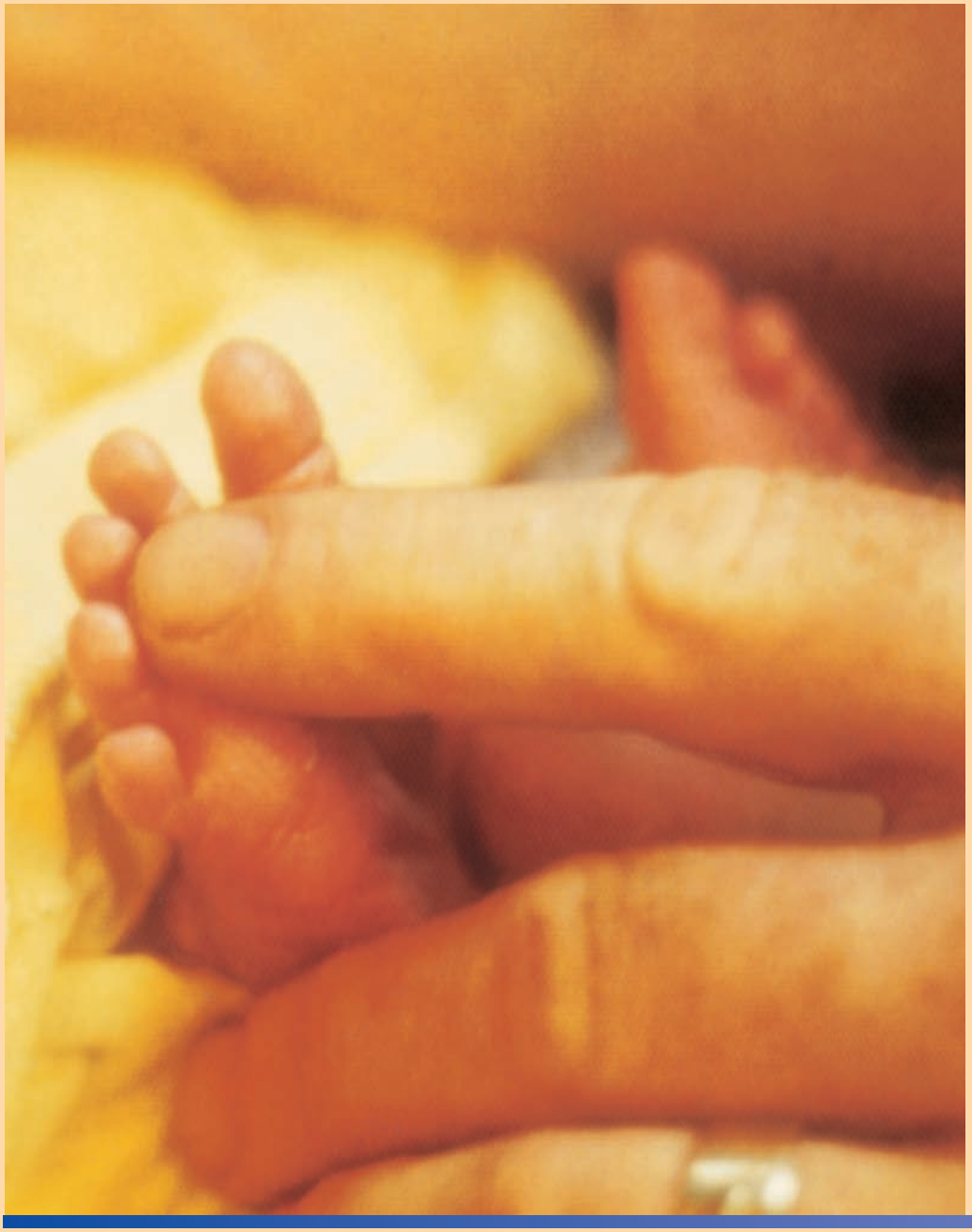
CHAPTER 10



Should We or Shouldn't We: Choosing Whether and How to Have Children

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What Do YOU Think?

Are the following statements TRUE or FALSE?
You may be surprised by the answers (see answer key on the following page).

T F 1 The birthrate in the United States has risen steadily since 1990.

T F 2 It is estimated that a third of women who marry will forego having children.

T F 3 Abortions have declined over the past decade.

