

Partner Support as a Protection Against Distress During the Transition to Parenthood

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Abstract

The majority of previous studies focused on mothers' distress and considered partner support from the father to the mother. The current research studies the level and the course of distress and partner support in new mothers and fathers during the transition to parenthood and tests the protective role of partner support against distress. Data were collected in a two-wave longitudinal design from 53 heterosexual couples. Mothers and fathers completed questionnaires at two measurement occasions, that is, in the third trimester of pregnancy and 3 months after childbirth. The results provided arguments in favor of a dyadic perspective on distress during the transition to parenthood. No difference was displayed between mothers and fathers before and after childbirth. The level of distress decreased in mothers and also in fathers but only for those whose partner's distress also decreased. The importance of partner support against postpartum distress was highlighted for mothers and fathers.

Keywords

transition to parenthood, postpartum distress, anxiety, parental stress, partner support

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The negative association between maternal postpartum distress and partner support has been documented previously (Séjourné, Vaslot, Beaumé, Goutaudier, & Chabrol, 2012), as well as the positive association between such support and mothers' mental well-being during the transition to parenthood (Nelson, 2003). The vast majority of studies about the transition to parenthood and its consequences have been carried out with mothers and with a cross-sectional design (e.g., Henderson & Redshaw, 2013). Less is known about fathers' distress during the transition to parenthood and the support they receive from their partner. This study overcame the shortcomings of previous research by using a two-wave longitudinal method and taking a dyadic perspective on distress and partner support during the transition to parenthood.

The transition to parenthood starts during pregnancy as soon as the parents establish an emotional link with the fetus. This transition continues for some time after the baby's birth, and it is difficult to precisely determine when it definitively ends (Perren et al., 2003). Different authors claim that the transition period lasts until between 3 months after childbirth (Deave, Johnson, & Ingram, 2008) and as much as 12 months after childbirth (Kuersten-Hogan, 2017). The pregnancy and the birth of a first child have a mainly positive connotation for future parents and their family (Favez, 2013). However, since the eighties, the transition to parenthood has been conceptualized as a real crisis (e.g., Wallace & Gotlib, 1990). The transition to parenthood is indeed considered as a stressful lifetime period in itself (Parfitt & Ayers, 2014). Caring for a newborn may have negative consequences for parents such as worry, sadness, exhaustion, and stress, which have been described as indicators of parental distress (Brannan & Hefflinger, 2001). In particular, distress after childbirth is characterized by deep sadness and frequent crying, sleep disorder, lack of interest in any activity, suicidal thoughts, high levels of stress and anxiety, and lack of interest toward the child (Zozula, 2006). It has been estimated that 8% to 27% of mothers display depressive symptoms after delivery and 4.8% to 13% of fathers suffer from depressive symptoms after childbirth (Knoester & Eggebeen, 2006).

The distress that appears during the transition to parenthood has particularly been investigated among new mothers (Keizer & Schenk, 2012). The authors of most previous studies have considered that mothers and fathers experience the period of transition to parenthood in different ways. Mothers, being regarded as the primary caregivers of the child, have been the center of attention of these studies, and the transition to parenthood has been viewed as having greater impact on mothers, who experience greater emotional difficulties than fathers (Perren et al., 2003). For example, Skreden et al. (2008) studied mothers' and fathers' psychological health during a 5-year period and showed that mothers were significantly more anxious than

fathers, especially immediately after childbirth. Psychological distress at a clinical level was also reported more frequently by mothers (29%) than fathers (11%) (Skreden et al., 2008).

