early and late in pregnancy. Results from their study of 106 women indicated that uncertainty and conflict in becoming pregnant were correlated with relatively low marital satisfaction at the start of pregnancy. Whether the pregnancy was wanted or not continued to predict marital satisfaction when assessed immediately prior to birth (34 weeks). The study did not extend into the postpartum period to determine the state of the marital relationship or the wantedness of the baby. However, as has been already noted, continued ambivalence about the pregnancy after 20 weeks has been associated with an increased risk for child abuse and woman abuse (Wilson et al., 1996).
However, Belsky and Rovine (1990) report seemingly contradictory findings in their longitudinal study of 128 families. Families were studied from the last trimester of pregnancy through their first child's third birthday. Data indicate that wives who experienced a decline in the quality of their marriages were more likely to have planned pregnancies than women whose marriages showed improvement. The authors write “however counterintuitive this result appears . . . wives who have not planned the pregnancy may, by being more anxious and/or doubtful about how things will turn out, benefit from the contrast between expectations and actual experience” (1990, p. 7). This contrasts to the study of Snowden et al. (1988), although it is not clear from the study of Belsky and Rovine whether the ambivalence towards pregnancy was short-lived and resolved in the early weeks or whether it continued until delivery.

The developmental task of the middle trimester is to begin to identify with the motherhood role and to renew and deepen the mother-daughter relationship. Pregnant women begin to consider their parenting potential in light of their own mother as role-model and begin to articulate a philosophy of motherhood. If a pregnant woman describes herself as having had a poor relationship with her parents when growing up, and discloses conflict, a lack of closeness with her mother, and parenting that was cold and rejecting, then there is an increased likelihood of child abuse after the baby is born (Altemeier et al., 1982; Green, 1988; Robinson, 1981; Schneider, 1982; Schneider, Hoffmeister, & Helfner, 1976).

The final task in the last trimester is to acknowledge the separate existence of the baby and to relinquish the pregnancy. This task is accomplished by choosing names and by designating and preparing a separate place for the infant in the home. Women begin to fantasize beyond the pregnancy and imagine themselves trying out new roles as good and competent mothers. Women with high self-esteem will feel good about themselves, see themselves as generally successful in life, and have secure and positive feelings about their mothering skills. Women with low self-esteem often view themselves negatively and have insecure feelings about their future mothering competence (Wilson et al., 1996). Research has shown that there is a strong correlation between low maternal self-esteem and child abuse (Anderson, 1987; Caldwell,
In effect, before the childbearing woman moves into new parenthood, considerable developmental work needs to be completed, some of which is premised on the woman’s positive view of her own mothering skills and her view of the relationship she had with her own mother. These works elucidate the complexity of the psychological preparation for childbirth undertaken by the pregnant woman, and provide a glimpse into the intrapsychic shifts she may be experiencing.

**Mother’s Adjustment**

Emotional reactions to the experience of childbirth and parenthood range from those new mothers who are happy and well-adjusted, to those for whom the experience produces depression, despondency, and relational dysfunction. Postpartum depression in women is unique insofar as it is only precipitated by childbirth or motherhood and is symptomatically distinct in etiology and onset from "typical" depression in adults (Ball, 1987). Although in part attributed to hormonal swings following delivery, the biomedical causes of postpartum depression disorders have also been linked to complications of pregnancy and childbirth, breastfeeding and weaning, premenstrual syndrome or other menstrual problems, and thyroid imbalance (Dunnewold & Sanford, 1994).

Psychosocial factors that increase a woman’s risk of experiencing postpartum depression include recent serious life stress, a lack of social support, marital relationship problems, a family history of depression, previous emotional and/or psychiatric problems, a previous postpartum depression, and a difficult infant (Cutrona, 1984; Cutrona & Troutman, 1986; Hapgood, Elkind, & Wright, 1988; O’Hara, Neunaber, & Zekowski, 1984; O’Hara et al., 1991; Nuckolls et al., 1972; Whiffen, 1988). Wilson et al. (1996) found that a history of antenatal depression has shown good evidence of association with postpartum depression.
Postpartum depression disorders can be classified into postpartum blues, postpartum mood and anxiety disorders, and postpartum (puerperal) psychoses. Each classification has distinct clinical features, and appears in all social classes and cultures (Robinson & Stewart, 1986).

The **postpartum blues** are a transitory disorder characterized by intermittent mild fatigue, crying, anxiety, and sleep disturbances that affect 50% to 70% of women, appear within the first few days, and resolve spontaneously within two weeks. **Postpartum mood and anxiety disorders** affect 10-15% of women. Women may not become depressed until six weeks after the birth and may have symptoms that include crying, tearfulness, irritability, anger, sleep disorders, fatigue exhaustion, negative and depressed feelings, anxiety and worry, and changes in appetite or eating habits (Dunnewold & Sanford, 1994). **Postpartum psychoses** occur in 1-2 per 1000 women, and may present as schizophrenia or severe states of confusion that may include delirium, hallucinations, marked variability of mood, and suicidal and infanticidal tendencies.

Oakley (1979) indicates that 84% of women experience postpartum blues, 71% experience anxiety on returning home after delivery, and 24% experience other depression. Dix (1985) maintains that postpartum blues occur in 25% to 50% of mothers and are a normal sequel to childbirth, postpartum depression occurs in 10% of women, and postpartum psychoses, necessitating immediate hospitalization, occur in 1 per 1000 women.

This range of different incidence rates suggests that from 25 to 84% of women will experience postpartum blues and will have reduced coping capacities when they return home with their baby. Furthermore, approximately 10 to 15% of women will have a prolonged postpartum depression that will affect their future abilities as mothers, wives, and women. Any new mother is at risk of developing a postpartum depression, although, in the case of puerperal psychoses, women with a previous personal or family history of depression (Robinson & Stewart, 1986) are at higher risk.

Pitt (cited in Ball, 1987) found that postpartum depression was not related to the events of labour and delivery or whether it was a first or subsequent birth. However, he did find a
significant relationship between anxiety and the increased incidence of postpartum depression. The most common symptoms were undue fatigue and sleep disturbances. Further study revealed that 43% of women were still depressed a year later. This long-standing depression in some women suggests that the initial postpartum transition may well extend into the second post-delivery year.

More recent research (Taylor et al., 1994) into postpartum mood disorders has focused on the “highs” as well as the “blues”. The highs are described as occurring in 10% of women and feature mild elation, or hypomania, in the first few days postpartum. The authors measured serum cortisol levels, normally elevated in response to stress, in 163 woman on the third day after childbirth. Significantly elevated levels of cortisol were found in women with the blues and significantly lower levels were found in women with the highs. High levels were related to instrument-assisted deliveries and low levels were associated with epidural anaesthesia. Both the highs and the blues have been found to be associated with later depression. This research both supports and refutes the work of Pitt (1987) cited earlier. Assisted deliveries and the instrumental intervention that accompanies them would most likely increase the anxiety of the childbearing woman, resulting in an elevated serum cortisol level. However, the association of the highs and blues with the use of obstetrical interventions or anaesthesia suggests that the events of labour and delivery do have an impact on the incidence of postpartum depression.

Some women may also feel a loss of personal identity and decreased self-esteem after the birth of the baby. Motherhood forever changes a woman's perception of herself since she will always perceive herself and be perceived as a mother (Oakley, 1980). This change in state-of-being, or paradigm shift (Lederman, 1984), can lead to feelings of loss and grief for the person she once was and can precipitate or exacerbate a postpartum depression disorder. As has previously been indicated, self-esteem issues in new mothers have been linked to an increased risk of child abuse postpartum (Wilson et al., 1996).

Further studies (Ball, 1987; Lederman, 1984; Nuckolls et al., 1972; Oakley, 1980; Oakley 1979) consider the mother's reactions after the birth of the baby with respect to psychosocial variables that impact on her ability to make a transition into parenthood. Such factors as the
father's involvement and participation, the extended family support system, previous success with coping with life changes, financial resources, a successful marital relationship, a positive birth experience, the health and temperament of the infant, etc., all impact either positively or negatively on a woman's postpartum reactions (Cutrona, 1984; Cutrona & Troutman, 1986; Hapgood et al., 1988; O'Hara et al., 1984; O'Hara et al., 1991; Nuckolls et al., 1972; Whiffen, 1988).

The demands of a normal newborn are never negotiable and new parents are often unable to distance themselves from the pressing needs of the infant. Although primary contact with the infant is often enjoyable and pleasurable, the repetitiveness of this intense level of contact can become unrewarding and unpleasant. Furthermore, this reduction in parenting satisfaction can be considerably increased if the baby is fretful or has colic (LaRossa & LaRossa, 1981).

In sum, movement through the early postpartum months is not without emotional quagmires for the new mother. How able a woman is to avoid a postpartum mood and anxiety disorder is a much related to luck as it is to her preconceptual and antenatal emotional history, her postpartum support system, the infant's temperament, and her marital happiness. This section of the review also serves to support a central study assumption that the birth of a baby significantly changes the life of a new parent. In this case, the changes are mother-related and can be substantial.

**Father's Adjustment**

New fathers are not immune to the development of postpartum physical and emotional disorders. The phenomenon of *couvade* refers to pregnancy-related symptoms and behaviours of expectant fathers (Trethowan & Coulon, 1965). Although anthropologically documented in pre-industrial societies, in western cultures the couvade syndrome usually takes the form of psychosomatic illness and expresses the father's identification with and attempts to share his wife's experience (Kitzinger, 1978).
Clinton (1987) found that the health of new fathers' was significantly different from non-fathers, and described a higher incidence in new fathers of emotional and physical discomforts such as increased fatigue, irritability, headache, difficulty concentrating, insomnia, nervousness, and restlessness. Zaslow (1985) studied 37 middle-class families with firstborn infants under five months. Results of home observations and analysis of interviews with the parents revealed that 62% of the fathers reported experiencing depressed mood at some point since the birth of the baby. These findings suggest that the psychological transition to fatherhood may be as dramatic as that to motherhood, and partially support the argument that fathers may be susceptible to developing postpartum depression disorders (Dix, 1985).

New fathers are also susceptible to emotional disequilibrium. Those men who have difficulty in establishing their fatherhood role and are deficient in confidence and nurturing skills tend to be more ambivalent about the added responsibility of a child. For some men, the development of a philosophy of fatherhood is extremely difficult and may lead to a temporary emotional regression as they resolve their ambivalence over their new role (Lederman, 1984; Solyom, Ainslie, & McManus, 1981). This confused emotional state may interfere with a father's ability to bond with his child and must be resolved as part of his developmental process.

Because there has been an evolution in the roles of fathers over time, confusion over what is appropriate fathering behaviour may exist. Lamb, Pleck and Levine (1987) present a historical perspective on North American fathering, with roles evolving from moral teacher (Puritan and colonial times) to breadwinner (up to the Depression) to masculine role-model (end of World War II) to the contemporary model of an active, nurturing, care-taking parent. However, Horne and Lupri (1987) suggest that in Canada today, the paternal role is still primarily an income-earning obligation, although today's father is likely to regard himself as more involved in fatherhood than his own father was.

In addition, Jordan (1986) argues that breastfeeding may increase a father's postpartum transition difficulties if the father perceives that the infant has supplanted him with his partner and therefore feels excluded from the autonomous, interdependent, "nursing couple". The father may feel resentful of the mother's involvement with the baby (LeMasters, 1957) and may
consciously or unconsciously sabotage her breastfeeding efforts as he engages in a form of "sibling" rivalry (Jordan, 1986). Belsky and Kelly write of the fathers in their longitudinal study, "For men the chief culprit is maternal preoccupation with the baby. While most new fathers expect the baby to become the main priority in the family, many are stunned at how little wifely attention or affection is left for them" (1994, p. 40).

The baby's presence brings the nuclear family triangle into play with the father often moving into the distant outside position as the mother draws close to the baby. For the father who was emotionally fused with and undifferentiated from his partner before the birth, this shift of the mother to the baby may challenge the stability of the marital relationship, resulting in dysfunctional behaviours (Kerr & Bowen, 1988). If the baby becomes a love object for the mother, almost replacing the father, then the marital relationship can become severely jeopardized and the father may consider the baby an intruder and a threat to his relationship with the mother (Bing & Colman, 1977).

The new father, it appears, is also not immune to postpartum emotional distress. The new father not only has to navigate his own postpartum course, accepting that his partner has less time and energy to devote to him, he must also work to integrate the infant into the family of procreation. It is little surprise that the birth of the infant has also caused significant shifts in his life, shifts that may have an impact on his relationship with his partner.

**Realignment of Roles**

The new parents go through a role distance/role embracement process as they interact with the baby. The woman may embrace the motherhood role and distance herself from her marital role. New fathers may manifest their distancing or disassociating from the parental role by behaviours that indicate incompetence and are excessive and beyond the childcare inadequacies expressed by all new fathers (LaRossa, 1977).

Because of the new roles and responsibilities that both parents must assume, the new father, as well as the mother, may be confused by the role expectations of contemporary society
that conflict with internalized expectations that are culturally and familially transmitted (Dix, 1985). This discordance may result in feelings of inadequacy, anger, or frustration that manifest as emotional and physical distancing, struggles for control, and the inability to cope with postpartum adjustment (Bowen, 1978; Carter & McGoldrick, 1980; LaRossa, 1977).

Postpartum couples are often challenged by the difficulties they encounter in the redistribution of household chores. Cowan et al. (1978) discovered that conflict over the use of time alone and as a couple and the division of labour were the most critical areas of conflict or disagreement for most couples. Women perceived more restraints on their time than did men and became susceptible to "role strain" or overload. Both partners perceived that their respective share of baby care was greater than their partner perceived it to be, and experienced a discrepancy between their perceptions of role arrangements.

The negotiation of a fair and equitable division of labour during this time of transition can become increasingly problematic, for women's mothering is one the few universal and enduring elements of the sexual division of labour (Chodorow, 1978). Couples are inclined to be involved in "labour disputes" as they attempt to assimilate their new parental roles and duties into their past schedule and distribution of household chores.

Terry, McHugh, and Noller (1991) studied role dissatisfaction and the decline in marital quality across the transition to parenthood. A sample of 59 first time, or primiparous, couples was administered questionnaires relating to their marital relationship and their satisfaction/dissatisfaction with their partner's role performance during the last trimester of pregnancy and again approximately three months after birth. A decline in affectional expression, measured by the Dyadic Adjustment Scale (Spanier, 1976), was experienced by both parents. The decline experienced by the women was related to their dissatisfaction with their partner's postpartum performance. The authors explain this decline by speculating that the women might discourage displays of affection as a means to convey their dissatisfaction with their partner's lack of contribution to household chores.
In addition, cultural and societal norms and expectations, as well as unique family traditions, impact on the equity of the role-sharing. The more traditional and patriarchal construct of the transitional family (LaRossa, 1977) may initiate a systemic level of change in the marriage. This transformation may produce anxiety and distress in couples who are forced to relinquish the non-traditional roles they occupied in the preconceptual period. A woman's withdrawal from paid work in preparation for childbirth may facilitate a change from the more egalitarian values and role demands of dual-career couples to the more stereotyped role set of traditional families (Lamb, 1978; LaRossa, 1977).

The opposite effect may also occur. MacDermid, Huston, and McHale (1990) studied sex-role attitudes and changes in the division of household labour associated with the transition to parenthood. The sample consisted of 98 couples, 29 of whom became parents during the first year of marriage and 23 during the second year of marriage. Forty-six couples who remained childless were also part of the study. Results indicated that all couples experienced declines in their feelings of love, marital satisfaction, and frequency of dyadic activities. Parents were different from non-parents only insofar as, when they became more child-oriented, they divided tasks along more traditional lines. In fact, the findings revealed that the changes toward a more traditional division of labour were welcomed by those new parents who held sex-role attitudes congruent with the changes. Interestingly, couples with traditional attitudes who took on non-traditional, or more egalitarian, marital roles were at increased risk for marital difficulties. This study is in contrast to the work of Terry et al. (1991) cited earlier, and is a clear indication that more research is needed in this area.

These studies emphasize that the birth of the firstborn has an impact on the marital relationship of the new parents, an under-lying assumption in this study. Postpartum role shifts may lead to role strain, and may result in increased conflict and relationship issues between the new parent dyad. These changes often lead to a decrease in affectional expression. Since affectional expression, a subscale of the Dyadic Adjustment Scale, will be measured as an outcome variable in this study, it will be interesting to determine whether this finding in the literature and the results of this study are congruent.
Economic Concerns

The practical aspects of financial planning necessitated by a change to a single income in the postpartum period may also result in shifts in the marital power structure. The increased reliance and dependence of a wife on her husband for financial survival strengthens the traditional structure of the marital relationship, and, hence, shifts the power in the postpartum transitional marriage (LaRossa & LaRossa, 1981).

Because of financial constraints, the tension produced by the role strain and tremendous lifestyle adjustments experienced by new parents cannot be dissipated as easily by entertainment and the more carefree living style of the double-income, childless couple. Belsky (1986) describes four types of problems experienced by couples during the transition to parenthood. These include: the physical burden of caring for the infant; the strain of the husband-wife relationship; doubts over competence and confidence with the responsibilities of parenthood; and personal confinement.

New parents are sometimes overwhelmed by problems in the postpartum period. The added distress of being confined and unable to escape momentarily these concerns through outside recreational activities may exacerbate their feelings of frustration. Having no financial resources may be one more expected but unwelcome change wrought by the birth of the baby.

Postpartum Sexuality

New mothers must adjust to an altered physical state after the birth with fluctuations in hormone levels caused by a return to a non-pregnant state and the possible establishment of breastfeeding. Diminished vaginal secretion due to steroid starvation is often a problem in the first three months postpartum and is particularly related to breastfeeding (Masters & Johnson, 1966). These hormonal shifts may affect a woman's mood and result in a loss of sexual interest (Alder et al., 1986). Decreased sexual tension experienced during the postpartum period may be attributable to fatigue, weakness, pain, and fear of personal injury (Masters & Johnson, 1966).
Hames (1980) reports that 64% of the women in her study of 42 couples were afraid of sexual intercourse following childbirth in the early postpartum period compared to 19% of men. For the men in her study, fear of hurting their wives was an important factor in their concerns about resuming sexual intercourse.

Ellis and Hewat (1985) administered a postpartum adjustment questionnaire containing ten questions relating to sexual adjustment to a convenience sample of 194 women. Although perceptions of the spousal relationships changed little, the sexual interest of the women declined over six months, with tiredness stated as the most common influencing factor.

Bieber and Bieber (1978) discuss a postpartum syndrome observed in both sexes that includes the symptoms of acute anxiety, depression, psychosomatic disorders, changes in affectional responses towards the spouse, changes in sexual behaviour, the onset of frigidity in the woman, potency difficulties in the man, an apparent loss of interest in the marriage, and the first involvement in extramarital affairs. Considering these symptoms, birth may well be a launching pad for future sexual dysfunction and marital difficulty.

In addition, women run the risk of feeling dangerously inadequate and vulnerable in the postpartum period, as they experience the ambivalence of being "great mother/bad wife" (Scarf, 1980). Women attempt to juggle the new behaviours and roles of motherhood with the old marital relationship behaviours and roles as companion/lover/partner to their spouse. This role dissonance in women, unless redressed, may present as marital system disequilibrium and sexual disturbance.

The decreased libido of the new mother, coupled with her submersion into new mothering roles, would most probably result in her having less sexual interest in her partner. This may present itself as an overall decrease in affectional expression, one of the variables being measured in this study.
Postpartum Marital Adjustment

At this time, it is appropriate to review more closely the early work of the life change theorists with respect to the marital issues that are subsumed into the crisis or transition to parenthood. Viewing families as small social systems, these theorists were interested in investigating the maturational and situational crises that precipitate change and reorganization in the family (Dyer, 1965; LeMasters, 1957; Hobbs, 1965; Hobbs & Cole, 1976; Russell, 1974).

LeMasters articulated the experience of postpartum very well when he wrote

... married couples find the transition to parenthood painful because the arrival of the first child destroys the two-person or pair pattern of group interaction and forces a rapid reorganization of their life into a three-person or triangle group system. Owing to the fact that their courtship and pre-parenthood relationship has persisted over a period of years, they find it difficult to give up a way of life... they find living as a trio more complicated than living as a pair. The husband, for example, no longer ranks first claims upon his wife but must accept the child's right to priority. In some cases, the husband may feel that he is the semi-isolate, the third party in the trio. (p.116)

LeMasters hypothesized that the addition of the first child constitutes a crisis event to a considerable degree, forcing the married couple to move from an adult-centered pair into a child-centered, triad system. Of the 46 middle-class couples in his research, 83% confirmed this hypothesis. In Dyer's study (1965), with respect to the marital system, significant relationships were found between crisis and the following: marital adjustment rating of the couple after birth, those rating their marriage as excellent experienced less crisis; preparation for marriage classes, those who had attended classes experienced less crisis; and number of years married, those married three years or more experienced less crisis.

In the study undertaken by Hobbs and Cole (1976) in 1975 to replicate the original study by Hobbs (1965), significantly fewer men (46%) and women (31%) in the later study rated their marriages as happier and more satisfying since the birth of the baby. The addition of a baby to the family was not regarded so much as a "blessed event" as it had been previously. In addition, Russell (1974) reported a negative correlation for both men and women between the amount of
difficulty experienced with the first child and the perception that the marriage had been improved by the addition of a child.

Hoffman and Manis (1978) collected data from a large number of American families in an attempt to determine the influences of children on marital interaction and parental satisfactions and dissatisfactions. Respondents (n = 1569 women, n = 456 men) were interviewed in their homes on a wide range of topics. Some of the questionnaires included measures of the traditionalism of the husband-wife relationship, attitudes toward marriage, effects of children on the marriage, and measures of satisfaction and dissatisfaction in parenthood.

With respect to the more traditional structure of the postpartum family, Hoffman and Manis (1978) reported consistent results that there was a trend towards a slight increase in the husband's power occurring during the early stage of parenthood, with a swingback thereafter, and that husbands helped less with the housework after the birth of the baby. This was explained, in part, by the increased availability of women to perform household chores by virtue of their location in the home rather than in the marketplace.

LaRossa (1977) explored the issue of conflict and power in marriage in his research on 16 couples, interviewed conjointly and in-depth, who were expecting their first child. LaRossa makes the point that the coercive pressures in our patriarchal society to enter a heterosexual relationship, marry, and have children, render marriage and parenthood not at all a free choice. Because of this, a feeling of ambivalence may permeate the husband-wife relationship. Couples who married and became parents because it was expected behaviour may experience increased tension in their marital relationship due to a feeling of entrapment (Gimenez, 1984; LaRossa, 1977).

LaRossa further maintains that "contemporary marriage is intrinsically related to the broader issue of male-female conflict", and "that marriage is a social relationship in which the paradox of human action (separateness and connectedness) is acute" (p.123). Sprey (cited in LaRossa, 1977) articulates this relational tension, writing
[a] human bond . . . is a paradox. Moving closer to another person also, by necessity, means moving apart. That is, increasing intimacy brings with it an increasing awareness of, and confrontation with, the uniqueness of other. The more special two people become to each other the greater may be the pressure, from both sides to possess the other totally, or in popular phraseology, to "become one". And that indeed, would mean the end of reciprocity. Intimacy, to be viable, thus requires the awareness, and acceptance, of the stranger in the other. (p. 724)

LaRossa presents a convincing argument for the power politics that often epitomize contemporary marriages. The social order and peace in marriage, in the absence of a common value and belief system, may be maintained through "negotiated management of differences, a cooperative 'treaty', which permits the parties to live (however precariously) in spite of their divergent points of view" (p. 147). LaRossa concludes that marriage is a political process and that the social order in a marriage may be achieved only through "the legitimate and illegitimate coercion of each spouse by his or her partner" (p.147).