T F 4 It is usually unsafe for a woman to have sexual intercourse during the last two months of pregnancy.

T F 5 Miscarriage and stillbirth are major life events for parents.

T F 6 The rate of infant mortality in the United States is about what it is throughout the industrialized world.

T F 7 Adopted children tend to be poorer than children who live with their biological parents.

T F 8 Men and women both can suffer from "postpartum blues."

T F 9 There is often a decline in marital happiness following the transition to new parenthood.

T F 10 Stress is common among both biological and adoptive new parents.

> It's unbelievable. . . . There's really no way a non-parent can think like a parent. It's really knocked me for a loop. And in my wildest dreams, I never thought of it. . . . Something just creeps into your life and all of a sudden it dominates your life. It changes your relationship with everybody and everything, you question every value and every belief you ever had. And you say to yourself, "this is a miracle." It's like you take your life, open up a drawer, put it all in a drawer, and close the drawer.

These comments show a 33-year-old man's thoughtful reactions to becoming a first-time father. As he reflects on it, becoming a parent is life defining and life altering. He is not alone. Having and raising children introduce profound changes and impose labor-intensive responsibilities. As we examine over the next two chapters, parenthood changes how we see ourselves, how we live, what we think about, and how we feel. Simultaneously, parents experience changes in their social relationships and how they are viewed by others. These changes are neither minor nor temporary. Becoming a parent is as profound a life change as any other we make.

Not everyone decides to become a parent. With widespread availability of effective contraception and access to legal abortion, women and men can decide whether and when to have children. The bulk of this chapter focuses on the choices people make whether or not to have children and the range of factors that figure in to the decision-making process. We examine the characteristics of those who decide to or are forced to forego parenthood. But those who embark on parenthood face other choices. *How* should they become parents? For some, bearing a child is difficult or impossible, leading them to attempt to adopt or take advantage of the ever-expanding options presented by advances in reproductive technology. And *when* should they become parents? Is there an optimal time or age for entering motherhood or fatherhood? Throughout this chapter, we explore these choices.

Answer Key for What Do You Think

1 False, see p. 262; 2 False, see p. 363; 3 True, see p. 367; 4 False, see p. 369; 5 True, see p. 372; 6 False, see p. 373; 7 False, see p. 377; 8 True, see p. 380; 9 True, see p. 383; 10 True, see p. 380.

Our focus then shifts to how women and their partners experience pregnancy, the transition to parenthood, and the changes parenthood introduces into our lives. Chapter 11 then explores the meaning and special challenges confronting mothers and fathers in the United States today.

Fertility Patterns in the United States

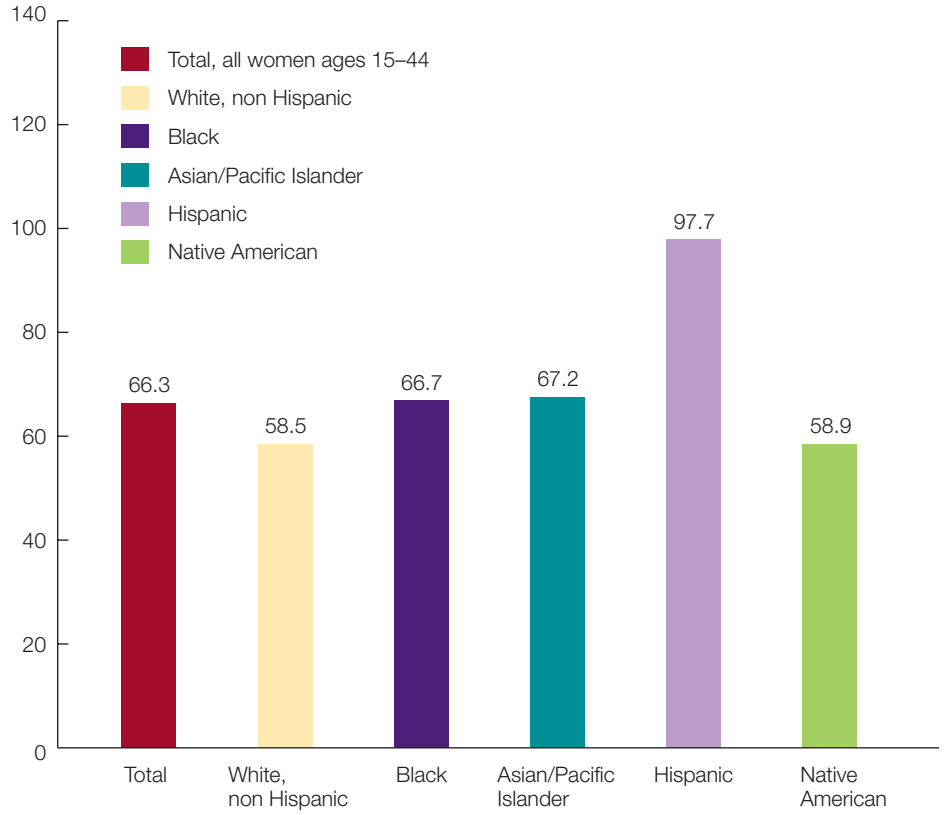
There were more than 4.1 million births in the United States in 2004, up only 1% from 2003 (Hamilton et al. 2004). The **crude birthrate,** a statistic reflecting the number of births per every 1,000 people in the population, was 14.0 in 2004. This has varied little in recent years: it is down 1% from 2003, but the rate has hovered around the same rate for the last few years. In a somewhat longer view, the crude birthrate has declined some 17% since 1990.

