One becoming two becoming three: An intervention to address the psychological issues of pregnancy

Karen Beck Wade

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ONE BECOMING TWO BECOMING THREE:
AN INTERVENTION TO ADDRESS THE
PSYCHOLOGICAL ISSUES OF PREGNANCY

A Thesis
Presented to the
Faculty of
California State University
San Bernardino

In Partial Fulfillment of
the Requirements for the Degree
Master of Arts
in
Psychology

Karen Beck Wade
January 1986
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January 16, 1986
ABSTRACT

Much has been written about, but little has been done to address the psychological changes inherent in becoming a parent. This project reviews the literature regarding the psychological experience of first time pregnancy for women and men, and presented some of the findings and current trends in research regarding the fetus in the emerging field of prenatal psychology. A pregnancy intervention program was developed utilizing a nine-session, one session weekly group experience. A modified weekend format was also developed. The objectives of the intervention were to foster the development of the parent identity during pregnancy, to deepen and strengthen the expectant parents' relationship with one another, and to enrich the parental-fetal attachment process. The intervention involved the production of an audio-visual presentation and a marketing strategy was implemented. A method to evaluate the effectiveness of the intervention was proposed and discussion of future applications of this model to special pregnancy situations and to research ends was summarized.
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Thank you all.
DEDICATION

To Christopher, with whom I became two;
   and to Lisa, with whom we became three;
This work has evolved from our journey.
I love you.
INTRODUCTION

Statement of the Problem

Rites of passage are described as the ceremonies and rituals accompanying and marking important life events which denote special changes in an individual's development and position in society (Davis-Floyd, 1985, Raphael, 1976). More traditional societies provide customs and practices which help the individual prepare for and make the transition into the new role that the rite of passage marks (Raphael, 1976; Kitzinger, 1979).

In contrast, our rapidly changing Western society has brought a sense of freedom from previously rigid, stereotypic roles determined by sex, race, religion or social position. Our great freedom of mobility has produced a nuclear family structure which has had to nurture itself apart from the supports, wisdom, comforts (and discomforts) of the extended family constellation. Nuclear families must fend for themselves in the midst of life's transitions and at times these transitions can be quite momentous (Bibring, 1959).

The period of first pregnancy and childbirth is a life event filled with questions and uncertainties as women and men move beyond their roles as wife and husband into the
roles of mother and father. Attitudes and practices surrounding child-bearing, birthing and rearing have changed dramatically in the last decade (Entwisle and Doering, 1981; Grossman, Eichler and Winickoff, 1980). These changes leave mothers and fathers-to-be with little cultural wisdom (even with the presence of close relatives) to guide them through the physical, psychological and social transitions they must undergo during pregnancy and childbirth (Bibring, 1959).

This project develops a prenatal intervention program which can act as the cultural equivalent to the rites of passage of more traditional societies. The intervention is anticipated to provide assistance in meeting the psychological needs of men, women and yet-to-be-born children as they move toward becoming a family as well as to prepare them for the attendant psycho-social changes which will impact each of them.

Changes in Hospital Perinatal Practices

One of the major changes surrounding perinatal practices is the method by which women give birth. At the turn of the century and before, most childbirth took place at home with the assistance of a mid-wife or experienced female relative. With the advent of medical technology and the increase in the number of hospitals in the early decades of this century, birth became a hospital event rather than a family experience. Women were left alone during labor
with the exception of a busy nurse who would periodically come in to check on her (Bean, 1972).

In an attempt to relieve women of the pains of childbirth, analgesics and anesthetics were liberally administered during both labor and delivery. Husbands, mothers, sisters and other significant support persons were left in waiting rooms for long periods of time without information about their loved one. The entire birth process was in the control of the attending medical personnel and was cloaked in mystery for the drugged mother and her family-in-waiting. Heavily medicated deliveries often required medical intervention to compensate for the mother's inability to cooperate in delivering her child, resulting in increased forceps deliveries and cesarean sections, sleepier and less responsive infants as well as prolonged recovery from anesthesia for the mother (Bean, 1972).

The forces of social change which touched almost every area of life and relationships in the 1960's also began a revolution in the ways of birth. A widespread disillusionment with technology in general, coupled with the consciousness-raising of the women's movement, launched the impetus by which women began to demand a greater voice in and control over the ways by which they would give birth (Arms, 1975; Grossman, Eichler and Winickoff, 1980). The "natural childbirth" movement had begun, emphasizing sensitivity to the needs of the mother, father and baby
during birth.

**Prepared Childbirth Training**

The names Dick-Read, Bradley and LaMaze (cited by Wideman and Singer, 1984) are synonymous with methods of prepared childbirth which require attendance in class and practice of techniques at home. Components of these birth education classes include: information regarding the anatomy and physiology of pregnancy, labor and delivery, fetal development, respiration techniques for different types of uterine contractions, conditioned relaxation between and during contractions, cognitive restructuring of attention during labor, and social support from the group members during class and the husband (or other partner) as "coach" during labor and delivery (Wideman and Singer, 1984).

A small amount of research suggests that those taking prepared childbirth training (conglomerately referred to as LaMaze classes) have more positive psychological attitudes regarding labor and delivery, less analgesia during the birth even, fewer obstetrical complications and healthier infants immediately post-partum than women who received no formal preparation for childbirth (Wideman and Singer, 1984). Although controlled studies regarding the effectiveness of prepared childbirth techniques are limited in scope, few in number and questionable in reliability (Wideman and Singer, 1984), prepared childbirth classes have made a widespread
impact in the United States.

In a survey of 400 hospitals in this country, Wideman and Singer (1984) reported that of those responding, 99% permit fathers to be present during labor and delivery, and 89% permit another significant person to be present in the absence of the father. The obstetricians of the reporting institutions almost unanimously encouraged attendance at a prepared childbirth class, and 70% of the hospitals report that over 50% of women divering at their institution have attended training classes.

Sensitivity to the Child at Birth

A growing awareness of the sensory capabilities and perceptions of the fetus and newborn is reflected in modifications in many hospitals' delivery room and post-birth handling routines. Frederick Leboyer (1975), a French obstetrician, proposed that the bright lights, delivery room clatter, and insensitive handling of the newborn are a rude introduction to life outside the womb. In the Leboyer method, the delivery room lights are dimmed, the room is hushed (often with soft music playing), the infant is not "spanked" or turned upside down to initiate crying/respiration but rather is massaged and stroked, and a bath of warm water awaits rather than a cold metal table.

Many hospitals permit extended maternal/paternal/infant contact immediately post-birth to facilitate bonding (Klaus
and Kennel, 1972), and rooming-in arrangements with mother and baby in the same room post-partum are further indices of a shift toward a true family-centered birth experience.

**Further Steps Needed**

As important, necessary and valuable as these changes have been, a major tenant of this paper and project is that they are not enough. LaMaze, Leboyer, Kennel and Klaus have greatly enhanced the experience of birth, but the transition to parenthood involves more than giving birth. Also, for the fetus, the transition to extra-uterine life is affected by more than the gentleness by which the world gives welcome. If society is to truly provide a rite of passage experience for expectant couples that will more adequately ease their transition to parenthood, attention must be addressed to the overall changes which pregnancy brings to the woman and the man.

This paper will address the psycho-social, and at times spiritual, issues of pregnancy as it is experienced by the expectant mother, the expectant father, the developing child, and the resulting inter-relationships. The literature review does not propose to be an exhaustive examination of the empirical findings relative to the pregnancy triad, but rather a summary of the major issues which appear to be at the heart of the pregnancy experience and which have had the greatest impact on the development
and direction of the intervention program. It is hoped that the intervention will respectfully and effectively address the psycho-developmental concerns of mother, father, and fetus as sensitively as the new methods of childbirth address the obstetrical-emotional concerns of giving birth.
Review of the Literature

The Expectant Mother

The nine months of gestation are not for fetal development alone, but equally important is the development of the woman into a mother (Cranley, 1981). The birth of a "mother identity" during pregnancy has been viewed as crucial to adaptation to pregnancy and parenthood.

Toward a psychology of pregnancy: psychoanalytic beginnings. Psychoanalytic theorists were the first to recognize and write about the importance of the childbearing event as a developmental milestone in the life of a woman. They viewed motherhood and motherliness as essential characteristics of an emotionally mature woman (Grossman, Eichler and Winickoff, 1980).

From Freud's perspective, the desire for a child was viewed as a health step toward a woman's resolution of "penis envy". Helen Deutsch (1945) elaborated on Freud's views and described pregnancy as the fulfillment of the deepest and most powerful wish of women. Further, the healthy ego development of a woman was closely tied to her development of a "motherly ego".

Deutsch (1945) described progression through the stages of pregnancy as incorporation, differentiation and separation. During incorporation, the woman invests
narcissistic love into the fetus. "Quickening", when the baby's movements are first detected by the mother, provides the opportunity for the woman to gradually differentiate the fetus from herself. Clark and Affonso (1979) described the separation phase as the anticipation of labor and delivery when the expectant woman prepares for role transition through a "giving up" of the fetus.

With successful passage through the stages of pregnancy comes a growing attachment to the fetus and an attributing of human personality characteristics to her unborn child. She may exhibit her growing bond with the fetus through: talking to the fetus, calling the baby a pet name, engaging the father in conversation with the fetus and rubbing and embracing her abdomen (Klaus and Kennel, 1982; Cranley, 1981; Leifer, 1977).

The psychobiological model. In the 1950's Grete Bibring enriched the psychoanalytic and psychology of women literature with writings based on ten years of clinical work with pregnant women. To Bibring, pregnancy should be viewed as a normal psychobiological crisis. Much like puberty and menopause, this psychosexual event triggered by hormonal changes can lead a woman to a new level of maturity and integration. There is opportunity during pregnancy to revive unsettled and partially resolved conflicts. Successful resolution to these conflicts leads to mastery of the task of motherhood.
Bibring also recognized that failure to resolve previous conflicts could lead to a lower level of functioning with consequences to the woman and to the mother-child relationship (Bibring, 1959; Bibring et al., 1961).

Recognizing the transitional nature of the childbearing year and its potential for greater maturity and integration vs. maladjustment and psychological disequilibrium, Schwartz (1980) and Colman and Colman (1971) have facilitated encounter-like pregnancy support groups. Expectant couples join together to share their feelings of conflicts, fantasies and fears toward the goal of enriching the experience of pregnancy as well as their preparation for parenthood. These authors describe psychological, and at times transpersonal-spiritual themes which characteristically emerge at particular stages of the pregnancy.

First trimester: ambivalence and anxiety. According to Schwartz (1980) and Colman and Colman (1971), the first trimester is marked by ambivalence. Deep fulfillment, wonder and joy in having conceived can combine with fear and anxiety over the loss of control of her life and her body. Anxiety regarding her ability to safely carry and deliver the child is prevalent. The physical symptoms common to early pregnancy: nausea, backache, fatigue can compound the ambivalence (Colman and Colman, 1971). Several studies have documented the relationship between
anxiety and physical discomforts of pregnancy, in general the higher the anxiety, the more physical discomfort and symptomatology that is experienced. These physical symptoms tend to be highest during the first and again during the third trimester (Entwisle and Doering, 1981; Grossman et al., 1980; Shereshefsky and Yarrow, 1973).

Although anxiety may continue to operate to some degree throughout the pregnancy (and will be described in more detail later), the major task of the first trimester is to resolve the ambivalence by coming to an acceptance of the pregnancy and its implications for herself and her relationship with her partner (Schwartz, 1980; Colman and Colman, 1971).

Second trimester: transfer of dependence. Schwartz (1980) and Colman and Colman (1971) assert that essential to the development of a unique "mother identity" for the pregnant woman is the resolution of her relationship with her own mother. Klaus and Kennel (1982) emphasize the importance of consciously re-examining one's own upbringing prior to becoming a parent in order that deficient mothering attitudes and behaviors are not unconsciously repeated with one's own child. In the latter part of the first trimester and into the second trimester the pregnant woman's increased sense of dependency may express itself as contradictory feelings of need for the care of her own mother, a sense of
competition with her for the life-giving role, and a
desire to not repeat her mother's mistakes (Colman and
Colman, 1971).