The issue of traditionalism is further explored by Belsky et al. (1986). They examined the proposition that women who describe their personalities in ways that deviate from traditional sex stereotypes will become less positive and more negative about their marriage after the birth of the baby, particularly if there is an increase in the traditionalism of their marital roles. Sixty-one white, middle-class, well-educated couples expecting their first child participated in a short-term longitudinal study that took place from the last trimester of pregnancy through the third postpartum month. The Personal Attributes Questionnaire, a scale consisting of 24 items to assess an individual's personal ascription of characteristics stereotyped as masculine (i.e., instrumental, agentic) or feminine (expressive, affectional), was administered along with three other questionnaires assessing the marital relationship.

Results revealed that as the division of labour became more traditional, women rated their marriage increasingly negatively. In addition, the women's evaluations of both positive and negative aspects of marriage could be significantly predicted by the women's relative scoring on the masculine-feminine questionnaire continuum. This is in direct contrast to the work of MacDermid et al. (1990) which indicated that couples who took on non-traditional roles that
were not congruent with their traditional sex-role attitudes were at risk for postpartum marital difficulties.

Yet Belsky et al. (1986) argued that women who were less traditional and more egalitarian found the postpartum division of labour to be more problematic. Conflict, for these women, developed over the disproportionate amount of housework and baby care that was part of their postpartum experience. These women experienced "decreased feelings of love, lower levels of marital satisfaction, and heightened ambivalence towards the marital relationship" (p.521).

Spousal differences in marital satisfaction during the transition to parenthood was also the focus of a study by Tomlinson (1987). Ninety-six couples, recruited from childbirth classes, who were expecting their first child were administered questionnaires in the last trimester of pregnancy and at 12 weeks postpartum. The couples were assessed to determine whether sex-role attitudes, marital equity, perceived father involvement, and infant temperament affected marital adjustment in the postpartum period, measured by the Dyadic Adjustment Scale (Spanier, 1976).

The Dyadic Adjustment Scale includes four subscales: Dyadic Satisfaction, which measures overall satisfaction with the marriage; Dyadic Cohesion, which measures the quality of the interaction; Dyadic Consensus, which relates to agreements in values and decision-making; and Affectional Expression, which measures both the sex relationship and the degree of affectional exchange.

This study is similar to Russell's (1974) in that little evidence was found to conclude that parenthood had a severe impact on the marriage of the majority of the couples. Although a significant decline in marital satisfaction was observed, the author argues that the mean scores for post-birth marital satisfaction are well above the dysfunction level suggested by Spanier.

This decline was reflected in the two subscales of the DAS pertaining to Affectional Expression and Dyadic Cohesion. The decline in the expressed affection was most marked in
the first three postpartum months, with little change from three months to nine months postbirth. Given the tumultuous postpartum experience of many couples, this finding is not surprising. However, the Affectional Expression Subscale of the DAS has a reliability of only .73 in comparison to the overall scale reliability of .96 (Spanier, 1977), and results of this subscale must be interpreted with caution (Westbrook, 1978). The decline on the Dyadic Cohesion subscale suggests that the couples experienced decreased participation in activities of common interest.

Final analyses indicated that the marital relationship before birth, whether good or bad, appeared to be the best single predictor of marital satisfaction after the birth of the baby. The mothers' feelings about their postpartum marital relationships were positively influenced by non-traditional sex-role attitudes and greater involvement of fathers in infant care, and were negatively influenced by marital inequity (Tomlinson, 1987).

Westbrook (1978) studied the marital relationships of 200 women with babies two to seven months old to determine their relationship to the early maternal experience of women. She hypothesized that "the quality of a woman's marital relationship would be significantly associated with her experience of child-bearing (attitudes and affective responses) and with the type of relationship she established with her child" (p.192).

A significant association was found between type of marital relationship and maternal reactions. The women with positive relationships had the least disturbed reactions, had fewer negative attitudes, expressed little rejection, had few problems in labour, and believed that their marital satisfaction had increased. However, the experiences of women with ambivalent marital relationships were characterized by high levels of separation anxiety, outward hostility, and defensiveness. These latter women appeared to be most in need of interpersonal support during their transition to parenthood.

O'Hara (1985) studied the relationship between depression and marital adjustment during pregnancy and after delivery. Fifty-one couples completed the Beck Depression Inventory and the Dyadic Adjustment Scale during the second and third trimesters of pregnancy and at three
and nine weeks postpartum. In addition, the couples participated in an interview assessment of their depressive symptomatology in the second trimester and at nine weeks postpartum.

For both men and women, the symptoms of depression decreased over the pregnancy and the postpartum period. In light of the considerable literature relating to postpartum depression in women, this finding is difficult to understand, although O'Hara does remark that the frequent administration of the Beck Depression Inventory may have lead to an "artifactual lowering of the scores because of overfamiliarity with the instrument" (p.53).

Significant correlations were obtained between the depressive symptoms of the men and women and the marital satisfaction of the men and women at each of the three assessment points. The husbands' marital satisfaction at six weeks postpartum was significantly correlated with their wives' satisfaction with the social support they were receiving. O'Hara suggests that men who were more satisfied with their marriage were more likely to provide increased support to their wives. An alternative interpretation might be that women who did not feel adequately supported were more likely to demonstrate their unhappiness with behaviours that increased the tension and conflict in their marital relationship.

Waldron and Routh (1981) studied the effect of the first child on the marital relationship of 46 couples. The Locke-Wallace Marital Adjustment Scale, measuring marital satisfaction, and the Bem Sex Role Inventory, measuring male and female nurturing responsiveness, were administered during the third trimester and again at six to eight weeks after birth. Results indicated the women's marital adjustment scores and their overall degree of happiness were significantly lower following the birth of the first child.

No relationship was found between sex-role characteristics and decrease in marital satisfaction. This is an interesting finding in light of the literature reporting the decrease in marital satisfaction experienced by women in postpartum relationships that become overly traditional (Belsky et al., 1986; Tomlinson, 1987) and the increased risk for marital difficulties experienced by couples with traditional values involved in non-traditional activities (MacDermid et al., 1990). However, the women's overall ratings of happiness and their absolute
responsibility for decision-making were important items in accounting for the decrease. That is, those women who had abrogated the responsibility for decision-making to their partners experienced a decreased degree of happiness in their postpartum marital relationship.

Cowan and Cowan (1992) recently published the results of their longitudinal study, the “Becoming a Family Project”. They followed 96 couples, 72 expectant couples and 24 non-parents, over a ten-year period, from the onset of pregnancy until the child’s kindergarten year. Of particular note are the findings that couples who reported the most marital difficulty postpartum tended to be the ones who were experiencing the most strain in their relationships before they became parents; and the couples who felt that they had productive ways to handle conflict reported the least dissatisfaction and distress in the first years of parenthood.

Cowan et al. (1985) suggest that men and women segue from couplehood to parenthood with different transitional issues to attend. They write

... husbands and wives also travel different paths into parenthood. His transition begins more slowly, first putting him in touch with the father’s role of provider. Many men then become more actively involved in their children’s birth and early care, but they do not become as involved as they expected to be during the first year of parenthood. Her transition involves a more radical shift from the world of work to home, with a significantly larger portion of her self devoted to the care and nurturing of the baby. “Their” transition is defined by the fact that beyond their different experiences of the transition, both men’s and women’s parent aspect of self seems to expand, the partner/lover aspect gets squeezed, and marital conflict increases. . . it is not merely a growing difference and rising conflict that determines the quality of their marriage. Rather, it is how effectively parents learn to work together to meet these challenging changes that differentiates couples who adapt well from those who experience distress during their transitions to parenthood. (p. 477)

Although their foci were different, often addressing specific issues, these studies provide some affirmation for the question posed in Subproblem 2 of this study: ‘Does the rapid reorganization of the childless dyad into a three-party family system pact on their marital system?’ It seems certain to say that the movement from couplehood to parenthood does have
costs. These costs and their relationship to differentiation from the family of origin will be further explored in this study.

**Infant-Parent Attachment**

The postpartum marital relationship can also be examined with respect to parent-infant attachment. Attachment theory (Ainsworth, Blehar, Waters, & Wall, 1978; Ainsworth & Wettig, 1969; Bowlby, 1958; 1969; 1973; 1980) is a common theoretical approach to the study of parent-infant/child relationships. Attachment theory focuses on parents as protectors and providers of security, and holds that infants are active participators in the parent-infant interactions, initiating behaviours that will elicit response and attention from a parent, usually the mother.

Goldberg (1991) writes that

"Since infants’ survival depends on the care they receive from adults, there is a genetic bias among infants to behave in ways which maintain and enhance proximity to caregivers and elicit their attention and investment. A complementary evolutionary history biases adults to behave reciprocally. (p.393)

Infant-parent attachment is a foundation for the future security of the yet-to-be adult. The quality of the postpartum marital relationship can impair or enhance the building of this foundation. Howes and Markman (1989) conducted a longitudinal study to determine whether premarital and postpartum marital traits of the new parents’ relationship would impact on the functioning of the child. Twenty families (39 parents) with children between one and three years old completed measures of marital satisfaction, conflict, and communication at three times: premarriage, postbirth, and three to five years later. Parents also completed descriptions of their child postbirth, with respect to security of attachment, sociability, and dependency.

Study findings indicated that there was a predictive association between mothers’ premarital relationship quality and later child security of attachment and sociability and fathers’ premarital relationship quality and child dependency three to five years later. Children of more
maritally-dissatisfied fathers tended to be more dependent, while children of more maritally-dissatisfied mothers tended to be more insecure and unsociable. These findings indicate that the quality of the parents’ relationship before marriage as well as after the child is born relates to subsequent child-functioning (Howes & Markman, 1991).

**Summary**

Postpartum adjustment is a multi-faceted experience for most new parents. Women must come to grips with the identity crisis they may experience as they take up the mothering roles and begin to articulate a philosophy of motherhood. Physical recovery, sleep deprivation, and difficulties with breastfeeding, when coupled with the role gain and role strain that characterize the early parenting weeks, may compound the adjustment difficulties inherent in any life transition or crisis.

New fathers must also begin to integrate the new roles and responsibilities of parenthood into their repertoire of adult behaviours. They may experience psychosomatic complaints that mimic the woman's experience, and transient psychological and emotional distress that parallels her experience. In addition, they may feel supplanted by the baby, acutely feeling the loss of the woman’s attention.

The marital relationship may be at risk if the sudden reversion to the traditionalism that characterizes the transitional family in the early postpartum weeks threatens a woman's sense of autonomy and self-identity. Marital tension can also be a product of the inequity of the postpartum division of labour and the sheer repetitiveness and boredom of women's work that revolves around caring for a new baby. Furthermore, those couples who married and became parents because of cultural or familial coercion may well begin to reflect negatively on their new status as parents, resenting the changes wrought by the intensity of the postpartum crisis.

Most couples experience a decline in marital satisfaction after the birth of the baby. The strongest predictor of the health of the postpartum marriage is the health of the relationship before the baby is born. Couples with effective strategies for managing conflict and
communicating concerns experience the least dissatisfaction in their marital relationship in the early postpartum years.

The age of the baby is also a factor when considering the postpartum marital relationship. Couples with babies under one year reported more marital satisfaction than did couples with babies who were two years of age. The honeymoon period in the first postpartum year that occurs after the birth of each child may act to decrease the marriage dissolution rate for this group of parents. However, the dissolution rate increases with the age of the infant. In addition, the quality of the marital relationship may also be a factor in determining the quality of the infant-parent attachment.

This section of the literature review has focused on the actual physical and psychological experiences of most new parents in the early postpartum months. Considering all the changes new parents will experience, it certainly appears that they do not have an 'easy row to hoe' in their new roles. In addition, this literature directly relates to the study question, whether the movement from a childless couple to a three-party system has costs for the marital relationship of the new parents. The answer appears to be a resounding 'yes'. How these costs will be managed may be predicated on the differentiation the new parent has experienced from his/her family or origin. The next section of the literature review will outline the various differentiation issues that may be called into play during the transition to parenthood.
Family Systems Theory

Overview

Family systems theory, which focuses on the positioning of individuals on a continuum of differentiation or fusion in their family of origin, is a particularly fine screen upon which to project the experiences of new parents after the birth of a first child. Family therapists (Bowen, 1981; Carter & McGoldrick, 1980; Kerr & Bowen, 1988; Lewis, 1988a; 1988b) argue that birth is a critical stage for the young family to weather as the marital system makes space for a new family member and the nuclear family realigns with the extended family (Midmer & Talbot, 1988). Poor levels of differentiation and individuation in new parents can exacerbate stress and anxiety levels within the family system and can result in varying degrees of dysfunction in the nuclear and extended family (Bowen, 1981; Kerr & Bowen, 1988).

Family systems theory is a way of looking at how families operate, with respect to the communication and behaviour patterns among family members. The family systems movement developed within psychiatry after World War II (Bowen, 1981). It subsumes into its conjecture the underpinnings of early psychoanalytic theory (Freud, 1913; 1924), object relations theory (Klein, 1964), as well as general systems theory, or cybernetics (von Bertalanffy, 1968).

Bowen (1981) writes that

[w]hen the observing lens is opened to include the entire family field, there is increasing evidence that man is not as separate from his family, from those about him, and from his multigenerational past as he has fancied himself to be. This in no way changes what man is or has always been. He is as autonomous as he has always been, and he is as “locked in” to those about him as he has always been. The family focus merely points to ways that his life is governed by those about him. (p. 370)
Key concepts have been developed by family systems theorists to describe family relationships, family process, and the development and transmission of interactional patterns across generations. Kerr and Bowen (1988) have written about concepts that include impact of family of origin, differentiation of self, fusion, chronic anxiety, nuclear family emotional process, triangulation, emotional cut-off, multi-generational transmission process, family projection process, and covert loyalties. Williamson and Bray (1988) have elaborated on issues of intimacy, intergenerational intimacy, intergenerational intimidation, and personal authority in the family system (PAFS).

The Family of Origin

The family of origin, or the first family, is a powerful force in the development of relationships within the nuclear family and the subsequent family of procreation. The family of origin experiences of the child become a springboard for the interpersonal relations of the future adult. Framo states that “of all the forces that impinge upon people (culture, society, work, neighborhood, friends, etc.), the family by far has the greatest imprinting influence” (1981, p.133). Interpersonal successes and/or failures in adult life often owe their genesis to the early experiences in the family of origin, in particular to the early parent-child relationship and interactions (Ainsworth et al., 1978; Ainsworth & Wettig, 1969; Bowlby, 1958; 1969; 1973; 1980). Yet too often, the influences of the family of origin are ignored or rejected as sources of behaviour motivation in interpersonal relationships. Williamson writes that

... relatively few people are aware of how they continue to be influenced and controlled in their behaviour by the unachieved goals and the unresolved problems of the parental and grandparental generations. (1978, p.94)

Framo describes an intergenerational relational process, asserting that

[w]henever a group of people are closely related to each other, as in a family, they reciprocally carry part of each other’s psychology and form a feedback system which in turn patterns and regulates their individual behaviors. The creative leap of this family-system theory was the recognition of this interlocking, multi-personal motivational system whereby family members collusively carry psychic functions for each other. (1982, pp. 195-196)
Considering this intergenerational and interpersonal perspective, feedback is an important component within the multigenerational family system. Framo further asserts that "current family and marital difficulties stem largely from attempts to master earlier conflicts from the original family; these conflicts . . . are lived anachronistically through the spouse and the children" (p. 192). The circular, cybernetic aspects of these interpersonal relations often mire individuals in relational processes that are not only dysfunctional but also motivated at an unconscious level.

So deeply embedded and unconscious are the ancestral ties that bind, individuals in families are often only rarely aware of these multigenerational influences on their roles and behaviour, since

[the “family way” of seeing things and doing things becomes automatic and unquestioned, like the air one breathes. It is very difficult for anyone, no matter how grown-up or mature, to avoid the family role assignment when he is in the presence of his family. (Framo, 1982, p. 32)

Framo (1976) articulates some of the main concepts of early family systems theory when he describes styles of functioning in families, including styles that are autonomous, superficial, fused, or alienated. Individuals who relate in an autonomous, or differentiated style are able to view their parents objectively, with a minimum warping of their views of family reality. Although a superficial style appears to contain some elements of the autonomous style, the individual relates situationally and superficially, and attempts to minimize, deny, or gloss over any dysfunctional family history. Fused, or undifferentiated, individuals, although often appearing as having a warm and close relationship with their family, are in reality over-involved and unable to function with autonomy, or establish peerhood with their parents. Whereas those individuals who are alienated, in contrast to their fused counterparts, are unable to handle the emotionality within the family system and cut themselves off, increasing the likelihood that they will continue to repeat the old ineffective and conflicted behaviours.
Within this framework, members in an undifferentiated family are maintained in a dance of dysfunction, unconscious of the multigerational transmission of roles and behaviours since

... parents cannot see or act toward their children or each other as they are but, instead, as screens to project on or as imagoes through whom they can work through past, unsatisfied longings and hurts which stem from their own original experiences with their own families. Each family, then, has its own fossil remains which are preserved from past generations and largely determine what goes on in the present. (Framo, 1982, p. 68)

**Differentiation of Self**

A fundamental tenet of family systems theory is the concept of differentiation of self. Bowen (1972; 1978; 1981) and Kerr (1981; 1985; 1988) were principals in the development of this theory which focuses on two counterbalancing life forces that exist in all relationships. They describe a theory that

... assumes the existence of an instinctually rooted life force - *differentiation*, or individuation - in every human being which propels the developing child to grow to be an emotionally separate person, with the ability to think, feel, and act for him/herself. Also assumed is the existence of an instinctually rooted life force - togetherness - that keeps the members of a family emotionally connected and operating in reaction to one another. The result of these counterbalancing life forces is that no one achieves complete emotional separation from his family; the early attachment is never resolved. (Kerr & Bowen, 1988, p. 41)

Searles concurs, stating that “individuation is not a once-and-for-all, irreversible process. ... A healthy adult ... lives a daily and yearly life which involves, in its most essential ingredients, experiences - whether measured in moments or phases of his life - of symbiotic relatedness and re-individuation” (1973, p.250).

Using examples from different stages of the life cycle, Karpel defines individuation as

... the process by which a person becomes increasingly differentiated from a past or present relational context. This process encompasses a multitude of intrapsychic and interpersonal changes that share a common direction. In different relational contexts, the specific changes may vary greatly. They may involve an infant’s gradual realization that
the source of his gratifications is an object, a body, which is separate from his own and which becomes for him "mother"; an adolescent's determination to violate an unwritten family rule that mother chooses all the children's clothing; a husband's struggle to see himself as capable of surviving without the painful relationship that exists between his wife and himself; a mother's recognition that her child is, in fact, not as anxious, dependent, shy or whatever, as she has felt herself to be. Individuation involves the subtle but crucial phenomenological shifts by which a person comes to see him/herself as separate and distinct within the relational context in which s/he has been embedded. It is the increasing definition of an "I" within a "We." The term "fusion" is used to describe the person's state of embeddedness in, or undifferentiation within, the relational context. The essence of this perspective is the perception of the process of individuation and fusion as a universal developmental and existential struggle and as a fundamental organizing principle of human growth. (1976, pp. 66-67)

Kerr and Bowen (1988) theorized that three different subsystems drive human behaviour: the emotional, the feeling, and the intellectual systems. The emotional system is broadly defined as a "naturally occurring system in all forms of life that enables an organism to receive information (from within itself and from the environment), to integrate that information, and to respond on the basis of it" (p.27). They further comment that

Family Systems Theory postulates that the operation of the emotional system reflects an interplay between two counterbalancing life forces - individuation and togetherness . . . the development of physical, emotional, and social dysfunction bears a significant relationship to adjustments people make in response to an imbalance of individuality and togetherness in a relationship system. (p. 59)

The feeling system differs from the emotional system in that feelings are "felt" not just experienced and so provide the individual with a cognitive awareness that is deeper than superficial emotions. By bringing both instinctive and unconscious affect and cognition to the experience, the feelings become more complex. For example, individuals "feel" guilt, shame, jealousy, and rejection. These feelings require some degree of filtration through the individual's sieve of past memories and experiences. The intellectual system refers to an individual's thinking brain, and the actions of cognitive discrimination and objective observation of nature.

However, this objectivity may be compromised by the influence of the emotional and feeling

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4 Although the intellectual system may become fused with the emotional and feeling systems in undifferentiated individuals, Kerr and Bowen (1988) were clear that differentiation levels and degrees of fusion were not tied to psychopathology, to a lack in cognitive ability, or to personal effectiveness and efficacy.
systems, on either an acute or chronic level. The resulting fusion of these three systems in an individual then results in a state of undifferentiation (Kerr & Bowen, 1988).

Within the family system, the mutual interaction of the three subsystems - emotional, feeling, and intellectual - creates an emotional field that is contributed to by all members and in turn influences the behaviour of all members. Individuals begin to occupy different reciprocal functioning positions that have a considerable influence on their beliefs, attitudes, values, feelings, and behaviour. Expectations of other family members that relate to any specific functioning position can entangle an individual into "stuck" behaviours from which certain personality traits begin to develop (Kerr & Bowen, 1988).

Differentiation of self involves processes both within individuals and within their relationships with others (Bowen, 1978; Bray & Williamson, 1987; Kerr, 1981; Kerr & Bowen, 1988). People operate on different levels of differentiation depending on the degree of emotional separation they experienced and achieved within their family of origin. The ability to discriminate between thoughts and feelings, to control thoughts and feelings, and to take responsibility for any actions resulting from this discrimination process constitutes differentiation of self within the individual (Bray & Williamson, 1987). Papero notes that "... the degree that a family member can maintain the separation of thinking and emotional systems and can guide personal behaviour with carefully thought out beliefs and principles in a highly anxious field, he or she displays a personal level or degree of differentiation” (1983, p.149).

Within the larger system, differentiation involves an ability to function autonomously, with some sense of personal authority, without being controlled by others, responsible for others, or impaired by others (Bray & Williamson, 1987; Williamson 1982a; 1982b). Kerr notes that

> [c]omplete differentiation exists in a person who has fully resolved the emotional attachment to his family. He has attained complete emotional maturity, in the sense that his self is developed sufficiently that, whenever it is important to him, he can be an individual in the group. He is responsible for himself, and neither fosters nor participates in the irresponsibility of others. (1988, p. 41)
Kerr and Bowen (1988) distinguish between *functional* and *basic* levels of differentiation. The *functional* level of differentiation, also called the *pseudoself*, or “pretend self” (Kerr, 1988, p. 43), shifts according to the level of anxiety in the relational system at any point in time. This differentiation is situational and chameleon-like, changing frequently to meet the needs of the family or marital system. The individual is subjectively oriented to the world, since the pseudoself is always negotiable and is changed under pressure (Kerr, 1981). This pattern of interaction would be similar to the superficial style described by Framo (1976).

