PREPARING FOR PARENTHOOD: INDIVIDUAL AND COUPLE MODELS OF ANXIETY AND MARITAL SATISFACTION

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by

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ABSTRACT

One of the most significant life transitions in adulthood is becoming a parent. Many prior studies found that many couples experiencing the transition to parenthood have a decrease in marital satisfaction following the birth of their first baby (e.g. Belsky & Kelly, 1994); however, few studies attempt to examine what factors during pregnancy impact antenatal marital satisfaction. If declines in relationship satisfaction can be prevented during pregnancy, couples may experience less difficulty in the transition to parenthood. One way to help is when couples engage in behaviors to prepare for the birth of their baby. Yet, little is known about the role of proactive coping both individually and communally and their relation to anxiety and marital satisfaction. Additionally, parenting efficacy has been found to be important with new parents after the birth of their baby to predict role satisfaction, mood, and marital adjustment (e.g. Teti & Gelfand, 1991). Because few prior studies have examined parenting efficacy during pregnancy, the current study will examine the role that parenting efficacy has on feelings of responsibility for the pregnancy and proactive coping efforts. Some researchers argue that the transition to parenthood cannot be examined solely through one partner, or only the couple, because there are three different viewpoints in a marriage that need to be examined: his, hers, and theirs (Cowan et al., 1985). The current study will use this approach to explore how preparing to have a baby can impact both the individual and the couple. Structural equation models will be used to examine the pathways between
feelings of responsibility about the pregnancy, parenting efficacy, and proactive coping on anxiety and marital satisfaction.
INTRODUCTION

The transition to parenthood is a period of disequilibrium, with first-time parents experiencing new expectations and situations (Levy-Shiff, 1999). Many first-time parents report that they feel unprepared for the transition to parenthood and the adjustments that may accompany their new roles as parents (Vanzetti & Duck, 1996). Some couples prepare for parenthood through activities such as antenatal classes, but little is known about other ways in which couples prepare themselves for the transition as well as why some couples prepare more than other couples. Many couples prepare for the transition to parenthood by researching information on pregnancy and how to care for the baby. What remains less clear is how these methods of preparation can impact both the husband and wife separately, and how it may prepare them for parenthood as a couple.

Additionally, although efficacy about one’s ability to carry out parenting tasks has been found to be linked with mental health postpartum (Teti & Gelfand, 1991), little has been done to determine if parenting efficacy is linked to outcomes such as marital satisfaction or anxiety levels during pregnancy. One way that parenting efficacy might impact an expectant parent during pregnancy is by motivating them to prepare for the birth of their baby. Researchers argue that proactive coping behaviors can be beneficial when preparing for an upcoming stressor (Aspinwall & Taylor, 1997). By engaging in activities that are needed to get ready for the delivery and bringing the baby home, parents may feel more prepared for the transition to parenthood. These types of coping strategies, however, have not been studied in the context of couples making the transition
to parenthood. The present study will investigate if proactive coping during pregnancy can help alleviate the anxiety that many individuals feel prior to becoming parents, and additionally to determine if preparation during pregnancy can increase marital satisfaction.

*Parenthood and Marital Satisfaction*

One of the most consistent findings during the transition to parenthood is a decrease in marital satisfaction and marital adjustment following the birth of a couple’s first child (e.g. Belsky & Kelly, 1994). Specifically, marital satisfaction is found to be at a high in the last trimester of pregnancy and generally declines thereafter (Cowan et al., 1985; Heinicke, Guthrie, & Ruth, 1997; Waldron & Routh, 1981). While a majority of studies report couples experiencing a decline in marital satisfaction and an increase in marital conflict over the transition, some researchers have found that as many as 50% of couples may not experience these detrimental changes and may experience the same or even an increase in marital satisfaction (Belsky & Rovine, 1990). If not all couples experience the same decrease in satisfaction after the birth of a first child, it is important to determine what makes these couples different and if factors during pregnancy could alter how a couple adjusts to the transition to parenthood. Relationship satisfaction prior to the pregnancy can indicate how the transition to parenthood may impact a couple. Also, satisfaction with the marital relationship prior to the pregnancy has been found to predict later marital satisfaction (Lawrence et al., 2008). However, little is understood about what can be done during pregnancy to help ease the transition to parenthood.
Moreover, researchers have argued that men and women experience marriage differently (e.g. Bernard, 1974). The period surrounding the transition to parenthood especially seems to impact husbands and wives differently. Some researchers, in fact, have argued that there are three different experiences that occur and should be investigated during the transition to parenthood: his, hers and, theirs (Cowan et al., 1985). They argue that men are more active during the birth and the early care of the baby, but then tend to take on a role as a provider financially for the new family. A woman’s transition into parenthood tends to be more dramatic, with a shift in both work life and home life. Women also tend to shift their focus with a greater percentage of their time being devoted to caring for the baby than do their husbands. Thus, women may experience both more positive and negative changes during the transition than their husbands (Feldman & Nash, 1984). Women may also experience greater declines in marital satisfaction during the transition to parenthood than men (Belsky, Spanier, & Rovine, 1983). As a couple, the transition can involve more conflict and less time for the relationship as more time is shifted to caring for the baby. However, a recurring problem in the literature on the transition to parenthood is the focus on only one partner, traditionally the expectant mother (e.g. Bienat & Wortman, 1991). By only focusing on one partner rather than the couple, many potential implications of the dyadic interaction between partners goes unobserved. By using couples and examining how both the husband and wife interact with each other and how the actions of one partner may impact the other, a more complete picture of what is occurring during the transition can be understood.
Anxiety during Pregnancy

Pregnancy is an experience that precedes a major life transition and has been found to be an anxiety-provoking time period for both expectant mothers and fathers (e.g. Entwisle & Doering, 1981). Researchers found that those seeking treatment for anxiety disorders report lower marital satisfaction than those without the disorder (Chambless et al, 2002). Thus, the anxiety that couples experience during the transition to parenthood could partially help to explain the decline in marital satisfaction and why some couples experience more of a decline than others. Some parents may worry more about what will happen during the pregnancy and after the birth of the baby than other parents. While some anxiety during pregnancy can be beneficial and even adaptive for expectant parents (Leifer, 1980), excessive anxiety can be problematic during pregnancy. Anxiety can be especially troubling in pregnant women because it has been found to be related to problems during both delivery and in the postpartum period (Rizzardo et al., 1988). One factor that may be related to lower anxiety during pregnancy is a strong belief in one’s ability to parent effectively. Another potential way to lessen anxiety during the pregnancy and across the transition is for couples to prepare for the upcoming birth and educate themselves about the changes that accompany the transition. Courses in childbirth preparation have been shown to reduce anxiety in pregnant women (e.g. Hetherington, 1990), and approximately 70% of all women attend some type of antenatal class (Lu, Prentice, Yu, Inkelas, Lange, & Halfon, 2003). However, less is known about other ways in which couples prepare for the transition. Therefore, it is important to
understand what could be provoking anxiety during pregnancy and how it can be managed.

