26

Attachment and Depression Across the Transition to Parenthood

Social Policy Implications

Jeffry A. Simpson, W. Steven Rholes, and Sandra Shallcross

The transition to parenthood is one of the happiest, most stressful, and most life-altering events that most people ever experience (Cowan & Cowan, 2000; Heinicke, 1995). For many partners, having a child predicts eventual declines in marital quality (Belsky, Lang, & Rovine, 1985; Cowan, Cowan, Heming, Coysh, Curtis-Boles, & Boles, 1985) and personal well-being (Alexander, Feeney, Hohaus, & Noller, 2001; Feeney, Hohaus, Noller, & Alexander, 2001; Simpson, Rholes, Campbell, Tran, & Wilson, 2003). Some partners, however, report no declines or actual improvements (Cowan & Cowan, 2000; Tucker & Aron, 1993). Thus, individuals differ in how well they weather the trials and tribulations of having a first baby. Who are the more "vulnerable" individuals? What has happened or is happening in their personal lives and relationships that might explain these negative outcomes? And how can answers to these questions inform policy making to improve the health and well-being of new parents going through transition to parenthood?

For the past decade, we have studied how couples navigate the opening months of the transition to parenthood. Guided by attachment theory (Bowlby, 1969, 1973, 1980), we have adopted a diathesis-stress approach to understanding how and why certain people who encounter specific *stressors* experience increases in depressive symptoms across the transition. Our research has focused on the first 6 months of the transition when the stress of being a new parent is strong and chronic, the novelty of this new life role has begun to

The Wiley-Blackwell Handbook of Couples and Family Relationships, First Edition.
Edited by Patricia Noller and Gery C. Karantzas.

cue of abandonment is low or declining partner support, especially when one is distressed and may need support (Bowlby, 1973, 1988). Thus, when anxiously attached individuals encounter situations that tax them and their relationships, their perceptions, evaluations, and actions are likely to be impacted by concerns that they do not have—or will not receive—sufficient care and support from their partners when they need that the most.

Less anxious people, who are more likely to be securely attached, ought to fare better during the transition to parenthood. For most of their lives, these people have had their needs for proximity and support adequately met (Hazan & Shaver, 1994). This knowledge permits secure people to develop strong internal resources (e.g., positive beliefs and expectancies about themselves as being good relationship partners, which allows them be more benevolent and compassionate) as well as strong external resources (e.g., choosing and encouraging more supportive partners, developing larger and more supportive social networks). These internal and external resources are likely to lead secure individuals to rely more directly on their partners and close friends for comfort and support, particularly when they are upset (Mikulincer, Florian, & Weller, 1993). In fact, attachment security is likely to serve as an "inner resource" that allows securely attached people to appraise stressful life experiences more positively, to resolve them better, and to cope with them more effectively (Mikulincer & Florian, 1998). These capacities should *buffer* highly secure people from experiencing negative personal outcomes, including increases in depressive symptoms across stressful life transitions.

Attachment and the Transition to Parenthood

Attachment theory was developed in part to explain the origins of depression and other psychological disorders (Bowlby, 1980, 1988). Adopting a diathesis-stress perspective, Bowlby (1988) hypothesized that increases in depressive symptoms should occur when vulnerable people (e.g., highly anxious women) confront stressors that strain their relationships. Such experiences, if strong and persistent, should trigger depressive symptoms or even clinical depression by increasing negative beliefs about the self or confirming negative views of others (i.e., that partners are unloving or unsupportive). This negativity, in turn, may lead anxious individuals to behave less constructively toward their partners (cf., Anderson, Beach, & Kasl, 1999). Greater attachment security, on the other hand, should buffer individuals from depressive symptoms, especially during chronically stressful life transitions (Mikulincer & Florian, 1998).

Insecurely attached people are more prone to depression and depressive symptoms. Highly avoidant and highly anxious people, for example, tend to experience major depressive episodes more than secure people do (Mickelson, Kessler, & Shaver, 1997), with anxious persons typically reporting the most depressive symptoms, secure individuals reporting the least, and avoidant persons falling in between (Cooper, Shaver, & Collins, 1998). Similar effects are found in women making the transition from high school to adult life (Burge, Hammen, Davila, & Daley, 1997; Hammen et al., 1995). In these and other studies, highly anxious women are particularly susceptible to depressive symptoms (Carnelley, Pietromonaco, & Jaffe, 1994; Hammen et al., 1995).