In recent decades, the United States has also experienced a decrease in the **fertility rate,** the number of births annually per 1,000 women 15 to 44 years old, from 118 in 1960 to 66.3 in 2004 (National Center for Health Statistics 2003; Hamilton et al. 2004). This represents a more recent decline of 9% since 1990, but a slight increase from the last couple of years (64.8 in 2002, 66.1 in 2003). Finally, the **total fertility rate,** a more complicated statistic that estimates the number of births a hypothetical group of 1,000 women would have if they experience across their childbearing years the age-specific rates for a given year, indicates that there would be 2,048.5 births per 1,000 women, or 2 children per woman. This, too, reflects a decline (3%) since 1990.

Fertility and birthrates vary considerably according to social and demographic characteristics such as race, ethnicity, education, income, and marital status. Figure 10.1 shows variation by ethnicity. Within the Latino population, rates vary from a high among Mexican Americans to a low among Cuban Americans. Cultural, social, and economic factors play a significant part in influencing the number of children a family has. Because of a combination of higher fertility rates and continuing immigration patterns, Hispanics have become our nation's largest minority group, thereby surpassing African Americans.

Fertility rates also vary by education and income. Women with a high school education had the highest

Figure 10.1 ■ Fertility Rates Ethnicity, 2002



SOURCE: Hamilton, Martin, and Sutton 2003.

rate (67.4 per 1,000). College-educated women had the next highest rate (65.3), followed by women with graduate degrees (59.2) and women with less than high school (57.3). Income effects on childbearing are a little more complex. For females between the ages of 15 and 29, birthrates are highest among women with the lowest incomes (<$10,000) and lowest among women with high incomes (>$75,000). Among women 30 to 44, we see almost the opposite pattern. The birthrate is highest among women with high incomes ($50,000–$74,999) followed closely by women with family incomes more than $75,000; the lowest birthrates are found among women with family incomes between $10,000 and $29,999 (http://www.commissions.leg.state.mn.us/lcesw/, 1999).

Approximately 18% of American women between the ages of 40 and 44 have not had children. Among women of that same age who had ever married, 12% were reported to be childless (U.S. Census Bureau 2002). Among all women without children, most expect to have at least one child. Although the percentage who intend to forego parenting is difficult to estimate, it is likely no more than 10%.

Unmarried Parenthood

In 2004, a record number of unmarried women gave birth. Nearly 1.5 million nonmarital births occurred, an increase of 4% from the preceding year. These births represented almost 36% of all births, with increases occurring for women of all ages and races. As reflected in the data in Table 10.1, although there are increases among all of women there are also significant variations across ethnic and racial groups in the percentage of births to unmarried mothers.

There are prominent age differences as well in unmarried childbearing. More than four of five (82.6%) births to teenagers were outside of marriage. Among women 20–24 years old, more than half of the

Table 10.1 ■ Percentage of Births to Unmarried Mothers by Ethnic Origin, 2004

Ethnic Origin of Mother	2004	2003
All Ethnic Groups	35.7	34.6
Non-Hispanic whites	24.5	23.6
Non-Hispanic blacks	69.2	68.5
American Indian	62.3	61.3
Asian or Pacific Islander	15.5	15.0
Hispanic	46.4	45.0

childbirths in 2004 were to unmarried women. Nearly 30% of the 25- to 29-year-old women who gave birth in 2004 were unmarried at the time of delivery.