The encounter group leaders assert that the major
task of the second trimester is the transfer of the
feelings of dependency from the woman's mother to her
husband. She may become obsessively concerned that some
harm might befall her husband thus leaving her to through
the birth and to care for the infant alone. It becomes
very important that the woman's partner is able to assume
the role of care-giver and nurturer. Without the ability
to express her dependency needs to a significant other
in whom she can trust to give the needed support, the
pregnant woman's sense of isolation and psychological
burden increases (Grossman, Eichler and Winnickoff, 1980).

Third trimester: anxiety revisited. The third
trimester is a mixture of pride and fulfillment as well
as anxious anticipation. A women may truly enjoy the
courtesies and attention accorded her as a result of her
advanced pregnancy status and may exult in her life-bearing
role. One the other hand she may feel unattractive,
ugainly and concerned about if she will ever regain her
prepregnancy dimensions (Schwartz, 1980).

The impending arrival of the baby gives opportunity
to perform practical tasks such as decorating the nursery,
buying a layette and infant seat, and taking LaMaze
training. Colman and Colman (1971) suggest that such activity masks underlying anxiety regarding labor and delivery and motherhood.

Anxiety as adaptive in pregnancy: mixed findings.
The role of anxiety in pregnancy has been discussed from several perspectives. Braxelton (1973) engaged normal primiparas in advanced pregnancy in psychoanalytic interviews. He was greatly concerned that the anxiety that was uncovered seemed to be of pathologic proportions and questioned whether these women were ready to assume the role of mother. After the birth he observed that these same women had utilized the prenatal anxiety to reorganize their psyches for the task of motherhood. He described the anxiety of pregnancy as a "shakeup of the circuits" which served to allow the woman to form new attachments to the infant.

Contrary to their own expectations, Grossman et al. (1980) found that among those in their sample who expressed anxiety on pencil-and-paper measures and in clinical interviews, there were lower levels of adaptation to pregnancy, birth and post-partum psychological adjustment than in those subjects who always said they felt "fine". Anxiety levels remained consistent between the first trimester interview and the eight month interview and were related to the subjects general level of adaptation to life.
The authors suggest that anxiety may well have been present in the non-expressing group who could have been utilizing a different coping strategy. It is also possible that the techniques utilized to measure anxiety in this study were not sufficiently sensitive.

Perhaps for those who are prone to anxiety, the expression of that anxiety is a helpful strategy. Uddenburg, Fagerstrom and Hakanson-Zaunders (1976) found relationships between reproductive conflicts, the expression of anxiety symptoms and length of time in labor. From 47 normal primiparas without complications of pregnancy, labor or delivery, 44% exhibited post-partum difficulty in psychological adjustment. Among this "mental handicap" group the researchers found that if the women had admitted to anxiety symptoms prenatally her length of labor was shorter than the cohort of women who denied anxiety symptoms prenatally. Among the women who didn't experience post-partum adjustment problems, there was no relationship between expressed anxiety symptoms prenatally and length of time in labor.

The authors suggest that utilization of denial and repression of anxiety protects the psyche from pain, but that the expression of anxiety may somehow prepare the woman physiologically for birth, and eventually motherhood.

The transpersonal dimension: symbols in dreams and fantasies. In keeping with the psychobiological model,
Colman and Colman (1971) suggest that a pregnant woman's psychobiology predisposes her to "altered states of consciousness" providing periods of heightened sensitivity and awareness. At this time there is little empirical data in this regard, however the subjective reports of those who work closely with interiorly attuned pregnant women provide rich experiential insight into enhancing the phenomenal field of awareness during pregnancy (Schwartz, 1980; Colman and Colman, 1971).

Transpersonal psychology concerns itself with the spiritual dimensions of human existence as expressed in the symbolic and mythic patterns which emerge within the life of an individual, community or culture. Transpersonalists assume that important symbols are consistent across time and culture, thus a "transpersonal experience" involves tapping into a universal, collective awareness (Walsh and Vaughn, 1980).

The heightened emotional and spiritual sensitivity reported by pregnant women expresses itself in both verbal and pictured symbols or images. Words like fruit, bounty, seed, plenty may have fuller meaning. Likewise, the primal themes from fairy tales in which something evil takes away or harms the baby, as in Snow White, Rapunzel and Sleeping Beauty, may be particularly fear-producing (Colman and Colman, 1971). The woman may feel connected to all of humankind and to the re-generative aspects of all species
(Schwartz, 1980) She may identify with the goddess or Divine Mother archetypes (Colman and Colman, 1971). Women of Christian faith, particularly Roman Catholic, may be drawn to Marian imagery or devotion (Stumbo, 1984).

Symbols and images in dreams, both collective and personal, can reveal elements of the struggle in the psyche to resolve the conflicts of impending motherhood. Psychiatrist Thomas Verny (1980) has written that women dream more intensely during pregnancy and that those who dream more (or are aware of dreaming more) are more peaceful and accepting of their pregnancies. Gillman (1968) compared the dream content of pregnant vs. nonpregnant women and found that the pregnant women dreamt about babies 40% of the time vs. only 1% of the dreams of the control group. A basis for the hypotheses of the Swedish study on reproductive conflicts, expressed anxiety and time in labor (Uddenburg et al., 1976) were the findings of Winget and Kapp (1972) who reported that women whose dream content had themes of anxiety and threat had shorter labors than those pregnant women who reported dreams without anxiety.

In investigating the manifest dream content of 13 women for two week periods during each of the trimesters, Jones (1978) provides support for the stage theory of Deutsch and the trimester-psychodynamic themes of Schwartz and Colman and Colman. First trimester dreams about the pregnancy centered around a self-orientation, similar to
Deutsch's incorporation stage. After quickening the dreams with pregnancy reference imaged the child as "differentiated" from the self, in likeness to Deutsch's second stage of the same name. Dreams with architectural imagery—expanding spaces, faulty interior dwellings or those in need of repair were most common in the second trimester (Jones, 1978), consistent with the notion of heightened inner sensitivity during this period (Schwartz, 1980; Colman and Colman, 1971).

Bibring's concept of the psychosexual developmental crisis giving rise to a resolution of past conflicts was supported by Jones' finding that many dreams had past reference content in which the dreamer reviewed life experiences and choices preceding marriage and pregnancy. Jones and Gillman both found dream content with environmental threats, harm or misfortune. Gillman (1968) reported that 40% of the pregnant women's dreams reflect these misfortune themes vs. only 10% of the dreams of the control group.

Dreams and fantasies regarding harm, loss and death have been suggested to reflect a sensitivity to the issues of life and death (Schwartz, 1980). Colman and Colman (1971) report that their clients have said that feeling so close to life brings them closer to the reality of death. This imagery of life and death again reflects a transpersonal dimension, the death of the known psychic self and the
re-birth of the new parent self (Schwartz, 1980).

**Implications for the intervention.** With the goal in mind of encouraging the development of the "mother" identity, the intervention will provide opportunities for the pregnant woman to express ambivalence regarding her pregnancy and changing role. The intervention designers have adopted the position that the expression of anxiety and conflict is more adaptive for the psychobiological model of pregnancy, labor and delivery than denial and repression. The woman will be given opportunities to express her dependency needs, reflect on her childhood and relationship with her own parents, and enrich her attachment bond with her unborn child. There will be emphasis upon understanding her own symbolic language through her dreams and daytime fantasies.

The psychological birth of the "mother" identity does not take place in a vacuum. The expectant mother's relationship with her spouse or partner has repeatedly been found to be the most significant factor in a woman's adaptation to pregnancy and parenthood (Entwisle and Doering, 1981; Grossman et al., 1980). It is important to consider the expectant father as his parent identity emerges.
The Expectant Father

The forces of social change which have opened the doors for greater involvement of women in the work force have also encouraged men to be more involved in the lives of their children. Accompanying this greater involvement have been a number of research projects directed toward developing an understanding of the impact of pregnancy, birth and fathering upon the psychological development of the man (Weiss, 1983). At this point in time, when compared to what has been written about women and pregnancy, the literature regarding the male transition to parenthood lacks both breadth and depth. However, several major and smaller studies do provide important insights into the male experience of the pregnant months and subsequent early fathering (Entwisle and Doering, 1981; Grossman et al., 1980; Wapner, 1976).

A psychoanalytic-developmental view of fatherhood. A psychoanalytic theory on early fatherhood was proposed by Benedeck (1970). From this perspective the biological root of fatherhood is seen as the drive for survival. The birth of a son allows immediate identification by the father who then projects his own aspirations onto the infant. Opportunity to overcome his own regressive-dependent tendencies as well as to compete with his own father are provided through becoming a father himself. Through conquering his own fear of competing he becomes a link
between his father and his son, furthering his psycho-sexual maturity (Benedeck, 1970). According to later research on fathering, the development of a "father" identity begins long before a man seriously considers becoming a father.

During childhood, as a boy observes and experiences his own father or father-figure, his father identity takes root (Benson, 1968; Colman and Colman, 1971). Benedeck (1970) believed that a man's experience with his parents early in life influenced his ability to father and to accept and express his own feelings of tenderness toward his offspring. A harsh and punitive father forces repression and denial of tenderness, while a loving father encourages acceptance of loving feelings.

Grossman and colleagues (1980) found that the man's perception of having been loved and nurtured by his mother and an identification with these aspects of her corresponded with positive feelings toward his fathering role. Conversely, most men in this study insisted they were not like their fathers who they perceived as cold and distant.

A boy's personality development and attitude toward his masculinity also influence his ideas about fatherhood (Biller, 1974). Parke (1981) speaks of the gradual way one becomes a father as becoming acquainted with the demands and joys of a new family role. As a man and woman decide when and whether to have a child, another crucial step in
the father identity is formed. Indeed, whether a pregnancy is planned or unplanned, wanted or unwanted affects how the man adapts to the pregnancy (Benson, 1968; Biller, 1974) and certainly to his internalizing of a positive paternal role.

For a man, pregnancy is not a biologically induced crisis in that there are no hormones at work within his body to activate his psychological processes. Nonetheless, upon learning his wife or partner is pregnant, he embarks on a psychological journey that is not unlike his wife's. Similar to women, men often pass through predictable phases throughout their partner's pregnancy when certain psychological themes or issues predominate (Colman and Colman, 1971).

**First trimester: varied reactions.** During the first trimester, a man may have mixed reactions to the news of his impending fatherhood. Just as the woman, he may also have a sense of pride in his fertility and ability to impregnate his wife (Colman and Colman, 1971). Many men have expressed a feeling that the reality of becoming a father hadn't "hit" them in the first trimester (Grossman et al., 1980). Some men know very little about babies and relieve some anxiety through reading books on the subject (Parke, 1981). Financial concerns do seem to be pressing concerns for men particularly in the early months. An expectant father may take on extra work to
help meet the upcoming financial obligations. Psychoanalytic theorists see this flurry of work activity as a sign of anxiety (Parke, 1981). Whether an expression of anxiety or of great sympathy for one's wife, observed symptoms of pregnancy like nausea, backache, weight gain and fatigue have been observed in 10 to 15% of expectant fathers (Parke, 1981).

**Second trimester tensions: dependency, envy, sexual identity.** Husbands may feel left out and confused by a wife's self-absorption with her pregnancy and her heightened dependency needs upon her mother. Expectant fathers are going through troubled times too, and Parke (1981) has found that during the second trimester a man may often turn to his own mother for the nurturing he needs. He will call her on the telephone or write more frequently than he has previously. This supports Grossman et al.'s (1980) findings that men felt strong identification with their mothers when exploring their own nurturing feelings. Resolving his relationship with his father is another important event of the first and second trimesters of pregnancy (Colman and Colman, 1971).

As the fetus moves within his wife's womb, and as the abdomen expands in the second trimester, a man may feel a combination of emotions which create inner tension. He may feel envy toward his wife's ability to carry a child and/or in competition with the baby for his partner's
attention. Because of his own feelings of powerlessness to contribute something of himself to the pregnancy, jealousy toward the male obstetrician's active role may reach its height during the second trimester (Colman and Colman, 1971).