Papero writes that

*t]he pseudoself covets approval and the person appears to function well when receiving relationship-based approval. In the face of disapproval, however, pseudoself based functioning can decline rapidly or radically change to conform to the demands of the relationship. (1983, pp. 149-150)

Kerr elaborates further that

*t]he functional level can be enhanced or harmed by relationships, drugs, beliefs, cultural values, religious dogma, and even superstitions. It can rise and fall quickly or be stable over long periods, depending largely on the status of central relationships . . . Functional level may be higher at work than it is at home . . . [and] may either increase or decrease after the birth of a child. (Kerr, 1988, p. 42)

However, the *basic* level of differentiation, similar to the autonomous functioning described by Framo, (1976) is called the *solid self* (Kerr, 1981). The solid self operates from a position of non-negotiation and reflects the degree of emotional separation individuals achieve in their family of origin at a bedrock level. The individual is objectively oriented to the world. The basic level is fairly well established by the time a child reaches adolescence, and usually remains fixed for life, although it can be changed by unusual life experiences or a structured effort to increase it (Kerr, 1988, p. 42). “The solid self is made up of firmly held convictions and beliefs that are formed slowly and can be changed only from within the self. Coercion and persuasion from others cannot change them” (Kerr, p. 44).
Therefore, *functional* differentiation is situational and dependent on the relationship processes, while *basic* differentiation is consistent and not dependent on the relationship processes. Furthermore, the basic level of differentiation in an individual is extensively impacted on by the level of differentiation achieved by the individual's parents. Kerr and Bowen write that

> the degree of emotional separation between a developing child and his family influences the child's ability to differentiate a self from the family. . . . In a poorly differentiated family, emotionality and subjectivity have a strong influence on family relationships. The high intensity of emotionality or togetherness does not permit a child to grow, to think, feel, and act for himself. The child functions *in reaction* to others. (1988, p. 97)

This multi-generational process reflects the transmission of levels of either differentiation or fusion to the family system. People leave their families with levels of differentiation that are rarely modified by later life experiences. Only through intensive differentiation therapy, on a long-term basis, can the most noticeable positive movement on the differentiation-fusion continuum occur (Kerr, 1985).

It is important to note, however, that Bowen (1971) does not maintain that lower levels of differentiation are associated with emotional illness, psychopathology, or decreased intelligence. Individuals at either end of the differentiation continuum experience relationship challenges in their day-to-day lives. However, those individuals who are poorly differentiated may experience more stress and anxiety when dealing with these challenges, possibly exacerbating them into long-standing problems that are more difficult to resolve. He writes that

> the lower the person on the scale, the more he holds onto religious dogmas, cultural values, superstitions, and outmoded beliefs, and the less he is able to discard the rigidly held ideas. The lower the person on the scale, the more he makes a federal case out of rejection, lack of love, and injustice, and the more he demands recompense for his hurts. The lower he is on the scale, the more intense the ego fusions, and the more extreme the mechanisms, such as emotional distance, isolation, conflict, violence, and physical illness to control the emotion of too much closeness. In general, the lower the person on the scale, the more the impairment in meaningful communication. (p. 176)
Fusion refers to how "emotionally stuck" individuals are in relationships with others (Bowen, 1978; Kerr, 1981). Kerr maintains that

[f]usion in a relationship can provide both a relief from and a source of anxiety. It is an interesting paradox. The more intense the togetherness needs of the people who comprise the relationship, the more they will look to the relationship to meet those needs and to relieve anxiety. At the same time, the more intense the fusion, the greater the chance that the emotional pressures of the relationship will force them into compromised uncomfortable positions. This leaves people with the dilemma of needing closeness to relieve the anxiety of emotional isolation and needing distance to relieve the anxiety of relationship suffocation. (1981, p. 240)

Individuals who are fused behave in an emotionally reactive, dependent, or irrational manner in relationships, replacing calm objectivity with intense subjectivity. "The level of fusion reflects the degree of unresolved emotional attachment to the family of origin. In families, fusion is indicated by family members' attempts to think for each other, feel for each other, and/or function for each other. When the level of family fusion is high, one or more family members usually develop some impairment or symptom" (Bray & Williamson, p. 33).

Kerr and Bowen write that

[a] child who is most caught up in the family emotional problem separates the least, is the most relationship dependent of the siblings, and "inherits" the most chronic anxiety. A child who is least involved in the family problem separates the most, is the least relationship-dependent of the siblings, and inherits the least anxiety. (1988, p. 117)

In sum, individuals appear to function on a continuum, which features differentiation at one pole and fusion at the other. "People who have achieved the least amount of emotional separation from their families (the most-entangled child in a poorly-differentiated family) have the least ability to differentiate thinking from feeling. People who have achieved a lot of emotional separation from their families (the least-entangled child in a well differentiated
family) have the most ability to differentiate thinking from feeling” (Kerr & Bowen, 1988, p. 78).

**Chronic Anxiety**

Varying levels of anxiety exist within the family system, impacting on the individual’s differentiation of self. Kerr and Bowen assert that

[differentiation of self is one of the two variables or processes defined by family systems theory to explain level of functioning; the other variable is chronic anxiety. The lower the person’s differentiation, the less his adaptiveness to stress. The higher the level of chronic anxiety in a relationship system, the greater the strain on people’s capabilities. . . . Symptom development, therefore, depends on the amount of stress and on the adaptiveness of the individual or the family to stress. (1988, p.112)

Kerr and Bowen distinguish between acute and chronic anxiety, writing

[acute anxiety generally occurs in response to real threats and is experienced as time-limited. People usually adapt to acute anxiety fairly successfully. Chronic anxiety generally occurs in response to imagined threats and is not experienced as time-limited. Chronic anxiety often strains or exceeds people’s ability to adapt to it. Acute anxiety is fed by a fear of what is; chronic anxiety is fed by a fear of what might be. (1988, p. 113)

While both acute and chronic anxiety contain inborn and learned components, learned responses are more important factors in chronic anxiety. “Whereas specific events or issues are usually the principal generators of acute anxiety, the principal generators of chronic anxiety are people’s reaction to a disturbance in the balance of a relationship system” (Kerr, 1988, p. 47).

Kerr further elaborates, writing

[i]t follows that when people maintain comfortable contact with emotionally significant others, they are more likely to adapt successfully to events that are potentially stressful. An example of this is what may occur during a pregnancy. The relationship of the couple may be in harmony and contributing to the emotional well-being of both people until the wife gets pregnant. The anticipated birth can sufficiently disturb the emotional equilibrium in the marriage that one of the two parents-to-be gets into an unfavorable position emotionally. The woman may feel over-loaded by the anticipated responsibility for the infant and want to lean on her husband for more emotional support. The husband

66
may react to his wife's neediness by becoming critical of her and pulling away. His distancing isolates the wife, which further increases her anxiety and yearning for support. Her level of anxiety may remain high for many months, until the family system establishes a new equilibrium that includes the child. Had the husband and wife not been so reactive to each other, they could have adapted to the pregnancy more successfully. (1988, p. 47)

Thus, chronic anxiety tempers the ability of the individual to remain differentiated within the family system. "As anxiety increases, people experience a greater need for emotional contact and closeness and, in reaction to similar pressures from others, a greater need for distance and emotional insulation. The more people respond based on anxiety, the more they are irritated by differences. They are less able to permit each other to be what they are" (Kerr & Bowen, 1988, p. 212). This high degree of anxiety, which can become intolerable during family life transitions and crises, often increases feelings of being overloaded, overwhelmed, and isolated (Kerr, 1988, p. 50). These feelings sometimes propel the individual into relegating the responsibility for their life functioning to another, allowing themselves "to be taken care of, to have responsibility lifted" (Kerr & Bowen, 1988, p. 121).

Alternatively, unable to tolerate the high levels of emotional reactivity and anxiety within the family of origin, individuals will "cut off" emotionally and/or physically in order to deal with this fusion (Bray & Williamson, 1987). Similar to the alienated style of relating outlined by Frano (1976), this emotional distancing, which can manifest itself through infrequent visits or interaction with the family, or through psychological withdrawal or preoccupation when with the family, provides the individual with only a veneer of differentiation.

In order to become "unstuck" from the relationship, individuals must work to eliminate the emotional subjectivity and increase the rational objectivity in their relational processes. However, this process towards change in differentiation can upset the homeostasis of the family system. Even if the equilibrium maintained in the family is abounding with dysfunction, a family system in emotional equilibrium is symptom free at any given level of differentiation (Anonymous, 1972).
Bowen theorized that

[the system is disturbed when any family member moves towards regression. The system will then operate to restore that former symptom-free level of equilibrium, if that is possible. The family system is also disturbed when any family member moves toward a slightly higher level of differentiation, and it will move as automatically to restore the family system to its former equilibrium. Thus, any small step toward differentiation is accompanied by a small emotional upheaval in the family system. This pattern is so predictable that absence of an emotional reaction is good evidence that the differentiating effort was not successful. (1972, p.140)

**Nuclear Family Emotional Process**

In addition, the ability to deal with chronic anxiety and differentiation issues in families is influenced by the differentiation status of the partners in the marital dyad. If the partners in the marital relationship have high levels of differentiation and are able to view the world from the vantage point of objectivity, the chronic anxiety within their dyadic system will be low and their relational patterns will be relatively free from dysfunction. However, in families characterized by little differentiation among members, the fusion exists to the point where the individual and the family become inseparable and subsumed into an "undifferentiated ego mass" (Bowen, 1971).

Bowen writes that

... a conglomerate emotional oneness ... exists in all levels of intensity - from the family in which it is most intense to the family in which it is almost imperceptible. The symbiotic relationship between a mother and child is an example of a fragment of the most intense versions. The father is equally involved with the mother and child, and other children are involved with varying lesser degrees of intensity. The basic notion to be conveyed at this moment is that of an emotional process that shifts about within the nuclear family (father, mother, and children) ego mass. The number of family members involved depends on the intensity of the process and the functional state of individual relationships to the central mass at that moment. (p. 171)
In a family with this undifferentiated ego mass at its plexus, patterns of interaction among the parents and children often become repetitive and may represent communication patterns from past generations. Anxiety experienced by one individual in the undifferentiated family ricochets around the fused system, causing behavioural responses in other family members. While the most-differentiated in the family may escape from being sucked into the generalized, and often dysfunctional, family response to anxiety, the least-differentiated family members often respond to the anxiety most intensely, sometimes using anxiety-reducing techniques, such as triangulation and emotional cut-offs.

**Triangulation**

Kerr (1988) writes that "the relationship system in families and other groups consists of interlocking triangles" (p.52). Bowen (1971) considered the "triangle" (three-person system) the "molecule" of any emotional system, whether it exists within the family system or the larger social system. Because of the instability that characterizes a two-person relationship, incorporating a third person into a triangulated relational process can stabilize the system. Individuals who are fused with members of their family of origin must detriangulate to free themselves from the enmeshing bonds of the parents (Hovestadt et al., 1985).

Kerr writes that

... the triangle is a paradigm for describing the dynamic equilibrium of a three-person system. The major influence on the activity of a triangle is anxiety. When the level of anxiety is low, a relationship between two people can be calm and comfortable. ... Inevitably some increase in anxiety level disturbs the equilibrium of the relationship. A two-person system may be stable as long as it is calm, but since that level of calm is very difficult to maintain, a two-person system is more accurately described as unstable. When the level of anxiety increases, typically a third person becomes involved in the tension of the twosome, creating a triangle. This involvement of a third person decreases anxiety in the twosome by spreading it among three relationships. This shifting reduces the possibility that any one relationship will emotionally overheat. (1988, p. 52-53).

In triangles, there are two insiders and an outsider. In periods of high tension, the outside position is preferred, in periods of calm the insiders try to preserve what they have while
the outsider tries to break in (Kerr, 1988). In families, Kerr states that "the triangles that involve one's mother are usually the most critical ones. . . . For most people, the relationship with their mother is the one in which their emotional vulnerability is the greatest. . . . The relationship with one's siblings is heavily influenced by the character of the relationship each sibling had with the parents. . . . In general, it is quite difficult to accomplish anything in a sibling relationship until more differentiation has been achieved in relationship to one's parents. . . . While growing up, a person's attitude and way of reacting emotionally to a particular sibling was strongly influenced by having taken sides in the interaction between the mother and that sibling" (p.3).

Kerr goes on to elaborate that

[t]he key to understanding triangles is recognizing that emotionality drives them. The greater the togetherness orientation of the people, the greater the potential anxiety and the greater the likelihood of triangulating. The process is driven by the emotional reactivity of people and the level of emotion that gets attached to a particular issue. Reduction of anxiety and emotional reactivity will reduce the activity of triangles, but the basic pathways remain intact for future use. (1981, p. 242)

In addition, Kerr writes that

. . . triangles are forever - at least in some families. Once the emotional circuitry of a triangle is in place, it usually outlives the people who participate in it. If one member of a triangle dies, another person usually replaces him. The actors come and go, but the play lives on through the generations. Children may act out a conflict that was never resolved between their great-grandparents. So a particular triangle was not necessarily created by its present participants; nor do triangles anew [sic] or completely dissolve with the ebb and flow of anxiety. (1988, p. 53)

This process of triangulation has important implications for the childbearing couple. The birth of the first child also serves as midwife for the birth of the nuclear family triangle, resulting in a renaissance of triangles from generations long past as well as an activation of the critical mother-child relationship. The increased stress and anxiety that are part of the postpartum experience may exacerbate any chronic anxiety already resident in the marital system. Being a new parent involves commitment to learning parenting roles, sharing in infant care-taking tasks, and communicating around toxic issues in a positive way, and the performance
of these basic tasks may be constrained by chronic anxiety, triangulation, and differentiation issues.

New parents with low levels of differentiation may be over-stressed in this situation, for as Kerr and Bowen (1988) state

[t]he higher the level of differentiation of people in a family or other social group, the more they can cooperate, look out for one another’s welfare, and stay in adequate contact during stressful as well as calm periods. The lower the level of differentiation, the more likely the family, when stressed, will regress to selfish, aggressive, and avoidance behaviours; cohesiveness, altruism, and cooperativeness will break down. (p. 93)

Triangulation of the infant as a way to decrease the anxiety in the postpartum marital system might well be used as an avoidance behavior by some new parents. The needs of the infant, whether they be care, nutrition, or support-based, become grist for the triangulation mill. Rather than openly addressing interpersonal issues with communication objectivity, couples might be more inclined to argue about infant issues as a way to decrease the marital system anxiety. In addition, the mother-infant bond may prompt a “sibling rivalry” response by the father, who perceives himself to be at the outside of the new nuclear family triangle.

Emotional Cut-Off

In 1972, Bowen described emotional cut-off by saying “Distance and silence do not fool an emotional system” (p. 136). He was referring to the anxiety-reducing strategy employed by many who cut themselves off from their family of origin believing that this will increase their detachment and objectivity. Kerr comments that “emotional cut-off is a product of people’s emotional reactiveness and the distorted images people hold about one another” (1984, p. 22), and Papero states that “people distance themselves from the family to avoid emotional intensity, yet their reactive need for closeness and intense emotionality leads them into relationships to which they are equally reactive” (1983, p. 151).
According to Kerr (1984), cut-offs can be accomplished in two ways. The first way is through physical distance, such as moving away from the family of origin home and visiting only infrequently. These external mechanisms can give the illusion of having worked out toxic issues in the family, since the emotional intensity of the relationship subsides during the intervals when family members are apart. The second type of emotional cut-off is accomplished through internal mechanisms, whereby the individual withdraws from and avoids emotionally charged interactions with the family. There are many withdrawal mechanisms, from excessive television watching to addictive behaviours, and simple avoidance strategies such as escaping to wash dishes after a family meal rather than staying at the table to discuss highly-charged family issues (Kerr, 1984, p. 249).

Kerr goes on to say that “the more intense the emotional fusion the person experienced while growing up, the greater the likelihood of a significant cut-off later on. . . . Emotional cut-off is an interesting paradox in that it at one and the same time reflects a problem, solves a problem, and creates a problem. It reflects the problem of the underlying fusion between generations. It solves a problem in that, by avoiding emotional contact, it reduces the anxiety of the moment. It creates a problem in that it isolates and alienates people from each other who could benefit from contact with each other if they could deal with each other better” (1981, p. 249-250). Kerr adds that “many people start their new families with a determination to correct what they perceived as their parent’s mistakes. Implicit in this kind of attitude is a denial of one’s own part in whatever problems existed. . . . In general, when a person blames his parents, they will also blame others for problems in their future relationships. . . . Determination alone to change things does not usually work because one’s efforts rest on false assumptions about the nature of the problem” (1984, p. 14).

**Multi-Generational Transmission Process**

In addition, individuals inherit, through a multi-generational transmission process, lesser or greater degrees of differentiation (Bowen, 1978). Bowen describes this process as
[a] pattern that develops over multiple generations as children emerge from the parental family with higher, equal, or lower levels of differentiation than the parents. When a child emerges with a lower level of self than the parents and marries a spouse with equal level of differentiation of self, and this marriage produces a child with a lower level who marries another with an equal level, and this marriage produces one with a lower level who marries at that level, there is a process moving, generation by generation to lower and lower levels of undifferentiation. . . . Along with those who fall lower on the differentiation of self scale are those who remain at about the same level, and those who progress up the scale. (Anonymous, 1972, p. 122)

According to Kerr (1981) "this process describes the ebb and flow of emotional process through generations. . . . To think in these multigenerational terms is to be able to see serious physical, emotional, or social dysfunction in this generation as an end product of an emotional problem that had been growing in the family for many generations" (p. 248).

Over generations, families may move to higher or lower levels of differentiation. Better differentiated individuals and families will experience less chronic anxiety and have less need for stabilizing mechanisms such as projection, triangulation, and cut-offs, and will have less family system dysfunction. Poorly differentiated families and individuals will be less adaptable and more vulnerable to stress, responding with increased reactivity to the chronic anxiety in the family system (Kerr, 1981). Each past generation influences the emotional process of future generations. Although individuals may reject this transmission process and deny this influence, "the greater the denial of the influence of the past, the greater the tendency to replicate the past. Revolting against one's past . . . is a process that prevents change" (Kerr, 1984, p. 32).

**Family Projection Process**

But the past continues to exert itself since fusion or differentiation may be projected onto children through a family projection process (Bowen, 1976). Children who are most emotionally merged with their families will have projected onto their behavioural screens greater or lesser levels of differentiation, which owe their genesis to the past and which act as templates for their future interactions. As Bowen states, " . . . parents project part of their immaturity by focusing on
one of the children; this child normally tends to be the one most emotionally attached to the parents and has the lowest level of differentiation of self" (1978, p. 477).

Kerr expands this stating, “the projection process . . . is a process in which parental emotionality defines what the child is like, a definition that originally may have little to do with the realities of the child, but that eventually does become a reality in the child” (1981, p. 246). These children become more susceptible to anxiety in the family, and as adults, react with greater emotionality and less objectivity in their future families of procreation. Kerr further describes this process by writing that

[a]s an example, a mother who feels insecure about her abilities in interpersonal relationships may manifest this by focusing on any sign in the child that can be interpreted as a sign of similar insecurity in the child. If the mother thinks she sees such a sign, it can quickly become a fact in her mind that the child is insecure. As a result, she increasingly relates to him as if he were insecure and the child is molded by the mother’s anxious focus. The child begins acting more and more in a way that confirms the mother’s original diagnosis. Once this process is established, both the mother and child play equal roles in continuing it. (p. 245)

**Covert Loyalties**

Part of this family projection process is attendant on family loyalty. Loyalty to the family of origin implies a commitment to the family that is built on trust and fairness (Bray & Williamson, 1987). Covert loyalties develop across generations, are transmitted through a multigenerational process (Boszormenyi-Nagy & Ulrich, 1981), and, "fueled by a sense of indebtedness, represent a major source of societal dysfunction in general and marital and family dysfunction in particular" (Williamson, 1981, p. 442). These invisible loyalties operate at an unconscious level and mold and direct individual behaviour (Bray & Williamson, 1987).

Boszormenyi-Nagy and Spark write that

[e]ach family member is constantly subject to varying patterns of expectations to which he/she does or does not comply. . . . The loyal member will strive to align his own interests with that of the group. (1973, p. 97)
These theorists suggest that during any important relational process in the family, ghosts dressed in invisible loyalties are hovering undetected in the background where they impact on and influence behaviour outcomes. Boszormenyi-Nagy and Spark (1973) assert that internalized and unconscious obligations and connectedness within the family are often experienced as duty, loyalty, and obligation. Failure to respond correctly and appropriately to these covert and implicit behaviour prescriptions and admonitions results in varying degrees of guilt within the non-complying family member.

These loyalties arise out of and drive forward the multigenerational transmission process through succeeding generations (Kerr, 1981). For example, unresolved and unexpressed grief in one generation of a family is passed to subsequent generations (Bray & Williamson, 1987; Kerr, 1981). Boszormenyi-Nagy and Ulrich write that

[w]hen imbalances are accrued over the generations, a family’s image of itself is skewed. As individuals grow, they tend to look outside the family, especially to marriage partners, for compensation for those attributes they believe they did not receive in their own families. When a marriage begins with such oppressive expectations, it is difficult for the partners to develop a workable and intimate involvement. (1985, pp. 6-7)

Split loyalties are a related concept, and occur when an individual is involved in a conflicted relational triangle and must choose loyalty to one person at the expense of loyalty to the other (Bray & Williamson, 1987). Boszormenyi-Nagy & Ulrich maintain that

... the point of greatest relational tension, occurs when one person becomes involved with a legacy of split filial loyalty, that is, when the parents set up conflicting claims so that the child can offer loyalty to one parent only at the cost of his or her loyalty to the other. Whereas the term “loyalty conflict” indicates a breach between a trustworthy filial loyalty and a competing peer (spouse) loyalty, “split loyalty” connotes a fragmented primary loyalty or trust base. (1981, p.165)

Both individuals in the marital dyad bring their family of origin to the family of procreation hearth. Covert loyalties, the tugs of generations long past, may first begin to conflict in earnest with the birth of the first child. As Boszormenyi-Nagy and Spark state
One gets married to the wishful improved recreation of one’s own family of origin. Each mate then struggles to unwittingly coerce the other to be accountable for his/her felt injustices and disappointments. (1973, p. 54)

Cowan et al. (1985), referring to new parents’ differing views of reality, suggest that in every entry into parenthood there are really three transitions - his, hers, and theirs. One might easily rephrase this to say that in every postpartum marital relationship there are three parties in the relationship: the husband, the wife, and the family ghost(s).

**Intimacy**

Intimacy is defined as the ability to be emotionally close and vulnerable with another person while maintaining clear boundaries of identity and a core sense of differentiation (Bray & Williamson, 1987; Bray et al., 1986; Williamson, 1981; 1982b). This intimacy is voluntary and can be initiated, received, declined, or terminated at the discretion of the individual. This ability to “own” rather than be “owned by” emotional closeness to another contrasts with fusion, which is an involuntary, emotional "stuck-togetherness" that binds individuals unwillingly in dysfunctional relationships.

Intimacy exists as one pole on a continuum with isolation as the other polar extreme. Intimacy consists of four components: trust, love-fondness, self-disclosure, and commitment, and can refer to how near or far individuals allow themselves to be with respect to another in a relationship (Doherty & Colangelo, 1984; Doherty et al., 1985; Doherty et al., 1987). Hovestadt et al. write that “the healthy family develops intimacy by encouraging the expression of a wide range of feelings, creating a warm atmosphere in the home, dealing with conflicts without undue stress, promoting sensitivity in family members, and trusting in the goodness of human nature” (1985, p. 290).

Williamson (1982b) describes relational intimacy as a fusion-like state that is voluntary entered and departed from at will, while Bray et al. write
[r]elational intimacy includes both intergenerational intimacy within the family of origin and intimacy with peers, particularly with the spouse. “Intergenerational intimacy” means knowing the “persons of” and, therefore, the private meaning of the inner life experiences on one’s “former parents”. (1984a, p. 168)

Kerr maintains that “emotional autonomy is not to be confused with a denial of one’s emotional need for others. Denial can result in a pseudo independent posture toward others and relates to a lack of emotional autonomy. The higher the emotional autonomy or differentiation of self, the greater the capacity to be in close contact with emotionally significant others without having one's thinking, emotions, and behaviour governed by those relationships” (1984, p. 9). In effect, ultimate intimacy requires absolute autonomy.

**Intergenerational Intimacy**

Yet, intimacy with one’s parents is only achieved by decreasing the degree of intergenerational intimidation, described by Williamson as “sourced ultimately in the primitive fear of parental rejection and exposure to death. A second form of intimidation is the fear of being invaded and occupied by the parental spirit” (1981, p. 442). Williamson maintains that a person who has terminated the hierarchical boundary with his/her parents and has “left home” has completed three steps.