Bowlby (1988) hypothesized that highly anxious women who enter parenthood perceiving that their partners are not sufficiently available and supportive should experience more postnatal depressive symptoms. As we have discussed, highly anxious individuals place great value on their relationships (Hazan & Shaver, 1987), and they anchor their self-concepts on the quality and well-being of their relationships (Campbell, Simpson, Boldry, & Kashy, 2005; Crocker & Wolfe, 2001). As a result, they should feel dejected if they perceive that their partners cannot or will not provide the amount of care and support they need, especially when in the throes of a chronic, stressful life transition. To complicate matters, the working models of anxious persons should lead them to expect and perceive less support from their partners than their partners may actually be providing. During the first few months of the transition, therefore, perceptions of low or declining partner support should be associated with more negative partner and relationship perceptions by highly anxious women, which should trigger increases in depressive symptoms. This process model is shown in Figure 26.1.

Prenatal perceptions of the partner should also predict the degree to which depressive symptoms remain stable (either high or low) across the transition to parenthood. For example, if highly anxious women experience depressive symptoms, their symptoms should remain constant across the transition or might increase if they perceive that their relationships are not functioning well. For highly anxious women, therefore, the connection between prenatal and postnatal depressive symptoms (i.e., the temporal stability of their depression scores) should be partially mediated by their prenatal perceptions of their spouse or their marriage. For less anxious women, other factors are likely to affect their depressive symptoms, such as work, leisure activities, or involvement in other events. Accordingly, the relation between prenatal and postnatal depressive symptoms should *not* be mediated by relationship perceptions in less anxious women.[1]

We tested these hypotheses in a large sample of married couples, all of whom were awaiting the birth of their first child (see Simpson et al., 2003). The sample consisted

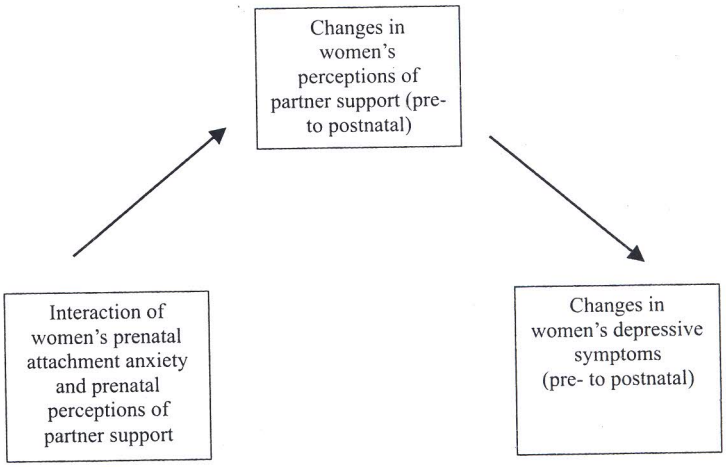

Figure 26.1 A model of how women's prenatal attachment anxiety interacts with their prenatal perceptions of spousal support to predict changes in their marital satisfaction and depressive symptoms, mediated through changes in their prenatal-to-postnatal perceptions of spousal support

of 106 couples (wives and their husbands) recruited from childbirth classes in Texas, United States. Both partners completed self-report questionnaires approximately 6 weeks before the birth of their first child (at Time 1) and approximately 6 months after delivery (at Time 2). The average age of women and men was 28.5 years, and the average length of marriage was 3.8 years. Seventy percent of the sample were European American, 20% were Hispanic American, and the rest were Asian American or African American.

At Time 1, women reported their romantic attachment orientations (on anxiety and avoidance scales), their perceptions of the amount of support available from their husbands, and their depressive symptoms. Husbands at Time 1 reported their romantic attachment orientations, their perceptions of how supportively they behave toward their wives, and their depressive symptoms. At Time 2 (6 months after the birth), both spouses completed the same scales a second time. We tested whether highly anxious women who entered the transition perceiving relatively less spousal support were more likely to experience pre-to-postpartum increases in depressive symptoms over the transition, along with the specific psychological variable(s) that could have generated these changes.

Anxiety and depressive symptoms

As predicted, we found that highly anxious women experienced significant increases in depressive symptoms during the transition, but that highly avoidant women did not. Also as anticipated, women who perceived more spousal support *before* childbirth did not report changes in depressive symptoms, even if they were highly anxious. However, highly anxious women who perceived less prenatal support became significantly more depressed across the transition, whereas less anxious women became slightly *less* depressed. The working models of highly anxious women probably explain at least part of this effect because highly anxious women perceived less support than would be expected based on their husbands' reports of support offered.