Observing the changes in his partner's body can also elicit a sense of identification with the feminine aspects of himself. If he has never been aware of these feminine pulls, this can be a frightening experience and raise issues of unresolved sexual identity (Lacoursiere, 1972; Levinson, 1978). Schwartz (1980) cites the work of Herzog that during the second trimester some men relive a childhood stage of hermaphrodite fantasy that he can both fertilize and bear children. Dream content can reflect images of bearing and delivering babies. Herzog sees this as a healthy sign that pregnancy envy is being acknowledged and passed through.

Contrary to current notions that greater androgyny in males eases the transition to parenthood, the empirical evidence of Grossman et al. (1980) found that men who described themselves in more stereotypically masculine traits adapted better to pregnancy than those men with more androgynous or feminine traits. The authors hypothesized that a self-perception in line with the cultural ideal gave these men a self-confidence and a clear differentiation between themselves and their pregnant wife and unborn
child, allowing them to feel less conflict. The researchers noted anecdotally that these "high masculine" men may have sacrificed heightened emotional awareness for the lack of conflict they experienced.

Third trimester: emotional investment. Anticipation marks the third trimester and at last the man can direct his anxieties and energies in outward, constructive activities (Colman and Colman, 1971). His emotional investment will likely be at its highest now. Emotional involvement in the pregnancy has long term effects according to Entwisle and Doering (1981). They found a strong correlation between the degree of interest in the pregnancy and subsequent interest in the infant. Wapner (1976) surveyed the attitudes of expectant fathers attending LaMaze classes, and found them to be expressing confidence and acceptance regarding their impending fatherhood. They felt nurturant toward their wives, expressing a desire to "take care" of her and were highly emotionally involved in the pregnancy. Many said they "felt pregnant". Colman and Colman (1971) report that anxiety for the safety and health of his wife and fetus is reflected in dream content with images of bloody deliveries and a sense of these being his fault.

Emotional investment in the pregnancy takes another form, the beginnings of attachment to the unborn child. Weaver and Cranley (1983) developed a Paternal-Petal
Attachment Scale which documents attitudes and behaviors which would indicate that fathers begin attaching to their infants prior to birth through attributing characteristics to the fetus (e.g., "I wonder if the baby heard that?"), talking to the unborn child, and enjoying watching the fetal movements. This paternal-fetal attachment has been shown to have a strong, positive correlation to the strength of the marital relationship.

The compelling emotions of the man immersed in his experience of pregnancy certainly have the potential of leading him into a transpersonal dimension of awareness. Schwartz (1980) recorded this reflection of an expectant father: "...no matter what we say about men and women and their individual part in producing a child, I am constantly awed by the wonder of it...maybe that's why I step back from it because it's awesome and fearsome...primordial (pp. 117-118).

Implications for the intervention. As men typically have so few social outlets in which to express their feelings and concerns, an important aspect of the intervention will be to provide a mode of support and exchange for men who find their developing fatherhood an enriching, albeit turbulent experience. As well as dialoging with their partners about their ambivalences, anxieties and needs, time will be provided for same gender groupings in which it is hoped that a sense of male
"pregnancy consciousness" will emerge. Men as well as women will have opportunities to explore their childhood experiences and relationships which have influenced their concepts of parenting. Men, too, will be encouraged to develop an awareness of their inner symbolic language in dream and fantasy and have the opportunity to enrich their bond with their unborn baby.

Grossman et al. (1980) observed that a wife's willingness to involve her husband in the pregnancy was a determinant of how invested he became in the pregnancy experience. A positive marital relationship has also been found to be important in how a father interacts with his infant after birth (Benson, 1968; Biller, 1974). It appears that the husband-wife relationship is critical to the successful transition to parenthood of both the man and the woman.
The Expectant Parents' Relationship

As the previous sections have discussed, pregnancy is a time which brings with it enormous changes in a woman's and man's perceptions of self. In general, expectant parents live together and their individual psychological processes interact with one another's. In the transition to parenthood, of which pregnancy is a part, the adaptation of both parents to the pregnancy and to life with their infant later is highly dependent on how well they share in and support the changes their partner is going through (Entwisle and Doering, 1981; Grossman, Eichler, and Winickoff, 1980; Weiss, 1983). Hobbs and Cole (1976) found a significant association between the quality of the marital relationship and the transition to parenthood. They also noted that the healthier a couple's marriage prepregnancy, the less likely they were to have difficulty adjusting to their first child.

In their review of the literature on marital relationship and pregnancy, Weaver and Cranley (1983) identify nurturance and communication as the two essential aspects of the adaptive relationship. Nurturant behavior fosters gentleness and emotional closeness (Colman and Colman, 1971; Kitzinger, 1979; Wapner, 1976).

Communication and changing roles. Healthy communication is essential throughout the transition to parenthood as the couple redefines their needs and roles. In her longitudinal
study of couples pre- and post-natally, Broom (1984) found only moderate consensus between spouses on post-partum issues during their transition to parenthood. Husbands and wives prioritized issues differently, although men were better than women at perceiving the topics of greatest concern to their spouses. The danger in misperceiving the amount of agreement in a relationship is that it may lead to false consensus and little impetus to discuss important matters.

Fishbein (1984) found that if a pregnant woman's expectations of her husband's childcare responsibilities were not in line with his, a higher stress level was reported by the man when compared to couples where there was more role congruence. The issue of changing roles is of particular interest because as Levine (1977) has stated, our society is experiencing a cultural lag, with our images and expectations of women changing faster than those of men despite the fact that the roles of men and women in family life are interdependent.

Deutscher (1970) emphasizes the need for a couple to work on communication and emotional sharing during the transition to parenthood. In a longitudinal study of several couples going through pregnancy and the first year post-partum, Cowan et al. (1978) found that the couples coped with the realities and demands of child rearing through sharing and communication.
Sexuality and identity. During pregnancy, the fragile emotions and changing identities of both husband and wife often are reflected in their fluctuating sexual needs (Schwartz, 1980). Great patience, kindness and understanding in this sensitive area are needed even in relationships where communication on sexual issues has never been a problem. A woman's changing body image and accompanying psychological changes can make her more or less available for sex throughout pregnancy. His partner's changing shape can release a variety of responses in a man, from heightened arousal to a questioning of his own masculinity, to adoration of an untouchable virginal goddess, to complete lack of sexual interest in his partner (Schwartz, 1980).

From the second trimester through mid-third trimester, the physiological changes of pregnancy parallel those of a sexually aroused nonpregnant woman. Increased vascularity in the genital area, heightened vaginal lubrication, tensed breasts and nipples, and a tilting of the uterus all combine so that many women during this stage of pregnancy experience a continual sense of arousal, increase in eroticism and desire for intercourse more than at any other time in their lives (Bing and Colman, 1977). Masters and Johnson (cited by Schwartz, 1980) report that in primigravidas there is an overall decrease in sexual relations during the first trimester, but 80% report an increase in frequency and
satisfaction, even over prepregnancy levels, during the second trimester. At any time, however, emotional concerns or physical discomfort can override the heightened sensuality (Bing and Colman, 1977).

Heightened eroticism can come as a pleasant surprise to a couple, or it can be interpreted as unsatisfiable dependency. This can especially be the case if the husband is not feeling very sexual toward his pregnant wife. Unexpressed needs for intimacy or distance can cause tension in the expectant parents' relationship. When the abdomen becomes an obstacle to conventional sexual practice, an opportunity for experimentation in other forms of sexual/affectionate expression presents itself (Schwartz, 1980). Herzog (cited by Schwartz, 1980) noted that in high-intimacy couples, men enjoyed experimenting with dual sex roles. These men, comfortable with their feminine dimensions, desired to make love in a way that they would "feel penetrated at the same time they were penetrating". Herzog found this experimentation most often in the second trimester, nicely coinciding with the woman's increased libido.

Male sexual satisfaction has been documented to be the most critical in the first trimester of pregnancy. Men who reported higher sexual satisfaction in the early months adapted better to the pregnancy later, compared to those men who reported less satisfaction (Grossman et al., 1980).
In his survey of men in LaMaze classes (closer to delivery), Wapner (1976) found that these expectant fathers reported an overall decrease in sexual activity, but were not overly concerned about it.

**Implications for the intervention.** Deepening and strengthening the expectant parents' relationship will be a major objective of the intervention. Through communication "exercises" as well as shared quietness, emotional closeness and sensitivity to the concerns of the partner will be fostered. An environment in which couples are free to discuss their needs regarding intimacy as well as negotiate their changing roles and tasks post-partum is central to the intervention process.

The cause of all this psychological and relational turbulence has yet to be discussed. The fetus, whose growing abilities and developing sensitivities to the womb environment is directly and indirectly effected by maternal and relational factors.
The Developing Fetus

For centuries, poets, philosophers and mystics have been fascinated with the secret life of the child still in the womb. Folklore throughout the world is replete with admonitions to the pregnant woman to avoid places or situations which could cause fright or other strong, negative emotion which might adversely affect the baby. Recently, scientists have directed their attention to attempting to understand not only the physiological development of the fetus, but its possible psychological development as well. Prenatal psychology is emerging as a field of inquiry with several major areas of research. This section will provide a brief overview of the major domains of prenatal psychology: fetal sensory and reflexive development, learning in utero, and most germane to this project, the possible effects of maternal emotional states, particularly stress, on infant outcome.

Fetal sensory capabilities. Liley (1972), an Australian fetologist, provided novel insights into the sensory abilities of the human fetus. His research described taste, touch, visual and hearing capabilities in five to six month old fetuses. If accidentally tickled on the scalp during an obstetrical examination the fetus would quickly move away. If cold water was injected into the amniotic sac, vigorous kicking was observed. When saccharin was injected into the amniotic fluid the fetal swallowing
rate doubled over a pre-recorded baseline swallowing rate. When a foul-tasting oil was likewise allowed to enter the fetal environment, the response was that swallowing ceased and that the fetus "grimaced". The fetus was also observed to turn away or startle when a bright light was shown directly on the mother's abdomen.

Fetal hearing has been the most easily studied sensory ability as well as the most fruitful. Swedish investigators have documented fetal hearing at 24 weeks gestation and claim that the fetus produces sound which imitates what has been heard ("Fetus listening," 1970). Liley (1972) observed that the fetus seemed to "jump" in time to a beating drum from the 25th week. Recordings of the uterine environment reveal it to be a noisy place with intestinal rumblings, muffled sounds from the mother's voice and the dominant, ever-present maternal heartbeat (Liley, 1972).

Exploration of fetal hearing abilities led one audiologist to study fetal reactions to different types of music. Fetuses remained calm during the compositions of Mozart and Vivaldi, but became quite agitated when the music of Beethoven, Brahms or any contemporary rock music was played (Clements, 1977). What a fetus hears in utero is at the forefront of current research in human prenatal learning.

Prenatal learning. The first published study concerning
learning involved a classical conditioning experiment with sixteen third trimester fetuses. The unconditioned stimulus was a loud noise, eliciting the unconditioned response, a sharp kick. The conditioned stimulus was a vibration applied to the mother's abdomen. After 15 to 20 pairings of the vibration with the loud noise, the vibration alone elicited the sharp kick (Spelt, 1948). Lack of a control group compromised Spelt's work and he was subsequently unable to replicate his results when utilizing proper controls (Lamb and Campos, 1982).

An article in the APA Monitor (Cordes, 1984) highlights more recent and reliable studies in the field of prenatal learning, both animal and human. DeCaspar (cited by Cordes, 1984) hypothesized that newborns have had learning experiences prior to birth because all of their senses are intact far prior to birth. In one-and-a-half to four-day-old infants DeCaspar and colleagues found that the babies could be conditioned to suck to tapes of their own mothers' voice rather than to that of another woman.

Interested in whether this preference for the maternal voice was innate or learned prenatally, the researchers asked another group of pregnant women to read a certain nursery rhyme book aloud twice a day during the six weeks prior to the baby's calculated due date. Within 48 hours of birth 10 of the 12 newborns preferred to suck while listening to the same story they had heard in utero to an
alternate story they had not heard as fetuses. Research continues into what aspect of the nursery rhyme the fetuses were responding to (cadence, voice tone, etc.).

Interestingly, the two-day-old babies did not show a preference for their father's recorded voice over that of another male and their sucking behavior suggested that they preferred to hear tapes of an in-utero maternal heartbeat to recordings of a male voice reading nursery rhymes.