The first step in leaving home means

... taking emotional responsibility for one’s life and destiny by assuming a stance of emotional independence as far as basic nurturance or protection from any outside source is concerned. This is implicit in Bowen’s (1978) concept of a “strong I position”. It is the antidote to the danger that the client working toward the differentiation of a self within the family of origin will move the dependency and the fusion from the parents to the spouse. The person who terminates the hierarchical boundary with the parents is much less likely to move dependency to the spouse. (1981, p. 444)

The second step in leaving home includes

... no longer being programmed by the transgenerational script. The adult no longer is compelled to work upon the unresolved problems of the previous generations and no longer has to carry, stored within the body itself, a toxic burden of unmourned loss and
aborted grief, sourced in “forgotten” experiences of the previous generations. The adult is not required to work to reach the unachieved goals of ancestors. He is not obligated to carry ritualized in his personal code the highest family values and ideals. It implies that he no longer needs to carry in emotional vaults the rich affective family heritage, whether soaked up through experience or absorbed unconscious to unconscious, through the uncanny conduits of transgenerational communication of human hurt and rage and grief. (1981, pp. 444-445)

The final step in leaving home means

. . . that the adult generation no longer yearns for validation from the older generation, as far as appearance, job, marriage, children, values, and life style are concerned. Perhaps toughest of all to negotiate, “leaving home” means that the adult is no longer controlled by nor required to make restitution for parental “goodness” or “badness”, or for the more tragic aspects of parent vulnerability and failure whether past or present, real or imaginary. (1981, p. 445)

**Personal Authority**

Without a termination of intergenerational intimidation and the development of intergenerational intimacy, the individual is unable to achieve personal authority in both the family of origin and the family of procreation. Personal authority in the family system (PAFS) relates to the establishment of a peerhood relationship with parents through the termination of the intergenerational hierarchical power structure (Bray & Williamson, 1987; Bray et al., 1986; Williamson, 1981; 1982a; 1982b) and is seen as a synthesizing construct between individuation and intimacy (Williamson, 1982b).

Personal authority exists on a continuum as the opposite of intergenerational intimidation, which is founded on the child’s primitive fear of parental rejection, and, ultimately, death of self (Bray & Williamson, 1987, Williamson, 1981). “Personal authority is reflected in the behavioural patterns that are characteristic of an integrated and differentiated self (Bowen 1978), such as the exercise of choice over individual destiny in life and the pursuit of personal health and well-being” (Bray & Williamson, 1987).
Bray et al. argue that there are three qualifying factors necessary for the development of PAFS, specifically:

The first of these factors is the ability to order and direct one’s own thoughts and feelings, to choose to express or not express these, to respect one’s judgment as an adequate basis for action, and to take full responsibility for the consequences of these actions. Second is the ability to initiate, to receive or to decline to receive intimacy, and to tolerate the same freedom in significant others while simultaneously maintaining clear self-boundaries. Thirdly, PAFS includes the ability to relate to all other human beings, including one’s parents, as peers in the fundamental experience of being human. (1986, p. 424)

Furthermore, Bray et al. contend that two specific tasks are involved in the process of acquiring personal authority in the family. The first is to eliminate the fusion, or emotional dependency upon parents, and relinquish the "need to be parented" since "[n]o further parenting of any sort is then needed, expected, or demanded" (p. 425). The second task involves a declaration to the parent of the opposite sex that the individual is no longer the primary love object in the parent’s life. This declaration deconstructs the long-standing triangulation of the individual in the parental marriage. The authors describe the major questions individuals ask and answer as they develop more personal authority in their family.

The first of these is how to leave the parental home psychologically. This implies getting control over one’s own destiny and recovering aspects of the self that are bound to various significant relationships within the three-generational family system. The second dominant question is how to leave the parental home psychologically and at the same time to stay connected to and intimate with the “former parents”. The goal is to take a strong “I” position and, at the same time, to have an intimate relationship with family members. The overall drama is how to embrace and assimilate one’s history and heritage in an explicit way and simultaneously to transcend the emotionality of the family. (1986, p.424)

Bray and Williamson write that

[Personal authority is reflected in the behavioural patterns that are characteristic of an integrated and differentiated self, such as the exercise of choice over individual destiny in life and the pursuit of personal health and well-being. A person with such personal authority can remain connected and intimate with the family of origin, while
simultaneously acting from a differentiated position within the family of origin. (1987, p. 35)

Furthermore, according to Williamson, personal authority in the family system is not “a personality construct but rather a set of relational skills, interactional behavioral patterns, and, a way of being in the world that can be observed in family interactions and other significant interpersonal relationships” (Bray et al., 1984a, p. 169), often developing during the fourth decade of life (Williamson, 1981). These skills and patterns include the ability

1. to order and direct one’s own thoughts and opinions;

2. to chose to express or not to express these, regardless of social pressure;

3. to make and respect one’s judgments, to the point of regarding these judgments as justification for action. This ability is a kind of “second level” experiencing of the experience of self, of an order which cannot be captured by language. Personal authority is the ability to establish a social-emotional distance within the cognitive process itself, in order to be able to think about “thinking about”. It is the ability to establish a cognitive hierarchy voluntarily and episodically, and to adopt a “meta position” vis-à-vis the internal and external world. All of this implies a renegotiation of invisible loyalties;

4. to take responsibility for the consequences of such action as noted above, indicative of a readiness to take responsibility for the totality of one’s experience of life. To forfeit responsibility for personal experience is to forfeit personal authority in the same measure. To some extent these four points characterize “individuation”;

5. To initiate, or to receive or decline to receive intimacy and social connectedness voluntarily, along with the ability to establish or reestablish clear boundaries to the self, at will. It has been noted earlier that intimacy and fusion are not entirely different psychological states, since subjectively the essence of intimacy is fusion with the other. Intimacy, then, is fusion plus the reciprocal ability, more or less consistently available, to move into or out of the fused state spontaneously or at will;

6. To experience and relate to all other persons, without exception, and therefore including the former parents, as peers in the experience of being human. This requires a termination of the intergenerational hierarchical boundary. Personal authority is the ability to acknowledge in others, and personally to identify with and then to transcend, the absurdity of the human experience. (Williamson, 1982b, p. 311)

It must be noted, however, that, when considering personal authority and intimacy issues, Williamson (1982a) argues for a circular rather than linear perspective on differentiation/
individuation and fusion. He maintains that ‘‘individuation’ is not opposite to or other than ‘fusion’. One is not ‘good’ and the other ‘bad’. Rather ‘individuation-fusion’ is an unending dialectical dynamic in human relationships. If either aspect is denied in one context, it will resurface in another. Neither the individual nor ‘individuation from’ exist apart from the other and ‘fusion with’” (p. 37).

Should the adult not achieve personal authority by the fourth decade of life, Bray et al. argue that hierarchical dysfunction may exist in the intergenerational family system. “This dysfunctional hierarchy results in continuing fusion and triangulation with the parents and the parental marriage on the part of the adult in the second generation” (Bowen, 1978). It also implies continuing covert loyalty commitments to the previous generation(s) (Boszormenyi-Nagy & Spark, 1973; Boszormenyi-Nagy & Ulrich, 1981). This in turn militates against a differentiated self within the family of origin and therefore sabotages personal authority” (Bray et al., 1984a, p. 169). Although most childbearing couples will not be in the fourth decade of life, nevertheless, the process of establishing a peerhood relationship may begin with the birth of the first child of the next generation.

**Differentiation and the Marital Relationship**

If, as Williamson suggests, “relatively few people are aware of how they continue to be influenced and controlled in their behaviour by the unachieved goals and unresolved problems of the parental and the grandparental generations” (1978, p. 84), then early experiences in the family of origin will have a huge impact on the quality, or health, of the marital relationship.

In 1979, when developing definitions and criteria for healthy marriages, Lewis and Spanier articulated three general theoretical tenets: 1) the higher the marital quality in the family of origin, the higher the marital quality in the family of procreation; 2) the higher the happiness in one’s childhood, the higher the marital quality; and 3) the more positive the relationship between an individual and his/her family, the higher the marital quality. Framo concurs, adding that “of all the forces that impinge upon people . . . the family has the greatest imprinting
influence" (1981, p. 133), and that “the greatest gift parents can give to their children is a viable marriage based on each parent having a strong sense of self” (1981, p. 134).

Individuals select dyadic partners who share a similar level of differentiation of self and who have need of the same amount of emotional reinforcement in their relationships (Bowen, 1976; 1978; Framo, 1976). "When people leave their families and form new emotionally significant relationships, they tend to select mates with whom they can replicate the more influential aspects of the relationship process that existed in the original family" (Kerr & Bowen, 1988, p. 167). The old family system is well represented in these new relationships, since individuals bring in tow their baggage of covert loyalties, multigerational triangulation patterns, and anxiety-reduction strategies.

Many unconscious factors contribute to the process of selecting and being attracted to a partner. Framo (1981) theorizes that individuals choose each other on the basis of rediscovering the lost aspects of their primary object relations in their family of origin. These aspects are then projected upon their partner in an attempt to achieve a good "fit" or to develop complementarity. In consequence, marital disharmony occurs as "spouses project disowned aspects of themselves upon their partners and then begin to fight them in their mate" (p. 138). Framo further writes that the "problems that adults have with their spouses are reconstructions and elaborations of earlier conflict paradigms from the family of origin" (1976, p. 185). Bray and Williamson (1988) also concur, and add that impairment with the development of personal authority, individuation, and intimacy within the family of origin will result in a reemergence of these toxic issues within the future family of procreation.

Of singular importance in the marital relationship is the degree of anxiety, either chronic or acute, that is experienced. Kerr and Bowen (1988) assert that the anxiety created within an individual drives him/her into reactive subjectivity, thereby influencing subsequent thoughts, feelings, and actions. This anxiety-driven process triggers a similar response in the other relational partner, causing the dyadic system to whirl about in spirals of emotional reactivity. These emotional whirling dervishes are becalmed intermittently only to be reactivated by some shift in the balance of the dyadic relationship since
People are more reactive to each other's distress and consume more energy trying to avoid saying and doing things that might cause upset. Paradoxically, as one person pushes for more surface calm, the other may feel unresponded to and push for reactions. Perceived slights, hurts, criticisms, and rejections are progressively more influential in people's responses. There is more preoccupation with whether one has 'gotten enough' and/or 'given enough' in the relationship. As boundaries dissolve, there is increased pressure on people to think, feel, and act in ways that will enhance one another's emotional well-being. All these processes contribute to the anxiety people experience while trying to maintain a relationship. (Kerr & Bowen, 1988, p. 77)

Three methods of anxiety reduction predominate in the marital relationship: emotional distance; adaptation to preserve relationship harmony; and the generation of conflict (Kerr & Bowen, 1988). Emotional distance, similar to cutting-off from the family of origin, involves physical avoidance and psychological withdrawal. Emotional and physical intimacy in the relationship are in jeopardy because of this distancing tactic, as are trust, commitment, mutual self-disclosure, and mutual vulnerability.

Adaptation or accommodation "requires that each person give up a little of his individuality or 'self' to mold himself more to the wishes of the other person. The result can be viewed as an emotional trade-off; the threat to togetherness needs is temporarily removed at the price of giving up some individuality" (Kerr & Bowen, 1988, p. 81). "Peace at all costs" is the operational credo with this anxiety-reduction strategy, although eventually the "costs" may be too high leading to "emotional bankruptcy".

Conflict is the third anxiety-relieving strategy. This is destructive conflict that is not undertaken with the final goal of conflict-resolution. Rather, anger and stubborn refusals are used to provide emotional distance and to reduce the threat imposed by the idea of compromise or capitulation (Kerr & Bowen, 1988). Chronically conflicted relationships can develop because of the addictive quality of conflict and the familiarity of anger as a communication modality.

This influence of the family of origin on the marital relationship in the family of procreation has been the subject of research. Fine and Hovestadt (1984) studied the association
between an individual’s perceptions and rational thinking about marriage in general and the level of perceived health, or competent functioning, in his/her family of origin. The Family of Origin Scale (Hovestadt et al., 1985), developed to measure an individual’s perceptions of levels of autonomy and intimacy in the family of origin and a semantic differential scale containing statements that focused on marriage in general were administered to 128 single, never married, undergraduate college students, aged 18-16 years. Those respondents with higher scores on the Family of Origin Scale (FOS), in contrast to those with lower scores, also scored significantly more positively on the perceptions of marriage scale. The authors concluded that higher levels of rationality and better perceptions of marital relationships may be transmitted through the family of origin.

Administering the Family of Origin Scale (Hovestadt et al., 1985) and the Dyadic Adjustment Scale (Spanier, 1976) to 75 couples, Wilcoxon and Hovestadt (1983) attempted to determine the predictive value of four demographic variables (years of marriage to current spouse, number of children living in the home, age, and annual income) and perceived health in the family of origin as determinants of dyadic adjustment. Although perceived health in the family of origin and the four variables were not found to be significantly correlated with dyadic adjustment, the discrepancies between the scores of the husbands and wives on the Family of Origin Scale were found to be significantly and inversely related to dyadic adjustment. That is to say, couples who perceived their family of origin to be similar to their partner’s had better dyadic adjustment scores than did couples who perceived their families of origin to be dissimilar. These findings appear to substantiate the contention that individuals chose marital partners with similar levels of differentiation and similar family of origin experiences (Bowen 1976; 1978; Framo, 1976).

The value of the FOS as a research tool has been contentiously debated, beginning with Lee, Gordon and O’Dell in 1989 who argued that the scale had no research value. Mazur, Mangrum, Hovestadt, and Brashear (1990) countered that “although the FOS measures dimensions that differ somewhat from those hypothesized by the the authors, it has potential value in applied research” (p. 423). Gavin and Wamboldt (1992), using a sample of 63 premartial couples, concluded that a change in interpretation of the FOS scores was needed to make it a reliable measure of the the health of the family of origin, yet Schouten (1994) argues that these claims are “unsubstantiated and potentially misleading” (p. 53). The debate continues about whether the FOS is a multidimensional tool that accurately measures the health of the family of origin, as initially claimed by Hovestadt et al. in 1985, or whether it is unidimensional and in need of further evidence of construct validity. Consequently, the studies cited in this paper that report significant findings using the FOS must be viewed with this unresolved debate in mind.  

84
In an attempt to determine an association between levels of adjustment and years of marriage, Wilcoxon and Hovestadt (1985) administered the Family of Origin Scale (Hovestadt et al., 1985) and the Dyadic Adjustment Scale (Spanier, 1976) to 100 couples who had been married for different lengths of time. Couples were placed into data cells, each representing four years of marriage to a current spouse, which covered a time span from 0-20 years. Discrepancies scores on the Family of Origin Scale were calculated for each couple and correlated with the couple’s score on the Dyadic Adjustment Scale.

Results indicated that couples who had been married longer were better adjusted, and that less discrepancy between the spouse’s scores on the Family of Origin Scale was significantly related to higher scores on the Dyadic Adjustment Scale. Sustained marital satisfaction and marital longevity appeared to be influenced by similarity in family of origin experiences. This association between similar family of origin experiences and dyadic adjustment was also found to be a factor with those couples who had been married for fewer years.

In addition, a decline in the strength of the association between similarity of family of origin experiences and dyadic adjustment was found in long term marriages. Those couples who had been married longer indicated that differences in their family of origin experiences had less impact on their marital adjustment. This may be explained in part by the adaptation and adjustment couples had undergone in order to maintain a long standing marriage. As well, as Bray et al. have maintained (1984a), resolution of personal authority issues usually occurs in the fourth decade when the couples in the study may have been married for 20 years.

From a clinical perspective, Nelson (1987) examined the concept of differentiation in marriages with a symptomatic spouse. Questionnaires, including the Family of Origin Scale (Hovestadt et al., 1985) and the Personal Authority in the Family System Questionnaire (Bray et al., 1984a) were administered to 40 clinical and 20 non-clinical couples. Results indicated that there were no differences in both groups between the spouses’ individual scores of differentiation from their family of origin. This study further reinforces the perspectives of Bowen (1976; 1978) and Framo (1976) that, with respect to differentiation, “like marries like”.

85
In 1991, Cunnington studied the relationship and predictive value of perceived health in one's family of origin, (Family of Origin Scale, Hovestadt et al., 1985) and personal authority in the family system (Personal Authority in the Family System Questionnaire, Bray et al., 1984a) on marital adjustment, (Dyadic Adjustment Scale, Spanier, 1976). Conventionality (Edmonds' Conventionalization Scale, Edmonds, 1967) as well as age and number of years married were also studied in a sample of 66 married couples, residing together, with at least one child.

Results supported the supposition that early family of origin experiences impact on later life functioning, in particular on the quality of the marital relationship. Married couples did have similar levels of differentiation. Personal authority in the family system, once corrected for conventionality, was the only family of origin variable that was found to be significantly predictive of marital adjustment.

However, in this study, an association between personal authority issues and marital adjustment was found only for husbands, and was not supported for wives. In addition, the author found that, contrary to the literature (Bowen, 1978), differences in differentiation, measured by personal authority, were not related to nor predictive of lower levels of marital adjustment. Nor did this study support theoretical perspectives (Bowen, 1976; 1978; Framo, 1976) and research findings (Wilcoxon & Hovestadt, 1983, 1985) that perceived health in the family of origin was a predictor of subsequent marital adjustment.

This last section of literature relating to differentiation and the marital relationship has huge relevance for this study. A principal assumption in this study is that the birth of a first child will have more impact on the marital relationship of individuals with lower levels of differentiation than on the relationship of individuals with higher levels of differentiation. Much of the literature reviewed suggests that the perceived health of one's family of origin and early family of origin experiences have an impact on all future life functions, and that the health of the family of origin is directly related to the health of the family of procreation. This review appears to provide considerable support for this important study assumption.
Differentiation and Postpartum Transition

Few studies have focused on the specific relationship between differentiation of self and the transition to parenthood in new parents or on the impact of the family of origin on the postpartum experience. Clemental and Crockatt (1979), outlining the marital therapy of a couple treated conjointly following the birth of their first child, describe how the birth, a major psychosocial transition or crisis, awakened dormant unconscious conflicts stemming from the couple's experiences of their respective parents' relationships. They remark that

[t]his history illustrates how early experiences of the parental marriage in families of origin are internalized and can significantly shape the children's subsequent marriages. Marriage, conception, childbirth, and childrearing are potent triggers for the return of hitherto repressed identifications with parental figures. With the birth of the first child, in particular, identification with the child and parents reawakens powerful conscious and unconscious memories and conflicts from the earliest stages of childhood and infancy. The 'internal family' deriving from past experiences emerges and interacts with current experiences to shape the new family in which both novel and archaic elements coexist. (p. 168)

Solyom et al. (1981) examined the effect on the mother-infant relationship of the emotional availability of the father. They explored the issue of a lack of reconciliation in a woman's relationship with her mother to determine whether it constituted a risk for the mother-infant pair, and whether the father's support of the mother after birth mitigated this risk.

Three married couples were followed longitudinally as volunteer participants in an infant study program. The couples were young and psychologically isolated from their extended families, receiving no ongoing support. There were significant psychological risk factors in the mothers' backgrounds, and there were major psychological differences in the fathers' backgrounds and in the fathers' behaviours and attitudes during the pregnancy and early postpartum period.

All three of the mothers had significant negative and conflictual experiences with their mothers in their childhood. Only one father had the emotional capacity to be able to provide his wife with adequate support, modeling good "mothering" for his partner. The other two fathers
were psychologically unable to support their wives, becoming withdrawn, absent from the household, and distancing themselves from their fathering responsibilities. In these two cases the marital relationship became endangered and at risk.

The authors concluded that unresolved conflict in the family of origin of the fathers prevented them from nurturing their equally vulnerable partners during the transition to parenthood. The reworking of the relationship with parental figures was seen as a critical component for the healthy psychological preparation for motherhood and fatherhood. Fathers might be called upon to "mother" their wives during this period, a capacity they may lack if they have not resolved their difficulties with their own mother.

Blos (1985) focused on intergenerational separation-individuation issues in the mother-infant pair. He studied mother-infant pairs who attended a child development clinic for mother-infant psychotherapy, a form of psychotherapeutic intervention, where the mother and the infant/toddler are both present in the office. Blos speculated that with each pregnancy and birth, especially the first, the mother experiences a regression that is an essential, normal, and necessary part of motherhood as a developmental transition, or crisis. Old conflicts with her own mother need to be resolved before the new mother can respond adequately and positively to support her baby's growth and development. The new mother must increase her differentiation from her own mother, thereby detoxifying the relationship she is establishing with her infant.

Fraiberg and her colleagues (1980) studied the "Ghosts in the Nursery" and argued that the "unresolved and forgotten trauma, pain, and conflict that occurred between the new mother when she was small and her own mother are unwittingly reenacted in the next generation by the child, now become the mother, and her current infant. The baby becomes the object upon which the mother unconsciously displaces, projects, externalizes, and acts out her strong and conflicted feelings" (Blos, 1985, pp. 42-43).

Colarusso (1990) also focused on separation-individuation processes and explored the effect of biological parenthood on their accomplishment. The first individuation to occur involves the mother-infant pair and requires the resolution of the symbiosis that characterizes
this earliest relationship. The second individuation occurs in late adolescence/early adulthood, when young adults exert their independence and begin, through differentiation processes, to establish a peerhood relationship with their parents.

Colarusso speculates that the third individuation occurs with parenthood when "the child-become-adult" uses her or his physically mature body and still-growing capacity for intimacy to create a new life and assumes the parental role in the separation-individuation process. Parenthood facilitates the third individuation by producing a situation in which infantile themes and relationships can be reworked in relation to phase-specific, adult, developmental tasks and conflicts" (1990, p. 184). By becoming parents, adults are confronted with their own experience of being parented, and their relationship with their mother and father is up for examination. This intense scrutiny of the parenting they received allows the new parent the opportunity to embrace that which was valuable and discard that which was not.

Belsky and Isabella (1985) attempted to study the relationship between recollected experiences in the family of origin and changes in the marital relationship after the birth of the first baby. They hypothesized that a warm, positive experience of parenting in one's family of origin would forecast more positive and less negative changes in the postpartum marital relationship. Their sample consisted of 50 middle-class, volunteer couples who were expecting their first baby. Data were collected in the last trimester of pregnancy and at three months and nine months postpartum. Marital adjustment was measured with the Dyadic Adjustment Scale (Spanier, 1976), a 32-item instrument designed to assess marital adjustment. Parents also completed a 65-item Parental Acceptance-Rejection Questionnaire in the postpartum period.

Results indicated that retrospective reports of how one was reared by one's parents and the quality of the parents' marital relationship in the family of origin reliably predicted changes in marriage from the last trimester of pregnancy to nine months postpartum. Most significantly, husband-wife differences in the evaluations of their marital relationship increased over time when individuals recalled being reared in a cold-rejecting as opposed to a warm-supporting manner, especially if individuals recalled their parent's marital relationship as troubled.
However, Belsky and Isabella caution that the conclusions of this study are not generalizable to a larger population due to the restricted nature of the sample population. Nevertheless, the impact of the family of origin on the postpartum marital relationship was demonstrated to be considerable and needed to be further investigated in a more representative sample.

With consideration for marital and family therapists, Wilcoxon and Cecil (1988) also studied family of origin experiences and the transition to parenthood. Volunteer married couples (n = 118 persons), who were in the third trimester of their pregnancy and who were attending prenatal classes, were recruited for the study. The couples completed the Dyadic Adjustment Scale (DAS) (Spanier, 1976) and the Family-of-Origin Scale (FOS) (Hovestadt et al., 1985) during the last three months of pregnancy and 5-6 months postpartum.