Parenting Efficacy

One primary concern of all expectant parents that may influence anxiety and adjustment to parenting is whether they will be a good mother or father – in other words, parenting efficacy may have important implications for the transition to parenthood. Bandura (1977) defined self-efficacy as an individual’s judgment of their own personal capability to be successful in carrying out activities that are required of them. Efficacy for tasks can be developed from relationships with others, personal experiences, and physiological states of an individual (Bandura, 1999). Furthermore, self-efficacy is the gaining of knowledge and skills and the belief in one’s ability to effectively use this increase in knowledge and skills.

How confident a parent feels in their ability to adequately take care of their child can be determined in part through parenting efficacy. Parenting self-efficacy examines how competent a parent feels about their ability to positively influence both the development and behavior of their child (Coleman & Karraker, 2000). One potential important predictor of parenting efficacy during pregnancy may be the degree to which an individual feels responsibility for the pregnancy. Efficacy about parenting has been found to be related to parenting behaviors and well-being of the parent. For example, parents with perceived high parenting efficacy are found to engage in better parenting practices and mothers with high efficacy for parenting tasks experience less psychological distress (Halpern & McLean, 1997). Parenting efficacy after the birth of
the baby is linked with anxiety, depression and marital satisfaction (Teti & Gelfand, 1991). An important outcome of high self-efficacy is the ability to manage the impact of disruptions, stressors, and obstacles, which is important when becoming parents. While parenting efficacy has been found to be an important link in understanding an individual’s perception of their parenting ability in the postpartum period, less is known about the antecedents and consequences of parenting efficacy during pregnancy. One longitudinal study, however, found that confidence in future parenting ability, as measured during pregnancy, predicted a mother’s emotional state, attachment to the baby, and adaptation to the transition to parenthood postpartum (Williams, Joy, Travis, Gotowiec, Blum-Steele, Aiken, Painter, & Davidson, 1987). Additionally, parenting efficacy may increase a couple’s preparation for the pregnancy through activities such as attendance at birthing classes, which may in turn lessen anxiety and improve marital satisfaction. Thus, the first aim of the current thesis is to examine both pregnancy responsibility as a predictor of parenting efficacy and the role of parenting efficacy, at both the individual and couple level, on marital satisfaction and anxiety.

Coping during Pregnancy

Another way that anxiety and distress about the pregnancy can be minimized is through effective coping strategies. Coping is seen as a primary method to manage anxiety and distressing emotional states (Folkman & Lazarus, 1988). Coping entails a series of steps that has the potential to moderate the impact a stressful event can have on health outcomes (Lazarus, 1993). Various coping strategies can be utilized during stressful experiences and transitions. Many traditional coping strategies are most useful
when an event is occurring in the present time, rather than when a stressor is anticipated to occur in the future. One way in which people can cope with upcoming stressors is through proactive coping. In proactive coping, an effort is made in advance to prevent or modify a potentially stressful event before it occurs (Aspinwall & Taylor, 1997). The proactive coping model discusses five components: 1) building a reserve of resources, 2) recognition of the potential stressors, 3) appraisal of the potential stressors, 4) preliminary coping, and 5) eliciting feedback about their efforts (see Folkman & Moskowitz, 2004, for a review). Proactive coping has typically been studied in situations such as a pending lay-off or upcoming medical test (e.g. Folkman & Moskowitz, 2004). Using proactive coping prior to a stressor being experienced has been found to be beneficial (e.g. Folkman & Moskowitz, 2004).

Aspinwall and Taylor (1997) discuss three ways in which proactive coping is different than other types of coping. First, proactive coping is used prior to traditional coping as a means to accumulate resources to prepare for the stressor, rather than after a stressor occurs when specific needs are addressed through traditional coping strategies. For example, when a lay-off is pending individuals may be able to save money for when they are not working. Second, different skills are required to cope with an imminent stressor as opposed to one that has already occurred. In the example of a pending lay-off when preparing to experience a job loss, the individual can prepare their résumé and begin to look for a job. Third, various coping strategies are differentially effective with proactive coping than with coping during an event. Again, returning to the pending lay-off example, if an individual waits to look for a new job until after being laid-off, this
person is now competing with all of the other co-workers who have also been laid-off. 
Alternately, if the individual employs this strategy proactively prior to the lay-off, there may be less competition for the jobs.

During pregnancy, proactive coping may help to buffer against negative consequences, which can lead to decreases in marital satisfaction or greater anxiety. Some of the ways couples can proactively cope during pregnancy include attending childbirth classes, talking with other couples who have already experienced the transition to parenthood, or gathering information about having a baby through books or the Internet. However, to date, proactive coping during pregnancy has not been systematically examined in the literature. Thus, little is known about the predictors and consequences of proactive coping. As with parenting efficacy, it seems likely that the more responsibility one feels for the pregnancy the more likely they should be to engage in proactive coping. Moreover, the more one proactively copes the less anxious one should feel during pregnancy. Thus, a second aim of the current thesis is to examine how pregnancy responsibility is related to proactive coping and how proactive coping is related to anxiety and marital satisfaction – specifically, whether parenting efficacy mediates the link between proactive coping and these outcomes.

Communal Coping

While proactive coping may be important in reducing the negative impact of a stressor, another equally important issue is how the stressor is appraised. While coping has traditionally been viewed as a solipsistic strategy, another way in which coping can occur is communally. Lyons and colleagues (1998) argue that there are three components
to communal coping. First, the event is occurring jointly among two or more network members. Second, communication must take place between members of the network about the situation, without discussion about the stressor or ways that might help to lessen the impact of the event, communal coping cannot occur. Finally, individuals in the group experiencing the stressor must work together to determine strategies to reduce the negative impact it has on the group and its members. By working together, individuals feel as though they are not alone and that it may be easier to overcome the stressor.