"Maybe We Shouldn't": Foregoing Parenthood

What should we call couples who don't have children? In the past, the most common way to describe them was as *childless,* meaning simply that they had no children. However, the term *childless* conveys the sense that such women or couples were "less something" that they wanted or were *supposed to have.* This description no doubt describes the experiences of those women 15 to 44 years old who have an "impaired ability" to have children or those couples who seek help for infertility. Both are *involuntarily childless.* In 2002, roughly 2 million couples, 7% of married couples in the United States, reported not using contraception for 12 months without the woman becoming pregnant. Around 1.2 million women, 2% of the 62 million American women of reproductive age, sought help for infertility. An additional 6 million women reported having at some point in their lives received infertility services (Centers for Disease Control and Prevention 2005). We say more about such efforts and interventions in a later section.

In more recent years, the term *childless* has been joined by *child free.* In the United States, we have experienced a cultural and a demographic shift toward more voluntarily childless women and **child-free marriages**—couples who *expect and intend* to remain non-parents. The term *child free* suggests that those who do not choose to have children need no longer be seen objects of sympathy, lacking something essential for personal and relationship fulfillment. The suffix *-free* suggests liberation from the bonds of a potentially oppressive condition (Callan 1985).

Using a U.S. Census Bureau report by Amara Bachu (1999), we can examine some trends and characteristics definitive of this trend. Looking at the last two decades of the twentieth century, Bachu notes the following:

- Among 40- to 44-year-old women (an age by which most women woulkd have had their first child), the percentage without children nearly doubled between 1980 and 1998, from 10% to 19%.
- Among married or previously married women, the percentage without children doubled between 1980 and 1998, from 7% to 14%.
- Among never-married women, the percentage of 40- to 44-year-olds who had never had children *declined* from 79% in 1980 to 67% in 1998. This is a reflection of the increase in births to unmarried women noted earlier in this chapter.

The preceding sketch does not single out the child free from the involuntarily childless who are physically unable to have children. Kristin Park (2002) cites a variety of estimates from other research suggesting that between 6.6% and 9.3% of women within childbearing ages do not expect to have any children. She also suggests that as many as 25% of the childless population is truly child free because they are intentionally without children.

Who are the women who remain child free? Research indicates that compared to mothers, the child free are women with the highest levels of education, those employed in high status occupations such as managerial and professional occupations, and those in families with high levels of family income from dual-earner or dual-career marriages (Park 2002; Ambry 1992). They are also less religious, firstborn or only children, and less gender traditional (Park 2002). Hispanic women are less likely than black or white women to expect a childless future (Henslin 2000; U.S. Census Bureau 1998, Table 110). Bachu (1999) offered the following observation:

> Childlessness among married couples today is no longer an uncommon situation. Compared to past decades, women are marrying and having their first birth much later in life. Among women in the childbearing years, postponement of marriage and childbearing is viewed as pathway to a good job

and economic independence. The cost of raising a child and the availability and affordability of child-care have further promoted childlessness among women.

What Rosemary Gillespie feels has changed over the past quarter century is the emergence of "a more radical rejection or push away from motherhood" (2003, 133). She asserts that an increasing number of women are resisting and rejecting the cultural expectations that automatically associate women with motherhood. Instead, she suggests, "modernity has given rise to wider possibilities for women" (2003, 134).

Couples usually have *some* idea that they will or will not have children before they marry. If the intent isn't clear from the start, or if one partner's mind changes, the couple may have serious problems ahead. Many studies of child-free marriages indicate a higher degree of marital adjustment or satisfaction than is found among couples with children. Given the time and energy required by childrearing, these findings are not particularly surprising. It has also been observed that divorce is more probable in child-free marriages, perhaps because child-free couples do not stay together "for the sake of the children," as do some other unhappily married couples.