However, recent evidence suggests that mothers' and fathers' experiences during the transition to parenthood are neither different nor separate. Parental couples have been shown to function as a dyad when facing childbirth (Galdiolo & Roskam, 2014; Galdiolo & Roskam, 2017). Moreover, positive correlations have been reported between mothers' and fathers' depressive symptoms, suggesting that distress affects both parents as well (Kerstis, Engström, Edlund, & Aarts, 2013). The reason why mothers and fathers may experience similar distress during the transition to parenthood may be that the reasons for feeling distress (except for biological issues, e.g., hormone fluctuations) concern both mothers and fathers. For example, becoming a parent, either a mother or a father, can cause distress because of the change of role from being a nonparent to having responsibilities for caring for a new baby, the feeling of loss of freedom (Warren, 2004), sleep deprivation (Skouteris, Wertheim, Germano, Paxton, & Milgrom, 2009), and the imbalance between professional and private life (Graham & Oakley, 2005).

Hopefully, these risk factors are compensated by protective factors. Among these, it is noteworthy that couple satisfaction, partner's involvement with the child, and partner's support may play a protective role with regard to parental distress (e.g., Parfitt & Ayers, 2014). In the current study, the protective role of partner support against distress during the transition to parenthood was studied. Partner support is mainly based on three dimensions, that is, instrumental support (e.g., help with childcare and housework), emotional support (e.g., listening, validating feelings, reassurance), and informational support (e.g., offering advice, giving suggestions) (Brock et al., 2014). General partner support from the female and/or male partner has been related in correlational studies to psychological and physical well-being (e.g., Lindorff, 2000), more enjoyable and less tense couple interactions, better relationship quality and greater relationship intimacy (e.g., Gleason, Iida, Shrout, & Bolger, 2008), and better coparenting practices and parenting styles (e.g., Belsky, 1984). But the protective role of partner support against distress specifically in the transition to parenthood has mainly been considered in terms of support from the father to the mother but not in the reverse direction, as if the father was just a support provider who does not himself need his partner's support.

Since the 1990s, a large number of studies have tested the relation between partner (i.e., paternal) support and mothers' well-being in heterosexual couples. Most of them are cross-sectional and have reported a positive correlation between paternal support and psychological well-being in new mothers

(e.g., Twamley, Brunton, Sutcliffe, Hinds, & Thomas, 2013). This positive relation has been explained by the fact that paternal support allows the mother to be reassured, to be listened to and loved, and to feel relaxed. The father's support helps decrease both the pressure and the amount of work for the mother. Consequently, her levels of distress and depressive symptoms fall (Laxman et al., 2015). A small number of longitudinal studies have also focused on the relations between paternal support and the mother's psychological well-being. For example, Salmela-Aro, Nurmi, Saisto, and Halmesmaki (2010) found that partner support during pregnancy predicted a higher rate of couple satisfaction and better mental well-being in mothers during the postpartum period. Other authors (Delicate, Ayers, & McMullen, 2018) have reported that emotional support from the partner, that is, fondness, admiration, expansiveness, and awareness, acts as a buffer and makes the transition to parenthood smoother for the mother.

The current study overcomes the shortcomings of previous research by using a two-wave longitudinal design and taking a dyadic perspective on distress and partner support during the transition to parenthood. The importance of taking such a dyadic perspective has been suggested in recent research showing that childbirth tends to cause mothers and fathers to function as a dyad because it requires shared responsibilities and a greater attention to the other partner (Galdiolo & Roskam, 2017). The three aims of the current study were (1) to compare the level of distress and partner support in both new mothers and fathers during pregnancy and after childbirth using a two-wave longitudinal design, (2) to test the effect of partner support for the other parent on the level of distress after childbirth, and (3) to estimate the course of distress during the transition to parenthood in both new mothers and fathers and to test whether a change in distress was predicted by a change in partner's distress and support. Based on the literature review, we proposed that distress would be higher among mothers than fathers. In addition, we hypothesized that partner support would be related to lower distress symptoms after childbirth. Also, we anticipated that distress would be found to increase during the transition to parenthood. Finally, we supposed that a positive change in partner support would be negatively associated with the course of distress.

Method

Participants

Fifty-three heterosexual couples consisting of first-time mothers and fathers from a community sample participated in the study. They were recruited when the mothers were in the third trimester of pregnancy ($M_{\text{pregnancy}} = 30$ weeks; $SD = 0.96$). Sociodemographic data are shown in Table 1.