Similarly, Coyne and Fiske (1992) proposed the concept of relationship-focused coping, which suggests that individuals do not process stressors isolated from others but rather address stressors within the context of the relationships they are in. Even when coping is undertaken by an individual, rarely does it only impact the person coping with the stressor, it also has ramifications for other members of their network. While for many events, individuals appraise an event as happening to them and see stressors as individualistic, other times stressors are viewed as happening more broadly to the social network and are appraised as communal. Belsky and Kelly (1994) argue it is important for couples to view the transition to parenthood as happening to the couple communally rather than individually. Pregnancy may be an especially important event to see as communal because of the implications it may have for the couple both during pregnancy and postpartum. If couples view the experience collectively rather than separately, then they will work together to discuss the situation and determine ways to reduce the potential negative impact on their lives (Shapiro, Gottman, & Carrère, 2000). In this way, the transition may actually bring them closer as a couple, rather than create stress
and tension between them which can lower their marital satisfaction and increase their anxiety. Thus, the final aim of the current thesis is to examine how communal coping is linked with pregnancy responsibility, parenting efficacy and anxiety and marital satisfaction couples preparing for the transition to parenthood.

Present Study

In the current thesis, I examined the influence of parenting efficacy, proactive coping, and communal coping in first-time expectant couples. I hypothesized that there will be a relationship between these three factors and anxiety and marital satisfaction at both the individual and couple level. In order to investigate these aims, online and phone interviews were used to collect information from couples about preparation during pregnancy, as well as levels of anxiety and marital satisfaction.

Two specific models of the processes will be tested – one at the individual level and one at the couple level. As shown in Figure 1 below, for the individual model, I predict that participants who feel more individual responsibility for the pregnancy will engage in more proactive coping activities in the form of Internet use which will, in turn, be related to higher parenting efficacy. Also, participants with higher levels of parenting efficacy are proposed to have better marital satisfaction and lower levels of anxiety. With respect to gender, I predict that these relationships will be stronger for female participants as they are more likely to take personal responsibility for the pregnancy, whereas men are more likely to believe the responsibility belongs to their wife or, at the most, should be a communal responsibility.
For the couple model, shown in Figure 2 below, I predicted that couples who feel more efficacious about parenting activities will feel more communal responsibility for the pregnancy. Additionally, higher couple parenting efficacy will be related to more communal proactive coping (operationalized as husband’s attendance at OB/GYN visits). Couples with greater communal responsibility for the pregnancy and more communal proactive coping will have better marital satisfaction and lower levels of couple anxiety.
Figure 2. Proposed Couple-Level Model

Communal Cognition

+ Communal Coping

- Communal Responsibility for Pregnancy

+ Parenting Efficacy

+ Communal Responsibility for Issues

- Anxiety

+ Relationship Satisfaction
METHODS

Sample

The sample was composed of 104 heterosexual married or cohabitating couples that were primiparous who participated in the Baby Transitions in Marital Exchanges Study (Baby T.I.M.E. Study). Both the husband and wife needed to be employed, expecting their first child, and in their third trimester of pregnancy to be eligible to participate. Couples were also required to be fluent in English. Participants were recruited from local birthing classes and online message boards. Additionally, the snowballing technique was used to recruit participants.

Procedure

Couples who agreed to take part in the study completed interviews in their third trimester (between 24-32 weeks of pregnancy). Participants completed online questionnaires and then completed a second portion of the interview over the phone with trained interviewers. Participants completed both the online and phone questionnaire independent of their partner and an effort was made for both partners to complete their interviews within the same day. The combined online and phone interview took each participant approximately one hour to complete, couples were compensated $25 for their time.
**Materials**

*Sociodemographics*. The following demographic information was collected from participants: *age* (which ranged from 18 to 52); *years with partner* (which ranged from 1 month to 12 years); *household income*, and the *percentage of income* each spouse provided. *Education level* was categorized as some high school, high school, some college, college education, or advanced degree. *Employment status* was categorical with responses of full-time, part-time, self-employed, or currently not working. Information about *prior miscarriages* and *pregnancy symptoms* were also collected from the women in the study. See Table 1 for means and ranges of the sociodemographics for the current sample.

*Parenting Self-Efficacy.*

Participants completed an adapted version of Self-Efficacy for Parenting Tasks (SEPTI-TS) (Coleman & Karraker, 2003) which was modified to 14 questions that reflected activities required to care for infants. Examples of items included: “I will have difficulty determining what is and is not safe for my baby to do” and “My baby will feel very loved by me.” Potential responses ranged from 1 to 6 (1 = “disagree strongly, 2 “disagree somewhat”, 3 = disagree a little”, 4 = “agree a little”, 5 = “agree somewhat”, 6 = “agree strongly”). Some of the items were reverse coded and a sum score of the items was created ($\alpha = .68$). See Appendix for sample questionnaires.

*Proactive Coping Strategies*

*Internet use.* To determine how much participants were using resources on the Internet to prepare for the transition to parenthood, they were asked “How often in the
past 6 months have you accessed websites (including chat rooms and blogs) related to pregnancy, childbirth, and parenting?” Participants were asked the same question for posting and reading websites. Possible responses included not at all, less than once a month, 2-4 times a month, weekly, or daily.

**Communal coping.** To assess communal coping, attendance by the husband at OB/GYN appointments was reported by wives. All female participants were asked “What percentage of OB/GYN appointments does your husband/partner accompany you to?” Potential responses included attendance at 0%, 25%, 50%, 75%, or 100% of the OB/GYN appointments.
Table 1. Descriptive Statistics of Demographic and Major Study Variables