Cordes (1984) cites Krasnegor as stating that the surface has only been scratched in understanding what the fetus learns prenatally. Given the ethical considerations of invasive experimentation with human fetuses, the animal laboratories are further along in providing insight into prenatal learning potentials. Both odor preferences and taste aversions have been induced in rat pups prenatally. There is no doubt that fascinating findings are in store for those interested in prenatal learning.

**Maternal emotions and fetal outcome.** A pregnant woman is unique to other humans in that she can share an element of her physiological responses accompanying emotion with another person, her unborn child. For example, if an expectant mother is suddenly frightened, the adrenal glands produce catecholamines which flood her circulatory system. She experiences an increased heart rate, more rapid respiration and an increase in perspiration. These
catecholamines cross the placenta and invade the fetal circulation as well (Montagu, 1964).

During the 1940's researchers at the Fels Institute were among the first to inquire into the potential effects of maternal emotion on the fetus. In a study of emotionally undisturbed women, the Fels researchers monitored parameters of autonomic nervous system (ANS) activity at several points throughout the pregnancies. Wide variability within and between subjects was found at the sittings. Increased maternal ANS activity correlated with an increase in fetal heart rate and fetal movements (cited by Montagu, 1964).

A Fels researcher, Sontag (1941), directed his attention to the consequences of long-term emotional disturbance in the pregnant woman. He too found that when the mother was undergoing mental stress, corresponding fetal activity increased several hundred percent. When the emotional disturbance in the mother was prolonged over weeks, hyperactivity in the fetus was also extended. At birth, these hyperactive fetuses were low birthweight infants. Most of the newborns were also hyperactive and hyperirritable with gastrointestinal disturbances.

More recently Grossman et al. (1980) found correlations for first time mothers between high maternal anxiety and depression scores in the first trimester and infants with higher irritability in the post-partum period.
These correlations did not hold for multiparous women. The authors suggested that just as the psychological experience of first pregnancy is more intense than a subsequent pregnancy, so this intensity is somehow passed on in utero.

In the years between Sontag and Grossman et al., many studies have been published with findings correlating stress with complications of pregnancy, labor and delivery and negative fetal outcome (Newton et al., 1979; Standley, Soule and Copans, 1979; Crandon, 1979a, 1979b; Uddenberg et al., 1976). A major problem in interpreting these findings into a cogent understanding of how stress effects pregnancy is due to the varieties of definitions utilized for stress. Stress during pregnancy has been operationalized to mean pregnancy anxiety (Standley et al., 1979), incongruence between conscious and unconscious feelings regarding pregnancy (Verny, 1980, citing Rottman, 1974 and Lukesch, 1975; Uddenberg et al., 1976), generalized anxiety as measured on the IPAT (Crandon, 1979a, 1979b), measures of negative life events (Norbeck and Tilden, 1983; Newton et al., 1979).

Other issues complicating interpretation of study results include a failure to control for high risk groups such as teenage mothers and those with pre-existing medical conditions which could have negatively biased study results (cited by Norbeck and Tilden, 1983). Reliability has also
been compromised when mothers were asked post-partum to evaluate stressful events during the pregnancy. It is possible that those who had complicated or premature deliveries would tend to, with hindsight, interpret certain events more negatively than they would have if asked prior to delivery (Newton et al., 1979).

Despite the confusion that exists methodologically in attempting to understand the relationship between stress (broadly defined) and pregnancy outcome, the issues raised in these studies are too serious to ignore. It would seem important to provide the pregnant woman with an opportunity to define her personally perceived sources of stress and assist her in developing a management-coping plan.

Speculative frontiers in prenatal psychology. In response to the deleterious findings associated with negative maternal emotional states, others have begun to reason that if stress hormones can cross the placental barrier, what about physiological correlates of positive emotions? Swedish neuroendocrinologist Feydor-Freyburgh (1985) asserts that the pregnant woman has within her power the capability of establishing a neuro-endocrinological dialog with her unborn baby. From 100 days gestation the hypothalamus is intact and involved in experiencing and interpreting, albeit primitively, maternal neurochemical messages. He further suggests that these messages, both positive and negative, prepare the embryo-fetus to adapt to
extra-uterine life. Although the balance of neuroendocrine messages would most helpfully be weighted on the positive side, negative impulses and experiences are a reality of life outside the womb and therefore to experience them before birth is adaptive.

Veldman (cited by Linn, Linn, and Febricant, 1985) has developed a technique called haptonomy. Expectant mothers are instructed to send "love" messages to their babies at a particular time each day. This is accomplished through placing both hands on the abdomen and for the first few minutes to concentrate on sending love through the right hand. The observation has been that the baby will move toward the right hand. Alternatively, the love message is sent through the left hand and the baby will change its position to the left. After several weeks of these daily scheduled love messages, Veldman asserts that if the mother neglects to send the love message at the regular time, the fetus will become agitated until the accustomed attention is delivered.

The ideas discussed in this section have given rise to The International Society for Prenatal Psychology (ISPP) which assembles at a European site for annual conferences with presentations from various research and clinical fields in the area of prenatal experience. A sister organization, The Pre- and Perinatal Psychology Association of North American (PPPANA) was launched in 1983 to provide dialog for
North Americans with similar interests biannually. Presentations at the 1985 PPPANA conference reflect the diversity of interests represented in its membership: "The Biochemistry of Bonding" (Feydor-Freyburgh), "Cellular Consciousness", proposing and demonstrating a primal therapists journey to the "memory" of conception (Farrant), "A Program to Facilitate Pre-Birth Bonding" (Bowen), "Apparent Prenatal Consciousness as Revealed in Hypnosis" (Cheek), "Parental Singing as a Focus for Pre- and Périnatal Stimulation of Infants" (Thurman), "Stress Management during Pregnancy (Olkin), "Prenatal Development of the Ego" (Luparia).

The titles of many of these presentations bely the fact that some of these concepts are beyond the realm of scientific validation and enter into the realms of philosophy and experiential therapy. The wide variety of offerings (of which these represent only a small portion) suggests that as the field of prenatal psychology matures, both philosophically and in scientifically generated theory, the gestational months may come to be recognized as having lifelong impact on development.

Indeed, Riegel's dialectal model of development (1976) in which the biology and the environment of the individual are constantly interacting could be found to extend to the very time of conception. As technology and scientific methods improve and the biochemistry of maternal emotions
comes to be better understood, the primitive biology of the conceived individual's genetic code may be found to be interacting with its neurohormonal environment through every moment of its intrauterine existence.

Implications for the intervention. In integrating this evolving body of knowledge into a program for expectant parents, care must be taken to distinguish fact (sensory and physiological development) from that which has growing validity (potential negative effects of stress) from pure speculation (that a memory of conception exists). The intervention will emphasize relaxation and communication skills as mediators of stress. Basic information regarding fetal development, with an emphasis upon the hearing capabilities and sensitivity to voices will be included. The notion of creating a positive biochemical environment for nurturing the fetus will be introduced using relaxation, meditation and creative visualization techniques.
Conclusions from the Literature

The psychological experience of pregnancy has largely been unresponded to by the health and mental health communities. Obstetrical treatment and technology is well-developed, and the great majority of women in our country have access to prenatal and obstetrical care.

Equally important, but largely ignored has been the psychological side of pregnancy and the enormous personal and relational stresses it brings about with potentially negative effects for all members of the new family.

Pregnancy is also an opportunity for growth, psychologically and spiritually. The woman's psychobiology provides impetus for the resolution of past conflicts and can propel her to greater integration and maturity. Men as well have found the pregnant months to be deeply engaging and meaningful in their own development. In addition, Stumbo (1984) states, "Many men and women alike experience pregnancy as very spiritual, sensing keenly the mystery and magic surrounding the awesome process, a process transcending their individual parts, their plans and preparations, an experience mystically intimate within them while simultaneously larger than them" (p. 11).

In 1973 Shareshefsky and Yarrow outlined the elements of a prenatal counseling program. They recommended that expectant parents be encouraged to participate in dreamwork, the identification of negative attitudes and transference
issues. They advocated a clarification of feelings, concerns and relationships. They also felt that anticipatory guidance in the form of exploring future issues that might interfere with successful adaptation to pregnancy and parenthood should be a component. Since then, Verny (1980), Schwartz (1980), Grossman et al. (1980), Weiss (1983) have advocated prenatal support and transition to parenthood groups. The proposed project is in line with and in the spirit of these recommendations.

It is likely that the earliest proponent of psychological support during pregnancy was Grete Bibring. In the late 1950's she observed the deficiencies of the nuclear family in an increasing technological age. Her insights, then largely ignored, are more relevant now as the father's experience of pregnancy is equally as vital as that of the mother:

Pregnancy, like puberty or menopause, is a period of crisis involving profound psychological as well as somatic changes. As the modern family becomes isolated, and as other important group memberships break down, the individual must rely increasingly on the nuclear family, especially on the marital relationship, and this unit is rarely equipped to replace all these figures in their varied supportive functions.

With increasing emphasis on the "scientific" in our society, less and less attention is paid to the unscientific, the irrational, the emotional and spiritual dimensions of human existence...

...What was once a crisis, with carefully worked out traditional customs of giving support to the woman passing through this crisis period, has become at this time a crisis with no mechanisms
within society for helping the woman involved in this profound change... If this be so, then the importance of appropriate psychological care as part of the prenatal program becomes obvious... to bring the psychological support in line with the achievements of today's obstetrics (Bibring, 1959, pp. 117-118).
THE INTERVENTION

The process of developing "One Becoming Two Becoming Three" has been a journey in itself. Several people have collaborated on the project providing creativity, insight and encouragement at critical times. This section describes the group process through which the original ideas were generated, the creation of an audio-visual production, the curriculum development and the overall objectives of the intervention. Two formats of the intervention program are presented, a nine-week design and a weekend design. A description of the marketing and promotional strategies utilized to promote the intervention program concludes this section.

Development of the Intervention

Through a unique series of conversations a group of four people was assembled who shared a common interest in the field of prenatal psychology and prebirth bonding. These persons included a pediatric head nurse, an obstetrical nursing supervisor, a pastoral counselor/psychotherapist (the only male), and myself, a nurse/lactation consultant turned graduate student.

The Framework: An Environment to Grow In

The first meeting together was a brainstorming session
to share ideas about how to fill the gap we all sensed to exist in current approaches to childbirth education. Several of us had read and were greatly interested in *The Secret Life of the Unborn Child* (Verny, 1980), in which a Canadian psychiatrist reviewed the literature and presented in popular form some findings regarding prenatal fetal awareness and the lifelong impact of prenatal and birth events. Although we were aware that many of the studies cited were very controversial and lacked some scientific validity, nonetheless the concepts were fascinating.

Another book which was influential at the beginning of our process was *The World of the Unborn: Nurturing Your Child Before Birth* (Schwartz, 1980). Schwartz, more briefly than Verny, described some of the trends in fetal research. As an environmental psychologist, she was concerned about increasing the quality of the birth environment, psychologically as well as in a physical-aesthetic way. She led pregnancy support groups as a means of broadening the expectant parents' inner architecture in preparation for their new roles and identities as parents. Many of the transpersonal symbols and meditations-reflections eventually adopted into the program format are either adaptations from or direct replicas of her experiential exercises.

With these two books as the impetus for our vision, we desired to develop a program which could both provide
practical information regarding fetal development and the transition to parenthood, but also address the deeper issues of anxiety/conflict and tap the enriching wells available within the transpersonal-spiritual dimension. We envisioned a group experience of six to eight couples who would meet together once a week for ten weeks (this number arrived at rather arbitrarily) facilitated by a male-female, two member team modeling an egalitarian relationship. We sensed that the group members would become an "extended family", providing relationships in which the sharing of joys and concerns related to becoming parents would better prepare them for this personal and social role transition. We believed this support group would be particularly meaningful to men who generally have fewer outlets to share their emotional experiences than women do.