Mediation findings

We also hypothesized that women's pre-to-postnatal declines in perceived spousal support would mediate the relation between (i.e., act as the causal connection between) the prenatal interaction effects mentioned above and increases in depressive symptoms. As predicted, highly anxious women who perceived less spousal support prenatally also perceived significant declines in spousal support over time. These declines, in turn, predicted significant pre-to-postnatal increases in depressive symptoms. This finding supports the model depicted in Figure 26.1.

Husbands' perceptions of wives' dispositions

We found that highly anxious women perceived less support from their husbands than less anxious women did (see also chapter 28 in this volume). This finding most likely occurred

for one of three reasons. First, the husbands of highly anxious women might have offered or provided less support. Second, highly anxious women may not have perceived the support that was actually available to them. Third, both processes could have transpired. Even though highly anxious women perceived less prenatal support than less anxious women did, women's prenatal levels of anxiety and men's prenatal reports of the support they provided were not correlated. Six months after childbirth, however, the husbands of highly anxious women reported that they were providing significantly *less* support than the husbands of less anxious women, even when husbands' attachment scores and other measures were statistically controlled. This finding suggests that some highly anxious women may have behaved in ways that undermined their husbands' willingness to provide support a few months into the transition (see Anderson et al., 1999).

To test this possibility, we examined whether husbands' postnatal ratings of their wives' dependency (emotional clinginess) and emotional instability mediated the relation between wives' attachment anxiety and their husbands' postnatal perceptions of support provided. As expected, the relation between women's attachment anxiety (assessed at 6 months postpartum) and their husbands' postnatal perceptions of support became nonsignificant once husbands' ratings of their wives' dependency and emotional instability were statistically controlled. This effect suggests that husbands' negative views of their highly anxious wives (as being dependent and emotionally unstable) could be one of the reasons why they withdrew support 6 months into the transition.

Depression maintenance

Bowlby (1980, 1988) also surmised that the association between prenatal and postnatal depressive symptoms should be mediated by perceptions of spousal support, especially among highly anxious women. As predicted, we found that highly anxious women who reported more depressive symptoms prenatally continued to be relatively more depressed at 6 months postpartum, but *only if* they held more negative prenatal perceptions of their husbands' support. Less anxious women who reported more prenatal depressive symptoms did not stay depressed if they held more negative prenatal relationship perceptions, but they did if other negative life events intervened. In sum, prenatal perceptions of the partner and relationship assume a stronger role in maintaining depressive symptoms among highly anxious women.

Policy Issues and Implications

According to these findings, only a subset of couples going through the first few months of the transition to parenthood experience personal or relational difficulties. Most couples weather the trials and tribulations of having a new baby reasonably well. New mothers who are more anxiously attached, however, are vulnerable to negative outcomes. We believe that our findings have important implications for intervention efforts for two reasons. First, our research identifies which *people* are most likely to benefit from interventions

before they (and their partners) enter this challenging phase of life. Second, our research highlights the *psychological processes* that mediate the connection between being vulnerable to problems prenatally (i.e., being highly anxious *and* concerned about deficient partner support) and postnatal increases in depressive symptoms. Our findings, therefore, may help practitioners develop more effective interventions.

Causes for support perceptions

Perceptions of partner support harbored by new mothers may be one major source of problems encountered during the early stages of the transition to parenthood. Highly anxious women report increases in depressive symptoms, particularly when they enter parenthood perceiving lower levels of emotional support from their mates. However, if they perceive greater prenatal partner support, highly anxious women do *not* experience changes in depressive symptoms. Unfortunately, few highly anxious women view their husbands as highly supportive prenatally.

Several factors may contribute to decreases in perceptions of support in these women. First, highly anxious individuals have perceptual biases that may motivate them to "underperceive" the emotional support that may actually be available from their partners (Collins et al., 2004). Greater attachment anxiety develops in response to prior attachment figures whose love and caregiving were unstable, variable in quality, or unpredictable (Ainsworth, Blehar, Waters, & Wall, 1978; Cassidy & Berlin, 1994). Based on these experiences, highly anxious people become wary of attachment figures and expect them to be unsupportive, uncaring, or not fully committed to the relationship, especially during times of need.

Second, some anxious women might unwittingly act in ways that discourage their partners from providing more support. Compounding matters, men who are married to highly anxious women tend to perceive their wives as more immature, emotionally weak, dependent, and clingy in the months following childbirth. These negative attributions may partially explain why the husbands of highly anxious women report significant declines in their supportiveness across the transition. The partners of highly anxious women may respond to their wives' passive, disorganized, or caustic attempts to elicit support by reducing the support that they provide, or by offering support that is not well suited to the needs of their anxious mates. This perceived lack of responsiveness may confirm the negative expectations of highly anxious women, resulting in increased distress and even *more* ineffectual attempts to garner support. This negative relational cycle highlights the need for interventions that address the cognitions and behaviors of *both* partners in support groups, couples therapy, and/or individual therapy.