Study findings indicated that those couples with low FOS scores, indicating low differentiation from the family of origin, also recorded low postpartum scores on the DAS, indicating dyadic adjustment concerns. Conversely, those individuals with high scores on the FOS, indicating a higher degree of differentiation, also achieved higher scores on the DAS, indicating a better dyadic relationship. Wilcoxon and Cecil conclude that

the transition to parenthood is less stressful on marital adjustment for husbands and wives with healthy family-of-origin experiences. By contrast, marital adjustment may be impeded by the stress of transition to parenthood for spouses with negative experiences of their family of origin. The study also indicates that perceived healthiness in one's family-of-origin experiences is a more salient consideration than many other variables (e.g., years of marriage, education, income), especially for women. (p.27)

The authors suggest that, as well as discussing the common adjustments most new parents experience after the birth of a baby, an emphasis could be placed on family of origin issues during prenatal classes and/or postpartum classes. An educational intervention of this sort might prevent marital difficulties that emanate from family of origin issues, and that arise in the postpartum period.
This last section of the literature review relates directly to the study hypothesis, that antenatal differentiation from the family of origin has a positive relationship to the postpartum marital relationship. Cited studies suggest that individuals with healthy family of origin experiences may have a less stressful marital adjustment period in the postpartum period. However, further research is needed to determine which particular antenatal differentiation variables, if any, are strongly associated with or predictive of better postpartum marital adjustment. This study will attempt to broaden the understanding of the interplay between differentiation and future life events, and, more specifically, will focus on the marital relationship after the birth of a first child.
Summary

Family systems theory focuses on the process of differentiation of self from the family of origin, and is complex and multi-faceted. Differentiation may not be absolute but may contain an inherent relativism, with individuals experiencing higher and lower levels of differentiation and stronger or weaker “I” positions in different situations. Individuals may present as individuated with a pseudoself, which is negotiable in relationships, as opposed to a solid self, or bedrock base of differentiation, which does not vary situationally. Those with low levels of differentiation respond subjectively and reactively, while those with higher levels tend to be more objective in their relational and behavioural responses. In either case, differentiation levels are representative of the emotional system of the individual and are not in any way tied to psychopathology, lack of cognition, or personal effectiveness in life.

Much of the energy in an undifferentiated family system is used to combat chronic anxiety. This anxiety is long-standing and multigenerational, inherited by one generation from another along with other family memorabilia. Individuals who are undifferentiated, or fused, employ a variety of anxiety-reducing strategies in their relations with their family of origin or spouse. Most notably, they triangulate others into their relationships in a effort to deflect the anxiety onto a third party.

Some triangles in the family of origin have survived several generations and are perpetuated in the subsequent family of procreation. The most crucial triangle exists in the relationship of a child and his/her mother. Relationship problems with siblings are often difficult to resolve until this most basic and important mother-child triangle is addressed. In addition, highly anxious individuals may use emotional cut-off, withdrawal, and emotional distancing as ways to cope with the chronic anxiety in the family system.

The nuclear family emotional process refers to a conglomerate emotional oneness that fuses members of families until they are stuck together. A multigenerational transmission process perpetuates past relationship problems by projecting them onto the contemporary
generation of family members. Individuals may be further stressed by ancient and often covert loyalties that bind them to dysfunctional relationship processes.

Intimacy within the family system refers to the ability to engage and disengage voluntarily from close emotional oneness, with full ownership and responsibility for choosing either relational process. Within the family system, adult children must overcome intergenerational intimidation in order to develop intergenerational intimacy. This intimacy between adult-child and parent occurs with the development of a peerhood relationship. Personal authority in the family system, usually occurring in the fourth decade, involves termination of the hierarchical boundary that exists between parents and children.

Individuals tend to establish spousal relationships with partners with the same level of differentiation. Subsequent problems with marital partners are often continuations and reconstructions of earlier conflicts within the family of origin. Marital adjustment appears to be influenced by childhood experiences of the individual spouses in their family of origin. Never-married individuals who perceive that their family of origin had relational health appear to have more positive perceptions about marital relationships in general than do their counterparts, who characterize their family of origin as less healthy, and who have less positive perceptions about marriage. Married couples who describe their family of origin as having good function also appear to achieve better dyadic adjustment in their family of procreation.

As young adults become biological parents, they may experience a third individuation as they filter their early childhood experiences in their family of origin through the screen of new parenthood. At this time they may begin the process of establishing a peerhood relationship with their parents, thereby slowly increasing their personal authority within the family system and reducing the degree of intergenerational intimidation they may have experienced. The birth of the first child may shift the balance of the dyadic relationship to the extent that the anxiety in the system becomes more difficult for the new parents to manage.

Unresolved issues and conflicts in the family of origin may impact on both the new mother's and new father's ability to provide warm nurturing to either their child or each other.
Recollections of the quality of the marital relationship of their parents may also impact on their postpartum marital relationship, either positively or negatively.

Those individuals who perceived their parent’s marital relationship as problematic may experience an increase in postpartum marital difficulties. The quality of the perceived health of the parental marital relationship and how one was reared by one’s parents is predictive of changes in the marital adjustment of childbearing couples from the last trimester of pregnancy to nine months postpartum. In addition, low differentiation from the family of origin appears to be related to the quality of the postpartum marital relationship. Individuals with low differentiation may experience more postpartum marital difficulties, while individuals with high differentiation appear to have a healthier marriage after the birth of the baby.

Although some studies have focused on the interrelationship between the early experiences in the family of origin and subsequent experiences within the family of procreation, there is only a general understanding that, as might be expected, good experiences in the past lead to good experiences in the future. More research is needed to pin down which pieces of the differentiation puzzle fit most appropriately into the postpartum picture. However, this may be akin to catching a transparent butterfly, for, quite ironically, the subcomponents of differentiation are fused together in an undifferentiated way.

Yet, the Personal Authority in the Family System Questionnaire, as a valid and reliable measure, does allow for some distinction between differentiation issues, and categorizes spousal, intergenerational, and personal differentiation characteristics into discrete subscales. Through the use of the PAFSQ in this study, a clearer picture will be formed of which differentiation issues, if any, impact most significantly on the health of the marital system in the postpartum period.
CHAPTER III

Methodology

The recruitment of the sample population, the sample characteristics, the instruments administered, the study procedures, and the statistical methodology are described in this chapter. This chapter also includes a restatement of the hypothesis and the subproblems addressed in the study.

Overview

This study is a descriptive, short-term longitudinal cohort study of a convenience sample of first-time expectant parents. The main purpose of this study is to examine whether differentiation of self and the relational patterns that new parents experience with their family of origin affect their marital adjustment in the early months after the birth of a first child. Secondary research questions will address whether the birth of the first child impacts on the dyadic relationship of new parents or affects the way they relate to their family of origin. A major assumption in this study is that the birth of the first child is, at least, a life transition and, at most, a crisis in the lives of new parents.

Volunteer pregnant individuals were recruited and asked to complete standardized questionnaires assessing their relationship with their family of origin and their marital relationship both before the birth of their first child, (Time 1), and within 3 to 6 months after the birth of the baby, (Time 2). This study has a simple pretest-posttest group design. In this study, the unit of analysis is the individual. Thirty-five individuals, 17 couples and one woman, answered all the pre- and posttest questionnaires, and 38 individuals answered some of the questionnaires. When applicable, differences in the number of respondents are indicated in the tables.
Study Instruments

After listening to a presentation about the research study, reading a letter describing the study (Appendix A), and agreeing to participate in the study, prenatal respondents were asked to complete the following forms and questionnaires at Time 1:

1. Consent Form (Appendix B)
2. Personal Information Form (Appendix C)
3. Dyadic Adjustment Scale (Appendix D)
4. Personal Authority in the Family System Questionnaire (Appendix E)

After the birth of their infant (Time 2), the subjects were sent an information package with a letter (Appendix F) asking them to provide postpartum information and complete the study questionnaires a second time. These forms include:

5. Postpartum Questionnaire for Mother (Appendix G)
6. Postpartum Questionnaire for Father (Appendix H)

Personal Information Forms

Self-report forms were developed specifically for this study. The antenatal form was used to collect socioeconomic and demographic information from the respondents.

Postpartum Questionnaire

A postpartum form was used to collect information about the birth experience and the health of the infant. (See Appendixes C, G, H) The forms were scrutinized with respect to the study inclusion criteria, which included that the infant was born at full term and that the infant and mother were both within the normal range of good health.
**Dyadic Adjustment Scale-DAS**

The Dyadic Adjustment Scale, developed by Spanier in 1976, was used to measure marital adjustment. The DAS is a 32-item self-report scale with four subscales. Spanier (1989) describes the subscales as,

**Dyadic Consensus** assesses the extent of agreement of partners on matters important to the relationship, such as money, religion, household tasks and time spent together.

**Dyadic Satisfaction** measures the amount of tension in the relationship, as well as the extent to which the individual has considered ending the relationship.

**Affectional Expression** measures the individual’s satisfaction with the expression of affection and sex in the relationship.

**Dyadic Cohesion** assesses the common interests and activities shared by the couple. (p. 12)

The scale has a theoretical range of 1-151. The individual subscales have the following ranges: Dyadic Consensus, 0-65; Dyadic Satisfaction, 0-50; Affectional Expression, 0-12; Dyadic Cohesion, 0-24. Higher scores are related to greater marital adjustment. Scores achieved are situational, and only represent the respondent’s assessment of the dyadic relationship at that point in time.

This scale is based on the Locke-Wallace Marital Adjustment Scale (Locke & Wallace, 1959), a 15-item inventory relating to disagreement, conflict resolution, cohesion, and communication in the marriage. The DAS is an assessment tool for measuring the quality of the adjustment in dyadic relationships whether marital or non-marital. The questionnaire was first tested on 218 married, working and middle-class couples in central Pennsylvania. The DAS is a Likert-format, paper and pencil instrument that takes 5 minutes or less to complete.

**Reliability**

Spanier (1976) found that the reliability for the entire 32-item was quite high at .96. Reliability for three of the different subscales is: Dyadic consensus .90, Dyadic Satisfaction .94,
Dyadic Cohesion .86. Reliability for the 4-item Affectional Expression is .73, a low enough reliability coefficient to dictate caution with the interpretation of results (Fredman & Sherman, 1989).

Validity

1. Content Validity

Spanier (1976) used three judges evaluated the DAS items for content validity. Items were only included if they were: 1) relevant measures for contemporary relationships in the 1970s; 2) consistent with definitions previously suggested by Spanier et al. (1975) for adjustment and its components; and 3) carefully worded with appropriate responses.

2. Criterion-Referenced Validity

Criterion-related validity was determined by administering the test to a sample of 218 married persons and a sample of 94 divorced persons. The divorced sample differed significantly from the married sample (p < .001) using a t-test for assessing differences between sample means (Spanier, 1976). Construct-validity was determined by correlating the DAS with the Locke-Wallace Marital Adjustment Scale. The correlations between the scales was .86 among married respondents and .88 among divorced respondents (p < .001).

3. Previous Studies Using the DAS in Pregnancy

The DAS has been used in previous studies in pregnancy (Midmer et al., 1995; O’Hara, 1985). In a study with a similar sample at the same site of the present study, Midmer et al. (1995) discovered a DAS mean score for couples in the antenatal period to be 117.63 for the total Dyadic Adjustment Scale. Antenatal couples scored 50.21 for Dyadic Consensus, 41.46 for Dyadic Satisfaction, 16.85 for Dyadic Cohesion, and 9.11 for Affectional Expression. All scores decreased in the postpartum period with a total mean score at 6 months postpartum of 114.16. The mean score for the 218 married couples in the original study by Spanier (1976) was 114.8.
**Personal Authority in the Family System Questionnaire-PAFSQ**

The Personal Authority in the Family System Questionnaire (Bray, Williamson & Malone, 1984b) was designed to measure family systems concepts, including individuation, fusion, triangulation, intimacy, isolation, intergenerational intimidation, and personal authority, which originated with Bowen (1978), Boszormenyi-Nagy and Ulrich (1981) and Framo (1981). Personal authority, as described by Williamson (1982b), is the ability to order and direct one’s thoughts, to chose to express or not express these thoughts, to make and respect one’s judgments, to take responsibility for decisions and the consequences of decisions, to initiate or decline intimacy voluntarily, and to relate to others, parents included, as peers.

The entire PAFSQ has 132-items rated on a 5-point Likert scale. The paper and pencil test is lengthy and can take up to 30 minutes or more to complete. It is also somewhat awkward, with a separate answer sheet from the actual question booklet itself, indicating, perhaps, that the tool was designed for the convenience of the researcher not the respondent. The PAFSQ for individuals without children contains 125 items grouped into seven overlapping scales. The Nuclear Family Triangulation Scale was not included as it is based on the relational processes with older children in the family system.

**Scales of the PAFSQ**

1. **Spousal Fusion/Individuation**

These items measure the degree to which an individual operates in a fused or individuated manner in a relationship with the mate or significant other. Spousal individuation is the ability to have an autonomous and self-directed relationship with a spouse, without any control or impairment by the spouse. Spousal fusion is characterized by a high degree of subjectivity and reactivity, which results in impaired dyadic functioning. Individuals with high personal authority would relate to their partners with a high degree of individuation. The scores
on this scale range from a low of 20 to a high of 100. Higher scores indicate more individuation, and less fusion.

2. Intergenerational Fusion/Individuation

These items measure the degree to which an individual operates in a fused or individuated manner with parents, or parent-figures. Similar to the degree of spousal fusion/individuation, the individual with high personal authority in the family system would be individuated from her/his parents, or parent figures. The scores on this subscale range from 8-40, with higher scores indicating more individuation, and less fusion.

3. Spousal Intimacy

The subscale items assess the degree of intimacy and satisfaction an individual has with his/her mate or significant other. Intimacy is defined as voluntary closeness (Williamson, 1982b) and includes dyadic satisfaction, trust, mutual vulnerability, and self-disclosure. High personal authority in the family system is associated with high spousal intimacy. Scores range form 11-55, with higher scores indicating more intimacy.

4. Intergenerational Intimacy

These items assess the degree of intimacy and satisfaction an individual experiences with parents. Similar to spousal intimacy, this measures satisfaction, trust, and closeness with parents. High personal authority correlates with high intergenerational intimacy. Scores range from 25-125, and higher scores indicate more intimacy.

5. Intergenerational Triangulation

The items measure triangulation between a person and his/her parents. Triangles and coalitions in the family are evident when there is high chronic anxiety in the family system. Individuals with high personal authority are able to be more objective and less reactive in their
family relationships, thereby decreasing the use of triangulation tactics to cope with anxiety. Scores on this subscale range from 11-55, and higher scores indicate less triangulation.

6. Intergenerational Intimidation

Items on this subscale assess the degree of personal intimidation experienced by an individual in relation to his/her parents. Parental intimidation is characterized by a need to live up to the expectations of others, with an inability to make decisions and assume responsibility for the consequences of the decisions. Persons with high personal authority are unlikely to be intimidated in this fashion by their parents. Scores range from 29-145, and higher scores indicate less intimidation.

7. Personal Authority

This scale measures the interactional aspects of personal authority in the family system and the ability to have a peerhood relationship with parents. Part of the peerhood relationship involves having a separate and intimate relationship with a mother and a father, rather than with collective “parents”. Subscale scores range from 18-63, with higher scores indicating more personal authority. The individual subscale scores on the PAFSQ and their ranges and interpretations are summarized in Table 1.

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Low</th>
<th>High</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spousal Intimacy</td>
<td>11</td>
<td>55</td>
<td>higher score = more intimacy</td>
</tr>
<tr>
<td>Spousal Fusion/Individuation</td>
<td>20</td>
<td>100</td>
<td>higher score = more individuation</td>
</tr>
<tr>
<td>Intergenerational Intimacy</td>
<td>25</td>
<td>50</td>
<td>higher score = more intimacy</td>
</tr>
<tr>
<td>Intergenerational Fusion/Individuation</td>
<td>8</td>
<td>40</td>
<td>higher score = more individuation</td>
</tr>
<tr>
<td>Intergenerational Triangulation</td>
<td>11</td>
<td>55</td>
<td>higher score = less triangulation</td>
</tr>
<tr>
<td>Intergenerational Intimidation</td>
<td>29</td>
<td>145</td>
<td>higher score = less intimidation</td>
</tr>
<tr>
<td>Personal Authority</td>
<td>18</td>
<td>63</td>
<td>higher score = more personal authority</td>
</tr>
</tbody>
</table>
Reliability

The reliability of the PAFSQ was assessed in two different studies by Bray et al. (1984a). In the first study, the reliability means for the entire test were .90 and .89 respectively. Test-retest reliability estimates were also calculated. The reliability estimates ranged from .55 to .95 with a mean test-retest reliability of .74. A second study (Bray et al., 1984a) produced acceptable reliability with coefficients of .74 to .96. These correspond favorably with the results of the first study described above.

Internal consistency was also assessed using a clinical sample of 83 clients who completed the PAFSQ following therapy. The coefficients of internal consistency of the theoretically constructed scales ranged from .74 to .96 and were all within an acceptable range.

Validity

1. Content Validity

Bray et al. (1984b) evaluated the items for content validity with two different groups. One group was a class of seven advanced psychology students enrolled in a course on family systems theory and the other was a group of nine mental health professionals with extensive training and clinical experience in this area. Items were re-worded, moved to different scales, or deleted based on the evaluations.

2. Criterion-Referenced Validity

Criterion-referenced validity was attempted by comparing the PAFSQ with other instruments used to measure family functioning (Bray, 1984b). These included the Family Adaptability and Cohesion and Evaluation Scales-I (FACES-I) developed by Olson, Bell and Portner (1978) and the Dyadic Adjustment Scale (Spanier, 1976). Overall, the correlations
between the PAFSQ and the FACES-I are very low, which suggests that the test assess different phenomena. This low correlation may also reflect a methodological problem in trying to compare different types of instruments as the FACES-I scales, in contrast to the PAFSQ, are not linear measurements.

3. Correlations with the DAS

Several of the PAFSQ scales correlated significantly with the Dyadic Adjustment Scale (Spanier, 1976), however the largest correlation was between the DAS and the Spousal Intimacy scale (r = .69) (Bray et al., 1984b). This further supports the construct validity of the PAFSQ, as individuals who reported high intimacy with their partner also scored high on dyadic adjustment. Greater dyadic adjustment also correlated with more individuation and less triangulation, and although the correlations were not large, they were all in the predicted direction.

The authors (Bray et al., 1984b) conducted further studies to no avail, in an attempt to achieve larger significant correlations between the PAFSQ and other established questionnaires. These findings of low correlations, although not invalidating of the PAFSQ, appear to indicate that the items in the PAFSQ measure different behaviours and concepts than those measured in other family functioning assessment tools.

4. Construct Validity

Construct validity was found to be good when assessed through a factor analysis of the items in the PAFSQ (Bray et al., 1984b). The factor analysis produced 8 scales which were markedly similar to the 8 conceptual scales. The results of the higher-order factor analysis (Bray et al., 1984a) supported only some theoretical constructs in family systems theory (Boszormenyi-Nagy & Ulrich, 1981; Bowen, 1978; Framo, 1976; Williamson, 1981; 1982b) and served to highlight the complexity that is inherent in relationships between adult children and their parents.
Hypothesis

The research hypothesis in this study is:

Higher levels of differentiation from the family of origin, as measured by the Personal Authority in the Family System Questionnaire in the antenatal period, are associated with a smaller decline in the level of marital adjustment, as measured by the Dyadic Adjustment Scale, from the antenatal to the postpartum period.

The hypothesis will be tested by correlating each subject’s antenatal score on the Personal Authority in the Family System Questionnaire (PAFSQ) with each subject’s change in marital satisfaction (measured by the Dyadic Adjustment Scale [DAS] from the antenatal to postpartum period. The antenatal PAFSQ score is the predictor/independent variable and the change in DAS scores is the outcome/dependent variable.

Subproblems

Of secondary importance is the exploration of the following subproblems:

1. Does the antenatal pattern of relational functioning within the family of origin, as measured by the PAFSQ, change after the birth of the first baby?

2. Is the rapid reorganization of the childless dyad into a three-party family system associated with a change in their marital system, as measured by the DAS?


**Research Population**

Subjects for this research project were couples attending childbirth education classes at Mount Sinai Hospital, Toronto, a large tertiary care facility with approximately 3,500 deliveries annually. Individuals who attend prenatal classes at this hospital tend to be white, educated, predominantly middle-class, married, and professional. Demographic data collected from this population in a previous study (Midmer et al., 1995) revealed that the average age of both the women and men was approximately 30 years. In this study, the majority of the individuals (98%) were married and employed in professional positions (65%), with 42% indicating British ethnicity, 45% indicating European ethnicity, and 13% from other ethnic backgrounds.

**Research Sample**

In this prospective study, a convenience sample was recruited from the individuals attending hospital prenatal classes. Participation was restricted to women who were in the beginning of the last trimester of their first full-term pregnancy. Only subjects in whom the pregnancy was within normal limits were recruited. Following birth, only families with infants who delivered at full term (38-41 weeks) and who were within the normal range of health were retained in the study. As has been previously mentioned, couples who take these classes tend to be well-educated, and exclusion from the study because of English literacy concerns was not an issue. There were no other demographic exclusion criteria.

**Sampling Procedure**

Prenatal learners were recruited at the first class of six different series of childbirth education classes. These classes were sequentially scheduled to start within a three month period. Each prenatal class series at the hospital was enrolled with 10-12 couples. Subjects were approached in the first class of six consecutive class series. It was expected that some individuals might not be in attendance at the first class, or that some would decline to participate in the study. Each prenatal teacher was advised about the study and agreed to allow 10 minutes, either at the end or beginning of the class for discussion of the study.
The purpose of the study was outlined to the group and a letter (Appendix A) describing the study was distributed to the prenatal learners in the first class. The research instruments were administered to the sample population at two different time periods. The first time (Time 1) was in the third trimester of pregnancy. The second time (Time 2) was after the first three months of parenthood. The men and women were asked to sign individual consent forms to indicate that they understood the purpose of the research study and that they agreed to participate.

Those men and women who agreed to participate were each given a package of information containing the study instruments and a personal information form. The participants were asked to complete the forms individually and independently at home, and to return them to their prenatal teacher at their next childbirth class. Participant anonymity was protected by assigning each subject with a numbered code, which was the only identification on the research questionnaires.

In order to determine when to send out the second set of questionnaires, the delivery dates for the study subjects were obtained from the records in the labour and delivery ward. The subjects were sent the second package of questionnaires at the beginning of the third postpartum month. These packages included a separate mother’s and father’s copy of the test materials, and were coded with the same number that was used on the first set of forms. A letter in the package thanked the individual for her/his continued participation in the study, and encouraged him/her to complete the forms individually and return them in a stamped, addressed envelope. Follow-up phone calls were made to the respondents several weeks after the mailing if they had not yet remitted the questionnaires. There was a total of 150 individuals enrolled to attend one of the 6 series of classes (12-13 couples in each class series). Due to the non-attendance of 5 individuals at the first class of their particular series of classes, there was a pool of 145 potential respondents available to complete the forms at Time 1, in the antenatal period.

Of the 145 potential subjects, 8 refused to participate in the study after the presentation of the study in the first prenatal class. One hundred and thirty-seven individuals agreed to
participate in the study, to take the forms home, and to complete them prior to returning to their next prenatal class. Of this group, 20 individuals, did not return their questionnaires in Time 1, although the prenatal teachers reminded the individuals to return their forms and they received a follow-up call. Twelve individuals (6 couples) delivered their baby early and, because they no longer met the inclusion criteria, data on these respondents were not entered into the analyses.

This left a total of 105 subjects, with completed questionnaires at Time 1, to score the questionnaires in Time 2, after the third postpartum month. Thirty-five individuals (33% of the original 105) completed all the questionnaires at both Time 1, in the antenatal period, and Time 2, in the postpartum period. A further three completed some of the forms (n = 38), therefore, the sample sizes vary for the different analyses and this variation is noted in the tables.