Although in our early meetings, the actual content hadn't been decided upon (as much research was ahead of us) we were clear on the type of environment we wanted to create within the program--warm, inviting, growth enhancing. Within this quite Rogerian ambience, we desired that each person and couple would emerge from the program with a renewed sense of self-appreciation, appreciation for their partner, their relationship and the marvel of their child as they crossed the bridge into familyhood. This "prenatal bonding", both between parents and with their baby, we believed would be a positive beginning to life after birth.
One of the early concepts we held was that our target population would be second trimester expectant parents. During the second trimester some of the fatigue and physical discomfort of the first trimester would be past, the physical "signs of life"—swelling abdomen and fetal movements—would be present, and the weightiness and weariness of the third trimester would still be in the future. Also, a second trimester workshop would avoid schedule conflicts with LaMaze classes, generally taken in the third trimester. We viewed the second trimester as the ideal period, physically and emotionally, in which to explore the issues of a changing identity and a changing relationship as well as providing more time in later pregnancy to continue implementing the communication and nurturing techniques we anticipated.

The Audio-Visual: Its Purpose and Production Process

All members of the planning group shared an admiration for the work of Lennart Nilsson, the Swedish photographer famous for his ability to photograph the fetus in-utero. Early in the brainstorming sessions it was decided that an audio-visual slide presentation including Nilsson's photos would enrich our program by creating greater awareness of the marvel of the developing fetal life within the mother's womb. It was hoped that the audio-visual would be marketable to other groups involved in similar projects.
As discussion regarding the audio-visual proceeded over several weeks, there was a definite trend away from the traditional media for childbirth education classes, which focuses on the hospital delivery of the infant in a surgical suite complete with sterile sheets, instruments and unobstructed view of the mother's perineum. These were certainly instructional media, but not in line with the philosophy and goals of this project. What evolved from those discussions was a desire to express the spiritual, the transcendent, the transpersonal dimensions of life before birth. Pregnancy would be interpreted as a participation in the ongoing rhythms of life and creation as evidenced and expressed in nature. This project, now an aesthetic endeavor, was beyond the abilities of the group members. It was time to hire a photographer.

After locating a photographer and discerning his sensitivity to the project, a contract was made and fee agreed upon. The fee would be divided among the project members. After several hours of brainstorming with the photographer regarding which types of images would convey the desired message, a deadline of six weeks to project completion was agreed upon. Appropriate to our subject matter, the actual production time took nine months to complete.

Difficulty in obtaining models, interpretive differences between photographer and group members,
procrastination and burn-out all contributed to delays in production. Future marketing considerations also became a source of delay.

A sound track was chosen from a Vangellis recording. However, in contacting the recording company for permission to use it for commercial purposes, permission was denied. Anticipating similar responses from other recording companies, it was decided that an original sound track would be more beneficial. Thus, a composer was hired to compose and record a 15 minute soundtrack.

Perhaps the most trying experience of creating an original audio-visual production was what occurred after all the images were photographed and the soundtrack recorded: equipment failure. A specialized unit was used to dissolve the images so that as one fades out, the next image is superimposed and gradually gains clarity and intensity. Another piece of equipment is necessary to send electronic-impulse signals to the dissolve unit to progress the slides in a certain order with a predetermined timing. These impulse signals are recorded on the soundtrack.

In editing the finalized version of the production, the photographer and I spent some ten hours growing in expertise in simultaneously running the equipment and recording the impulses. The irony of all this labor in programming the equipment to run itself was that we had to run the production manually at its first public preview.
The recording unit malfunctioned on the critical day. During the manually operated preview showing, one of the slide carousels jammed momentarily putting the rest of the slides out of synchronization!

We are very pleased and proud of the eventual outcome of the audio-visual as an aesthetic expression. It truly does reflect that which we intended. However, at this time, we are considering converting it to either a videotape or 35 millimeter film format to simplify the technical aspects of both showing and marketing it.

The marketability of the production is still in question due to copyright permissions still pending from Nilsson and others. However, regardless of whether this production can ever be marketed, it will be a true asset to the overall intervention program.

The Curriculum takes Shape

Within the first two months of our irregularly scheduled meetings, one group member, the pediatric nurse, had to drop out of the process because of other commitments. The obstetrical nurse indicated that her greatest interest and energy could best be spent in the marketing/promotional area as well as in developing the anticipated audio-visual program. Thus the curriculum development was left to the male pastoral counselor/therapist and myself.

The preliminary curriculum was a skeleton design with
topics filled in for each of the ten weeks. This preliminary curriculum was then used by the obstetrical supervisor to convince the hospital administration to accept the program as part of their educational offerings for patients.

Within the preliminary design, several elements emerged. We decided to utilize a journaling process to facilitate collection of personal thoughts and feelings as well as a tool for sharing with others. During the time between sessions, participants would be encouraged to record their dreams, fantasies and feelings in the journal so that it would become a mirror of their emerging parenthood throughout the pregnancy. Gestalt-type communication exercises to express ambivalence and needs would be a feature as well as role playing to illustrate conflict and conflict resolution.

Later, in seven sessions, involving 18 hours, the detailed curriculum for each minute of each two-hour session was formulated. In this process, parts of two sessions were combined, thus leaving a nine week series.

We were aware that in the early weeks trust between group members would be growing and thus concentrated on topics that would be discussed primarily between partners with less group interaction. Beginning with the fifth week, more group trust is assumed and participants will be interacting with others who are not their partner.

The most recent adaptation to the curriculum has been
a weekend format. For marketing purposes, discussed later, the nine sessions were molded into a Friday evening through Sunday afternoon design. While sacrificing some of the skill building that utilizing the process over nine weeks would have enhanced, the "trade off" in the weekend design is an intense experience of community and sharing.
Objectives of the Intervention

The objectives of the proposed project are reflected in its title, "One Becoming Two Becoming Three". Content of the program is consistent with the issues discussed in the review of literature.

Objective One

Foster the development of the emerging parent identity in each participant through:

a. lifespan reflection
b. age regression through creative visualization
c. journaling
d. symbolic language in dreams and fantasies
e. conflict resolution

Objective Two

Deepen and strengthen the couple's relationship as they prepare for the changes inherent in caring for a newborn through:

a. enhancing communication on difficult issues (i.e., ambivalence, sex, role changes)
b. fostering emotional closeness
c. anticipation of postpartum adjustments

Objective Three

Create an optimum environment for the physical and psychological development of the fetus through:
a. increasing parental awareness of fetal capabilities
b. reducing maternal/relational stress
c. promoting parental-fetal attachment
The Nine Week Format

Session I — "Getting to Know You"

Goals: 1. To reduce anxiety and promote open and relaxed attitudes regarding the workshop, the leadership and personal participation through: leaders' overview of the content and flow of the workshop and expectations regarding participation, leaders' self-disclosure of personal interest and hopes for the workshop, and providing opportunity for group members to become acquainted.

2. To familiarize group members with a general method of the workshop, reflection, journaling and interaction.

Inclusion Activity (20 minutes)

Upon arrival to the meeting place, couples will be greeted and invited to participate in a getting acquainted exercise, "Filling the Womb". Each couple will receive a womb-shaped piece of poster board with instructions to fill the womb with representations of their personal interests (i.e. career, recreation, hobby), their hopes as expectant parents and their concerns as expectant parents. These representations may be expressed in words, in artistic symbols or may be pictures cut out of magazines provided by the leaders.

Overview of the Workshop and Leaders' Introductions
Each couple will introduce itself within the context of its filled womb. Leaders introduce the idea that even now, to a limited degree, the parents are sharing these aspects of themselves with their unborn child (Verny, 1980; Schwartz, 1980).

Break (10 minutes)

Grouping (5 minutes)

Brief introduction to the journal and to the journaling process in and out of the workshop.

Couple Exercise (15 to 20 minutes)

The "Trust Walk" exercise. One spouse/partner is blind-folded and goes for a walk led by the other partner's hand, touch or voice. Roles are then reversed. This exercise is intended to evoke feelings of trust, security and vulnerability in the person walking, and gentleness, protectiveness and sensitivity in the one who guides. This interdependency is an essential component as the couple walks together through the unfamiliar terrain of expectant parenthood.

Personal Reflection (10 minutes)

Instruction by the leaders followed by personal written reflection on what was experienced during the trust walk, both as walker and as guide. Reflections may be poetry, prose, outline, symbol, sketching or any other meaningful expression of the experience.
Journal Exchange and Interaction (10 minutes)

Couples exchange journals to gain insight into the partner's experience then interact on their reflections.

Grouping (5 minutes)

General questions by the participants will be addressed, followed by closure for the evening.

Session II -- "Our Creation"

Goals: 1. To provide information regarding the developing fetal awarenesses and responsiveness.

2. To provide an experiential dimension in which couples can share the profound meaning the growing child has to them.

Inclusion Activity (20 minutes)

To become re-acquainted, group members will recall what they remember from each person's/couple's introduction the week before. Opportunity will be provided for any members to share a meaningful experience that occurred since the previous meeting.

Lecture/Questions (25 minutes)

Lecture, followed by brief question-and-answer session regarding recent research findings related to fetal sensibilities: sight, sound, taste, touch and theories of fetal consciousness (Liley, 1972; Verny, 1980).

Break (10 minutes)

Audio-visual Presentation (30 to 32 minutes)

Following each couple's placement comfortably on pillows
and blankets on the floor and a verbal contexting for the slide/music presentation (5-7 minutes), the audio-visual will be shown (15 minutes) followed by a period of guided imagery "Meditating with the Baby" (Schwartz, 1980) with room still darkened and music continuing. (10 minutes)

Silent/Written Reflection and Journal Exchange with Partner (15 minutes)

Group members share any insights or special meanings the audio-visual and meditation had for them.

The Candle Symbol and Closure (5 minutes)

Leaders context the meaning of the lighted candle as spiritual dimension of the workshop. The light, warmth, melting, reshaping of the candle symbolizes life, spirit, transformation which occurs during pregnancy although religious terms and understandings for this phenomena will vary. From now on, the candle will be lit from the opening to the closure of the workshop sessions. Any participants who wish to participate in sharing in the spiritual dimension are invited to.

**Session III -- "Turbulent Times"**

Goals: 1. To understand the potentially negative effects of stress on pregnancy and fetal outcome, and to identify personal stressors in order to better mediate them.

2. To examine ambivalence regarding the pregnancy and the coming baby and to provide a safe environment to express such mixed emotions.
Reading and Candle-lighting (5 minutes)

Life Events Inventory (10 minutes)

A self-administered tool to assist in identification of personal stressors.

Lecturette on Stress and Pregnancy (25 minutes)


Partners exchange inventories (5 to 10 minutes)

Partners may add insight into additional sources of life stress.

Break (10 minutes)

Grouping Brainstorming (5 minutes)

Group brainstorming on sources of ambivalence during pregnancy.

Written Reflection and Couple Interaction (10 minutes)

Sources of pregnancy ambivalence and personal stressors.

Communication Exercise -- I'm uncomfortable/I'm afraid (Schwartz, 1980) (20 minutes)

Technique in which partners take turns expressing a list of personal statements which begin with I'm uncomfortable and then I'm afraid. As one partner is talking, the other engages in receptive listening. The listener then reflects what he or she heard the partner say. Roles are then reversed. After both partners have completed their turns,
there is a brief resolution phase when each partner sums up what he or she can do to help him or herself and what he or she thinks they can do to help the partner. Leaders demonstration followed by couple interaction.

Lecturette-Discussion -- Dream Themes and Pregnancy (10 minutes)

Relaxation Exercise (5 minutes)

Guided imagery to music as stress reduction technique.

Closure

Session IV -- "Will You Still Love Me Tomorrow?"

Goals: 1. To understand that fluctuating sexual needs and feelings are normal and to be expected.

2. To open communication regarding needs for intimacy during pregnancy.

Reading and Candle-lighting (5 minutes)

Simulation: Sex and Pregnancy (20 minutes)

Leaders role-play vignettes representing couples in conflict regarding sexual needs:

1. reluctance to make love because of fear of hurting the baby,

2. husband perceives wife and baby as a unit unto themselves and feels left out,

3. wife desires sex, but husband has virgin/goddess image of her,

4. wife feels her body is ugly and a turn-off to her husband.
Open discussion in response to vignettes: What could you identify with? What was missing that could have been portrayed?

Break (10 minutes)

Compare/contrast what came out in the groups: male list, female list; common issues, gender themes.

Written Reflection (10 minutes)

"As a man, I . . . "

"As a woman, I . . . "

Couple Interaction Exercise -- "Drawing the Body" (Schwartz, 1980) (15 minutes)

Partners take turns tracing the shape of their partner's body on a large piece of paper. Each person fills in the body with something they are feeling (i.e. in the chest area someone might write "lonely", in the head, "distracted").