<p>|                      | Husband | | | Wife | | |
|----------------------|---------|---------------|---------|---------------|---------------|
|                      | M       | (SD)          | Range   | M             | (SD)          | Range        |
| Age                  | 29.99   | 4.77          | 19 - 52 | 28.06         | 3.80          | 18 - 41      |
| Years married        | 3.29    | 2.10          | 0 - 12  | 3.38          | 2.23          | 0 - 12       |
| Anxiety              | 4.23    | 4.16          | 0 - 22  | 5.03          | 3.95          | 0 - 18       |
| Relationship satisfaction | 43.61  | 4.30          | 33 - 49 | 43.27         | 5.00          | 19 - 49      |
| Internet use         | 2.45    | 1.19          | 1 - 5   | 4.24          | 0.95          | 1 - 5        |
| Pregnancy responsibility | 0.99  | 0.10          | 0 - 1   | 0.33          | 0.47          | 0 - 1        |
| Thinking about pregnancy | 0.94  | 0.23          | 0 - 1   | 0.45          | 0.50          | 0 - 1        |
| Parenting efficacy   | 70.69   | 5.84          | 54 - 83 | 71.88         | 0.57          | 1 - 3        |
| Education (%)        |         |               |         |               |               |              |
| High School          | 9.60    |               |         | 7.70          |               |              |
| Some College         | 24.00   |               |         | 16.30         |               |              |
| College              | 41.30   |               |         | 53.80         |               |              |
| Advanced Degree      | 25.00   |               |         | 22.10         |               |              |</p>
<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>(SD)</th>
<th>Range</th>
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<tr>
<td>Age</td>
<td>34.00</td>
<td>18.00</td>
<td>18 - 52</td>
</tr>
<tr>
<td>Years married</td>
<td>3.34</td>
<td>2.16</td>
<td>0 - 12</td>
</tr>
<tr>
<td>Anxiety</td>
<td>4.66</td>
<td>4.07</td>
<td>0 - 22</td>
</tr>
<tr>
<td>Relationship satisfaction</td>
<td>43.44</td>
<td>4.63</td>
<td>19 - 49</td>
</tr>
<tr>
<td>Internet use</td>
<td>3.34</td>
<td>1.40</td>
<td>1 - 5</td>
</tr>
<tr>
<td>Pregnancy responsibility</td>
<td>1.60</td>
<td>0.43</td>
<td>.50 - 2</td>
</tr>
<tr>
<td>Thinking about pregnancy</td>
<td>1.72</td>
<td>0.41</td>
<td>0 - 2</td>
</tr>
<tr>
<td>Parenting efficacy</td>
<td>71.28</td>
<td>4.35</td>
<td>61 - 80</td>
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Household Income

<table>
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<tr>
<td>$20,000 - $40,000</td>
<td>10.6%</td>
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<tr>
<td>$40,000 - $60,000</td>
<td>16.3%</td>
</tr>
<tr>
<td>$60,000 - $80,000</td>
<td>29.8%</td>
</tr>
<tr>
<td>$80,000 - $100,000</td>
<td>10.6%</td>
</tr>
<tr>
<td>$100,000 - $120,000</td>
<td>12.5%</td>
</tr>
<tr>
<td>More than $120,000</td>
<td>16.3%</td>
</tr>
</tbody>
</table>
Pregnancy Responsibility

To examine how responsibility for the pregnancy was viewed by participants, two questions were asked: 1) When issues arise about the pregnancy, whose responsibility is it to try to deal with the issues? and 2) When thinking about the pregnancy, how do you consider it? with potential responses for both items ranging from 1 to 5 (1 = “completely my responsibility”, 3 = “completely our responsibility”, 5 = “completely my spouse’s responsibility”). Because no husbands reported a 1 or 2 and no wives reported a 4 or 5, the variables were recoded to reflect variability between pregnancy as completely the wife’s responsibility to completely communal. The mean of the two items was calculated to compose the pregnancy responsibility variable.

Outcome Variables

Anxiety. Participants’ anxiety was assessed through self-report questions from the SCL-90R (Derogatis, 1994). Participants were asked to report how they felt in the last week in regards to 10 different items (e.g “felt nervous”; “felt so restless you could not sit still”). Possible responses ranged from most (5-7 days) = 3, moderate (3-4 days) = 2, a little (1-2 days) = 1, or none/rarely (<1 day) = 0 that week. A mean score was created from the responses (α = .80), with higher scores indicating higher levels of anxiety.

Marital Satisfaction. The Relationship Assessment Scale (Hendrick, 1988) was used to determine marital satisfaction (e.g. “How well does your partner meet your needs?”; “How good is your relationship to most other couples?”) The measure consisted of seven questions with potential responses ranging from 1 = “never” to 7 = “very often”.
The last two questions were reverse-coded and a sum score of the seven items was created ($\alpha = .79$).

**Overview of Analyses**

To test the models proposed in Figures 1 and 2, structural equation modeling (SEM) was utilized (EQS 6.1, Bentler, 2006). SEM allows for the testing of all components of the mediational model simultaneously while also modeling measurement error. Preliminary examination of the data revealed that all of the assumptions of linear regression and SEM (e.g., linearity, random residuals, multivariate normality) were met with the current dataset. Examination of the bivariate correlation matrix also did not reveal any problems with multicollinearity (see Tables 2, 3, and 4 below). Potential covariates were entered into regression models with anxiety and marital satisfaction as the outcomes – significant covariates in these respective models were entered into the SEM models as free-to-float variables (discussed below).

<table>
<thead>
<tr>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1- Pregnancy Responsibility</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2- Internet Use</td>
<td>0.10</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3- Parenting Efficacy</td>
<td>-0.16</td>
<td>-0.13</td>
<td>--</td>
<td></td>
<td></td>
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<tr>
<td>4- Anxiety</td>
<td>0.05</td>
<td>0.06</td>
<td>-0.17</td>
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<tr>
<td>5- Relationship Satisfaction</td>
<td>-0.27 **</td>
<td>-0.10</td>
<td>0.22 *</td>
<td>-0.07</td>
<td>--</td>
</tr>
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*p < .05 **p < .01 ***p < .001.
Table 3. Correlations for Individual-Level Study Variables for Husbands (N = 104 Individuals)

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<th>5</th>
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<tr>
<td>1</td>
<td>Pregnancy Responsibility</td>
<td>--</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td>Internet Use</td>
<td>0.12</td>
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<tr>
<td>3</td>
<td>Parenting Efficacy</td>
<td>0.07</td>
<td>-0.06</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Anxiety</td>
<td>0.08</td>
<td>0.07</td>
<td>-0.42</td>
<td>***</td>
</tr>
<tr>
<td>5</td>
<td>Relationship Satisfaction</td>
<td>-0.04</td>
<td>-0.03</td>
<td>0.14</td>
<td>-0.18</td>
</tr>
</tbody>
</table>

*p<.05  **p<.01  ***p<.001.