Today, although greater in number than in the past, child-free women and couples may find themselves perceived as career oriented, materialistic, individualistic, or selfish, with child-free women more negatively perceived than child-free men. Of these stereotypes, only career orientated seems to accurately apply to the child free, especially the women (Park 2002). From in-depth interviews with 24 voluntarily child-free women and men, Park identified a variety of strategies they used to reduce the stigma attached to not wanting children (Park 2002). These strategies included the following:

- *Passing.* This involves pretending to intend someday to become parents.
- *Identity substitution.* This includes feigning an involuntary childless status, as well as letting other statuses (for example, as a voluntary single or an atheist) dominate a social identity.
- *Condemning the condemners.* In keeping with other instances of reaction to being labeled deviant, this reaction consists of suggesting that some people have children for the wrong, or for selfish, reasons or that they do so without thinking fully about the responsibility.
- *Asserting their "right" to self-fulfillment.* Park contends that this is a modern type of justification.
- *Claiming a biological "deficiency."* The individual lacks the desire or lacks the nurturing "instinct."
- *Redefining the situation.* This turns potential accusations around by showing how the lifestyle allows nurturing qualities to be used in other ways or allows the individual to be productive. Some also claim that their careers just don't allow for the inclusion of children.

An inspection of the preceding strategies shows that some are more defensive than others, suggesting the acceptance of pronatalist norms. Others are more proactive, redefining childlessness as something socially valuable (Park 2002).

Waiting a While: Parenthood Deferred

Although most women still begin their families while in their 20s, we can expect that the trend toward later parenthood will continue to grow, especially in middle- and upper-income groups. A number of factors contribute to this. More career and lifestyle options are available to single women today than in the past.

Many couples today (especially those in middle-and upper-income brackets) defer having children until they have established their own relationships and built their careers. These parents are usually quite satisfied with their choice.

Marriage and reproduction are no longer economic or social necessities. People may take longer to search out the "right" mate (even if it takes more than one marriage to do it), and they may wait for the "right" time to have children. Increasingly effective birth control (including safe, legal abortion) has also been a significant factor in the planned deferral of parenthood.

Besides giving parents a chance to complete education, build careers, and firmly establish their own relationship, delaying parenthood can be advantageous for other reasons. As shown, raising children is expensive. Waiting, delaying parenthood until economic position is more secure, makes good sense given the economic effect of parenthood. Older parents may also be more emotionally mature and thus more capable of dealing with parenting stresses (although age isn't necessarily indicative of emotional maturity).

Cost estimates that have tried to include both college expenses and estimated wages lost project that raising a "typical" child amounts to a 22-year investment of between $761,871 (lower-third income bracket) and $2.78 million dollars (upper-third income bracket). For middle-income-bracket families, the estimate is $1.45 million (Longman 1998).

Choosing When: Is There an Ideal Age at which to Have a Child?

Although we have briefly addressed the question of delayed or deferred parenthood, we should point out that delaying parenthood "too long," like having children "too young," carries risks and brings costs. For example, research on the health effects for mothers caused by their age at first birth reveal that both "unusually young" and "unusually old" mothers face health risks. Mothers who bear their first child in their teens face nearly twice the risk of anemia as women who have their first child between ages 30 and 35 (Mirowsky 2002).

But there are significant risks for pregnancy- and labor-related distress among older first-time mothers, too. For example, pregnancy-related hypertension rates are highest for mothers under 20 and over 40 years of age. Late first births and the care associated with infants take their physical toll on women. The kind of physical energy required to care for children tends to decline with age (Mirowsky 2002).

Both in the United States and elsewhere, women have increased their age at first motherhood. In the United States, the median age at first birth in 1972 was 22 years; in 1998 the median age had increased to 24.3 years. In Italy, the Netherlands, Denmark, and Spain, the typical age at first motherhood is near or beyond 30 years (Mirowsky 2002). Zheng Wu and Lindy MacNeill (2002) report that, in Canada, too, delaying childbearing has become increasingly popular. Probable factors to explain these widespread trends are the increasing age at which women and men marry, women's increased labor force participation and educational attainment, and the increasingly effective measures of reproductive control (Wu and MacNeill 2002).

Preventing and Controlling Conception

Effective pregnancy prevention or control is critical to both deferred or delayed parenthood and "child-free" lifestyles. According to a Kaiser Family Foundation Survey on men's role in contraception and pregnancy prevention, most women and men believe men should be more active participants in choosing methods of contraception. In pregnancy prevention, 66% of men and 70% of women endorse expanded roles for men; only 8% of men and 4% of women say men should play a smaller role (Ten Kate 1998). In addition, the survey found the following:

Reflections

If you don't have any children now, do you want to have them in the future? When? How many? What factors do you need to take into consideration when contemplating a family for yourself? Does your partner (if you have one) agree with you about having children?