Grouping -- Vignettes Continued (10 minutes)

Returning to the vignettes, leaders model how certain need conflicts can be moved toward understanding and resolution.

Communication Exercise -- "I Need/I Want" (Schwartz, 1980) (15 minutes)

Using same format as "I'm uncomfortable/I'm afraid", partners take turns expressing and distinguishing between want and need in relation to sex and intimacy.

Closure
Session V — "The Inner Parent"

Goals: 1. To create an awareness of how the attitudes of our parents remain a part of us.

2. To identify those parts of our upbringing which need further resolution, which parts we hope to pass on, and which attitudes we hope not to relive in our new family.

Candlelighting (5 minutes)
Open discussion of the week's experience (10 minutes)
Overview of the Evening (10 minutes)

See goals of the session

Guided Fantasy - "Visiting the Childhood Home" (10-12 minutes)

In a relaxed and meditative setting, participants will be guided in imaging the home they grew up in. At first the outside of the home will be experienced, the yard, the sights and sounds of birds, trees, neighbors, pets. Upon entering the home, the ambience, feeling tone of the home will be absorbed. Look at furniture, pictures, bookshelves. Listen to the music, the voices. Visualize the parents in typical activity, see them interacting with each other, with the child-self, with siblings. What is the tone of the conversation, what are the attitudes you feel and absorb?

Journaling about the Visit Home (15 minutes)

Break (15 minutes)
Small Group Sharing (2-5 minutes)

What words summarize your childhood experiences.
Use as few words as possible.
Coupling (5 minutes)

Share experience briefly with spouse for confirmation/additions.

Reflection/Prayer (13-15 minutes)

"What is it I most need to let go of/forgive? Why?"

Participants are free to walk and move around as they struggle with these issues.

Coupling and Journaling (15-20 minutes)

Time to share the evening's discoveries and quandries with spouse/partner. Journaling to include "I" statements regarding hopes for the relationship with the coming child.

Meditating with the Baby (10 minutes)

Holding each other and touching the mother's abdomen, couples share with the baby what it is they hope for in their life together.

Closure

Session VI -- "Re-birthing"

Goals: 1. To provide an opportunity for inner healing of bruises and hurts of childhood through the love and acceptance of another.

2. In recognizing one is lovable, there is greater freedom to love and give of oneself.

Candlelighting (5 minutes)

Overview of the Evening (10 minutes)

See goals of evening. For most people direct memories of fetal life and birth are deeply buried. These events did
effect our life in ways we may not understand. By touching on our pain in early life, we engage in themes which may have their roots in our gestation or birth.

Participants will be directed to pair off with someone they feel close to/drawn to who is not their spouse or significant other. The accepting presence of a caring, but emotionally neutral person can be of greater assistance than one's spouse who lives with your bruises every day.

Re-Connecting with the Past (10 minutes)

Awareness of painful childhood memories will be closer to the surface because of last session's activities as well as any insights which may have arrived during the week. Participants will be led in a very brief guided fantasy back to their childhood home to refresh their awareness. They will re-read their journal entries and make any additions that are appropriate.

Pairing #1 (35 minutes)

One person will decide to be the journeyer, the other will act as an accompanist who travels silently, but reverently with the journeyer. The journeyer will have 7-10 minutes to share what it was like to grow up, its joys and pains. The accompanist will listen attentively, receptively. The accompanist may only speak to ask a question of clarification. When the journeyer has finished, the accompanist briefly summarizes what he or she has heard (2 to 3 minutes). When all pairs are comfortably positioned,
facilitators will lead the group in a guided fantasy of pregnancy and birth. The journeyer will be re-birthed and the accompanist will act as a comforting, welcoming parent figure (10-12 minutes). Following re-birthing, there is a recovery period when the journeyer may need to write, or just be silent to absorb the experience. According to the journeyer's need, accompanist may or may not be present during recovery (8-10 minutes).

Break (flexible 15 minutes to allow for additional time needs of some participants)

Pairing #2 (35 minutes)
Roles are reversed in the pairs and the same sequence of events occurs.

Re-Grouping (10 minutes)
A brief opportunity for participants to share what it was like to be re-birthed as well as to accompany another.

Closure

Session VII -- "The Feminine/Masculine Journey"

Goals: 1. To allow the participants to trace the development of their sexual/gender identity as males and females as well as to identify areas of androgyny within themselves.

2. To provide a setting in which issues of particular concern to each sex can be discussed in same sex groupings.

3. To identify any areas of sex role conflict or
confusion which might need further work.

Candlelighting (5 minutes)
Opening Instructions (5 minutes)

Special handouts will be provided on which participants will map out "How I learned to be a man/woman", or "How I got to be here from there".

Journey Mapping (20 minutes)

What have been the significant life events and who have been the significant people in my masculine/feminine/androgynous development?

Same sex groupings (40 minutes)

An opportunity to share journeys, dreams, images, concerns that are of particular interest to each sex. At appropriate point in time, facilitator of each group will "storytell" the development of a hypothetical man (for men's group) or woman who typifies role-identity conflict.

Participants will be invited to identify with, elaborate on, or differentiate from the person in the story (e.g., a career-oriented woman who is feeling the pull to stay home or a man who is struggling with how involved he will be in childcare).

Break (10 minutes)

Total Re-Grouping (15 minutes)

With the assistance of a reporter from each gender group, impressions will be shared regarding what is common between the sexes and what are the issues which are distinct.
Journaling (7 minutes)

"What am I most aware of from the evening's discussion?"

Meditation/Reflection -- "I Am a House" (Schwartz, 1980) 12-15 minutes)

Participants are led in a guided fantasy that they are a house. Visualize the outside, the garden, the windows, the material it is made of, its place among other houses (if any). What are the shapes and colors, what types and where are the furnishings. Are there others present inside? Some you would like to invite?

(Jones, 1978, in her dissertation on dreamwork states that inner architecture is a common feminine theme in dreams. It may be necessary to find a parallel masculine image or to find a common androgynous symbol.)

The last half of this time will be for an artistic rendering of the house in the journal.

Closure

Session VIII -- "Life After Birth"

Goals: 1. To probe the issues of adjustment to baby and family life which are common in the post-partum period.

2. To raise issues about which the couples may not have yet discussed, or have not reached agreement on.

3. To help couples identify the process by which they come to consensus and negotiate issues of disagreement.

Candlelighting (5 minutes)

Linking (10-15 minutes)
Open discussion of how last week's content has been present throughout the week and now.

Overview of Evening (10 minutes)

Aspects of working on relationships in transition: expectant parents become parents, the fetus becomes an infant. Everyone has expectations of the roles and behaviors they intend to fulfill and those that others in the family are expected to fulfill. Tensions arise when these expectations are incongruent. Tension is an opportunity to re-evaluate and negotiate.

Fantasy Exercise -- "Our Baby Will Be..." (10 minutes)

Participants will be lying down in the darkened room fantasizing about what the coming baby will look like, feel like, what kind of temperment, what kind of daily routine, what it will be like to hold the baby. Soft background music accompanies the fantasy. Suddenly, in the midst of the imagery, there is the sound of an infant crying, screaming (a tape). Who moved first to get up with the baby? Does this racket fit with the fantasy of life with a baby? How did you feel to hear the screaming?

Follow-up Lecturette -- "Temperment Differences in Infants: What You Expect You May Not Get" (5 to 7 minutes)

Written Exercise -- Child/Home Care Responsibility Questionnaire (adapted from Weiss, 1983; Broom, 1984) (7-10 minutes)

Each person will fill out a questionnaire which asks
what percentage of time each partner will perform a given task and what percentage of time is perceived that the partner will engage in these responsibilities. Couples then briefly compare answers.

Mini-groupings for Discussion (12 to 15 minutes)

In groups of two or three couples, questionnaire responses are shared and discussed. This will help couples to know they are not alone in their disagreement.

Break (10 minutes)

Post-partum Conflict Simulation (10 minutes)

Leaders role-play an early post-partum situation in which an exhausted new mother has just finished breast-feeding the baby and the baby is now asleep. It is 10:00 PM and her husband begins to make advances indicating he wants to make love. A tense conversation ensues revealing the husband's feeling of being left out and his jealousy at the intimacy his wife and baby share. The wife is exhausted in adjusting to her new role and his needs sound like demands to her.

The absorbing nature of the breast-feeding relationship in terms of the mother's time and energy can heighten the already difficult post-partum adjustments. Men (and women) have differing feelings regarding breastfeeding. Some men feel sexually possessive of the partner's breasts and are against breast-feeding for this reason. The decision to breast-feed should be by mutual consensus. Regardless of the breast-feeding issue, the simulation reflects common
tensions of early parenting.

Instructions for couple-time (5 minutes)

Printed handouts will be given which can then be added to the journal. The couples will be asked to discuss and identify the issues in their relationship that need further negotiation (e.g., How much cooking will each person do? Will the baby sleep in our room or in a separate room? What about feeding our baby?).

Couples will also be asked to reflect on the process by which they discussed these issues. Does one person dominate? Do either feel put-down or intimidated? Were they able to share their real feelings? Does one person "give in" even if the solution isn't a just compromise?

Couple Time (15 to 20 minutes)

It should be noted that this is not the time to solve the problem, but a time to identify what issues need further working out.

Closing Exercise -- "Affection Bombardment" (5 minutes)

Anticipating that there might be some tension and hurt within participants because of the subjects discussed, this exercise is designed to generate warm, positive feelings before leaving. Couples re-join the couple grouping they were a part of earlier in the evening. As each mini-grouping forms a circle, one group member at a time is in the center while the others take turns hugging and rocking that person.
Closure

Session IX -- "Blessings"

Goals: 1. To facilitate individual and group closure regarding the significance of the series experience on personal and relational development.

2. To part allowing participants to "gift" each other with hopes and blessings for each other's family life.

Candle-lighting following a pot-luck together (5 minutes)

Individual Recollection (20 minutes)

Using the first week's womb, the series handouts and the journals, participants will recall the process they have undergone in the previous eight weeks. The organizing questions for their reflection will be: "What uncertainties remain?", "What hopes do I possess?", "What strengths and assets have I discovered?", "What wounds/ragged edges do I claim?", "What special things have I discovered about my spouse/partner?", "What has my baby offered/given to me already?".

The Family Treasure and Covenant (30 minutes)

The Family Treasure is an expression of the couple's values which they look forward to sharing with their coming child(ren). A values clarifying strategy is utilized which allows the couples to identify and represent in symbol/drawing form: 1) something at which together they are very good, and something at which together they would like to improve; 2) a belief or a value which they share and will likely never
give up; 3) a value or belief by which their family will live; 4) a dream or vision they hope to achieve together; 5) a belief they wish that all humankind would share; 6) four words they hope they are remembered by.

These representations are drawn on large piece of poster board. In the event the couple can't agree to a shared value, each is permitted to draw their individual representation in the designated space. The poster board has a pocket into which the Family Covenant is placed.

Throughout the weeks of the series, the couples have been dialoging around what kind of relationship they will have with each other and with their child. The Family Covenant is an opportunity for them to formalize their new commitments to each other and to their offspring.

Sharing with the Baby (15 minutes)

The audio-visual "One Becoming Two Becoming Three" will be presented anew. This time as they watch, couples will be sharing of themselves in a deeper and more responsive way than at the first presentation.

Benediction and Closure (40 minutes)

Each couple will write on a card a wish, hope, prayer or blessing that is meaningful for each other couple/family. In a ceremonial way, with everyone seated in a circle, each couple will share something of special significance from their Family Treasure, Covenant, or recollection time. The couple who has shared will then offer their written hopes
to each of the other couples, placing their "gift" in that Family's Treasure. When all have concluded their sharing and their gifting, the leaders will offer their gifts to each couple, a candle similar to the one which has burned throughout the series.

Closure (and tears)
Weekend Format Adaptations

Adapting the nine-week series into a weekend design required very minor modifications. The weekend will be very full and intense, but no content was lost in the remodeling. A (*) below indicates the session is out of its sequence in the nine-week format. It was decided that Session VI (Re-birthing) might be too intense for the evening session following a very long day. Session IV (Will you Still Love Me Tomorrow?) can be presented in a light-hearted and humorous way and may be a very nice way to end a full day.