Table 1. Sample Demographics.

Demographic	Mothers (N = 53)		Fathers (N = 53)		Total sample (N = 106)	
	M	SD	M	SD	M	SD
Mean age (years)	27.6	3.62	29.06	4.3	28.31	4
Duration of the relationship years	—	—	—	—	6.38	2.9
	N	%	n	%	n	%
Country						
Belgium	44	83	42	84	86	82.7
France	7	13.3	5	10	12	11.5
Colombia	1	1.9	1	2	2	2
Italy	1	1.9	1	2	2	2
Germany	0	0	1	2	1	1
Education						
High school or university	45	84.9	33	66	78	75.7
Secondary school	8	15.1	17	34	25	24.3
Primary school	0	0	0	0	0	0
Personal net monthly income						
No income	4	7.5	3	6.1	7	6.9
€1-1,500	18	34	9	18.4	27	26.5
€1,500-2,500	29	54.7	28	57.1	57	55.9
€2,500-3,500	2	3.8	6	12.2	8	7.8
€3,500-4,500	0	0	2	4.1	2	2
>€4,500	0	0	1	2	1	1
Marital status						
Married	—	—	—	—	46	45.1
Unmarried	—	—	—	—	56	54.9
Pregnancy intentions						
Planned	—	—	—	—	84	81.6
Unplanned	—	—	—	—	19	18.5
Pregnancy health status						
Risk	—	—	—	—	7	6.7
No risk	—	—	—	—	96	92.3
Sex of the child						
Female	—	—	—	—	36	35
Male	—	—	—	—	56	54.4
Unknown	—	—	—	—	11	10.7
Distress Wave 1						
Normally distressed	47	88.7	39	78	86	83.5
Mildly distressed	3	5.7	5	10	8	7.8

(continued)

Table 1. (continued)

	Mothers (N = 53)		Fathers (N = 53)		Total sample (N = 106)	
	M	SD	M	SD	M	SD
Demographic						
Moderately distressed	2	3.8	4	8	6	5.8
Severely distressed	0	0	2	4	2	1.9
Extremely distressed	1	1.9	0	0	1	1
Distress Wave 2						
Normally distressed	39	83	33	78.6	73	81.1
Mildly distressed	3	6.4	5	11.9	8	8.9
Moderately distressed	2	4.3	1	2.4	3	3.3
Severely distressed	3	6.4	2	4.8	5	5.6
Extremely distressed	0	0	1	2.4	1	1.1

Sampling Procedure

The study was approved by the institutional review board. Couples were recruited from a Belgian community sample with flyers posted in gynecology services, in maternity centers, in pregnancy support services, and on social networks. They took part in the study on a voluntary basis. Those who were willing to participate were invited to complete questionnaires, either online on the Qualtrics platform (78.8% of the participants) or in paper-and-pencil form (21.2% of the participants), twice, that is, first when the woman was in the third trimester of pregnancy and second when the baby was 3 months old and maternity leave ended. Mothers and fathers completed the same set of questionnaires and were asked to complete the questionnaires separately. They also signed an informed consent document in which they were informed about the longitudinal design of the study. They were assured that the data would remain confidential and that they were free to drop out at any moment without giving any reason. The four inclusion criteria were as follows: the mother should be in the third trimester of pregnancy, the couple must have been together for at least a year, both partners should be at least 21 years old, and they should both be parents for the first time. Parents did not receive any compensation for their participation in the research.