Possible targets of intervention

One overarching goal of any intervention should be to help highly anxious people identify and understand how they might unknowingly minimize or discount support that might actually be available from their partners. In our research, for example, highly anxious

women reported that their husbands provided significantly less support than their husbands claimed to give. This disparity is likely to generate further stress and strain on their relationships. In some relationships, therefore, recognition and acceptance of available support may be the first step toward reducing discrepancies between partners' perceptions of support provision.

Highly anxious people may also benefit from skills-based interventions that target the clear and direct expression of their needs for comfort and support while maintaining composure, particularly when they are upset. Highly anxious people crave support from their attachment figures, but they do not always seek it when they are distressed. Highly anxious women, for instance, seek less support from their mates during the transition to parenthood (Rholes, Simpson, Campbell, & Grich, 2001). They typically behave in a rather passive manner, perhaps because they may not know *how* to increase the support that could be available to them. Accordingly, highly anxious individuals may need to develop greater awareness of when they need support and then identify new ways of approaching their partners for support and communicating their needs. Learning how to seek support more assertively may also help highly anxious people develop stronger self-efficacy and greater self-worth in their relationships.

Of equal importance, the *partners* of highly anxious people may also need to be the targets of intervention. For example, the partners of highly anxious people might become more responsive if they recognize that, in certain stressful situations, some seemingly dysfunctional behaviors—especially persistent reassurance seeking—are difficult for their partners to control and may be *essential* to their partner's well-being. Skills-based interventions may help partners to structure and provide a more stable and supportive environment, especially during peak periods of stress (Feeney, Alexander, Noller, & Hohaus, 2003). Whereas less anxious women easily turn to their partners for support and reassurance when problems arise, highly anxious women may respond best to consistent reminders of their partners' love and support, even on days when there are no major difficulties and their anxious partners seem fine. The partners of highly anxious individuals may also need to learn how to tailor their support giving to better meet the needs of their insecure partners (cf. Simpson, Winterheld, Rholes, & Oriña, 2007). Postnatal outcomes are likely to be better if the partners of highly anxious people direct less anger at them when they (their anxious partners) feel frustrated and if they refrain from making negative attributions for their insecure partner's actions.

Possible intervention programs

Several different intervention programs could address the targets of intervention discussed above. Depending on the specific problem and goal, intervention programs could range from mass public education programs made available to all first-time parents to individualized psychological or psychiatric interventions designed to treat individuals or couples suffering from more severe problems or disorders. Different types of interventions could be developed and implemented, beginning with broadband prenatal transition to parenthood education programs that are then supplemented with postnatal support groups for new parents. For more difficult cases, individual or couple-based therapies

may be necessary to revise dysfunctional working models or expectations about parenthood, using relationship-focused therapies (Heinicke, Fineman, Ruth, Recchia, Guthrie, & Rodning, 1999; Whiffen & Johnson, 1998), and/or behaviorally-oriented skills training (Schulz, Cowan, & Cowan, 2006) designed to buffer vulnerable individuals from depressive symptoms.

The specific type of intervention that works best is likely to depend on the severity of attachment insecurities of one or both partners, the nature and quality of their relationship, and the abilities, skills, and capacities that each partner brings to parenthood. For example, highly anxious individuals tend to be emotionally engaged yet less compliant in psychotherapy than highly secure individuals, and some have speculated that anxious people might benefit most from psychodynamic or interpersonal approaches to therapy (Daniel, 2006). Because the transition to parenthood should activate the attachment-related vulnerabilities of highly anxious people, the most effective interventions may be those that integrate past experiences and working models with present issues and concerns (Suess & Sroufe, 2005). Couples-based interventions such as emotion-focused couples therapy should be particularly effective at addressing attachment concerns, decreasing corrosive relational dynamics, and reducing the depressogenic effects of inadequate support (see chapter 23 in this volume; Whiffen & Johnson, 1998). These therapies might be even more effective in combination with comprehensive prevention programs that have educational components and group-level interventions (e.g., support groups consisting of new parents).