Sample Characteristics

1. Demographic Information

Demographic information on the subjects was obtained from a Personal Information Form (see Appendix C). In order to determine whether there was any selection bias with respect to those respondents who filled out the antenatal questionnaire (pretest -Time 1) only, when compared to those respondents who filled out both the antenatal and postpartum questionnaires (posttest -Time 2), scores of the individuals who completed only the pretest were compared with the scores of the individuals who completed both the pre- and posttests.

---

6 The response rate of 34% of the 105 subjects at Time 2, in the postpartum period, was disappointing and a severe limitation to the study, yet it was also understandable. The literature is clear that new parents are often sleep-deprived, strained with new roles, and generally stressed. The Personal Data Form and the DAS are easy to complete. However, the PAFSQ is not a user-friendly questionnaire, needing focused attention to transfer responses onto a scoring sheet that is separate from the questionnaire itself. The time and attention needed to complete this questionnaire may not have been available for over-extended new parents. In order to increase the response rate, follow-up calls were made to the respondents, who often replied that the questionnaires were “in the mail”. Since the babies were getting older (age range from 7 - 28 weeks), comparisons of the parenting experiences of the subjects were becoming more difficult. Consequently, no further data were collected after 38 subjects had responded. However, the hypothesis was to be tested using multiple regression methods, and this sample was acceptable. Norman and Streiner (1994), (citing Kleinbaum Kupper, & Muller, 1988), indicate that the formula to calculate sample size when using multiple regression is simple: “Sample size = 5 (or 10) x the number of [independent] variables” (p. 116). There were 5 subscales of the PAFSQ entered into the equation, indicating that a sample of 38 respondents would be adequate.
Comparisons of means using t-tests were used to analyze differences in the two groups with respect to the following variables: age, years married, number of children from a previous relationship, years of education, and weeks pregnant (gestational age). As indicated in Table 2, the groups did not differ significantly with respect to these demographic variables, although there was a trend approaching significance (p. = >.05 and <.10)\(^7\) that the gestational age of the pretest only people was slightly higher than those who completed the pre- and posttests.

### Table 2. Demographics of Pretest Sample Compared to Pre- and Posttest Sample

<table>
<thead>
<tr>
<th>Variables</th>
<th>Pretest Only</th>
<th>Pre- &amp; Posttest</th>
<th>Significance*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>mean</td>
<td>n</td>
</tr>
<tr>
<td>age</td>
<td>64</td>
<td>30.4</td>
<td>38</td>
</tr>
<tr>
<td>years married</td>
<td>63</td>
<td>3.2</td>
<td>34</td>
</tr>
<tr>
<td>previous children</td>
<td>67</td>
<td>0.04</td>
<td>38</td>
</tr>
<tr>
<td>years of formal education</td>
<td>61</td>
<td>10.5</td>
<td>35</td>
</tr>
<tr>
<td>weeks pregnant</td>
<td>66</td>
<td>32.6</td>
<td>38</td>
</tr>
</tbody>
</table>

* p = < .05  
† p = > .05 and < .10 (trend)

2. Religion and Ethnicity

Analyses were conducted on religion and ethnicity using Chi square tests. No significant differences in the distribution across categories was detected between the pretest only group and the pre- and posttest group with respect to these variables. These analyses indicate that selection bias related to ethnicity ($\chi^2 = 10.84; df = 6; p = .09$) and religion ($\chi^2 = 4.96 df = 5; p = .46$) were not significant factors in the high attrition rate of study subjects, although there was a trend towards significance (p. = >.05 and <.10) with ethnicity, which may have been a factor in the high attrition rate of respondents. Characteristics of the final sample are outlined in Table 3.

---

\(^7\) Because of the small sample size, trends approaching significance with p values less than .10 but greater than .05 will be reported.
Table 3. Religion and Ethnicity of Pretest Only Compared to the Pre- and Posttest Sample

<table>
<thead>
<tr>
<th>Religion</th>
<th>Pre-Only</th>
<th>%*</th>
<th>Pre- and Post</th>
<th>%*</th>
<th>Ethnicity</th>
<th>Pre-Only</th>
<th>%*</th>
<th>Pre- and Post</th>
<th>%*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catholic</td>
<td>28</td>
<td>43%</td>
<td>15</td>
<td>39%</td>
<td>Eastern European</td>
<td>27</td>
<td>43%</td>
<td>23</td>
<td>61%</td>
</tr>
<tr>
<td>Jewish</td>
<td>19</td>
<td>29%</td>
<td>7</td>
<td>18%</td>
<td>British</td>
<td>14</td>
<td>21%</td>
<td>9</td>
<td>23%</td>
</tr>
<tr>
<td>Protestant</td>
<td>10</td>
<td>15%</td>
<td>7</td>
<td>18%</td>
<td>Asian</td>
<td>4</td>
<td>6%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Muslim</td>
<td>1</td>
<td>1%</td>
<td>0</td>
<td>0%</td>
<td>African</td>
<td>1</td>
<td>1%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>None</td>
<td>4</td>
<td>6%</td>
<td>6</td>
<td>16%</td>
<td>South American</td>
<td>2</td>
<td>3%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>4%</td>
<td>3</td>
<td>7%</td>
<td>Middle Eastern</td>
<td>2</td>
<td>3%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Missing</td>
<td>2</td>
<td>3%</td>
<td>0</td>
<td>0%</td>
<td>Other</td>
<td>10</td>
<td>15%</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Missing</td>
<td>7</td>
<td>10%</td>
<td>5</td>
<td>13%</td>
</tr>
<tr>
<td>Total</td>
<td>67</td>
<td>38</td>
<td></td>
<td></td>
<td>Total</td>
<td>67</td>
<td>38</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* May not add up to 100% due to rounding

(χ² = 4.63; df = 5; p = .46) (χ² = 10.84; df = 6; p = .09)

3. Scores on Instruments: DAS and PAFSQ

Comparisons of means were also computed for the antenatal scores of the pretest only group and the pre- and posttest group on the Personal Authority in the Family System Questionnaire and the Dyadic Adjustment Scale. There were no significant differences between the scores on the DAS achieved by the group who filled them out at Time 1 only, when compared with the antenatal scores achieved by the group who filled them out at both Time 1 and Time 2. There was an interesting finding which approached significance (t = 1.90; p = .060) with respect to dyadic cohesion. The pretest only group, i.e. the respondents who left the study, achieved lower scores than the pre- and posttest group, indicating lesser amounts of dyadic cohesion in the antenatal period.

With respect to the PAFSQ, there was a significant difference on the intergenerational fusion subscale (t = -3.07; p = .003). The group that answered both the pre- and posttests had
lower scores on this scale, indicating that they had more fusion and less differentiation from their family of origin than the pretest only group, who scored higher. Also, there was a trend towards significance on the intergenerational intimacy scale (t = -1.94; p = .055) and the intergenerational triangulation scale (t = 1.80; p = .076). Although they did not reach significance, those subjects who completed this scale only at Time 1 had higher scores on the intimacy scale, suggesting more intimacy with and more differentiation from their family of origin, yet lower scores on the triangulation scale, suggesting more use of triangulation techniques to deal with chronic anxiety within the family system. Data are presented in Table 4.

Table 4. Differences in DAS and PAFSQ Scores of the Pretest Only Sample Compared with the Pre- and Posttest Sample

<table>
<thead>
<tr>
<th>DAS SUBSCALES</th>
<th>Pretest Only mean</th>
<th>Pre- and Posttest mean</th>
<th>2 tail significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dyadic Consensus</td>
<td>59.12</td>
<td>58.16</td>
<td>.505</td>
</tr>
<tr>
<td>Dyadic Satisfaction</td>
<td>41.80</td>
<td>42.22</td>
<td>.657</td>
</tr>
<tr>
<td>Dyadic Cohesion</td>
<td>17.65</td>
<td>18.80</td>
<td>.060†</td>
</tr>
<tr>
<td>Affectional Expression</td>
<td>9.83</td>
<td>9.75</td>
<td>.822</td>
</tr>
<tr>
<td>DAS Total</td>
<td>120.09</td>
<td>120.83</td>
<td>.769</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PAFSQ SUBSCALES</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Spousal Intimacy</td>
<td>50.38</td>
<td>49.97</td>
<td>.702</td>
</tr>
<tr>
<td>Spousal Fusion</td>
<td>58.52</td>
<td>59.27</td>
<td>.615</td>
</tr>
<tr>
<td>Intergenerational Intimidation</td>
<td>105.65</td>
<td>107.14</td>
<td>.637</td>
</tr>
<tr>
<td>Intergenerational Fusion</td>
<td>30.35</td>
<td>27.16</td>
<td>.003*</td>
</tr>
<tr>
<td>Intergenerational Triangulation</td>
<td>26.88</td>
<td>30.65</td>
<td>.078†</td>
</tr>
<tr>
<td>Intergenerational Intimacy</td>
<td>99.85</td>
<td>93.18</td>
<td>.055†</td>
</tr>
<tr>
<td>Personal Authority</td>
<td>44.30</td>
<td>43.16</td>
<td>.462</td>
</tr>
</tbody>
</table>

* p. = < .05
† p. = > .05 and < .10 (trend)
Discussion

In sum, those subjects who filled out the questionnaires at Time 1 only, and then dropped out of the study, appeared to be more differentiated from their family of origin. As a group, they achieved significantly higher scores on the intergenerational fusion scale, indicating that they experienced less fusion with their parents when compared with those subjects who remained in the study and completed questionnaires at both times. This significant difference is evident on only one of the seven PAFSQ scales. However, as a group, although not reaching statistical significance, these respondents also scored higher on the intergenerational intimacy scale, again indicating more differentiation, and lower on the intergenerational triangulation scale suggesting that they dealt with the chronic anxiety in the family of origin with this anxiety-reducing strategy. The analyses indicate that selection bias related to level of differentiation may have been a factor in the high attrition of the study subjects. One can only speculate on the implications of this finding in this exploratory study.

One explanation may be that, since respondents who scored higher on the differentiation scales have less fusion with their family of origin, they may also experience less generalized anxiety because of this decrease in fusion. Higher degrees of differentiation result in decision-making that is more objective than subjective, and responsibility for actions is assumed by the individual. Intergenerational fusion is characterized by a lack of differentiation from parents or parent-figures. The institution of medicine is patriarchal in origin, and the hospital carries many vestiges of this patriarchy. Because of the power differentials in the medical system, doctors are authority-figures, and may also be conferred “father”- or “mother-like” status by young expectant parents. Expectant parents with high anxiety related to intergenerational fusion may be more likely to conform to the study expectations in order to please their physician and other members of the healthcare team.

In addition, because the respondents in this study were attending for prenatal classes in the same hospital where they would be delivering their baby, some of the subjects may have felt a subtle coercion to comply with the study requirements, resulting in an early assumption of the “compliant patient” role. For these subjects, non-compliance might increase anxiety, and those
couples with higher anxiety because of family system fusion might be more reactive to this anxiety, feeling obliged to stay in the study. Conversely, the respondents who scored higher differentiation might be more immune to this pressure to conform, might have felt less coercion to stay in the study, and more freedom to drop out of the study.

Another explanation may be that those respondents who did not complete the posttests may have been experiencing a more difficult postpartum transition period. If the new mothers and fathers were struggling with the diverse and demanding roles and responsibilities of new parenthood, they may have been too overwhelmed and stressed to complete the questionnaires at Time 2. If the differentiation levels of the respondents who dropped out of the study were indeed higher, then higher differentiation may mean these individuals fared worse in the postpartum period. Although this is counterintuitive, this issue needs to be addressed in further studies with larger samples and lower attrition rates, and the results of this study must be interpreted with caution.

**Time Range for Return of Questionnaires**

With respect to the return of the questionnaires postpartum, the range of times for the posttest questionnaires was from seven weeks to 25 weeks after the birth of the baby. The mean age for the infants was 16.5 weeks (SD 3.6). The majority of the posttest questionnaires was returned around four months postpartum.

**Statistical Methodology**

Data for this short longitudinal cohort exploratory study were the scores of the instruments described above. With respect to the study hypothesis, the independent variable for the study is the score achieved on the Personal Authority in the Family System Questionnaire during the antenatal period. The dependent variable is the change score achieved on the Dyadic Adjustment Scale when completed at Time 2, after the birth of the first child. In this study, unless otherwise indicated, the individual’s score is the unit of measurement.
Descriptive statistics were computed in relation to all the variables and the demographic data collected. Using the SPSS Statistical package, correlational analyses and hierarchical regressions were performed on the scores of the different subscales of the study instruments.

**Summary**

In this chapter, the hypothesis and subproblems of the study were reiterated, and the procedures and methodology for the study were described. This description includes the characteristics of the study sample, the development, validity and reliability of the study instruments, the recruitment procedures, and the statistical analyses.
CHAPTER IV

Results and Discussion

In this chapter, the hypothesis and research questions are re-stated. The data analyses used with respect to these questions are outlined. These analyses are based on the scores achieved by the subjects who completed study instruments (PAFSQ and DAS) at Time 1, antenatally, and Time 2, postpartum.

Hypothesis

The hypothesis for the study is as follows:

Higher levels of differentiation from the family of origin, as measured by the Personal Authority in the Family System Questionnaire in the antenatal period, are associated with a smaller decline in the level of marital adjustment, as measured by the Dyadic Adjustment Scale, from the antenatal to the postpartum period.

Analysis

Multiple regression methods were used to determine the statistical relationship between the five subscales of the PAFSQ related to the family of origin, measured prior to the baby’s birth, and the change in dyadic adjustment scores, measured in the postpartum period. The five subscales of the PAFSQ that relate to family of origin functioning (personal authority and intergenerational fusion, intimacy, triangulation, and intimidation) were entered into the regression equation in a hierarchical fashion to determine their relative contribution to the prediction of total DAS scores.

The issue of intimacy guided the hierarchical entry of variables into the regression. The ability to achieve intimacy with another individual, whether marital partner or parent, is
indicative of higher degrees of differentiation (Bray et al., 1984b; Kerr, 1984; Williamson, 1981; 1982b). Consequently, the intergenerational intimacy scale of the PAFSQ was the variable entered in the first block of the hierarchical regression.

Family systems theorists also argue that the development of a peerhood relationship between an adult-child and a parent is also a hallmark of good differentiation (Bray & Williamson, 1987; Bray et al., 1986; Williamson, 1981; 1982a; 1982b). Therefore, the personal authority subscale of the PAFSQ was the variable entered into the second block of the regression analysis. The third block of the regression analysis contained the intergenerational fusion, triangulation, and intimidation subscales as variables. The results were generated by SPSS for Windows Release 6.1, and are presented in Table 5.

These results must be interpreted with caution because of the violation of the basic assumption of independence that occurs with the use of the DAS change scores as the postpartum variable. Although one might argue that the respondents each bring their unique and independent family of origin experiences into their responses on the PAFSQ, their responses to the DAS subscales are not independent of their partner’s responses since they reflect a shared marital experience. Consequently these findings must be considered with this caveat in mind.
Table 5: Hierarchical Regression of Antenatal PAFSQ Subscales Related to Changes in Postpartum DAS Scores

<table>
<thead>
<tr>
<th>Predetermined Variables</th>
<th>Model 1</th>
<th></th>
<th>Model 2</th>
<th></th>
<th>Model 3</th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Beta</td>
<td>Sig T</td>
<td>Beta</td>
<td>Sig T</td>
<td>Beta</td>
<td>Sig T</td>
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</tr>
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<td>Intergenerational Fusion</td>
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<td></td>
<td>-.315521</td>
<td>.4741</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intergenerational Triangulation</td>
<td></td>
<td></td>
<td>.076233</td>
<td>.6597</td>
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<td>Intergenerational Intimidation</td>
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<td></td>
<td>-.102402</td>
<td>.4306</td>
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<tr>
<td>Intercept (constant)</td>
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<td>multiple R</td>
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<td>.42816</td>
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<td>.47043</td>
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</tr>
<tr>
<td>$R^2$</td>
<td>.177</td>
<td></td>
<td>.183</td>
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<td>.221</td>
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</tr>
<tr>
<td>$R^2_{adj}$</td>
<td>.152</td>
<td></td>
<td>.130</td>
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<td>.082</td>
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<td>F test</td>
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<td>3.47</td>
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<td></td>
</tr>
<tr>
<td>signif F</td>
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<td>.043</td>
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<td>.195</td>
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</tr>
<tr>
<td>Number of Cases</td>
<td>37</td>
<td></td>
<td>37</td>
<td></td>
<td>37</td>
<td></td>
</tr>
</tbody>
</table>

Discussion

The variable that showed the greatest correlation with the change in DAS scores was the PAFSQ subscale measuring intergenerational intimacy. The correlation between antenatal intergenerational intimacy and the change in postpartum dyadic adjustment from the antenatal to postpartum period was moderate at 0.42 ($p = .0130$). The adjusted $R^2$, the predictive value of this variable on postpartum dyadic adjustment, was 0.152, indicating that more than 15% of the variation in the postpartum DAS scores was attributable to the antenatal intergenerational intimacy scores on the PAFSQ.
Although the inclusion of the Block 2 variable (personal authority) also resulted in a significant overall equation \( (p = .0433) \), this significance is attributable to the strength of the correlation of the intergenerational intimacy variable. The personal authority variable itself was not significantly correlated with DAS change scores (Sig T = .6515). The addition of Block 3 variables (intergenerational intimidation, intergenerational fusion, and intergenerational triangulation) in the hierarchical regression attenuated the equation to non-significance \( (p = .1950) \) with respect to the change in dyadic adjustment scores in the postpartum period.

Intergenerational intimacy, similar to spousal intimacy, reflects the degree of closeness, trust and satisfaction an individual has with his/her parents. High intergenerational intimacy correlates with higher degrees of differentiation from the family of origin. The ability to enter voluntarily into an intimate relationship with a parent indicates that an adult-child owns rather than is owned by emotional closeness to a parent and contrasts to fusion, which is involuntary, emotional “stuck-togetherness”, a hallmark of dysfunctional relationships (Bray & Williamson, 1987; Bray et al., 1986; Williamson, 1981; 1982a; 1982b).

**Subproblem 1.**

1. **Does the antenatal pattern of relational functioning within the family of origin, as measured by the PAFSQ, change after the birth of the first baby?**

The first subproblem focuses on changes in relational functioning within the family of origin as a result of the birth of a first child. Five of the seven PAFSQ subscales measure factors relating to the new parents' family of origin. These are personal authority, intergenerational intimidation, intergenerational triangulation, intergenerational intimacy, and intergenerational fusion. Paired t-tests were used on each of these subscales to determine any notable differences in means between the antenatal and postpartum periods.
Analyses include only those individuals who responded to the study instruments in both the pre- and post-phases. The antenatal and postpartum scores for the five PAFSQ subscales of interest are summarized in Table 6.

<table>
<thead>
<tr>
<th>PAFSQ Subscale</th>
<th>n</th>
<th>Antenatal Mean</th>
<th>Postpartum Mean</th>
<th>t-tail Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intergenerational Fusion</td>
<td>37</td>
<td>27.16</td>
<td>28.56</td>
<td>0.007*</td>
</tr>
<tr>
<td>Intergenerational Intimacy</td>
<td>37</td>
<td>93.18</td>
<td>94.51</td>
<td>0.227</td>
</tr>
<tr>
<td>Intergenerational Triangulation</td>
<td>38</td>
<td>30.65</td>
<td>30.89</td>
<td>0.432</td>
</tr>
<tr>
<td>Intergenerational Intimidation</td>
<td>38</td>
<td>107.13</td>
<td>107.68</td>
<td>0.381</td>
</tr>
<tr>
<td>Personal Authority</td>
<td>37</td>
<td>43.16</td>
<td>44.56</td>
<td>0.122</td>
</tr>
</tbody>
</table>

* p = < .05

Discussion

In this sample, intergenerational fusion was the only subscale that demonstrated a statistically significant shift in average scores between the antenatal and postpartum periods. The shift represents a 5.2% increase in intergenerational fusion scores from the antenatal to postpartum period, on a scale that has a range from a low of 8 to a high of 40. On this scale, a higher score means that the individual has more individuation/differentiation from the family of origin, and, therefore, is less fused. This result indicates that after the birth of the baby, study subjects experienced significantly less intergenerational fusion and significantly more differentiation from their family of origin.

Becoming a new parent may also have resulted in their becoming a "new" adult in the eyes of their parents. However, these results must be viewed with some caution because of a possible violation of the principle of independence. Although the individuals were responding to
the PAFSQ from the perspective of their own unique family of origin, nevertheless their responses may be tempered by their interdependence in their marital dyad.

**Subproblem 2.**

2. **Is the rapid reorganization of the childless dyad into a three-party family system associated with a change in their marital system, as measured by the DAS?**

The second subproblem considers the effect the birth of the baby has on the marital system, as the transition is made from childless dyad to three-party family. Changes in scores on the four subscales of the DAS and the two subscales of the PAFSQ that address the dyadic relationship (Spousal Fusion/Individuation and Spousal Intimacy) that the individuals achieve at Time 2 when compared with the scores that they achieved at Time 1 could be associated with the effects of the birth of the infant.

In earlier regression analyses, the family of origin subscales of the PAFSQ were correlated with a composite DAS change score (Table 5). However, when considering individual perceptions of the marital dyad, both before and after birth, scores on all four subscales of the DAS (dyadic consensus, dyadic satisfaction, dyadic cohesion and affectional expression) will be reported separately for men and women. The two subscales of the PAFSQ that relate to spousal interactions, spousal intimacy and spousal fusion, will also be included in the analyses.

As in Subproblem 1, paired t-tests were used to measure shifts in ratings of marital adjustment between the antenatal and postpartum periods. A sub-analysis by gender was undertaken to deal with the violation of the assumption of independence that would have resulted from analysis using the whole data set. Tables 7 and 8 summarize the mean scores of the women and the men on each of the four DAS subscales and on the two PAFSQ subscales that relate to the quality of the marital relationship.
As indicated in Table 7, there were significant positive shifts in the women’s scores on the spousal fusion scale of the PAFSQ from Time 1 to Time 2. Higher scores indicate less fusion and more differentiation. There were also suggestions of possible difference in the spousal intimacy scale of the PAFSQ ($p = .066$) and in the dyadic cohesion scale of the DAS ($p = .065$). The lower scores on the spousal intimacy scale suggest that the women were experiencing less spousal intimacy in the postpartum period compared with the antenatal period. The lower scores on the dyadic cohesion scale at Time 2 also suggest a negative shift from the antenatal to the postpartum period, with the women experiencing less cohesion and shared daily activities and interests with their partner.
Table 8: Antenatal and Postpartum Scores on Subscales of the DAS and PAFSQ for Men

<table>
<thead>
<tr>
<th>PAFSQ/DAS Subscale</th>
<th>Time 1 Antenatal Mean</th>
<th>Time 2 Postpartum Mean</th>
<th>1-tail Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAFSQ - Spousal Intimacy</td>
<td>18</td>
<td>48.83</td>
<td>48.05</td>
</tr>
<tr>
<td>PAFSQ - Spousal Fusion</td>
<td>18</td>
<td>57.94</td>
<td>63.16</td>
</tr>
<tr>
<td>DAS - Dyadic Consensus</td>
<td>18</td>
<td>56.66</td>
<td>57.11</td>
</tr>
<tr>
<td>DAS - Dyadic Satisfaction</td>
<td>18</td>
<td>41.66</td>
<td>42.61</td>
</tr>
<tr>
<td>DAS - Dyadic Cohesion</td>
<td>18</td>
<td>18.05</td>
<td>17.11</td>
</tr>
<tr>
<td>DAS - Affectional Expression</td>
<td>18</td>
<td>9.55</td>
<td>8.83</td>
</tr>
<tr>
<td>DAS - Total Score</td>
<td>15</td>
<td>118.05</td>
<td>117.94</td>
</tr>
</tbody>
</table>

* p < .05

Table 8 highlights that there were also significant positive shifts in the men’s scores on the spousal fusion scale of the PAFSQ from Time 1 to Time 2. Higher scores indicate less fusion and more differentiation. This shift corresponds to a similar shift in the women’s scores on spousal fusion in the postpartum period, indicating that there is a mutuality in the decrease in spousal fusion experienced by the men and women after the birth of the infant.