Friday evening
7:00-7:30 P.M.: registration and pre-intervention measures (for research participants)
7:30-9:30 P.M.: Session I -- "Getting Acquainted"
"Filling the Womb", overview, trust walk

Saturday morning
8:45-10:45 A.M.: Session II -- "Our Creation"
The audio-visual and meditation with the baby
10:45-11:00 A.M.: Break with snack
11:00-1:00 P.M.: Session III -- "Turbulent Times"
Stress and ambivalence in pregnancy
1:00-2:00 P.M.: Lunch break
2:00-4:00 P.M.: Session V* -- "The Inner Parent"
Reflections on childhood influences
4:00-4:15 P.M.: Break with snacks
4:15-6:30 P.M.: Session VI -- "Re-Birthing
6:30-8:30 P.M.: Leisurely dinner
8:30-10:00 P.M.: Session VI* -- "Will You Still Love Me Tomorrow"
Fluctuating sexual needs

Sunday Morning

Gender/sex role development and same sex groupings
11:15-11:30 A.M.: Break with snack
11:30-1:15 P.M.: Session VIII -- "Life After Birth"
Post-partum adjustments and task negotiation
1:15-2:15 P.M.: Lunch
2:15-4:00 P.M.: Session IX -- "Benediction"
The family treasure, repeat audio-visual, gifting, closure
4:00-4:30 P.M.: Post-intervention measures and evaluations
Promotional Strategies for the Intervention

Early in the project process it was decided that a co-sponsorship of "One Becoming Two Becoming Three" by the local pastoral counseling center and the community hospital would lend credibility to this new type of program. Approvals were obtained from both the counseling center's Board of Directors and the hospital's administration. The counseling center would provide the facilitators (the curriculum designers) and the hospital would provide the facility.

The process of developing a brochure was a long one. It was hoped that endorsements from credible health and mental health professionals appearing on the brochure would be helpful tools in convincing prospective participants of the value of such an experience. Appointments were made and the preliminary curriculum used to describe the intervention to potential endorsers. Most received the idea very enthusiastically and slowly the endorsements were assembled. The lukewarm attitudes of the hospital obstetricians toward the intervention was particularly disappointment, although not surprising (obstetricians were the last to endorse LaMaze).

The brochure was finally ready four weeks before the first scheduled run of "One Becoming Two Becoming Three". Brochures were hurriedly sent out to counseling centers,
obstetrical and pediatric offices, hospitals in the local area, social service agencies, YMCA's and YWCA's, and prenatal exercise instructors. One newspaper report gave a sympathetic and favorable article in the community paper, however, the larger newspaper ran only an announcement. There was little response from expectant parents. Trial #1 did not happen. The feedback from a handful of people indicated two problems: the price was too high ($135.00 per couple) and the series was too long.

After a period of re-grouping, it was decided that a change to a weekend format would increase the market of potential participants from second trimester expectant parents to pregnant couples at any stage. A weekend is often easier to commit to than once a week for nine weeks. Fees for the facilitators could be reduced due to less set-up time required when the group would be intact for a weekend.

After comparing the various conference centers available locally, the least expensive facility would have required $108.00 per couple for room and meals. Despite this reasonable rate, there was concern that the market would perceive the total cost as too expensive when facilitator fees and lodging expenses, the cost of materials, and audio-visual equipment rental costs would be added to the price of room and board.

The other alternative was to offer a "commuter" weekend
at a local church or community facility including some catered meals in the package cost. A church in Redlands with a large and comfortable room agreed to let us use the room without charge in return for offering a discount to their members who attended. We decided to offer the weekend format at the church for $75.00 which would include five meals. Twenty percent discounts were available for the church members, for supporters of the co-sponsoring Christian Counseling Service and for couples who referred another couple who attended the weekend.

In marketing the weekend format, a different promotional strategy was utilized. Given the poor response from distribution of brochures through community service agencies, we decided to target our publicity toward those people in contact with expectant parents: obstetricians, nurses and childbirth educators. As the weekend format would not be competing timewise with LaMaze training classes, we felt that the childbirth educators would be a good source of referrals.

Our strategy involved sending out a mailing to approximately 100 people inviting them to an "Information Evening" regarding "One Becoming Two Becoming Three". We explained that we were interested in forming a network of people interested in birth and early family development issues and invited them to bring any of their cards or materials as well. A highlight of the evening was to be
the audio-visual presentation of our interpretation of the emotional and spiritual experience of becoming a family. A brochure was included as well as a postcard by which they could indicate which of two nights they would attend.

Ten people responded that they would attend the information evening, and an additional ten replied that they couldn't attend but would be interested in being notified of future events. The first information evening was cancelled due to a poorer response and the continuing problems in finalizing the audio-visual.

The information evening that was held included about twenty people with the guests that were brought by those responding. The evening included brief introductions by each of the members of the design team (now called "The Becoming Partnership), an overview of the objectives and content of the program and a demonstration of how a communication exercise regarding ambivalence in pregnancy would be utilized in the intervention. The audio-visual was well-received despite the technical problems. There was informal discussion over refreshments. The evening seemed to have generated some enthusiasm.

Despite this strategy, and brochures that were available eight weeks prior to the intervention, the registrations were meager. One couple registered, two other couples expressed great interest but were unable to attend because of schedule conflicts. We didn't believe we could
offer the weekend effectively for one couple.

At this point there is a sense that we have not yet found the key that will open the door to a more effective means of communicating the benefit of the intervention to expectant couples themselves. There are three couples who continue to be interested in the weekend program, there have been a few other inquiries as well. In the spring there may be an informal pilot weekend offered if enough interested people make themselves known. But, the search continues for a regular source of referrals in the future until the word-of-mouth reputation is such that active promotion is not as necessary.

We hope to find a sympathetic and non-traditional physician who would see such a program as helpful to the client. Obstetricians exert great influence over their patients. There are several midwives and non-hospital birthing centers where this non-traditional approach to preparation for parenting might find a home. The "labor" continues, and this "baby" will not be stillborn!
METHOD TO EVALUATE THE INTERVENTION

In order to evaluate the effectiveness of "One Becoming Two Becoming Three" in meeting its objectives: fostering the development of the parent identity, deepening and strengthening the expectant parents' relationship, creating a positive environment for fetal physical and psychological development, a pilot study is proposed with hypotheses which reflect the stated objectives. Participants who cooperate in the research aspect will complete identical paper-and-pencil instruments pre- and post-intervention.

Hypotheses

Hypothesis One

Upon completion of the intervention, participants will respond to items on the Parenting and Family Development Questionnaire pertaining to a) self-confidence in the parental role more positively, and b) will report less concerns related to pregnancy, birth, and post-partum adjustments than in pre-intervention measures.

Hypothesis Two

Upon completion of the intervention, participants will respond to items on the Parenting and Family Development Questionnaire pertaining to a) understanding of partner, b) ability to communicate with the partner, and c) feelings
of intimacy/trust more positively than in pre-intervention measures.

Hypothesis Three

Upon completion of the intervention, participants will report greater attachment to the fetus than in pre-intervention measures using the Maternal-Fetal Attachment Scale and the Paternal-Fetal Attachment Scale.

Subjects

Subjects for the pilot study will be those participants from the "One Becoming Two Becoming Three" workshop who give consent to also cooperate in a research project. Subjects and non-subject participants alike will be obtained for the project through a promotional strategy already described. They will be volunteers who have paid to attend a workshop for expectant parents. Optimum workshop attendance, and presumably subject participation, will be eight to ten first time expectant couples.

Procedure

In the week prior to the program, registered participants will be notified by letter that their cooperation in studying the effectiveness of this type of program would be appreciated. The letter will explain that, for those who agree to participate in the study, special questionnaires will be available during the registration period and again at the close of the program.
The time involvement will be about 15 to 20 minutes at each sitting. An informed consent form (see Appendix A) will accompany the letter and participants may bring the signed form to the workshop or give written consent at registration, prior to filling out the instruments.

Not agreeing to participate in the study will not disqualify the couple from participating in the intervention. However, all participants will be requested to complete an evaluation tool (see Appendix G) designed to gain feedback as to their perceptions of the flow and relevance of workshop content, facilitator effectiveness, comfort of facilities, what was most beneficial, least beneficial, and what could be added to enhance the program.

**Instruments**

The Background Information Questionnaire (see Appendix B) is designed to gain socio-economic and educational data as well as to determine the trimester of pregnancy and any other children in the family.

The Parenting and Family Development Questionnaire, Parts I and II, (see Appendix C and Appendix D) designed by Resnick et al. (1980) and modified by Weiss (1983) was further adapted to evaluate the objectives of the intervention. Part I asked subjects to state their concerns regarding pregnancy, birthing, and becoming a new parent as well as to express their opinion as to what their partner's concerns are in this regard. Part II asks the subjects to rate their
degree of comfort vs. discomfort regarding issues of pregnancy, themselves as parents, and the relationship with the partner/spouse.

The **Maternal-Fetal Attachment Scale** (Cranley, 1981) and the **Paternal-Fetal Attachment Scale** (Weaver and Cranley, 1983) are designed to measure attitudes and behaviors toward the fetus indicative of attachment (see Appendix E and Appendix F).

The **Background Information Questionnaire** would be administered only at the time of the pre-test, the other two instruments would be utilized at both pre-test and post-test.

**Analysis of Data**

The **Background Information Questionnaire** will provide descriptive information as to the age, parity and socio-economic status of the participants.

**Part I of the Parenting and Family Development Questionnaire** will utilize a gain score strategy between pre- and post-test measures to deduce a change/improvement in the concerns related to pregnancy, birth, and becoming a parent. Correlated t-tests will be utilized to compare responses between partners pre and post intervention. This strategy will evaluate the degree to which partners understood and expressed the concerns of the other.

Correlated t-testing will also be utilized to compare mean scores for **Part II of the Parenting and Family Development**
Questionnaire pre- and post-intervention to evaluate changes in levels of comfort/discomfort regarding the self-image as a parent and the couple relationship.

Degree of reported parental attachment to the fetus will also be evaluated utilizing correlated t-tests between pre- and post-intervention measurements of the Maternal-Fetal Attachment Scale and the Paternal-Fetal Attachment Scale.

Gender differences will also be analyzed, although no a priori hypotheses exist.
DISCUSSION

The first question to be raised as a result of this project is, "Why was it so difficult to obtain participants for the intervention?" There seem to be several reasons. First, the concept is very novel, not only to the consumer, but to health and mental health professionals as well. Leni Schwartz, whose work with pregnancy support groups was a foundation to the development of this intervention, wrote about her search for interested pregnant couples with whom she could "gel" a group. She describes her search over months, personally contacting potential participants of her own acquaintance, (and sometimes non-acquaintance) as well as contacting others she might hear about through friends and friends of friends. These people were treated to the experience free of charge, and still the struggle existed.

Schwartz's struggle, and this one, may have a common thread. Before one becomes a parent there seems to be very little anyone can say to convey to the first-time expectant parent the magnitude of change that having a baby will have in their life. There seems to be a certain type of romantic illusion about what real life with the baby will be like. With this type of attitude, the target population may not perceive they have a need to attend a program directed to a
need they aren't aware they have.

A third problem related to getting a new concept off the ground has to do with the lifestyle of the target population. At this time, the intervention is directed toward educated, middle and upper-middle class married couples in a first pregnancy. Such a social group typically will have both partners working and involved in a variety of social and professional commitments. Busy people often do only what they "have" to do. In regards to getting ready for the baby, a LaMaze class is a "have to" if both parents are to be present for the delivery.

A fourth situation which could effect the rate of acceptance of the program in the community is the conservative climate created by the local medical community. In light of their high rate of malpractice lawsuits, obstetricians have become increasingly protective of their patients as their own "turf". They are reluctant to share their power and authority regarding the birthing process with anyone. After all, if anything goes wrong in the pregnancy it isn't the childbirth educator or preparation for parenthood facilitator who will be left holding the responsibility bag, it's the obstetrician.