Recent experimental studies also imply that, regardless of their attachment orientations or specific life circumstances, individuals may benefit from interventions that enhance their felt security (chapter 14 in this volume; Mikulincer & Shaver, 2007). This research, which has used explicit (superliminal) and implicit (subliminal) security-based primes (i.e., information presented at or just below conscious awareness) to increase felt security and reduce negative affect toward disliked outgroups, reveals that people could be trained to view themselves, their partners, and outgroup members in a more caring, empathic, and benevolent way. Thus, interventions that induce feelings of greater attachment security might buffer new "expectant parents" from increases in depression across the transition, especially if interventions target both partners (see also chapter 14 in this volume regarding security priming). This novel intervention could augment more comprehensive treatment programs.

In addition, therapists could help highly insecure individuals and their partners find more effective ways to reduce different sources of stress associated with having a new baby, including stress that stems from the dysfunctional working models of one or both partners. Other sources of stress, however, may emanate from having to manage multiple and often competing life tasks, such as jobs, caring for extended family members, or other personal responsibilities. One way to reduce stress arising from these competing life tasks would be to establish standard maternity and paternity leave programs that allow new parents to reorganize their lives and adjust to the novel demands of parenthood.

We believe that *coordinated* education programs designed for new parents and delivered by professional personnel would best accomplish the goals outlined above. One principal way to reduce depression may be through good prenatal screening and early detection. Accordingly, professionals (e.g., pediatricians, obstetrics nurses, counselors) should

routinely include screening questions for depression, marital conflict, and extreme levels of attachment insecurity as part of their regular examinations of expectant parents, both before *and* after delivery. Depressed and vulnerable individuals could then be identified early and referred for proper treatment immediately. One critical period for screening is likely to be when mothers are in the hospital immediately after childbirth. Unfortunately, most of these stays are too brief to detect the early signs of postpartum depressive symptoms. The most vulnerable new mothers, therefore, should remain hospitalized for slightly longer periods of time (e.g., 2–3 additional days) following childbirth. Another benefit of slightly longer post-delivery hospital stays is that vulnerable mothers would have more time to recover from delivery before having to deal with full-time child care.

Most couples cannot fathom the many new challenges and difficulties associated with becoming first-time parents. For this reason, basic education programs must be developed to identify, explain, and provide solutions to the most common and pressing problems that arise during the first few months of the transition. One salient issue for any education program would be to identify and explain why some people are sensitive to the perceived absence of actual or available partner support. A second issue would be to identify and explain why certain people have unrealistic, mistaken, or overly optimistic expectations about what parenthood will really be like (see Delmore-Ko, Pancer, Hunsberger, & Pratt, 2000; Pancer, Pratt, Hunsberger, & Gallant, 2000), including how dysfunctional expectations might exacerbate relationship difficulties. Practitioners should also educate new fathers about how the transition is likely to affect them and permanently alter their lives. Many new fathers struggle with the unexpected loss of free time and unexpected family–work conflicts (Cowan & Cowan, 2000). To prevent the onset of depressive symptoms, new parents should also be taught to recognize symptoms of depression in both themselves and their partners. For many couples, education programs could be delivered by hospital staff or as part of regular childbirth courses. For others, particularly impoverished or disadvantaged groups, other means of delivery may be necessary.

After teaching new mothers and fathers the telltale signs of depression and marital problems, new parents need to know whom they can turn to for guidance, assistance, and support. All new parents should be given information about the different forms of assistance available to them (e.g., medications, counseling services, new parent discussion groups), which they could receive from their physicians, nurses, or public mental health centers. As discussed above, information and emotional support from peers or new parents who have recently gone through the transition might also provide benefits that other sources of support do not or cannot provide.

Conclusions

These policy recommendations are targeted primarily to highly distressed and highly insecure women during the first few months of the transition to parenthood. At later stages of the transition, other types of programs, interventions, or therapies targeted to certain men (e.g., highly anxious men, who may eventually feel deprived of contact with their wives, or highly avoidant men, who may increasingly feel the need for greater independence and autonomy) or certain emergent relationship issues (e.g., how to maintain quality

time and intimacy with one's partner, how to balance work, the relationship, and child care) may be required. As the permanence of changes in lifestyle associated with being new parents starts to restrict the autonomy and independence of highly avoidant people, we suspect that the burdens of parenthood may begin to adversely affect their personal and relational well-being as well.

In conclusion, the transition to parenthood is one of most challenging, joyful, stressful, and life-altering events that most people face. There is now a reasonably large body of research anchored in major theories and models that practitioners can use to identify which individuals and couples are most susceptible to personal or relational downturns in the first few months following childbirth. The prudent translation of this knowledge into effective intervention programs may help prevent the onset of depressive symptoms in some people and could stabilize "at-risk" relationships.