In order to identify differences between the women and men with respect to the significant findings, t-tests were computed for the scores between the groups. Table 9 outlines the differences in scores on spousal fusion between the women and the men at Time 1 and Time 2, and indicates that there were no significant differences between the two groups at each time point. Relevant to both Table 9 and Table 10, as previously discussed, analysis using both sexes violates the assumption of independence since these are composed of couples. Consequently, all findings need to be considered with reservation.
Table 9. Differences Between Women and Men on the Spousal Fusion Scale

<table>
<thead>
<tr>
<th>Spousal Fusion</th>
<th>Women</th>
<th>mean</th>
<th>Men</th>
<th>mean</th>
<th>2-tail Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time 1</td>
<td>n = 18</td>
<td>60.5</td>
<td>n = 19</td>
<td>58.1</td>
<td>.669</td>
</tr>
<tr>
<td>Time 2</td>
<td>n = 18</td>
<td>64.9</td>
<td>n = 19</td>
<td>63.1</td>
<td>.482</td>
</tr>
</tbody>
</table>

Paired t-tests were also computed to determine whether there were any significant differences in the scores on the subscales of the DAS achieved by the men and the women at each time point. This analysis is outlined in Table 10. Dyadic consensus scores for women were higher than the men's scores at Time 1, but at Time 2, women's scores had declined and men's had risen such that there were no significant differences between the sexes. A similar pattern was evident for scores in affectional expression. Women scored significantly higher scores in affectional expression from men at Time 1, but at Time 2, although the scores of both the men and women had declined, there were no significant differences between the sexes.

Table 10. Differences in DAS Scores for Women and Men at Time 1 and at Time 2

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Women Time 1 Mean</th>
<th>Men Time 1 Mean</th>
<th>2-tail Sign</th>
<th>Women Time 2 mean</th>
<th>Men Time 2 mean</th>
<th>2-tail Sign</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dy Consensus</td>
<td>60.52</td>
<td>56.89</td>
<td>.007*</td>
<td>58.76</td>
<td>57.26</td>
<td>.525</td>
</tr>
<tr>
<td>Dy Satisfaction</td>
<td>41.96</td>
<td>41.93</td>
<td>.979</td>
<td>42.93</td>
<td>42.42</td>
<td>.705</td>
</tr>
<tr>
<td>Dy Affect. Exp</td>
<td>10.15</td>
<td>9.42</td>
<td>.042*</td>
<td>9.23</td>
<td>8.68</td>
<td>.427</td>
</tr>
<tr>
<td>Dy Cohesion</td>
<td>18.11</td>
<td>18.00</td>
<td>.847</td>
<td>17.29</td>
<td>17.21</td>
<td>.948</td>
</tr>
</tbody>
</table>

* p = < .05

Discussion

Subscales measuring spousal fusion on the PAFSQ for the whole sample (Tables 7 & 8) indicated statistically significant shifts between the antenatal and postpartum periods. Spousal fusion scores increased from the antenatal to the postpartum period, 7% for women and 9% for
men. Higher scores on the spousal fusion/individuation scale of the PAFSQ indicate more individuation. The achievement of higher scores on this scale may be interpreted to mean that there is an increase in individuation/differentiation by the new parents after the birth of the baby. No significant differences between the women and men were detected on the spousal fusion scale from Time 1 to Time 2 (Table 9).

As indicated in Table 7, there was a finding which approached significance suggesting that women alone showed difference in their spousal intimacy scores from Time 1 to Time 2 ($p = .066$). These analyses suggest that as the women became more differentiated from their partners as individuals, registering significant differences on their spousal fusion scores, they may also have become less intimate and cohesive, although the changes in their scores were not significant.

Although these results regarding postpartum intimacy and cohesion did not reach the level of significance, they are similar to results in previous studies, with larger samples and significant findings, indicating that negative changes in the marital system after the birth of a baby are common (Belsky et al., 1986; O'Hara, 1985; Russell, 1974; Tomlinson, 1987; Waldron & Routh, 1981). Again, the small sample size in this study requires the use of caution when interpreting these findings.

Furthermore, there was also a suggestion of a difference ($p = .07$) on the dyadic cohesion subscale on the DAS for the women only (Table 7). The women achieved lower scores on dyadic cohesion in the postpartum period, suggesting that, after the baby was born, the women were less involved with day-to-day tasks and shared activities and interests with their partner. In order to determine whether there were significant differences in the scores on the DAS achieved by the mothers and the fathers, further analyses were computed.

These findings, reported in Table 10, show that the women indicated significantly more dyadic consensus and affectional expression in Time 1, than did the man. Dyadic consensus and affectional expression differences only reached significance in the antenatal period. These elements reflect the way the women and the men differ in their consideration of their agreement.
over matters important to the relationship, such as money, religion, household tasks, time spent together and their degree of affectional expression and sexual satisfaction.

In sum, the data reported on the whole group (Tables 7 and 8) indicate that the women and the men were less fused with and more individuated from their partners after the baby was born. The mothers showed differences with respect to being less cohesive with their partners regarding shared activities after the birth then they were prior to the birth. Both the women and the men experienced significant decreases in scores in their spousal fusion scores from the antenatal to postpartum period. Further analyses of the sub-groups of women and men indicate that there were no significant differences between the groups with respect to spousal fusion. Additionally, in the antenatal period, the women, in contrast to the men, perceived that there was more consensus and affectional expression in their dyadic relationships. It would appear that the women and the men are both experiencing changes from the pregnancy through to the postpartum period. Some of these changes are mutual and others appear to be gender-specific.

Summary

The study hypothesis was tested using a hierarchical regression of those scales of the PAFSQ that relate to family of origin functioning with the change in DAS scores achieved in the postpartum period. In testing three different hierarchical models to explain changes in the postpartum DAS scores, the model which included only the intergenerational intimacy scale, reached had the highest predictive value ($R^2 = .152$). Intergenerational intimacy antenatally correlated with marital adjustment postpartum. This finding supports the hypothesis in part. Individual differentiation, at least when considered as the achievement of intergenerational intimacy with parents, as measured on the PAFSQ, does modestly predict marital adjustment after the birth of the first child.

The first research question, whether the birth of the infant would be associated with a change in family relational functioning, was also positively answered. There was a significant increase in the intergenerational fusion scores, indicating that the individuals experienced less fusion and more differentiation from the family of origin after the baby was born. This may
indicate that, with the assumption of the roles and responsibilities of new parenthood, the new mother or father is moving towards a peerhood relationship with her/his parents. All other scores on the PAFSQ increased, although not significantly, indicating a similar movement towards increased differentiation to that observed for intergenerational fusion.

With respect to the second subproblem, whether the birth of the baby would be associated with the changes in the marital relationship, this was also answered affirmatively. As the literature has clearly indicated, the postpartum period can be at best a transition, and at worst a crisis, in the lives of new parents. (Dyer, 1963; Hobbs, 1965; Hobbs & Cole, 1976; LeMasters, 1957; Lewis, Owen & Cox, 1988; Russell, 1974). Results indicated both positive and negative changes were taking place. The mothers and fathers achieved significant changes in their spousal fusion scores indicating a movement to less fusion and more differentiation from their partner after the birth of the infant.

Note that the women alone showed differences with respect to decreased dyadic cohesion, which relates to the common interests and activities shared by the new parents. A mother who is focused on recovery from birth, initiating breastfeeding, and providing infant care will be concentrating time and energy on activities that may exclude her partner (Ball, 1987; Brouse, 1988; Dix, 1985; Lederman, 1984; Midmer & Clemmens, 1991; Oakley, 1979; 1980; Sheehan, 1981). A father may also be focused elsewhere, perhaps working longer hours to supplement income, or assuming greater responsibility for household chores (Dix, 1985; Horne & Lupri, 1987; Lamb et al., 1987). This situational narrowing of the range of activities of new parents may also impact on other areas of their dyadic relationship, such as the expression of affection. As has been noted, women, in contrast to men, scored significantly higher on the spousal consensus and affectional expression scales in the antenatal period, indicating that they viewed their dyadic relationship more positively than did their partners in the antenatal period.

The women also showed differences towards less spousal intimacy. Spousal intimacy, a subscale of the PAFSQ that has a strong correlation with the affectional expression subscale of the DAS, relates to affection and sexual satisfaction experienced in the dyadic relationship. The women scored lower scores in the postpartum period indicating they were less intimately
connected to their partners. It is interesting that these scores, representing affection and sexual satisfaction, went down in the postpartum period, at the same time that the fusion/differentiation of the partners, as measured by scores in spousal fusion, also changed after the birth of the infant, with both the women and men indicating less fusion and more differentiation from their partners. That women might construe spousal intimacy and fusion as interdependent concepts, would be an interesting focus for future research into gender-related differentiation topics.

It is also interesting to note that the significant increase in the scores of both the men and women on the spousal fusion scale of the PAFSQ does indicate changes in the postpartum marital relationship. The higher scores indicate less fusion and more differentiation. These scores may indicate that the new parents, with the assumption of parenting responsibilities, are experiencing personal growth, and are re-defining themselves as more individuated and separate from their partner. In addition, the inclusion of the infant in the family may act to divert fusion away from the dyadic partner, which may, for the women, result in their feeling less intimate with their partners. The birth of the first child also gives birth to the family of procreation and the nuclear family triangle. Fusion of the mother with the father may well decrease, but it is possible that his fusion may be replaced by a fused state, not to be confused with good infant-parent attachment, which may become apparent between the mother or father and the new infant.

Again, caution must be used in interpreting these results. Pregnancy is a rarefied, time-limited experience for both women and men. Many couples, thrilled and excited by the prospect of future parenthood, cleave more closely together, perhaps becoming temporarily more fused. The increase in scores on spousal fusion may be an indication of a true post-birth increase in differentiation or may be the reversion to the pre-pregnancy relationship state. It must be noted, that this study was exploratory by nature. Since multiple testes were conducted, some analyses that reached significance may positive by chance alone. Further research is needed with a larger sample and lower attrition rates to determine whether these study results are upheld.
CHAPTER V

Conclusions, Implications, Suggestions for Future Research, and Study Summation

This final chapter will present the conclusions of this study and the implications for clinical practice, marital and family theory, and provider and consumer education. The limitations of the study and recommendations for future research will also be outlined.

Conclusions

The results of this study support those statements in the literature that link early family of origin experiences to functioning in later life and to the marital relationship (Belsky & Isabella, 1985; Bowen, 1978, 1976; Bray & Williamson, 1988; Cunnington, 1991; Fine & Hovestadt, 1984; Framo, 1981, 1976; Kerr & Bowen, 1988; Lewis and Spanier, 1981; Nelson, 1987; Wilcoxen & Hovestadt, 1983; Williamson, 1978). Antenatal intergenerational intimacy, an indicator of differentiation from the family of origin, as measured by the PAFSQ, was correlated moderately with the change in the marital relationship after the birth of the infant.

Those individuals with high antenatal scores on intergenerational intimacy on the PAFSQ also reported less negative change in their DAS scores from the antenatal to the postpartum period. Intergenerational intimacy relates to the voluntary closeness individuals experience in their relationship with parents, and includes trust, mutual vulnerability, and self-disclosure. The ability to be intimate in this way with the family of origin appears to influence the quality of the dyadic relationship observed after the birth of the first child. This finding offers some correlational support for the thesis that there is an intergenerational transmission of factors relating to marital adjustment from the family of origin to the family of procreation.
Study findings also support the contention that an individual who begins to terminate the hierarchical boundary with her/his parents "leaves home", begins to establish a peerhood relationship, and increases her/his personal authority within the family system (Bray & Williamson, 1987; Bray et al., 1986; Williamson, 1982a, 1982b, 1981). The significant increases in intergenerational fusion scores achieved by the subjects in this study indicate that the individuals experienced less fusion with and more differentiation from their family of origin after the birth of the infant. By assuming the roles and responsibilities of new parenthood, an individual moves into a different developmental stage of the life cycle, usually becomes more self-directed, and may be viewed as more of a peer by members of the family of origin.

In addition, although not significant, the women showed decreased scores in dyadic cohesion, as measured on the DAS, and spousal intimacy, as measured on the PAFSQ, after the birth of the infant. These findings support the literature indicating that the birth of a first child has an impact on the postpartum marital relationship (Belsky et al., 1986; Cowan & Cowan, 1992; Cowan et al., 1985; Dyer, 1965; Hobbs, 1965; Hobbs & Cole, 1976; Hoffman & Manis, 1978; LaRossa, 1977; LeMasters, 1957; O’Hara, 1985; Russell, 1974; Terry et al., 1990; Tomlinson, 1987; Waldron & Routh, 1981). Dyadic cohesion relates to the common interests and activities shared by the couple and spousal intimacy measures the individual's satisfaction with and expression of affection and sex in the relationship. The presence of a newborn baby, with non-negotiable and constant needs, will disrupt the pre-baby rhythm of life the couple had previously experienced. With little time in the first months for activities other than attending the baby, a new mother or father may be less available as a social partner for their spouse, and dyadic cohesion may decrease. This lack of couple-time together may, in turn, impact on their level of intimacy.

**Implications**

The results of this study have implications for clinical practice, marital and family theory, and provider and consumer education.
Clinical Practice

The study findings have implications for clinicians who are working with pregnant health care consumers. Family physicians, obstetricians, midwives, social workers, prenatal registration nurses, and public health nurses have opportunities, when caring for pregnant women and their partners, to assess for psychosocial issues. This assessment should include a determination of the quality of the marital relationship during pregnancy as well as an identification of early experiences in the family of origin.

Armed with the knowledge that the degree of intergenerational intimacy experienced antenatally has a direct association with the postpartum marital relationship, and that this intergenerational intimacy is resident in the degree of differentiation achieved from the family of origin, clinicians can provide therapeutic interventions aimed at ameliorating any unfavorable effects from negative family of origin experiences that may impact on the health of the postpartum family system. These interventions may include informing the couple of how the family of origin impacts on their dyadic relationship, discussing the level of intimacy each member of the dyad has achieved with her/his parents, suggesting that the couple attend specialized antenatal classes that focus on the normal postpartum marital adjustment issues, or referring the couple to a marital or family therapist.

Marital and family therapists who work with couples preconceptually can begin to help the individuals unravel the threads of the fabric of their family of origin, determining which threads provide strength in their present lives and which are constricting their behaviours. During the antenatal period, therapists can provide childbearing individuals with anticipatory guidance about the changes in the postpartum period and normalize for them the common changes in the postpartum marital relationship. During the postpartum period, a therapeutic goal would be to help the couple move through the post-birth transition period, with the understanding that, although the family system homeostasis has been disturbed by the birth, a new life balance will eventually evolve.
Therapists can also move the spotlight away from the marital relationship itself and begin to focus on the exploration of family of origin issues and their impact on the family of procreation. The multigenerational influence of the family of origin on all aspects of life lived outside of the parental home (Boszormenyi-Nagy & Spark, 1973; Bowen, 1978; Framo, 1976) is an important integer in the equation of marital happiness achieved by adult-child family members both before and after the birth of a first child.

Understanding that the present marital relationship of the young couple in many ways reflects the marital relationship they observed in their family of origin, Bowen writes that

[F]amilies in which the focus [of therapy] is on the differentiation of the self in the family of origin automatically make as much or more progress in working out the relationship system with spouses and children as families seen in formal family therapy in which there is a principle focus on the marriage....the most productive route for change, for families who are motivated, is to work at defining the self in the family of origin, and to specifically avoid focus on the emotional issues in the nuclear family. (1978, p. 545)

Keeping these perspectives in mind, all clinicians who work with childbearing families can be vigilant and considerate of the impact of the family of origin on their clients.

Marital and Family Theory

The study findings also serve to reinforce what is already known and published in the marital and family systems literature. With respect to the family systems literature, this study supports the contention that the family of origin is related to the marital relationship that develops in the family of procreation, especially with respect to the intergenerational intimacy experienced by childbearing individuals. Differentiation from the family of origin facilitates the voluntary entry into an intimate relationship, and the degree of intergenerational intimacy achieved in the antenatal relationship with parents is a predictor of the degree of change that might be experienced in the marital system in the postpartum period.
This study also supports the concept that differentiation from the family of origin includes the development of a peerhood relationship with parents (Dyer, 1963; LeMasters, 1957; Lewis, Owen & Cox, 1988) or major life transition (Erikson, 1965; Hobbs, 1965; Hobbs & Cole, 1976; Russell, 1974). The "role gain" experienced by new parents often results in "role strain" as new behaviours are integrated into existing repertoires, marital and family communication processes are adapted, and relationships are renegotiated (Brouse, 1988; Dix, 1985; Midmer & Clemmens, 1991; Sheehan, 1981). The birth of a first child establishes the individual more as an adult and less as a grown child in the eyes of her/his parents, resulting in a decrease in intergenerational fusion. A fledgling peerhood relationship, which will ripen with full adult maturation, often becomes first evident with new parenthood (Bray & Williamson, 1987; Bray et al., 1986; Williamson, 1981; 1982a; 1982b).

In addition, the literature pertaining to whether birth is a crisis in the lives of new parents was also supported. The increase in spousal fusion scores indicated that the women and men were experiencing a more differentiated, less fused relationship with their spouse after the birth. However, for women, the birth of a first child can also result in negative changes in the marital relationship that can pull the woman away from her partner, resulting in her assessing the postpartum relationship as less cohesive and less intimate. These findings support the contention in the literature that all couples experience some marital shifts, and support the universality of the experience.

Education Issues

Provider Education

As has been indicated above, providers who care for childbearing families have numerous opportunities to facilitate their successful segue into parenthood. Curricular content focusing on the psychosocial issues that accompany movement into parenthood and the impact of the family of origin on all life experiences needs to be included as basic content in all training programs for physicians, nurses, and midwives. Unfortunately, modern prenatal care is still very
traditional, and has focused almost exclusively on the detection of medical and obstetrical problems, with little emphasis on psychosocial issues (Elbourne et al., 1989).

In contrast, recent publications have not only stressed the importance of assessing for psychosocial issues during pregnancy but have also recommended that such assessment be considered a standard of care (Culpepper & Jack, 1993, Midmer et al., 1996). This professional literature has begun to focus attention on the lack of training around assessment of psychosocial issues. As a result, changes in curricular content at the training schools for the different disciplines and continuing medical education for graduate providers will need to be effected if such assessment does indeed become an obstetrical care standard.

Furthermore, training programs for marital and family therapists and social workers also need to devote curricular time to the discussion of the impact of the birth of the first child on the marital dyad. This understanding of the common changes experienced in the postpartum marital relationship, and the impact of the family of origin on these changes, should be part of the basic training for therapists working with childbearing families.

**Consumer Education**

Another important educational implication of this study is for obstetrical health care consumers. Attendance at prenatal classes focusing on pain management during labour and delivery has become normative for many childbearing families, and has become subsumed into Canadian family-centered maternity care (Midmer, 1992). Those individuals who do not learn through formal classes or who do not attend such classes because of cultural or language differences are often offered antenatal education by prenatal registration nurses, community health nurses, and other community resources through a variety of tailored learning experiences.

Childbearing couples should be encouraged to attend antenatal psychoeducation sessions that focus on providing anticipatory guidance about the transition into parenthood. Sessions and classes that provide such guidance and that explore the impact of the family of origin on the marital relationship in the family of procreation have been found to decrease postpartum anxiety
and increase postpartum marital functioning (Midmer et al., 1995). By introducing antenatal couples to the ghosts of their family of origin, who are their constant companions, they are given the opportunity to embrace those who are constructive and exorcise those who are destructive to their marital relationship.

**Limitations of the Study**

Although this study has considerable implications for clinical practice and education, these implications must be viewed through the filter of the study limitations. This study only collected preliminary data from a very limited sample. Although significant findings and interesting differences were identified, future studies are needed to explore these areas further. Limitations include the self-selection of the sample, violation of the basic assumption of independence, data collection procedures, the demographic characteristics of the sample, the lack of generalizability of the findings, the difficulty with measurement of marital adjustment, and difficulty with the measurement of differentiation.

**Self-Selection of the Sample**

The individuals in this study agreed to participate after hearing about the study focus. They were issued the study questionnaires to take home and complete after they had signed the consent form. As has been described, some individuals did not return the first set of questionnaires and some individuals were removed from the study because they delivered early and no longer met inclusion criteria. In addition to this loss of study subjects, there was a very substantial attrition of study subjects (67%) from Time 1, the last trimester or pregnancy, to Time 2, three months after the birth. This is a severe limitation to the study and makes it impossible to generalize study findings.

Concerns over whether this attrition resulted in a final study sample (the pre- and posttest group) that was significantly different from the initial sample (the pretest only group) were addressed through the analyses of differences in demographic characteristics and in the scores achieved on the questionnaires by the two groups. No significant difference was detected, and
the pre-test only group and the pre- and posttest group were similar with respect to the tested characteristics. Unfortunately, it is not known whether they differed on characteristics that were not available for comparison.

It must be noted that in many of the studies cited in the literature, samples were recruited from clients who were attending health care providers or treatment programs in which they were clients. One can only speculate that those subjects recruited in the office of a provider, who was part of their health care team or connected to their health care team, or by treatment program staff, might feel a coercion, however great or slight, to participate in the study. These subjects, attending for care, might have less freedom to withdraw from the study, especially if a research team member was on site to collect completed questionnaires. In this study, compliance rather than coercion was an operational factor at Time 2, and although it was disadvantageous to the study, subjects had complete freedom to stay in or to leave the study. However, it must be acknowledged that such a high attrition rate is extremely serious.

**Violation of the Basic Assumption of Independence**

A serious limitation of this study is the individual analysis of data on subjects who were recruited into the study as couples. The analyses of the scores on the PAFSQ from Time 1 to Time 2 on an individual basis may be argued from the perspective that each individual has a unique family of origin upon which to base their scores. The analysis of differences in scores from the antenatal to postpartum period by gender violates the basic assumption of independence. Although the women and men were reporting on their experiences within a dyadic relationship, the men and women were intricately joined as couples. The study findings must be interpreted with this caution in mind.

**Collection of Data**

This lack of pressure to remain in the study may account, in part, for the high attrition rate and the small sample size. The completion of the study questionnaires at Time 1, antenatally, was accomplished relatively easily because study subjects were attending prenatal
classes and would return their completed questionnaires at a subsequent class. The completion of questionnaires at Time 2, postpartum, was very difficult. Subjects were sent the posttests in the mail and instructed to mail the posttests back in a stamped envelope upon completion.

Up to three phone calls (more would have verged on harassment) were made to subjects to encourage them to return the postpartum forms, yet few of these forms were actually returned. The conflicting roles and responsibilities of new parenthood, and the sheer volume of time spent in caring for an infant, may have been important factors in the low return rate in Time 2, after the birth of the baby. The small final sample size is a substantial limitation in the study, precluded some statistical analyses, and minimized the likelihood that small effect sizes would reach significance in the analyses.

In addition, the majority of the respondents were couples. Although they were advised to complete the forms independently, there was no guarantee that they fully complied with this request. By having the subjects complete the forms in the unsupervised privacy of their own homes, no control over the way the forms were completed was maintained, and one can only speculate that there is a possibility that the data collected were distorted by respondent collaboration.