Table 4. Correlations for Couple-Level Study Variables (N = 104 Couples)

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<td>2</td>
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<td>0.19</td>
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<tr>
<td>3</td>
<td>Anxiety</td>
<td>-0.30</td>
<td>** -0.20</td>
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<td>Responsibility</td>
<td>0.16</td>
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<td>-0.16</td>
<td>0.23 *</td>
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<td>0.22 *</td>
<td>-0.07</td>
<td>-0.05</td>
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*p<.05  **p<.01  ***p<.001.
RESULTS

The sample was composed of 104 heterosexual couples (N = 208 individuals). Couples on average had been married (or cohabiting) for 3 years ($M = 3.30$). The mean participant age was 34 years, ranging from 18 to 52 years with men being significantly older than women $F = (1, 206) = 10.45$, $p < .05$ (Men: $M = 30$; Women: $M = 28$).

Women had higher levels of anxiety than men (Women: $M = 5.03$; Men: $M = 4.23$) but similar levels of marital satisfaction (Women: $M = 43.27$; Men: $M = 43.61$). Women also had significantly higher levels of Internet usage than men $F = (1, 206) = 142.53$, $p < .05$ (Women: $M = 4.24$; Men: $M = 3.34$). Couples had high amounts of communal feelings of responsibility ($M = 1.66$). 6.7% of husbands attended 0% of the OB/GYN appointments, 28.8% attended 25%, 7.7% attended 50%, 19.2% attended 75%, and 37.5% attended 100% of the appointments with their wife. Prior to conducting SEM, preliminary analyses were conducted to identify potential variables that should be included as potential covariates. Based on the results of these analyses, age was initially entered into all models as free-to-float variable. In addition to age, spouse’s parenting efficacy was added in as a free-to-float variable in the individual models.

**Individual-level SEM Model for Wives**

To test the individual model, the data were analyzed using a partial structural model. Spouse’s parenting efficacy and age were initially put in as exogenous free to float variables. The spouse’s level of parenting efficacy was not significantly associated with any of the study variables and was removed from the model. In the model, paths
were retained for age with relationship satisfaction. Including these variables in the current model ensured that any initial inequalities with participants would be accounted for by the model, which allowed for the assessment of the unique effects of the main variables in the study. Although I retained the above paths in the final model, for ease of presentation, they are not shown in Figure 3 (see page 20). Because the variable of pregnancy responsibility is expected to be different by gender the models were analyzed separately for husbands and wives. Pregnancy responsibility for wives was coded such that a higher score indicates more individual responsibility for the pregnancy. For husbands, a higher score on pregnancy responsibility indicates more communal responsibility for the pregnancy (see Appendix E for syntax).

The maximum likelihood (ML) estimation method was used for the current model since there was no violation of the multivariate normality assumption. Bentler (2006) recommends that sample sizes are adequate when a recommended ratio N:q ratio of 7:1 (i.e., with 7 participants for each parameter estimate) is met. Others have suggested a recommended ratio between 5:1 and 10:1 (with 5 or 10 representing the number of free parameter estimates). The present sample of 104 was sufficient using this estimate. The N:q is a good measure of power because it factors the complexity of the model, instead of simply considering the number of variables in the model (Jackson, 2003). Additionally, the model was properly overidentified, with 21 known parameters to 9 unknown parameters.

The hypothesized model fit the data well $\chi^2(9, N = 104) = 10.15, p = .34, CFI = .94, RMSEA = .04 (CI = .00, .12)$. The fit indices demonstrate this model to be a good fit
of the data because the p-value for the chi-square is not significant, the comparative fit index (CFI) is above .90, the root mean-square error of approximation (RMSEA) is less than .05, and the confidence interval (CI) lowest number should be close to 0 and the highest number is close to 0.10. However, the program suggested that a direct pathway between pregnancy responsibility and relationship satisfaction should be added to the model. Adding this pathway significantly improved the fit of the model ($\Delta \chi^2 = (1, N = 104) = 7.29, p < .05$). As shown in Figure 3, the modified model provided a good fit to the data, $\chi^2 (9, N = 104) = 2.86, p = .97, CFI = 1.00, RMSEA = .00$. Examination of the model revealed that all but two of the individual pathways were significant and the pathway between parenting efficacy and anxiety was marginally significant (non-significant pathways were retained in the model as their removal did not change the fit – these pathways are represented with a dotted line to indicate non-significance). The modified model suggests that the more responsibility an individual felt for the pregnancy the less marital satisfaction they reported. Additionally, the model suggested that the higher the individual’s parenting efficacy the more marital satisfaction they reported. Contrary to prediction, Internet use (i.e., proactive coping) was not found to be significantly linked with any of the variables in the model.
Individual-level SEM Model for Husbands

To test the individual model, the data were analyzed using a partial structural model. Spouse’s parenting efficacy and age were initially put in as exogenous free to float variables. The spouse’s level of parenting efficacy and age were not significantly associated with any of the study variables and were removed from the model. The maximum likelihood (ML) estimation method was used for the current model since there was no violation of the multivariate normality assumption. According to Bentler’s (2006) recommends the present sample of 104 was sufficient using this estimate. Additionally, the model was properly overidentified, with 15 known parameters to 9 unknown parameters.

The hypothesized model fit the data well $\chi^2 (5, N = 104) = 3.88, p = .46, CFI = 1.00, RMSEA = .00 (CI = .00, .12)$. The fit indices demonstrate this model to be a good fit
of the data because the p-value for the chi-square is not significant, the comparative fit index (CFI) is above .90, the root mean-square error of approximation (RMSEA) is less than .05, and the confidence interval (CI) lowest number should be close to 0 and the highest number is close to 0.10. While the model was a good fit of the data, only one pathway was found to be significant (see Figure 4 below). An alternative model was conducted with anxiety and relationship satisfaction as predictors, parenting efficacy as a mediator, and pregnancy responsibility and Internet use as outcomes variables. This alternative model also fit the data well $\chi^2 (5, N = 104) = 5.35, p = .38, CFI = .98, RMSEA = .03 (CI = .00, .14)$, but was not better than the initial model (AIC initial model = -6.12; AIC alternative model = -4.65), which provided support for the initial model. Contrary to prediction, Internet use and feelings of responsibility about the pregnancy were not found to be significantly linked with any of the variables in the model.
Figure 4. Individual-Level Structural Equation Model for Husbands

Diagram:
- **Pregnancy Responsibility**
  - 0.12 -> **Parenting Efficacy**
- **Internet Use**
  - 0.07 -> **Parenting Efficacy**
- **Parenting Efficacy**
  - 1.00
  - 0.07 -> **Anxiety**
  - -0.07
  - -0.42*** -> **Anxiety**
- **Relationship Satisfaction**
  - 0.14
  - 0.99
  - 0.91