Note

1. Although highly avoidant persons also tend to be more depressed, prenatal perceptions of partner support and women's avoidance should not predict changes in depressive symptoms across the transition. Highly avoidant people want to be independent and emotionally self-sufficient, and they distance themselves from others when they are upset (Crittenden & Ainsworth, 1989; Simpson, Rholes, & Nelligan, 1992). During the transition to parenthood, therefore, highly avoidant women should *not* perceive low levels of spousal support; in fact, they may not even realize that support is low or deficient. If they do, perceptions of low partner support should not produce increases in depressive symptoms.

References

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation.* Hillsdale, NJ: Erlbaum.

Alexander, R., Feeney, J., Hohaus, L., & Noller, P. (2001). Attachment style and coping resources as predictors of coping strategies in the transition to parenthood. *Personal Relationships, 8,* 137–152.

Anderson, P., Beach, S. R. H., & Kaslow, N. J. (1999). Marital discord and depression: The potential of attachment theory to guide integrative clinical intervention. In T. Joiner & J. C. Coyne (Eds.), *The interactional nature of depression: Advances in interpersonal approaches* (pp. 271–297). Washington, DC: American Psychology Association.

Belsky, J. (1985). Exploring individual differences in marital change across the transition to parenthood: The role of violated expectations. *Journal of Marriage and the Family, 47,* 1037–1044.

Belsky, J., Lang, M. E., & Huston, T. L. (1986). Sex-typing and division of labor as determinants of marital change across the transition to parenthood. *Journal of Personality and Social Psychology, 50,* 517–522.

Belsky, J., Lang, M. E., & Rovine, M. (1985). Stability and change in marriage across the transition to parenthood: A second study. *Journal of Marriage and the Family, 47,* 855–865.

Belsky, J., & Pensky, E. (1988). Marital change across the transition to parenthood. *Marriage and Family Review, 13,* 133–156.

Belsky, J. & Rovine, M. (1990). Q-sort security and first-year nonmaternal care. *New Directions for Child Development, 49*, 7–22.

Belsky, J., Spanier, G. B., & Rovine, M. (1983). Stability and change in marriage across the transition to parenthood. *Journal of Marriage and the Family, 47*, 855–865.

Bowlby, J. (1969). *Attachment and loss: Vol. 1: Attachment*. New York: Basic Books.

Bowlby, J. (1973). *Attachment and loss: Vol. 2: Separation*. New York: Basic Books.

Bowlby, J. (1980). *Attachment and loss: Vol. 3: Loss*. New York: Basic Books.

Bowlby, J. (1988). *A secure base: Child–parent attachment and healthy human development*. New York: Basic Books.

Burge, D., Hammen, C., Davila, J., & Daley, S. E. (1997). The relationship between attachment cognitions and psychological adjustment in late adolescent women. *Development and Psychopathology, 9*, 151–167.

Campbell, L., Simpson, J. A., Boldry, J., & Kashy, D. A. (2005). Perceptions of conflict and support in romantic relationships: The role of attachment anxiety. *Journal of Personality and Social Psychology, 88*, 510–531.

Carnelley, K. B., Pietromonaco, P. R., & Jaffe, K. (1994). Depression, working models of others, and relationship functioning. *Journal of Personality and Social Psychology, 66*, 127–140.

Cassidy, J., & Berlin, L. (1994). The insecure/anxious pattern of attachment: Theory and research. *Child Development, 65*, 971–991.

Collins, N. L., Dunkel-Schetter, C., Lobel, M., & Scrimshaw, S. C. (1993). Social support during pregnancy: Psychosocial correlates of birth outcomes and postpartum depression. *Journal of Personality and Social Psychology, 65*, 1243–1258.

Collins, N. L., Guichard, A. C., Ford, M. B., & Feeney, B. C. (2004). Working models of attachment: New developments and emerging themes. In W. S. Rholes & J. A. Simpson (Eds.), *Adult attachment: Theory, research and clinical implications* (pp. 196–239). New York: Guilford Press.

Collins, N. L., & Read, S. J. (1994). Cognitive representations of attachment: The structure and function of working models. In K. Bartholomew & D. Perlman (Eds.), *Attachment processes in adulthood* (pp. 53–90). London: Kingsley.

Cooper, M. L., Shaver, P. R., & Collins, N. L. (1998). Attachment styles, emotion regulation, and adjustment in adolescence. *Journal of Personality and Social Psychology, 74*, 1380–1397.

Cowan, C. P., & Cowan, P. A. (2000). *When partners become parents: The big life change in couples*. Mahwah, NJ: Erlbaum.

Cowan, P. A., & Cowan, C. P. (1988). Changes in marriage during the transition to parenthood: Must we blame the baby? In G. Y. Michaels & W. A. Goldberg (Eds.), *The transition to parenthood: Current theory and research* (pp. 114–156). New York: Cambridge University Press.