As it is usual in longitudinal research, attrition occurred. In the first wave of assessment, three fathers (2.8%) stopped their participation. In the second wave of assessment, four mothers (3.7%) and seven fathers (6.6%) stopped their participation. One-way analyses of variances (ANOVAs) were conducted to test whether there were significant differences between the participants who dropped out and the others with regard to sociodemographic data,

distress, and partner support in Wave 1. The dropout subjects were only found to be older ($M_{\text{age}} = 30.33$ years, $SD = 5.31$) than the other participants ($M_{\text{age}} = 27.97$ years, $SD = 3.67$): $F(1, 101) = 4.63$; $p < .05$. Complete case analysis was performed as the level of missing data was low, that is, around or less than 5%. There was unlikely to be much gain from multiple imputation as there was very limited information to recover (Lee, Roberts, Doyle, Anderson, & Carlin, 2016). To make sure that there was enough statistical power to detect any effect, statistical power was calculated with the GPower 3.1.9.2 program (Erdfelder, Faul, & Buchner, 1996). For each statistical analysis, the sample size was sufficient (minimum sample size $N = 45$, $N = 49$, and $N = 36$, respectively, for t -test analysis, linear regression, and the repeated-measure analyses of variances).

Materials

Distress was assessed with the Depression Anxiety and Stress Scale (DASS; Lovibond & Lovibond, 1995) in Waves 1 and 2. The DASS is a 42-item questionnaire including three self-report scales: depression (“I couldn’t seem to experience any positive feelings at all”), anxiety (“I was scared for no good reason”), and stress (“I tended to react exaggeratedly”). The respondent indicates the extent to which he or she has experienced each symptom over the past week using a 4-point severity/frequency scale ranging from 0 (*does not apply at all to me*) to 3 (*applies entirely to me, or the vast majority of the time*). Cronbach’s alphas were calculated in the current sample for each scale (.96 for Depression, .92 for Anxiety, and .94 for Stress in Wave 1; .95, .91, and .95 in Wave 2). The reliability of the DASS total score was high, $\alpha = .96$. To limit the number of variables in the current sample, we computed a single score for distress by averaging the 42 items. The DASS can be evaluated with a severity rating index defined according to cutoff scores (e.g., normally distressed between 0 and 14, mildly distressed between 15 and 18, moderately distressed between 19 and 25, severely distressed between 26 and 33, and extremely distressed 34 or higher). On this basis, the majority of participants in the current sample were in the normal range of distress, that is, assessed as “normally distressed.” The distribution of distress in mothers and fathers in the current sample is given in Table 1.

Partner support was assessed in Waves 1 and 2 through self-reports, that is, perceived support, and through partner-reports, that is, given support. We used a cross-rater strategy for the partner support variables, allowing us to reduce measurement error and avoid shared method variance (Cole & Maxwell, 2003). The Dyadic Coping Inventory (DCI; Gmelch et al., 2008), a questionnaire assessing dyadic coping in intimate relationships, was used. It

is composed of seven items on the positive partner support subscale, that is, perceived support ("My partner shows empathy and understanding to me"), and seven items on the positive subject support subscale, that is, given support ("I listen to my partner and give him/her space and time to communicate what really bothers him/her"). Each item of the positive support scale of the DCI uses a Likert-type scale ranging from 1 (*Never*) to 6 (*Always*). Coefficient alphas were good, with .88 for perceived partner support and .86 for given partner support in Wave 1, and .85 and .85, respectively, in Wave 2.

Analysis Strategy

The assessment of normality was based on skewness and kurtosis values. Values indicated that partner support variables were normally distributed, with values of asymmetry (between -2 and $+2$) considered sufficient to prove normal univariate distribution (Georgy & Mallery, 2001). For distress, skewness and kurtosis indicated deviations from normality ($DASS_{wave\ 1}$ between 1.39 and 2.40; $DASS_{wave\ 2}$ between 2.05 and 5.33). Conceptually, these deviations from normality made sense. Like most mental health indicators, distress is expected to present an asymmetric distribution (i.e., to be positively skewed like most psychological disorders). Log transformations of the variables were computed and ensured a normal distribution ($DASS_{wave\ 1}$ between -0.8 and $.66$; $DASS_{wave\ 2}$ between $-.28$ and $-.51$). The transformed scores were used in the main statistical analyses.