Variables:
- Pregnancy Responsibility
- Internet Use
- Parenting Efficacy
- Relationship Satisfaction
- Anxiety
**Couple-level SEM Model**

In addition to examining an individual’s efficacy and feelings of pregnancy responsibility on marital satisfaction and anxiety, a couple-level model was also tested since the transition may impact individuals and couples differently. To test this couple-level mediational model, the data were analyzed using a partial structural model. Couple-level variables were created by taking the mean score for the couple in different domains. Mean couple education was initially put in as an exogenous free to float variables. In the model, paths were retained for 1) education with couple parenting efficacy and 2) education with couple marital satisfaction. Including these variables in the current model ensured that any initial inequalities with participants would be accounted for by the model, which allowed for the assessment of the unique effects of the main variables in the study. Although we retained the above paths in the final model, for ease of presentation, they are not shown in Figure 5 (see page 23).

Using EQS, communal responsibility was defined as a latent factor. Communal responsibility consisted of the variables of thinking about the pregnancy and whose responsibility it was to deal with issues that arose with the pregnancy. Participants could indicate on these variables if they viewed the pregnancy more individually or communally. Higher scores on these items indicate more communal thinking on each item. The path for whose responsibility it was to deal with issues about the pregnancy was fixed at 1.0 as it was theoretically assumed to account for most of the variance in the latent factor. The Maximum likelihood (ML) estimation method was used for the current model since there was no violation of the multivariate normality assumption.
Additionally, the model was properly overidentified, with 28 known parameters to 13 unknown parameters.

The hypothesized model did not fit the data well $\chi^2 (11, N=104) = 27.99, p = .01, CFI = .64, RMSEA = .11 \ (CI = .00, .12)$. Additionally, the path between attendance at OB/GYN appointment and couple anxiety was not significant and was removed. This modified model fit the data well $\chi^2 (12, N=104) = 13.37, p = .27, CFI = .94, RMSEA = .05 \ (CI = .00, .11)$, and was significantly better than the initial model ($\Delta\chi^2 = (1, N = 104) = 14.62, p < .05$). All of the pathways in the modified model were significant or marginally significant, which are reported given the small sample size. The modified model suggests that the more communal responsibility the couple felt for the pregnancy the more marital satisfaction they reported and marginally less anxiety they reported. The model suggested that the higher the individual’s parenting efficacy the marginally more attendance at OB/GYN appointments by the husband they reported. Additionally, another marginal result was found with increased attendance at OB/GYN appointment being related to higher marital satisfaction.
As suggested by Kline (2005), an alternative model was tested to rule out other potential models. A model was conducted with OB/GYN attendance and communal responsibility as potential predictors, parenting efficacy as a potential mediator, and anxiety and marital satisfaction as potential outcome variables. This alternative model was examined because it was possible that communal behaviors were leading to higher levels of parenting efficacy rather than parenting efficacy being a predictor to communal coping and thinking. Testing the fit between the modified and alternative models found that the alternative model was not a better fit of the data ($\chi^2 (11, N = 104) = 13.96, p =$...
.24, $CFI = .93$, $RMSEA = .05$ ($CI = .00, .12$); ($\Delta \chi^2 = (1, N = 104) = 0.59$, $p > .05$), which provided more support for using the proposed model.
DISCUSSION

The current study systematically examined the process by which parents prepare for their first baby and this process impacts anxiety and relationship satisfaction. A major strength of this study is that these issues were examined at both the individual and couple level – unlike prior research which had almost exclusively focused on mothers-to-be. Three main findings emerged from the analyses. First, at the individual level, perceived responsibility for the pregnancy was differentially related to the outcomes for husbands and wives. Specifically, wives who reported more individual responsibility for the pregnancy had lower levels of marital satisfaction than wives who reported more communal responsibility with their husband for the pregnancy. However, for husbands, no relationship was found between pregnancy responsibility and relationship satisfaction was not found for husbands. Second, for both husbands and wives, parenting efficacy was related to less anxiety (and better relationship satisfaction for wives only). For the couple-level model, those with greater parenting efficacy reported marginally higher husband’s attendance at OB/GYN appointments and marginally more communal thinking. Third, at the couple-level, those who reported higher attendance at OB/GYN appointments reported marginally more marital satisfaction. Each of these main findings will be discussed below with potential implications for theory and future research.
**Pregnancy Responsibility**

An important addition to the literature with this study is how expectant parents viewed responsibility about the pregnancy. At the individual-level, overall wives felt more personal responsibility for the pregnancy (as opposed to communal responsibility), but personal responsibility for the pregnancy was related to lower relationship satisfaction and lower parenting efficacy. For wives, it appears that personal responsibility is indicating that their partner is not as engaged in the pregnancy and, thus, they are left on their own to deal with the issues. This solitude may lessen their confidence in their ability to carry out parenting tasks when the baby arrives. Interestingly, while this relationship was found for wives, no significant findings emerged for husbands between pregnancy responsibility and any of the outcomes. One possible explanation for this lack of a finding is that husbands are able to choose how involved they are with the pregnancy, whereas wives do not have that option. Therefore, regardless of how the pregnancy responsibility is viewed, it may be less important to husbands and have less impact on their lives.

For couples, however, communal responsibility for the pregnancy was related to less couple anxiety and more relationship satisfaction. As Belsky and Kelly (1994) discussed, viewing the pregnancy and parenting experience as a communal event is important because it provides an environment where problems and concerns can be dealt with as a couple – essentially doubling the resources for dealing with issues. Since the couples in the current study were experiencing parenthood for the first time, the transition period may be especially stressful to them and by having a spouse to rely on could help to
provide support needed to successfully make the transition to parenthood. Taken together with the individual level findings, these results suggest that the husband’s perceived responsibility in the pregnancy plays a crucial role for the wife and the couple (if not for himself alone). This finding suggests the importance of examining all three perspectives in the transition to parenthood.