Cowan, C. P., Cowan, P. A., Heming, G., Coysh, W. S., Curtis-Boles, H., & Boles, A. J. (1985). Transition to parenthood: His, hers, and theirs. *Journal of Family Issues, 6*, 451–481.

Crittenden, P. M., & Ainsworth, M. (1989). Child maltreatment and attachment theory. In D. Cicchetti & V. Carlson (Eds.), *Clinical maltreatment: Theory and research on the causes and consequences of child abuse and neglect* (pp. 432–463). Cambridge, England: Cambridge University Press.

Crocker, J., & Wolfe, C. T. (2001). Contingencies of self-worth. *Psychological Review, 108*, 593–623.

Crohan, S. (1996). Marital quality and conflict across the transition to parenthood in African American and White couples. *Journal of Marriage and the Family, 58*, 933–944.

Daniel, S. I. F. (2006). Adult attachment patterns and individual psychotherapy: A review. *Clinical Psychology Review, 26*, 968–984.

Delmore-Ko, P., Pancer, S. M., Hunsberger, B., & Pratt, M. (2000). Becoming a parent: The relation between prenatal expectations and postnatal experience. *Journal of Family Psychology, 14,* 625–640.

Feeney, J., Alexander, R., Noller, P., & Hohaus, L. (2003). Attachment insecurity, depression, and the transition to parenthood. *Personal Relationships, 10,* 475–493.

Feeney, J. A., Hohaus, L., Noller, P., & Alexander, R. P. (2001). *Becoming parents: Exploring the bonds between mothers, fathers, and their infants.* New York: Cambridge University Press.

Feldman, S. S., & Nash, S. C. (1984). The transition from expectancy to parenthood: Impact of the firstborn child on men and women. *Sex Roles, 11,* 84–95.

Goldberg, W. A., & Michaels G. Y. (1988). Conclusion: The transition to parenthood: Synthesis and future directions. In G. Y. Michaels & W. A. Goldberg (Eds.), *The transition to parenthood: Current theory and research* (pp. 342–360). New York: Cambridge University Press.

Gottlieb, B. H., & Pancer, S. M. (1988). Social networks and the transition to parenthood. In G. Y. Michaels & W. A. Goldberg (Eds.), *The transition to parenthood: Current theory and research* (pp. 235–269). New York: Cambridge University Press.

Hammen, C., Burge, D., Daley, S. E., Davila, J. et al. (1995). Interpersonal attachment cognitions and prediction of symptomatic responses to interpersonal stress. *Journal of Abnormal Psychology, 104,* 436–443.

Hazan, C., & Shaver, P. R. (1987). Romantic love conceptualized as an attachment process. *Journal of Personality and Social Psychology, 52,* 511–524.

Hazan, C., & Shaver, P. R. (1994). Attachment as an organizational framework for research on close relationships. *Psychological Inquiry, 5,* 1–22.

Heinicke, C. M. (1995). Determinants of the transition to parenthood. In M. H. Bornstein et al. (Eds.), *Handbook of parenting, Vol. 3: Status and social conditions of parenting* (pp. 277–303). Mahwah, NJ: Erlbaum.

Heinicke, C. M., Fineman, N. R., Ruth, G., Recchia, S. L., Guthrie, D., & Rodning, C. (1999). Relationship-based intervention with at-risk mothers: Outcome in the first year of life. *Infant Mental Health Journal, 20,* 349–374.

Hobbs, D. F., & Cole, S. O. (1976). Transition to parenthood: A decade of replication. *Journal of Marriage and the Family, 38,* 723–731.

Levy-Shiff, R. (1994). Individual and contextual correlates of marital change across the transition to parenthood. *Developmental Psychology, 30,* 591–601.

Mickelson, K. D., Kessler, R. C., & Shaver, P. R. (1997). Adult attachment in a nationally representative sample. *Journal of Personality and Social Psychology, 73,* 1092–1106.

Mikulincer, M., & Florian, V. (1998). The relationship between adult attachment styles and emotional and cognitive reactions to stressful events. In J. A. Simpson & W. S. Rholes (Eds.), *Attachment theory and close relationships* (pp. 143–165). New York: Guilford Press.

Mikulincer, M., Florian, V., & Weller, A. (1993). Attachment styles, coping strategies, and posttraumatic psychological distress: The impact of the Gulf War in Israel. *Journal of Personality and Social Psychology, 64,* 817–826.