**Demographic Characteristics**

The sample in this study was a small and unique demographic group. The subjects were well educated, mature (approx. 30 years), professional and middle class. They had chosen to attend prenatal classes, making it likely that they are different from those individuals who do not choose to attend classes. These individuals may be similar to only a small percentage of childbearing Canadians. However, this demographic group is similar to the samples in studies cited in the literature review (i.e., educated, slightly older, married) and allows for comparisons with other studies exploring family system and marital issues after the birth of a first child.
Lack of Generalizability

The demographic specificity of the sample, as mentioned above, high attrition, and small sample size preclude generalization of study findings to the larger childbearing community, and the study is also limited in its application to other ethnic and socioeconomic groups in Canada. However, because the sample bears strong resemblance to samples in other cited studies, data from this study may have relevance and salience for this small window of childbearing individuals.

Difficulty with Measurement of Marital Adjustment

Situational Nature of DAS Scores

The Dyadic Adjustment Scale is situational in nature, measuring the quality of the dyadic relationship at any given point in time. Because the marital relationship is constantly evolving, scores on the DAS are only transitory. However, the longitudinal nature of the study and the testing of dyadic adjustment at two discrete points in time, which were significant in terms of the research questions, did allow for test score comparisons.

Representativeness of DAS Scores in Pregnancy

Equally problematic is how the scores on the DAS are interpreted. Because of the nature of pregnancy, it is difficult to determine whether the marital relationship in pregnancy is unique and time-limited, and, therefore, not representative of the preconceptual marital relationship, or whether it is a valid representation of dyadic functioning.

New parents will often experience a honeymoon period in the first few postpartum months, when the excitement of birth continues to temper positively the marital relationship (Miller & Sollie, 1980). This rarefied experience of new parenthood begins to dissipate after the first postpartum months. One can speculate that the marital relationship in the last trimester of
pregnancy is a “pre-honeymoon” phenomenon, although it may be too situational in nature to be a valid determinant of the longer-term marital relationship.

The shifts in the DAS in the postpartum period may be viewed from two perspectives. They may indicate that birth has effected an important shift in the dyadic relationship or they may indicate that the postpartum scores may simply be an indication of a return to the preconceptual marital functioning. The professional literature and the results of this study support the first perspective, that birth significantly and negatively impacts on the postpartum marital relationship. However, further studies would need to be undertaken to rule out the second perspective as a possibility.

Additionally, in this study, as in those cited in the literature, birth has been viewed as a crisis or transition in the lives of new parents. An alternate perspective might be that, because of intrapsychic process relating to the woman’s paradigm shift from “woman-without-child” to “woman-with-child” (Lederman, 1984), the woman in the postpartum dyadic relationship relates to her partner in a different way because she is a different woman. If she is a different woman, the decrease in affectional expression and dyadic cohesion are not only understandable but may also be warranted.

**Difficulty with Measurement of Differentiation**

**Quantifying Differentiation**

Quantification of differentiation was never a goal of Bowen’s (1974, 1976, 1978), yet without some quantitative analysis, research into differentiation issues would be possible only through qualitative study designs. Although probably not sensitive enough to measure precisely something so elusive a concept as differentiation, the use of an instrument, such as the Personal Authority in the Family System Questionnaire, is warranted in order to collect data for analysis. Ideally, the process issues and contextual richness of differentiation and its interplay with family relationships and behaviours is best studied qualitatively, yet such studies do not lend themselves to correlational analyses. Using pencil and paper questionnaires to try to determine the degree of
differentiation achieved by an individual is not ideal, yet remains one of the few ways to explore and scrutinize the theoretical concepts.

**Theoretical Gender-Bias**

Equally problematic is the gender-bias that may be inherent in family systems theoretical constructs such as differentiation from the family of origin. Hare-Mustin (1978) writes that “Bowen’s Differentiation of Self Scale (Bowen, 1966) can readily be identified as a sex stereotyped masculinity-femininity scale with femininity at the devalued end....Bowen ignores the fact that women’s socialization encourages them to be emotional and intuitive rather than rational” (p. 184). This argument is consistent with later works by Gilligan (1982), Miller (1984), and Surrey (1984, 1983), which advance the thesis that women are socialized to be connected, nurturant, and attached, characteristics that are often viewed as polar opposites from family system constructs that emphasize autonomy, rationality, and independence as cornerstones of differentiation.

Surrey (1984) emphasizes that women interact in relationships with “response-ability”, ever mindful of the need to respond to others and be responsible for the quality of the relationship. Although this may be viewed as women’s inherent dependency, Lerner (1983) suggests that although women act dependently, they often have a fully differentiated strong self, which is camouflaged for the sake of other family members, particularly the husband (Bograd, 1988). Ironically, Lerner argues that “[T]he weaker sex must protect the stronger sex from recognizing the strength of the weaker sex lest the stronger sex feel weakened by the strength of the weaker sex” (p. 701).

Bograd (1988) further elaborates by writing that Individual growth for women does not necessitate diluting intense relationships or disconnecting from the system. On the contrary, for women, the self develops within a context of relatedness, not by separating from it. Other aspects of the self (such as autonomy, competence, and self-esteem) become articulated through relational experiences of mutual empathy. The mature self — characterized by complexity and
fluidity — co-exists with intense affective connectedness. The goal for women is growth and differentiation within relational systems. (p.74)

These divergent views about women and differentiation are reconciled by Knudson-Martin (1994), who offers three strategies to reconceptualize family systems tenets in a way that includes findings from recent studies in female development. The first strategy involves conceptualizing the feeling system and the intellectual system as parallel and mutually reinforcing, thereby isolating the emotional system as the principal source of the reactivity that defines lack of differentiation. Women should not be considered less differentiated because of their penchant for using their feeling system in a relational context, for “[d]ifferentiated individuals use information from both the feeling and intellectual systems to make choices regarding behavior” (p.42).

The second reconceptualization involves reframing individuality to allow for self-discovery within the context of the development and maintenance of relationships. This would mean that individuality and togetherness are not inherently competitive, but are reciprocal processes, and as one increases so can the other. Within this model, women can continue to be nurturant, attached, and responsive and at the same time be individuals in their own right. This is the premise behind the spousal intimacy scale on the PAFSQ, wherein individuals are mutually vulnerable and attached, yet independent and separate.

The third tenet of this integrated and woman-inclusive family systems model focuses on emotional reactivity and the wellspring of chronic anxiety that are hallmarks of a lack of differentiation. “At low levels of differentiation, persons are excessively reactive to the emotions generated within a relationship system and have difficulty in maintaining either individuality or togetherness” (p.42). This reiteration is a more gender-neutral perspective on differentiation and allows for the different orientations and socialization processes of men and women.

Knudson-Martin concludes her thesis by writing that
By emphasizing the development of both the feeling and the intellectual systems and balancing autonomy and connectedness, it encourages men and women to move beyond the limits of traditional roles and supports a conceptualization of individuality in a context of commitment to others. (p.45)

In sum, the implications in this study need to be drawn with an appreciation of the tension that exists surrounding the possible lack of gender-neutrality of family systems concepts.

**Suggestions for Future Research**

The research possibilities around differentiation, the marital relationship and new parenthood are endless. Outlined below are some potential projects that are directly related to this study, as well as others dealing with different populations of childbearing women and other childbearing issues.

**Research on the Marital Relationship, Differentiation, and New Parenthood**

**Long-term Longitudinal Studies**

There is a need for long term longitudinal studies to follow young couples through the precontemplation of childbirth period, through the preconception-contemplation period, through pregnancy, and sufficiently long enough in the postpartum period to assess accurately the changes in differentiation and dyadic adjustment. These studies need to address the process and context of differentiation issues.

**Qualitative Research into Differentiation Issues**

Equally important and necessary are qualitative studies of both men and women to help in the understanding and determination of the gestalt of differentiation. These studies may subsequently lead to the development of more sensitive quantitative and gender-neutral
measurement inventories. Further study of gender-related differences in instrumentation related to differentiation tenets is also necessary. If there are true differences in differentiation for women and men, separate yet comparable measurement inventories may need to be developed.

**The Impact of Psychoeducational Interventions**

Studies testing the effectiveness of psychoeducational interventions are also needed. These studies would further validate that antenatal anticipatory guidance can mitigate the unfavorable dyadic relationship outcomes experienced after childbirth. Interventions aimed at family of origin issues also need to be developed and tested through randomized trials to determine their efficacy. Although there is information suggesting that the best time to intervene with childbearing couples around teaching about communication and conflict resolution is in the second trimester of pregnancy (Midmer et al., 1995), little is known about the best time to intervene around family of origin issues. Should interventions be planned for the precontemplation period? the preconception period? or during pregnancy? Further trials are needed to answer these questions.

**Cross-cultural Studies**

Family systems theory is predominantly North American in origin, and may have little relevance for other cultural groups. The evidence that is used to discuss marital changes in the postpartum period has been gleaned from homogeneous, English speaking populations and may have little application to different cultural groups. There is a dearth of literature about the psychosocial experience of different ethnic groups after the birth of a first child. McGoldrick, Pearce, and Giordano (1982) write that attitudes towards health and illness are strongly influenced by ethnic factors and that problematic behaviour in one group may be normative for another. Cultural context needs to be the backdrop of future research study.

Additionally, the ethnic intermarriage is also becoming a common family structure (McGoldrick & Preto, 1984). Within these families, differences in values, acculturation, religion, race, sex-role definitions, socioeconomic differences, familiarity with each other's
cultural context, and the degree of resolution of emotional issues about intermarriage may all interplay with respect to differentiation, family of origin, and marital adjustment during and after pregnancy. In these distinct types of family systems, many studies are needed to determine cultural differences with respect to family of origin and differentiation issues and marital adjustment during and after pregnancy.

Research on Different Populations

Studies in Same-Sex Relationships

Lesbian and, to a lesser degree, gay dyads are becoming new parents either through adoption, artificial insemination, or surrogate pregnancy. The studies cited in this study all relate to heterosexual dyads, yet lesbians have unique health care needs (Simkin, 1993) and often develop highly fused intimate relationships (Slater & Mencher, 1991). Research is needed to explore the experience of same-sex couples. Is their process of differentiation from the family of origin different? more difficult? easier? Does their dyadic relationship exhibit similar changes after the arrival of a new baby as does a heterosexual relationship? These questions and more could to be answered.

Lone, Single, and Teenage Mothers

Research also needs to be undertaken to determine the experience of lone mothers, (women who have no contact with or knowledge of the father of the baby); single mothers, (women who are separated from but still in a relationship with the infant’s father); and teenage mothers. Teenage and other young, single mothers often have little social support, low self-esteem, and feel powerless, helpless, and lacking in control over their lives (Watson, Wetzel, & Devanesen, 1991).
How does lone motherhood impact on a woman’s differentiation from her family of origin? Do lone mothers or teenage mothers exhibit more or less differentiation or fusion with their family of origin? How is a lone mother’s experience the same or different from the experience of a woman in a marital relationship? Are lone mothers, who have no connection with the infant’s father, different from single mothers, who are separated from but in a relationship with the infant’s father? Do teenage mothers who are supported by the father of the infant have different differentiation issues than teenage mothers who are reliant on their family of origin for support? These research questions are particularly salient given that, from 1961 to 1991, the percentage of lone-parent families nearly doubled, from 11% to 20% of all families with children in Canada (Baker, 1993).

Fathers

Many of the same questions asked for lone, single and teenage mothers would also apply to single and teenage fathers. In addition, men may experience obstacles to full engagement in their new role as fathers. These obstacles include lack of good father role models, no models of male nurturers, lack of competence, conflict with new mothers about degree of involvement with the infant, and mixed or negative feedback from their family of origin concerning appropriate involvement as a father (Cowan & Cowan, 1992). Given the increase in lone mother families, exploration into the reasons why men are relinquishing their fathering roles and abandoning their families (Stacy, 1993) might revolve around all of the issues indicated, including family of origin and differentiation issues.

Grandparents

All of the literature cited has focused on the experience of new parents. If new parents experience less intergenerational fusion with parents, do their parents also register the same decrease in fusion with their adult children? What impact does the birth of the first grandchild have on the marital relationship of grandparents? On their level of differentiation from each other and from other family members? Does the response of grandparents to parenthood reflect their family of origin experiences? How multigenerational is the pull from ghosts long gone?
Resource Utilization

Studies need to be undertaken to address the health care resources utilized by new parents. Do poorly differentiated individuals with high chronic family system anxiety use the health care system more? less? the same? Do shifts in dyadic adjustment impact on resource utilization? Is infant morbidity affected by differentiation and marital functioning concerns?

Parent-infant Attachment Studies

If mothers or fathers are poorly differentiated and fused with their partner or family of origin, does birth provide them with an opportunity to become fused with the infant? How is this different from healthy parent-infant attachment? What is the impact of this parent-infant fusion on the marital relationship? on relationships within the family of origin?

Breastfeeding Studies

Exploration of the impact of differentiation on breastfeeding would also be fascinating. Are long-term, successful breastfeeding mothers more or less differentiated? Do they have more or less spousal intimacy? Does breastfeeding affect spousal fusion? Does breastfeeding affect the marital relationship? Does breastfeeding increase or decrease mother-infant fusion?

Fertility and Reproduction Studies

Is the level of differentiation or the health of the marital relationship a factor in infertility? repeat miscarriage? spontaneous abortion? Is there a multigenerational transmission of a script for reproductive health? Is differentiation and the chronic anxiety within the family and/or marital system a factor in preterm births?
Study Summation

After reviewing the literature it becomes apparent that, of all the stages in the family life cycle, the birth of the first child may be the most exciting, challenging, disconcerting, and overwhelming that women and men will experience. Some individuals will jump into parenthood with an enormous splash, experiencing outright crisis and severe disorganization in their lives; others will slip gently into parenthood, experiencing only ripples of reorganization. What accounts for the difference?

Part of the explanation may lie in the coping strategies and crisis-resolution skills of the new mother and father. Those individuals with a repertoire of coping and adaptation skills are able to deflect the stress and strain of new parenthood with greater ease. A successful segue into parenthood appears to depend on whether new parents hold reality-based perspectives rather than romanticized views about the postpartum period. Realistic expectations around social support, role realignment, division of labour, and the traditionalization of the postpartum marriage are learned and can be enhanced through antenatal education.

The marital relationship can be rocked by the turbulence of new parenthood. How couples weather this developmental storm is as much related to the competence in their marriage and their management of conflict as it is to whether they have a difficult, or colicky baby. Role-strain and role-gain issues are particularly problematic for women, and women with a non-traditional orientation to sex-roles may experience distress in a traditional postpartum marriage. The literature has shown that, with few exceptions, couples experience a change in their marital relationship, and women experience a decline in their feelings of cohesion and intimacy with their partners after the baby is born. Sleep-deprived and exhausted, overwhelmed by infant care responsibilities, unable to negotiate with a screaming newborn, couples may quite literally be "running on empty".
How they viewed the marital relationship of their own parents is a strong influence on the postpartum marriage of new parents. The birth of the first child begins to blur the generational boundaries and shakes up the family system. The degree of differentiation that the young parent has developed within the family of origin becomes an important variable in the development of the family of procreation. Since individuals tend to marry a partner with the same level of differentiation, marital problems in the postpartum relationship, often reenactments of old family scripts, may suddenly emerge with the birth of the nuclear family triangle.

Chronic anxiety, always a feature in undifferentiated relationships, when exacerbated by the acute anxiety of dealing with a newborn, may catapult new parents into a behavior and communication quagmire. Using their parents as role-models, couples may revert to anxiety reduction through triangulation and emotional distancing, family traditions of dysfunction passed from generation to generation. Yet, if the new parents achieved intergenerational intimacy within the family of origin before the birth of the first child, this ability to be emotional close with their parents, an indicator of a higher level of differentiation, mitigated against negative changes in the postpartum marital relationship.

Having completed this study, it appears that findings uphold certain suppositions from the literature reviewed. This study has further shown that the family of origin is associated with changes in the marital system of the family of procreation following the birth of a first child. Those individuals with a greater capacity for intergenerational intimacy, characterized by the ability to be voluntarily close with a parent, also have a greater capacity for healthy marital functioning in the postpartum period. This study has also shown that the birth of the first child is related to a decrease in intergenerational fusion. This decrease in the hierarchical control of parents over adult children furthers the adult-child’s achievement of a peerhood relationship with parents. In addition, this study has shown that the birth of a first baby may be negatively related to women’s experience of the postpartum marital relationship, effecting a decrease in her sense of the couple’s cohesion and their spousal intimacy.
In sum, the birth of a first child, whether a transition or a crisis, is a disturbance in the lives and marriages of young parents. How individuals maintain the health of their postpartum dyadic relationship depends, in part, on their coming from a particular family of origin. Some individuals will be successful, others will not. Further studies are needed to provide direction to all new parents to maximize their potential for a successful postpartum marital experience.
Bibliography


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Appendix A

Letter to Respondents
Dear Parent:

I am a doctoral student in the Department of Adult Education at the Ontario Institute for Studies in Education. I am researching the changes a new family undergoes after the birth of a first child. In particular, I am studying how an individual's relationship with his/her first family, or family of origin, might influence the establishment of the second family, or family of procreation. I am especially interested in how the marital relationship of new parents might be influenced by the birth of a first child.

This study, in which I hope you will participate, involves my recruiting 50 couples who are attending prenatal classes. Participating couples will be asked to answer standard questions about their life, such as: amount of education completed, occupation, age, etc. Couples will be further asked to complete individually two self-report measures. The first, the Dyadic Adjustment Scale, contains questions pertaining to the couples' relationship. The second, the Personal Authority in the Family System Questionnaire, pertains to the relationship the individual has with his/her family of origin. It will take approximately 15 minutes to complete both questionnaires. These two questionnaires will be administered a second time, after the baby is born, at the postpartum reunion class that is part of the class series.

If you enter this study, you are perfectly free to withdraw at any time. If you do, all data I have collected from you will be destroyed. If you participate in the study, I will assign you with a numerical code and remove all identification from your questionnaire. Once the study is completed, I will send you a short report on my findings.

Thank you for considering this request for your participation. I would be pleased to discuss this further and answer any questions you might have regarding the research project. If you agree to take part, please read and sign the attached letter.

Sincerely,

Deana Midmer
Deana Midmer, BScN. MEd, FACCE
Appendix B

Consent Form
Dear Deana:

I have read the attached letter describing the research project you plan to undertake, and I agree to participate. It is clear to me that I am free to withdraw from the study at any time.

__________________________  __________________________
Date                                             Signature
Appendix C

Personal Information Form
Please indicate your response with a check mark or the appropriate number.

1. What is your age in years? _____ years.

2. What is your current marital status? married common-law separated or divorced single/never married
   
   How many years? ___ ___ ___ ___

3. Do you have any children? yes____ no____

4. What is your occupation? ____________________

5. How many years of formal education have you had? _____ years.

6. What is your religion?
   Buddhist _____ Muslim _____
   Catholic _____ Protestant _____
   Jewish _____ None/no organized religion _____
   Other, please specify religion _____

7. To which ethnic group do you or did your ancestors belong?
   British _____ African _____
   European _____ South American _____
   Asian _____ Middle Eastern _____
   Indian _____ Other, please specify _____

7. Was this pregnancy planned? Yes____ No____

8. Have there been any previous abortions or miscarriages?
   Yes____ No____
Appendix D

Dyadic Adjustment Scale
The Dyadic Adjustment Scale is copyrighted and was purchased for use in this study from:
Appendix E

Personal Authority in the Family System Questionnaire
The following questions ask about your current relationships with your parents, your spouse and your children. Please select the answers which best reflect your current relationships with these people. There are no right or wrong answers. Place your answers on the Answer Sheet provided. Do not mark on the Questionnaire. Remember: Give the answer that best applies to you.

If you are currently not married answer the questions below as they would apply to your relationship with your most important, current significant other (i.e., mate, steady friend, lover). If you do not have a significant other, then answer the questions as they might apply to your most likely or most recent significant other.

If one or both of your parents are deceased, then answer the questions about your deceased parent(s) in terms of how you remember or imagined your relationship(s) to be.

If you do not have children, leave the questions about children blank.

Please answer all questions as best you can. Place your answer in the appropriate place on the Answer Sheet.

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Revision 9/1/83

The Dr. Bray, the author of the PAFSQ, requests that it is not included in the appendix.
Appendix F

Postpartum Instructions Letter
Department of Adult Education  
The Ontario Institute for Studies in Education  
252 Bloor Street West  
Toronto, M5S 1V6  

Dear Parents:  

Some time ago, while attending prenatal classes, you kindly consented to complete questionnaires for a doctoral research project I am completing. The first set were administered before the baby was born, and the second set is now due for completion.  

With this letter, I am enclosing the second set of questionnaires and a single sheet requesting information on your birth. I am also including a stamped envelope to be used to return the questionnaires to me. It is most important that everyone respond again, as I am looking at any shifts that might have occurred as a result of the birth of the baby. As was the case before, please complete the questionnaires by yourself. Once again, please note that you have been assigned a number code, and will remain anonymous throughout the data analysis.  

I will be analysing the data and presenting my findings to a research tribunal. If all goes well, I will be publishing my report in a medical journal. If you are interested in receiving a copy of this report, please indicate on the bottom of this page and send this letter back to me with your completed questionnaires.  

I wish to thank you once again for the time you have committed to this project. If you have any questions, please do not hesitate to contact me.  

Sincerely,  

[Signature]  

Deana Midmer, BScN, MEd  
(416) 626-2855 H  
(416) 586-8814 B  

Encl.  

Please send a report on the findings of this project when it has been completed.
Appendix G

Postpartum Questionnaire for Mothers
COPING AS A FAMILY
AFTER THE BIRTH OF
A NEW BABY

Questionnaire Series II
Mothers Answers

Please complete when your baby is three (3) months or older

I.D. Number __________
1. ID. ________

1) What was your expected date of delivery? _____/____/____
   dd  mm  yy

2) When was the baby actually born? _____/____/____
   dd  mm  yy

3) Was it a boy or girl? ____________

3) How many babies were you pregnant with (single, twins, etc.)? ____________

4) How old is the baby now? ______ weeks

5) What was the baby’s birth weight? ____________

6) Since the delivery, has the baby had any health related problems?
   YES  NO

   If YES, please explain. ________________________________
   ________________________________

7) Since the delivery have you had any health related problems?
   YES  NO

   If YES, please explain. ________________________________
   ________________________________

8) Please indicate how the baby was delivered
   _____ Forceps/Vacuum
   _____ Caesarian section
   _____ Spontaneous Vaginal Delivery

9) Did your partner attend the birth?
   YES  NO

   If YES, please rate how supportive you felt he was. Mark an “X” on the scale below
   0--------------1--------------2--------------3--------------4
   not at all  somewhat  very
   supportive  supportive  supportive
Appendix H

Postpartum Questionnaire for Fathers
COPING AS A FAMILY
AFTER THE BIRTH OF
A NEW BABY

Questionnaire Series II
Fathers Answers

Please complete when your baby is three (3) months or older

I.D. Number __________
1) What was your wife's expected date of delivery? ___/___/___
   dd mm yy

2) When was the baby actually born? ___/___/___
   dd mm yy

3) Was it a boy or a girl? __________

4) How many babies were your wife pregnant with (single, twins, etc.)? _______

5) How old is the baby now? _______ weeks

6) What was the baby's birth weight? ____________

7) Since the delivery, has the baby had any health related problems?

   YES               NO

   If YES, please explain. _______________________________________
                      _______________________________________

8) Since the delivery, have you had any health related problems?

   YES               NO

   If YES, please explain. _______________________________________
                      _______________________________________

8) Please indicate how the baby was delivered.

   ____ Forceps/Vacuum
   ____ Caesarian section
   ____ Spontaneous Vaginal Delivery

9) Did you attend the birth?

   YES               NO

   If YES, please rate how supportive you felt you were. Mark an "X" on the scale below.

   0-----------------1-----------------2-----------------3-----------------4
   not at all       somewhat       very
   supportive       supportive     supportive