One major strength of the current study is that it is among the first to examine pregnancy responsibility in wives, husbands, and couples and to show that the perception of communal versus individual responsibility matters. However, future research is needed to examine this construct more in-depth. By examining how couples cope with parenthood and how they view responsibility about the child and childcare will important to understanding the decline in marital satisfaction after the birth of the baby (Cowan et al., 1985; Heinicke, Guthrie, & Ruth, 1997; Waldron & Routh, 1981). It is possible that having one parent who views the responsibilities as communal and the other parent viewing it as the responsibility of only one of the parents would lead to conflict and be detrimental to the marital relationship. Finally, a better measure of pregnancy responsibility is needed to more fully understand all three perspectives. In the current study, pregnancy responsibility was assessed on a single continuum from completely mine to completely communal to completely my spouse’s responsibility, which was ultimately recoded to be either personal (or the wife’s) responsibility or communal responsibility. Yet, results suggest that it may be more appropriate to separately assess how much individual and how much communal responsibility husbands and wives perceive with the pregnancy.
Parenting Efficacy

A second major finding was that higher parenting efficacy was related to lower anxiety for both husbands and wives, and higher marital satisfaction for wives. Consistent with prior literature, these results suggest that as individuals feel more efficacious about parenting tasks, they may feel more at ease about the transition to parenthood because they are prepared for the changes that will occur when the baby arrives. While researchers have found that levels of parenting efficacy in the postpartum period can impact mood (e.g. Teti & Gelfand, 1991), prior to this study, little was known about how perinatal levels of parenting efficacy is related to anxiety during pregnancy. This study reveals that parenting efficacy’s link with anxiety begins well before the birth of the baby and may be one important way that postpartum distress can be addressed prospectively.

At the couple-level analyses suggested that parenting efficacy’s link with anxiety and relationship satisfaction was potentially more indirect through communal coping and communal thinking – such that as couple efficacy increased communal coping and thinking also increased, which, in turn, was related to less anxiety and better relationship satisfaction. In other words, parenting efficacy appears to have a greater impact at the individual level rather than the couple level. However, the weaker results for the couple-level model may be related to methodological issues pertaining to the current study. For instance, the measure of couple parenting efficacy was simply the mean of the two individual efficacy scores, as opposed to a separate measure assessing how efficacious they felt as a couple with the impending parenting tasks. Thus, future research needs to
replicate these results to determine whether couple parenting efficacy and individual parenting efficacy really have different links with anxiety and relationship satisfaction.

Again, a major strength of the current study is the examination of parenting efficacy from three perspectives. While the prior literature has not examined parenting efficacy in couples, the results from the current study suggest it may be important to work with parents more extensively during pregnancy to increase their feelings of parenting efficacy. One question that remains to be answered is whether parenting efficacy’s link with coping, anxiety, and relationship satisfaction is weaker in parents who have already experienced parenthood (i.e., multiparous parents). Thus, future research should examine parenting efficacy in parents who are expecting their second child.

**Coping during Pregnancy**

The third main finding of the present study focused specifically on proactive coping during pregnancy. In the current models, Internet use was not found to be significantly related to any of the outcomes. One potential methodological explanation is that couples were interviewed during the third trimester when variability in Internet use was probably less than during the first trimester when expectant parents are more likely to be seeking out information about pregnancy and parenting. Additionally, other forms of proactive coping were not included in the current study, such as talking with other couples who had children, reading books about the pregnancy, or preparing the house for the arrival of the baby. One other form of proactive coping was included in the study but not in the analyses – attendance at birthing classes – because there a ceiling effect (and it was confounded with the recruitment strategy for the study). Furthermore, research
suggests that over 70% of expectant parents attend a birthing class (Lu, Prentice, Yu, Inkelas, Lange, & Halfon, 2003). Thus, future research needs to find proactive coping strategies for expectant parents that will sufficient variability to determine whether efficacy or pregnancy responsibility are related to proactive coping in individuals.

Despite the lack of findings for proactive coping through individual Internet usage, proactive coping was significant in the couple-level model. Specifically, and as predicted, communal coping (as measured by attendance at OB/GYN appointments by the husband) was related to higher levels of relationship satisfaction. Attendance at OB/GYN appointments by the husband may be a more sensitive measure of proactive communal coping than Internet usage. Theoretically, this result suggests that engaging in coping strategies together as a couple is beneficial to the relationship. However, one limitation of the current couple-level model is that it did not include measures of individual coping strategies to determine whether communal versus individual coping was more beneficial for the outcomes.

While the current study provides more understanding about the transition to parenthood to the literature, additional studies need to be conducted to more systematically examine various aspects of coping during pregnancy. Furthermore, numerous steps are involved in proactive and communal coping (e.g. Aspinwall, 2003), thus, it is important that future research examine how expectant parents initiate these coping strategies. Finally, engagement in proactive and communal coping may be important in the long-term adaptation to parenthood and therefore future studies should
look at these types of coping strategies over time to understand whether they are adaptive throughout the transition to parenthood.

**Limitations of the Current Study**

There are several caveats to consider with respect to the current findings. First, proactive coping and preparation for the baby were assessed with indirect measures of these constructs. Questions were not specifically designed to ask if expecting parents were engaging in proactive coping or how prepared they felt for the upcoming birth of their baby, instead measures were used to infer these constructs. Thus, the assumption is made that these variables are capturing these constructs. For example, Internet usage is not a complete measure to examine proactive coping since couples may also prepare for the birth in many additional ways. As stated above, while information was collected about the birthing classes, almost all the couples in the study had attended birthing classes (78%) and so there was little variability on this measure. A second limitation of the current study is the homogenous nature of the sample. Because the study consisted primarily of White, middle-class couples experiencing their first pregnancy, it is unclear how much these results would generalize to other couples. It may be that first time parents have higher levels of anxiety or relationship satisfaction than parents who already have children, and middle-class couples have more resources to deal with the transition than those with lower incomes or education. Finally, the results discussed here are qualified by the cross-sectional nature of the study design. All of the variables were measured at the same time and a temporal relationship between the variables cannot be determined. It may be that preparation during pregnancy has a larger impact on
outcomes such as anxiety and relationship satisfaction in the postpartum period or earlier in the pregnancy. Moreover, expectations about parenting efficacy may be more important when parents are faced with completing parenting tasks after their baby is born. Future studies need to be conducted to examine these finding both longitudinally and in multiparous parents. As the Baby T.I.M.E. study will consist of four waves of data over a 12-month period from pregnancy to postpartum, it will be possible for us to examine how these variables impact mental health and relationship well-being over time in the current sample.