Mikulincer, M., & Shaver, P. R. (2007). Boosting attachment security to promote mental health, prosocial values, and inter-group tolerance. *Psychological Inquiry, 18,* 139–156.

Pancer, S. M., Pratt, M., Hunsberger, B., & Gallant, M. (2000). Thinking ahead: Complexity of expectations and the transition to parenthood. *Journal of Personality, 68,* 253–280.

Rholes, S. W., Simpson, J. A., Campbell, L., & Grich, J. (2001). Adult attachment and the transition to parenthood. *Journal of Personality and Social Psychology, 81,* 421–435.

Russell, C. (1974). Transition to parenthood: Problems and gratifications. *Journal of Marriage and the Family, 36,* 294–301.

Ryder, R. G. (1973). Longitudinal data relating marriage satisfaction and having a child. *Journal of Marriage and the Family, 35*, 604–606.

Schulz, M. S., Cowan, C. P., & Cowan, P. A. (2006). Promoting healthy beginnings: A randomized controlled trial of a preventative intervention to preserve marital quality during the transition to parenthood. *Journal of Consulting and Clinical Psychology, 74*, 20–31.

Simpson, J. A., & Rholes, W. S. (1994). Stress and secure base relationships in adulthood. In K. Bartholomew & D. Perlman (Eds.), *Advances in personal relationships (Vol. 5): Attachment processes in adulthood* (pp. 181–204). London: Kingsley.

Simpson, J. A., Rholes, W. S., Campbell, L., Tran, S., & Wilson, C. L. (2003). Adult attachment, the transition to parenthood, and depressive symptoms. *Journal of Personality and Social Psychology, 84*, 1172–1187.

Simpson, J. A., Rholes, S. W., & Nelligan, J. S. (1992). Support seeking and support giving within couples in an anxiety-provoking situation. *Journal of Personality and Social Psychology, 62*, 434–446.

Simpson, J. A., Rholes, W. S., & Winterheld, H. A. (2010). Attachment working models twist memories of relationship events. *Psychological Science, 21*, 252–259.

Simpson, J. A., Winterheld, H. A., Rholes, W. S., & Oriña, M. M. (2007). Working models of attachment and reactions to different forms of caregiving from romantic partners. *Journal of Personality and Social Psychology, 93*, 466–477.

Suess, G. J., & Sroufe, J. (2005). Clinical implications of the development of the person. *Attachment and Human Development, 7*, 381–392.

Tucker, P., & Aron, A. (1993). Passionate love and marital satisfaction at key transition points in the family life cycle. *Journal of Social and Clinical Psychology, 12*, 135–147.

Whiffen, V. E., & Johnson, S. M. (1998). An attachment theory framework for the treatment of childbearing depression. *Clinical Psychology: Science and Practice, 5*(4), 478–493.

Wright, P. J., Henggeler, S. W., & Craig, L. (1986). Problems in paradise? A longitudinal examination of the transition to parenthood. *Journal of Applied Developmental Psychology, 7*, 277–291.

The Wiley-Blackwell Handbook of Couples and Family Relationships

Edited by Patricia Noller and Gery C. Karantzas

WILEY-BLACKWELL
A John Wiley & Sons, Ltd., Publication

This edition first published 2012

Blackwell Publishing was acquired by John Wiley & Sons in February 2007. Blackwell's publishing program has been merged with Wiley's global Scientific, Technical, and Medical business to form Wiley-Blackwell.

Registered Office
John Wiley & Sons Ltd, The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK

Editorial Offices
350 Main Street, Malden, MA 02148-5020, USA
9600 Garsington Road, Oxford, OX4 2DQ, UK
The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK

For details of our global editorial offices, for customer services, and for information about how to apply for permission to reuse the copyright material in this book please see our website at www.wiley.com/wiley-blackwell.

Library of Congress Cataloging-in-Publication Data

The Wiley-Blackwell handbook of couples and family relationships / edited by Patricia Noller and Gery C. Karantzas.
p. cm.
Includes bibliographical references and index.
ISBN 978-1-4443-3450-0 (hbk. : alk. paper)
1. Families–Psychological aspects. 2. Couples–Psychology. 3. Interpersonal relations. I. Noller, Patricia. II. Karantzas, Gery C.
HQ519.W55 2012
306.87–dc23

2011032986

A catalogue record for this book is available from the British Library.

This book is published in the following electronic formats: ePDF 9781444354089; Wiley Online Library 9781444354119; ePub 9781444354096

Set in 10.5/12.5pt, AGaramond-Regular by Thomson Digital, Noida, India
Printed and bound in Malaysia by Vivar Printing Sdn Bhd

1 2012