Preliminary analyses consisted of correlations between the main constructs, that is, distress, perceived support, and given support in Waves 1 and 2, among mothers and fathers. Using correlations and paired sample *t* tests, we also compared the level of support that one parent perceived from the other parent (perceived support) with the level of support that the other parent reported giving to him or her (given support) at both Wave 1 and Wave 2. The first main analysis compared the level of distress and partner support in new mothers and fathers during pregnancy (Wave 1) and after childbirth (Wave 2) through *t* tests on paired samples (mothers and fathers). The second main analysis tested the effect of the mean level of partner support (i.e., partner support either perceived or given, averaged across the two waves) on the level of distress after childbirth (Wave 2). It consisted of a regression model with the level of distress of one parent after childbirth (Wave 2) as the dependent variable and the mean level of perceived and given support (i.e., averaged across the two waves) as the predictors. The regression models also controlled for the parent's level of distress in Wave 1 (residuals) and for the mean level of the other partner's distress (i.e., other parent's distress averaged across the two waves). The third main analysis estimated the course of

Table 2. Correlations Between Distress and Partner Support.

	D Wave 1	D Wave 2	GS Wave 1	GS Wave 2	PS Wave 1	PS Wave 2
D Wave 1	—	.70**	.00	-.20	.04	.02
D Wave 2	.65**	—	-.06	-.30*	.07	.01
GS Wave 1	-.20	-.24	—	.64**	.65**	.53**
GS Wave 2	-.25	-.36*	.76**	—	.37*	.53**
PS Wave 1	-.03	-.15	.23	.32*	—	.78**
PS Wave 2	.06	-.03	.36*	.36*	.50**	—

Note. D = distress; PS = perceived support; GS = given support; coefficients above the diagonal are for mothers; coefficients below the diagonal are for fathers.

* $p < .05$. ** $p < .01$.

distress during the transition to parenthood among new mothers and fathers. We conducted repeated-measures ANOVAs, with time (Waves 1 and 2) as the two-level within-subjects factor. We tested if change in distress was predicted by change in partner's distress as well as by change in perceived or given support. Therefore, we computed difference scores for partner's distress and support by subtracting scores in Wave 1 from scores in Wave 2. All statistical analyses were conducted with the computer program SPSS23 (IBM, 2015).

Results

Preliminary Analysis

Correlations between distress and partner support for fathers and mothers separately are reported in Table 2. With regard to the stability of the constructs, the results showed that there was a positive relation between distress in Waves 1 and 2 as well as between perceived support and given support in Waves 1 and 2. They suggested a moderate to high stability in both distress and support during the transition to parenthood. With regard to the bivariate relation between distress and support, there was only one significant negative association between distress and given support in Wave 2 for both mothers and fathers.

With regard to the relations between the level of support that one parent perceived from the other parent (perceived support) with the level of support that the other parent reported giving to him or her (given support), the bivariate correlations ranged between .23 and .36 among fathers and between .37 and .65 among mothers, suggesting a limited overlap between cross-informant ratings of support. *T* tests on paired samples comparing perceived and given support showed that only fathers perceived lower support from their

Table 3. Descriptive Statistics for Distress and Support in Wave 1 and Wave 2 for Mothers and Fathers.

	Mothers, Wave 1 (N = 53)		Mothers, Wave 2 (N = 49)		Fathers, Wave 1 (N = 50)		Fathers, Wave 2 (N = 43)	
	M	SD	M	SD	M	SD	M	SD
Distress	21.50	17.38	18.19	19.32	20.96	18.88	21.30	24.08
Given support	4.55	.74	4.49	.68	4.43	.80	4.36	.80
Perceived support	4.30	.99	4.34	.92	4.33	.81	4.24	.73

partner than the partner, that is, the mothers, reported giving them, $t(42) = 2.05, p < .05, d = 0.35$.

Distress and Support in New Mothers and Fathers

T tests on paired samples (mothers and fathers) were conducted to compare the level of distress and given and perceived support between mothers and fathers separately in Waves 1 and 2. The results showed no significant difference between mothers and fathers for the three variables, suggesting that mothers and fathers experience similar levels of distress during the transition to parenthood as well as reporting that they give and perceive similar levels of support. Descriptive statistics are reported in Table 3.