Conclusion

This thesis was the first to examine the relationship between pregnancy responsibility, parenting efficacy, communal and proactive coping efforts during pregnancy. Findings from the current study suggest that these variables are important in explaining perinatal anxiety and relationship satisfaction. Specifically, feelings of personal responsibility about the pregnancy were related to lower relationship satisfaction for wives. Also, an increase in parenting efficacy was linked to increases in relationship satisfaction for wives and decreases in anxiety levels for both husbands and wives. For couples, parenting efficacy was marginally related to more communal coping through attendance at OB/GYN by the husband and more communal thinking about the pregnancy. Communal coping was also marginally related to higher relationship satisfaction. Couples who reported more communal thinking also reported marginally lower couple anxiety and higher relationship satisfaction. Taken as a whole, preparing for parenthood impacts both anxiety levels and relationship satisfaction in primiparous
couples. While the current study helped to further the literature on parents preparing for parenthood, there are still additional measures and study designs that would be beneficial to explore. Research understanding how becoming parents impacts couples is important so that more can be done to ease the stress of the transition to parenthood.
REFERENCES


Appendices A, B, and C

Tables
### Appendix A. Correlations for Husband's Variables with Potential Covariates (N = 264)

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<td>0.05</td>
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<td>0.17</td>
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<td>8- Power's efficacy</td>
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*Note: p < .05 **p < .01 ***p < .001.
### Appendix B: Correlations for WAIS Variables with Potential Correlates (N = 104)

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*p<0.05 **p<0.01 ***p<0.001
### Appendix C. Correlations for Couple Variables with Potential Covariates (N = 104)

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<td>3 - OB/GYN attendance</td>
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* p<.05  ** p<.01  *** p<.001.
Appendix D

Baby T.I.M.E. Measures
PARENTING EFFICACY

Please indicate how strongly you agree or disagree with each of the following statements.

Potential responses:
1 = disagree strongly
2 = disagree somewhat
3 = disagree a little
4 = agree a little
5 = agree somewhat
6 = agree strongly

1. I will have difficulty determining what is and is not safe for my baby to do.

2. Even when I have had an unusually distressing day, I know that I will be able to meet my baby’s emotional needs.

3. I will find it very distressing when my baby isn’t in a good mood.

4. I will feel like I have no control over my baby’s sleep habits.

5. I will be very good about never leaving my baby unattended.

6. My baby will feel very loved by me.

7. Providing physical comfort for my baby will be easy for me.

8. I will find it hard to loosen up and just play with my baby.

9. I will be able to sense when my baby is starting to become distressed.

10. I will be successful in getting my baby to eat on a fairly regular schedule.

11. I feel confident in my ability to find good, safe, quality childcare (e.g. babysitters or daycare providers).

12. I will feel comfortable with my ability to react appropriately should an emergency arise with my baby.

13. Sitting down regularly with my baby to read or do some other one-on-one activity will not be difficult for me.

14. When my baby needs me, I will be able to easily put aside whatever else I may be doing.
INTERNET USE

How often in the past 6 months have you accessed websites (including chat rooms and blogs) related to pregnancy, childbirth, and parenting?

To read:
1 = not at all
2 = less than once a month
3 = 2-4 times per month
4 = weekly
5 = daily

To post:
1 = not at all
2 = less than once a month
3 = 2-4 times per month
4 = weekly
5 = daily
PREGNANCY RESPONSIBILITY

When issues arise about the pregnancy, whose responsibility is it to try to deal with the issues?

1 = completely my responsibility
2 = partly my responsibility
3 = completely our responsibility
4 = partly my spouse’s responsibility
5 = completely my spouse’s responsibility

When thinking about the pregnancy, how do you consider it?

1 = completely my pregnancy
2 = partly my pregnancy
3 = completely our pregnancy
4 = partly my spouse’s pregnancy
5 = completely my spouse’s pregnancy
ANXIETY SCL-90R

Please indicate how often you have felt each of these ways in the PAST 7 DAYS.

Potential responses:

0 = none/rarely (<1 day)
1 = a little (1-2 days)
2 = moderate (3-4 days)
3 = most (5-7 days)

1. In the past week, how often have you felt nervous or shaky?

2. In the past week, how often have you been suddenly scared for no reason?

3. In the past week, how often have you felt tense or keyed up?

4. In the past week, how often have you felt so restless you couldn’t sit still?

5. In the past week, how often have you thought something bad was going to happen to you?

6. In the past week, how often have you had spells of terror or panic?

7. In the past week, how often have you had thoughts and images of a frightening nature?

8. In the past week, how often have you felt yourself trembling?

9. In the past week, how often have you felt your heart pounding or racing?

10. In the past week, how often been bothered by things that usually don’t bother you?
RELATIONSHIP ASSESSMENT SCALE

Potential responses: 1 = not at all to 7 = very well

1. How well does your partner meet your needs?
2. In general, how satisfied are you with your relationship?
3. How good is your relationship compared to most couples?
4. How often do you wish you hadn't gotten into this relationship?
5. To what extent has your relationship met your original expectations?
6. How much do you love your partner compared to other couples?
7. How many problems are there in your relationship?
Appendix E

Syntax for Pregnancy Responsibility
**Item wording for pregnancy responsibility (preg_resp):**

When issues arise about the pregnancy, whose responsibility is it to try to deal with the issues?

1 = completely my responsibility  
2 = partly my responsibility  
3 = completely our responsibility  
4 = partly my spouse’s responsibility  
5 = completely my spouse’s responsibility

**Coding for Wives:**

IF (preg_resp = 1) THEN preg_resp=1 (individual responsibility).  
ELSE IF (preg_resp = 2) THEN preg_resp=1 (individual responsibility).  
ELSE IF (preg_resp = 3) THEN preg_resp=0 (communal responsibility).

**Coding for Husbands**

IF (preg_resp = 4) THEN preg_resp=1 (individual responsibility).  
ELSE IF (preg_resp = 5) THEN preg_resp=1 (individual responsibility).  
ELSE IF (preg_resp = 3) THEN preg_resp=0 (communal responsibility).

**Coding for Couples**

IF (preg_resp = 1) THEN preg_resp=0 (individual responsibility).  
ELSE IF (preg_resp = 5) THEN preg_resp=0 (individual responsibility).  
ELSE IF (preg_resp = 2) THEN preg_resp=1 (individual/communal responsibility).  
ELSE IF (preg_resp = 4) THEN preg_resp=1 (individual/communal responsibility).  
ELSE IF (preg_resp = 3) THEN preg_resp=2 (communal responsibility).