Being Pregnant

Women and men who become parents enter a new phase of their lives. For those who bear their own children, this phase begins with pregnancy. From the moment it is discovered, a pregnancy affects people's feelings about themselves, their relationship with their partner, and the interrelationships of other family members.

In the United States in 2000, there were more than 6.4 million pregnancies, down 6% from the 1990 peak

of 6.8 million but up from 6.3 million in 1999. Between 1990 and 2000, the pregnancy rate dropped for both married and unmarried women, about 8% and 12%, respectively ("Estimated Pregnancy Rates for the United States" 2004).

Although the 1990–2000 decline in pregnancy rates occurred across the board among all women under 30 years of age, the drop was steepest among teens of all racial groups. The teen pregnancy rate dropped 27% during this period, reaching a rate of 84.5 pregnancies per 1,000 women 15–19 years old—*the lowest recorded teen pregnancy rate since 1976* (National Center for Health Statistics 2004). Pregnancy rates remain highest for women in their 20s, with 20- to 24-year-old women having the highest rates, followed by 25- to 29-year-olds (National Center for Health Statistics 2004).

Of the more than 6 million pregnancies in the United States in 2000, 63% resulted in births, 20% in abortions, and 17% in stillbirths or miscarriages ("Estimated Pregnancy Rates for the United States" 2004). Since 1990, trends in birth, abortion, and fetal loss have all declined: live births by 9%, abortions by about 25%, and fetal losses by 4%.

Both marital status and race affect pregnancy outcomes. In 1999, 75% of pregnancies among married women resulted in a live birth; 7% resulted in an abortion. Meanwhile, about 50% of pregnancies of unmarried women resulted in live births; 40% ended in an abortion ("Revised Pregnancy Rates," 2004). Black women and white women report that they want about the same number of births, but black women experience more pregnancies. Among black women there is an average of 4.6 pregnancies per woman, compared with just 2.7 for white women. Black women's pregnancies are twice as likely to end in abortions as pregnancies among white and Hispanic women (National Center for Health Statistics 2000).

Matter of Fact

It is fairly simple to figure out the date on which a baby's going to be born: Add 7 days to the first day of the last menstrual period. Then subtract 3 months and add 1 year. For example, if a woman's last menstrual period began on July 17, 2006, add 7 days (July 24). Next subtract 3 months (April 24). Then add 1 year. This gives the expected date of birth as April 24, 2007. Few births actually occur on the date predicted, but 60% of babies are born within 5 days of the predicted time.

Emotional and Psychosocial Changes

A woman's feelings during pregnancy will vary dramatically according to who she is, how she feels about pregnancy and motherhood, whether the pregnancy was planned, whether she has a secure home situation, and many other factors. Her feelings may be ambivalent; they will probably change over the course of the pregnancy.

Planned versus Unplanned: Was It a Choice?

It is estimated that nearly a fourth of all pregnancies carried to full term are unplanned. If we assume that a much greater percentage of pregnancies that end in abortions were also unplanned, the true percentage of

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Both expectant parents may feel that the fetus is already a member of the family. They begin the attachment process well before birth.

all unplanned pregnancies is likely much higher than the 23% cited by researchers (Bouchard 2005). Comparing planned and unplanned pregnancies reveals the following:

- Unplanned pregnancies present greater risks for problems associated with lack of readiness or preparedness for parenting on the part of pregnant women or expectant couples.
- Babies born from unintended pregnancies are more likely to suffer both physical and social disadvantages.
- Mothers who give birth to "unintended" babies are more likely to report experiencing psychological problems such as postpartum depression.

A woman's first pregnancy is especially important because it has traditionally symbolized the transition to maturity. Even as social norms change and it becomes more common and acceptable for women to defer childbirth until they have established a career or to choose not to have children, the significance of first pregnancy should not be underestimated. It is a major developmental milestone in the lives of mothers—and fathers (Marsiglio 1991; Notman and Lester 1988; Snarey et al. 1987).