Effect of Support on Distress

The linear regression analyses enabled us to test the effect of partner support for the other parent on the level of distress after childbirth for mothers and fathers separately, controlling for the level of distress in Wave 1 and for the mean level of the partner's distress. For mothers, a significant effect of the mean level of the partner's distress ($\beta = .6, p < .01$) and a significant effect of the mean level of given support ($\beta = .30, p < .05$) were found. In other words, the mother's level of distress after childbirth was predicted by the father's mean level of distress (averaging across Wave 1 and Wave 2) as well as by the mean level of support (averaging across Wave 1 and Wave 2) that the fathers reported giving to the mother. Overall, the model fitted well with the data and predicted 25% of the variance of distress in new mothers after childbirth, $F(4, 39) = 3.31$. For fathers, a significant effect of the mean level of the partner's distress ($\beta = .48, p < .01$) and a significant effect of the mean level of perceived support ($\beta = -.02, p = .05$) were found. In other words,

the father's level of distress after childbirth was predicted by the mother's mean level of distress (averaging across Wave 1 and Wave 2) as well as by the mean level of support (averaging across Wave 1 and Wave 2) that the father perceived from the mother. Overall, the model fitted well with the data and predicted 27.8% of the variance of distress in new fathers after childbirth, $F(4, 32) = 3.08$.

The Course of Distress

The repeated-measures ANOVAs enabled us to test whether change in distress was predicted by change in the partner's distress as well as by change in perceived or given support for mothers and fathers separately. Descriptive statistics are presented in Table 3. For mothers, a significant main effect only appeared for time, $F(1,32) = 6.23, p < .05$, showing that contrary to our expectations, mothers became less distressed during the transition to parenthood. For fathers, a tendency appeared for the interaction term between time and change in the partner's distress, $F(1, 33) = 3.5, p = .07$. The interaction is presented in Figure 1. It showed that distress after childbirth only decreased for those fathers whose partner's distress also decreased. Conversely, distress remained quite stable for fathers whose partner's distress increased. However, no effect of change in perceived or given support was displayed either for mothers or for fathers.

Discussion

The main purposes of the current research were (1) to compare the level of distress and partner support, either perceived or given, in both new mothers and fathers during pregnancy and after childbirth, (2) to test the effect of partner support on the level of distress after childbirth, and (3) to estimate the course of distress during the transition to parenthood among new mothers and fathers and to test whether change in distress was predicted by change in the partner's distress and support. The results gave a nuanced picture of the effects of partner support on distress, but they also led us to recognize, in line with Galdiolo and Roskam (2014), that taking a dyadic perspective on distress and partner support during the transition to parenthood is essential.

Toward a Dyadic Perspective

With regard to the dyadic perspective, we accumulated several pieces of evidence. First, contrary to our expectations based on the literature review, mothers and fathers displayed similar level of distress before as well as after