The "turf" issue may relate to childbirth educators too. With an abundance of LaMaze classes in the area, there are not enough pregnancies to go around. The childbirth educators may regard "One Becoming Two Becoming Three" as
a violation of their territory and a threat to their already limited supply of patients.

In time, with positive recommendations from those who attend the workshops, the above concerns should gradually be dispelled. However, the concerns do illustrate why a very novel program may have difficulty in initially getting started.

Once "One Becoming Two Becoming Three" is launched, what next? The first priority, after getting the intervention started, will be to evaluate if it actually did what we hoped it would do. The evaluation sheets and the proposed research design will provide some preliminary answers, at least a short term effect will be measured. The subjective evaluations as well as the paper-and-pencil instruments will be helpful in making any needed immediate changes in the workshop format.

Longitudinal research will be the only valid way to determine the effectiveness of the intervention in easing the transition to parenthood and promoting physically and psychologically healthier infants. Control groups who did not attend the intervention should be utilized as will a record-keeping of complications of pregnancy, labor and delivery, infant APGAR scores and neonatal assessment scales. Follow-up including assessments of parental adaptation to parenthood, infant development, and parent-child interactions will provide much more potent validation.
With more experience and data, adaptations of the intervention could be developed for special groups: single mothers, teenage mothers, unstable relationships and other types of difficult or problem pregnancies when both mother and infant are at risk for physical and psychological complications.

At the root of this vision to establish a more in-depth and comprehensive preparation for parenthood is a belief that the embryo and fetus are more sensitive and sophisticated than our current research methods and technology are capable of revealing. As the mysteries of the secret life of the child in utero unravel in the years ahead, it is hoped that this intervention will make a contribution toward a deeper understanding of human development, and the interacting of biology and environment from the very beginning.
APPENDIX A

Informed Consent Form

"One Becoming Two Becoming Three"
Preparation for Parenthood Study
Participation Consent

The preparation for parenthood study evaluates the effectiveness of "One Becoming Two Becoming Three" to enhance the experience of pregnancy and the transition to parenthood. Several questionnaires pertaining to attitudes, feelings, and concerns of pregnancy and early parenting will be administered before and after the "One Becoming Two Becoming Three" workshop. Each sitting will require 20-30 minutes to complete the questionnaires.

1. The preparation for parenthood study has been explained to me and I understand the explanation that has been given and what my participation will involve.

2. I understand that non-participation in the study would not jeopardize my participation in the "One Becoming Two Becoming Three" workshop. I may also discontinue my participation in this study at any time and without penalty.

3. I understand that the results of the study will be treated in strictest confidence and that I will remain anonymous. Within these restrictions, group results of the study will be made available to me at my request after January 1, 1986, through contacting the Becoming Partnership.

4. I understand that, at my request, I can receive additional explanation of the study after my participation is completed.

Signed _______________________

Date ________________________
APPENDIX B

Background Information Questionnaire

In order to provide better programs which will serve a variety of people, I am studying the experiences and feelings of many people—what they think, how they feel, the knowledge they have, and the skills they may use as parents. The following questionnaires have been developed to gather that information. Your honest answers will be appreciated and there are no "correct" answers. All the information gathered will be treated in a confidential manner.

Date ____________________________

Marital Status ________ Age ______ Sex _____ Race _______

Have you been married previously? ______________________________

Occupation________________________ Religious Preference ____________

Last 4 digits of: your social security number ______________________

_________ your spouse's social security number ______________________

1. What type of residence do you live in:

   Home _____ Apartment _____ Rooming House _____
   Trailer _____ Campus Housing _____ Other _____

2. Please check the category which indicates the highest level of education you have completed.

   ____ Grades 6,7,8 (circle one) _____ College Graduate
   ____ Grades 9,10,11 (circle one) _____ Attended Graduate School
   ____ High School Graduate _____ Masters Degree
   ____ Attended some College _____ Doctoral Degree
   ____ Community College Graduate

3. Please check the category which indicates your total annual household income.

   ____ under $10,000 _____ $25,000-$30,000
   ____ $10,000-$15,000 _____ $30,000-$35,000
   ____ $15,000-$20,000 _____ $35,000-$40,000
   ____ $20,000-$25,000 _____ over $40,000
4. Please indicate: ____ number of children you already have.
   number of natural children ____
   number of adopted children ____
   number of stepchildren ____

5. Please indicate: ____ number of pregnancies you have had which have not resulted in a birth.

6. Please indicate this baby's due date: ________________________________

7. Are you attending/have you attended a prepared childbirth class (ex: LaMaze, Bradley, hospital program)? (circle one)
   yes      no

   If yes, which one? ________________________________

8. If your answer to the above was "no", are you planning to take a class in the future? (circle one)
   yes      no      undecided

9. Where are you planning to birth the baby? (check one)
   ____ traditional hospital
   ____ hospital birthing room
   ____ birthing center
   ____ home
   ____ undecided
   ____ other (specify):
APPENDIX C
Parenting and Family Development Questionnaire

Please answer each of the following questions.

1. What is your greatest concern regarding pregnancy? 

2. What is your greatest concern regarding labor and delivery? 

3. What is your greatest concern regarding the postpartum (after the baby's birth) period? 

4. What is your greatest concern regarding being a new parent? 

5. What is your spouse's greatest concern regarding pregnancy? 

6. What is your spouse's greatest concern regarding labor and delivery? 

7. What is your spouse's greatest concern regarding the postpartum (after the baby's birth) period? 

8. What is your spouse's greatest concern regarding being a new parent? 

9. Write/describe what you know about your own birth. 

10. What would you like to know about your own birth?
APPENDIX D

Parenting and Family Development Questionnaire

Please read each question and put an "X" in the space which best describes how you feel.

HOW DO YOU FEEL ABOUT

<table>
<thead>
<tr>
<th>Uncomfortable</th>
<th>Comfortable</th>
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<tbody>
<tr>
<td>Incapable</td>
<td>Capable</td>
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<tr>
<td>Incompetent</td>
<td>Competent</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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</thead>
<tbody>
<tr>
<td>1. Being pregnant</td>
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<td>2. Becoming a parent</td>
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<td>3. Overall relationship with partner</td>
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<td>4. Recognizing tension in yourself</td>
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<td>5. Having sexual relations during pregnancy</td>
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<td>6. Getting by on less than your usual sleep</td>
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<td>7. Making decisions regarding your child's welfare</td>
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<td>8. Handling conflict in your relationship with your partner</td>
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<td>9. Communicating your sexual needs and feelings to your partner</td>
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<td>10. Your partner's flexibility to adapt to a new lifestyle</td>
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<td></td>
<td>Uncomfortable</td>
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<td>11.</td>
<td>Dealing effectively with the stress in your own life</td>
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<td>12.</td>
<td>Communicating your thoughts and feelings to your parents</td>
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<td>13.</td>
<td>How the household responsibilities will be divided after the baby comes</td>
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<td>14.</td>
<td>Your partner's ability to be a good parent</td>
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<td>15.</td>
<td>Your ability to be a good parent</td>
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<td>16.</td>
<td>Your partner's sensitivity/understanding of your feelings during pregnancy</td>
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<td>17.</td>
<td>Your sensitivity/understanding of your partner's feelings during pregnancy</td>
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<td>18.</td>
<td>Being able to grow in your own identity besides being a parent</td>
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<td>19.</td>
<td>The amount/quality of supportive relationships you have</td>
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<td>20.</td>
<td>Maintaining emotional closeness with your partner after the baby comes</td>
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APPENDIX E

Maternal-Fetal Attachment Scale

Please respond to the following items about yourself & the baby you are expecting. There are no right or wrong answers. Your first impression is usually the best reflection of your feelings.

Make sure you mark only one answer per sentence.

<table>
<thead>
<tr>
<th>I think or do the following:</th>
<th>Definitely</th>
<th>Yes</th>
<th>Uncertain</th>
<th>No</th>
<th>Definitely</th>
<th>Yes</th>
<th>Uncertain</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>1. I talk to my unborn baby.</td>
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<td>3. I feel all the trouble of being pregnant is worth it.</td>
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<td>3. I enjoy watching my tummy jiggle as the baby kicks inside.</td>
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<td>4. I picture myself feeding the baby.</td>
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<td>5. I'm really looking forward to seeing what the baby looks like.</td>
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<td>6. I wonder if the baby feels cramped in there.</td>
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<td>7. I refer to my baby by a nickname.</td>
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<td>8. I imagine myself taking care of the baby.</td>
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<td>9. I can almost guess what my baby's personality will be from the way s/he moves around.</td>
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<td>10. I have decided on a name for a girl baby.</td>
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</table>
I do things to try to stay healthy that I would not do if I were not pregnant.

I wonder if the baby can hear inside of me.

I have decided on a name for a baby boy.

I wonder if the baby thinks and feels inside of me.

I eat meat and vegetables to be sure my baby gets a good diet.

It seems my baby kicks and moves to tell me it's eating time.

I poke the baby to get him/her to poke back.

I can hardly wait to hold the baby.

I try to picture what the baby will look like.

I stroke my tummy to quiet the baby when there is too much kicking.

I can tell that the baby has hiccoughs.

I feel my body is ugly.

I give up doing certain things because I want to help my baby.

I grasp my baby’s foot through my tummy to move it around.
### APPENDIX F

**Paternal-Fetal Attachment Scale**

<table>
<thead>
<tr>
<th></th>
<th>Definitely Yes</th>
<th>Uncertain</th>
<th>Definitely No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I talk to my unborn baby.</td>
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<tr>
<td>2. I feel all the trouble of my wife being pregnant is worth it.</td>
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<tr>
<td>3. I enjoy watching my wife's tummy jiggle as the baby kicks inside.</td>
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<td>4. I picture myself feeding the baby.</td>
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<td>5. I'm really looking forward to seeing what the baby looks like.</td>
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<td>7. I refer to my baby by a nickname.</td>
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<td>8. I imagine myself taking care of the baby.</td>
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<td>9. I can almost guess what my baby's personality will be from the way s/he moves around.</td>
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<tr>
<td>10. I have decided on a name for a girl baby.</td>
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<tr>
<td>11. I do things to try to help my wife stay healthy that I would not do if she were not pregnant.</td>
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<td></td>
<td></td>
<td>Definitely</td>
<td>Yes</td>
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<tr>
<td>12</td>
<td>I wonder if the baby can hear inside of my wife.</td>
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</tr>
<tr>
<td>13</td>
<td>I have decided on a name for a boy baby.</td>
<td></td>
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<tr>
<td>14</td>
<td>I wonder if the baby thinks and feels inside of my wife.</td>
<td></td>
<td></td>
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<tr>
<td>15</td>
<td>I encourage my wife to eat meat and vegetables to be sure my baby gets a good diet.</td>
<td></td>
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<tr>
<td>16</td>
<td>It seems my baby kicks and moves to tell my wife it's eating time.</td>
<td></td>
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<tr>
<td>17</td>
<td>I poke the baby to get him/her to poke back.</td>
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<tr>
<td>18</td>
<td>I can hardly wait to hold my baby.</td>
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<tr>
<td>19</td>
<td>I try to picture what the baby will look like.</td>
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<tr>
<td>20</td>
<td>I stroke my wife's tummy to quiet the baby when there is too much kicking.</td>
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<tr>
<td>21</td>
<td>I can tell that the baby has hiccoughs.</td>
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<tr>
<td>22</td>
<td>I feel my wife's body is ugly.</td>
<td></td>
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<tr>
<td>23</td>
<td>I encourage my wife to give up doing certain things because I want to help my baby.</td>
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<tr>
<td>24</td>
<td>I grasp my baby's foot through my wife's tummy to move it around.</td>
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</table>
APPENDIX G

Participant's Evaluation

"One Becoming Two Becoming Three"

We would appreciate your candid comments regarding the "Becoming" workshop.

1. What was most helpful or meaningful to you?

2. What surprised you the most during our time together?

3. What was the most difficult, uncomfortable or painful aspect of the experience?

4. What would you choose to leave out of the "Becoming" sessions?

5. What could be added to the experience to make it more enriching, meaningful, or informative?

6. What do you think you gained from this experience that you may not have had you not attended?

7. Did "Becoming" meet your expectations? Why or why not?

8. Any other comments you care to add:
REFERENCES


Gillman, R.D. (1968). The dreams of pregnant women and