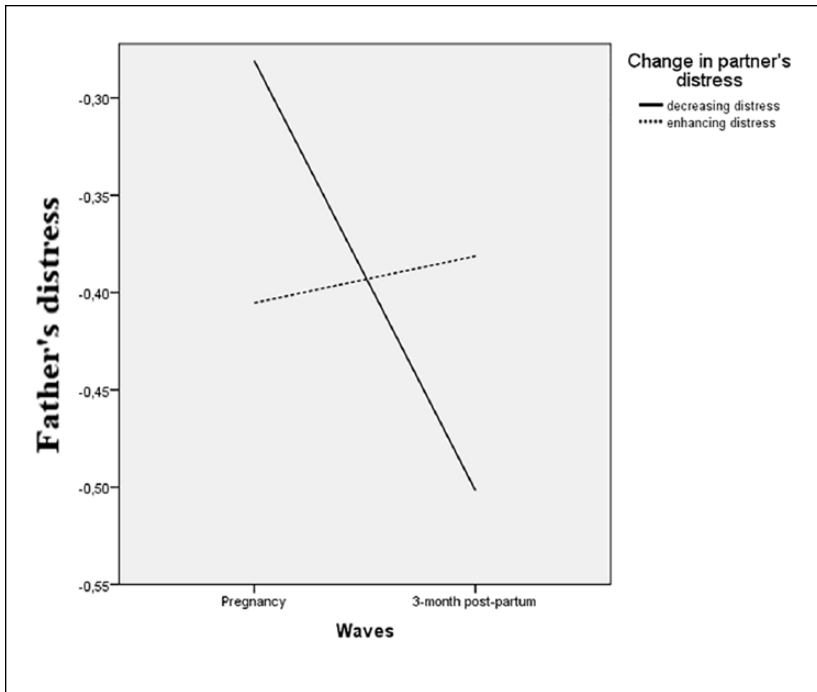


Figure 1. Interaction effect between time and change in partner's distress for father's distress.

childbirth. Second, mothers were significantly less distressed after childbirth than before, and fathers were significantly less distressed, but only when their partner's distress decreased. Our results suggest that in a community sample, the transition to parenthood can mainly be considered as a positive event for primiparous mothers, as well as for first-time fathers provided that the distress of their partner decreases after the birth of the child. The presence of a main effect of time for mothers and its absence for fathers can be explained by the fact that in prior studies, fathers have reported receiving less social support after childbirth than their spouses: During the postpartum period, women are regarded as vulnerable and receive a lot of attention and support from health care providers and their social network (Mao, Zhu, & Su, 2011). Also, fathers return to work more quickly than mothers and may find it difficult and stressful to reconcile private and professional life in the first weeks of life of their first child (Séjourné, Vaslot, Beaumé, & Chabrol, 2012). The way in which their partner (i.e., the mother) manages the transition to

parenthood may be of some importance for fathers, affecting how they can manage the transition in their turn. This moderation effect found for fathers suggests that they tend to follow the same developmental trajectory as their partner and to function in a dyad. Similarly, the mean level of the partner's distress was found to be related to the level of distress after childbirth in both mothers and fathers, suggesting that they face childbirth as a team rather than as independent individuals.

Taken together, these pieces of evidence address some of the omissions in previous literature, which has focused on maternal distress after childbirth and shed light on maternal depressive symptoms during the transition to parenthood. Fathers' psychological well-being during the transition to parenthood has often been disregarded. Our results stress the importance of considering fathers and mothers as facing the transition to parenthood as a dyad and not as independent new parents.

The Role of Partner Support in Protecting Against Distress

With regard to the effect of support on distress, the results displayed a nuanced picture. It was first shown that support was highly stable from pregnancy to 3 months postpartum. It may be that couples continue to function at the same level of support irrespective of the baby's birth. However, based on the time points of this study, the possibility cannot be excluded that partner support changes earlier in pregnancy. Second, the results showed that, as expected, partner support was related to distress after childbirth. This was the case for both new mothers and fathers, but the associations depended on whether perceived or given support was considered. Contrary to our expectations, mothers' distress was not related to perceived support, suggesting that the way in which they feel supported by their partner does not affect their distress. However, mothers' distress was positively related to the support their partner reported giving them. The higher the support given by the partner, the higher the mothers' distress. It may be that higher support was given by fathers to mothers with higher distress. Fathers may be aware of their partner's distress, and they may try to provide higher support in couple relationships.

With regard to the absence of association between mothers' perceived support and distress, it is possible that mothers need specific support related to parenthood, such as emotional support (the partner listens to the mother's emotions as a parent) or concrete support (the partner gives advice about parenthood to the mother), rather than general couple support of the kind considered in the current study with the DCI (Gmelch et al., 2008). Support specific to parenthood may be necessary to sustain mothers' sense of

self-fulfillment, and this sense of self-fulfillment may be essential for their psychological well-being (Martin, 2008). Conversely, general couple support may be unrelated to new mothers' needs to cope with postpartum distress. Just because a woman receives couple support, she does not necessarily receive support in the specific area of parenting and mother–newborn relationships.

In line with our expectations, fathers' distress was negatively related to the support that they perceived from their partner. The higher the support perceived by the fathers, the lower the fathers' distress. In other words, fathers were affected by the support they considered that they received from their partner, illustrating again the importance of taking fathers into account in postpartum intervention. Fathers do not seem to be only support providers for distressed mothers after childbirth. They appear to be affected by the transition to parenthood and to need partner support as well. However, the comparisons between perceived and given support showed that fathers perceived less support than their partner reported offering them. It may be that fathers were not aware of their partner's support or that they underestimated their partner's ability to support them during the transition to parenthood. Fathers may experience a causal attribution bias leading them to consider the mother to be too preoccupied with her newborn to be able to provide much support. They may assume that the mother lacks the resources needed to support them during this particular period and, consequently, underestimate their partner's ability to support them. Another possible explanation is that mothers thought that they were offering more support than was actually the case. However, in the absence of a real benchmark, it cannot be decided whether the perceived (self-report) or given (partner-report) support rating was the more realistic assessment of partner support. Correlations were moderate, suggesting a limited overlap between the two partners' appraisals of support, or, in other words, different interpretations of a complex dyadic reality. The current results therefore suggest the need for a cross-informant strategy for assessing partner support and providing a nuanced picture of results.

Limitations and Recommendations for Future Studies

While interesting in many ways, this study is by no means definitive. Several limitations have to be recognized. First, the sample participating in the current study was not representative of the entire population of first-time parents, as the majority of the participants in the sample were not severely distressed. Furthermore, the majority of participants were Caucasian with a high socioeconomic status. The number of participants was also limited. Consequently, the results cannot be considered as generalizable, and they need to be replicated.

Second, the current research documents relations between the constructs under consideration. It does not test causal pathways. Future studies should consider additional measurement time points and study intraindividual change in the longer run, for example, in an intensive longitudinal study (e.g., Raudenbush & Chan, 1992). Future studies should also investigate the role of partner support in quasi-experimental designs to causally test the influence of support on distress. Moreover, it would be interesting to include factors of moderation such as the security of attachment of the mother and the father.

Third, it would have been interesting to use the actor-partner interdependence model (APIM; Kashy & Kenny, 1999) to analyze data. The APIM is a model of dyadic relationships that includes a conceptual view of interdependence in a two-person relationship (Cook & Kenny, 2005). However, in order to carry out this analysis, a high statistical power is required and, consequently, a sample size greater than 50 couples. Moreover, it would be interesting to have more than two measurement time points. For the future, it would be useful to carry out APIM analyses with a larger sample size and with a third measurement taken in the first trimester of pregnancy or at the end of the first year of life, for example.

Finally, the study lacks a specific measurement of partner support in parenthood. The use of a general dyadic coping questionnaire may be questionable because the specific needs of new parents are ignored. Future attempts should be made to validate a questionnaire assessing partner support in the specific context of parenthood. Most existing questionnaires measure partner support in the general marital relationship, social support, or the quality of the coparenting alliance, and there is a serious lack of any tool measuring partner support in the specific context of parenthood.

Conclusion

The current study provides arguments in favor of a dyadic perspective on distress during the transition to parenthood. It also shows that partner support plays a protective role against distress. In particular, fathers report providing higher support to distressed mothers, and the support from their partner that fathers perceive is negatively related to their postpartum distress. Given that fathers and mothers face the transition to parenthood as a dyad and not as independent new parents, it is recommended that professional intervention should consider both mothers and fathers rather than focusing solely on the mother-child dyad. Fathers need to be supported and not just viewed as a support provider for mothers. Professional caregivers should pay particular attention to the bidirectional exchange of support in the parental couple as well as to each parent's expectations of support from his or her partner.

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