A couple's relationship is likely to undergo changes during pregnancy. It can be a stressful time, especially if the pregnancy was unanticipated. Communication is particularly important at this time because each partner may have preconceived ideas about what the other is feeling. Both partners may have fears about the baby's well-being, the approaching birth, their ability to parent, and the ways in which the baby will affect their relationship. All of these concerns are normal. Sharing them, perhaps in the setting of a prenatal group, can deepen and strengthen the relationship (Kitzinger 1989). If the pregnant woman's partner is not supportive or if she does not have a partner, it is important that she find other sources of support—family, friends, women's groups—and that she not be reluctant to ask for help.

The first trimester (3 months) of pregnancy may be difficult physically and emotionally for the expectant mother. She may experience nausea, fatigue, and painful swelling of the breasts. She may also fear that she will miscarry or that the child will not be normal. Her sexuality may undergo changes, resulting in unfamiliar needs (for more, less, or differently expressed sexual love), which may in turn cause anxiety. (Sexuality during pregnancy is discussed later in this chapter.) Education about the birth process, information about her body's functioning, and support from partner, friends, relatives, and health-care professionals are the best antidotes to her fear.

As illustrated in Table 10.2, not all pregnant women receive timely prenatal care or care commencing during the first trimester.

During the second trimester, most nausea and fatigue disappear and the pregnant woman can feel the fetus move within her. Worries about miscarriage will probably begin to diminish because the riskiest part of fetal development has passed. The pregnant woman may look and feel radiantly happy.

Some women, however, may be concerned about their increasing size; they may fear that they are becoming unattractive. A partner's attention and reassurance will ease this fear.

The third trimester may be the time of the greatest difficulties in daily living. The uterus, originally about the size of the woman's fist, has now enlarged to fill the pelvic cavity and is pushing up into the abdominal cavity, exerting increasing pressure on the other internal organs. Water retention (edema) is a fairly common problem during late pregnancy; it may cause swelling in the face, hands, ankles, and feet. It can often be controlled by reducing salt and refined carbohydrates (such as bleached flour and sugar) in the diet. If dietary changes do not help this condition, however, the woman should consult her physician.

Another problem is that the woman's physical abilities are limited by her size. She may be required by her employer to stop working at some point during her pregnancy. A family dependent on her income may suffer hardship. And the woman and her partner may become increasingly concerned about the upcoming birth.

Table 10.2 ■ Percentage of Mothers Beginning Prenatal Care in First Trimester, and Percentage with Late or No Prenatal Care

	First Trimester	Late or No Care
All women	83.2	3.9
White (non-Hispanic)	88.5	3.2
African American	74.3	6.7
Hispanic	74.4	6.3

SOURCE: Hamilton, Martin, and Sutton 2003.

Some women experience periods of depression in the month preceding their delivery; they may feel physically awkward and sexually unattractive. Many, however, feel an exhilarating sense of excitement and anticipation marked by energetic bursts of industriousness. They feel that the fetus is a member of the family. Both parents may begin talking to the fetus and "playing" with it by patting and rubbing the expectant mother's belly.

Sexuality during Pregnancy

It is not unusual for a woman's sexual feelings and actions to change during pregnancy, although there is great variation among women in these expressions of sexuality. Some women feel beautiful, energetic, sensual, and interested in sex; others feel awkward and decidedly "unsexy." A woman's feelings may also fluctuate during this time. Some studies indicate a lessening of women's sexual interest during pregnancy and a corresponding decline in coital frequency. A study of 219 pregnant women found that although libido, intercourse, and orgasm declined, the frequency of oral and anal sex and masturbation remained at pre-pregnancy levels (Hart et al. 1991). Generally, however, by the third trimester of pregnancy, approximately 75% of first-time mothers report loss of desire; between 83% and 100% report reduced frequency of sexual intercourse (Judicubus and McCabe 2002).

Men may feel confusion or conflicts about sexual activity during this time. They, like many women, may have been conditioned to find the pregnant body unerotic. Or they may feel deep sexual attraction to their pregnant partner, yet fear their feelings are "strange" or unusual. They may also worry about hurting their partner or the baby.

Although there are no "rules" governing sexual behavior during pregnancy, a few basic precautions should be observed:

- If the woman has had a prior miscarriage, she should check with her health practitioner before having intercourse, masturbating, or engaging in other activities that might lead to orgasm. Powerful uterine contractions could possibly induce a spontaneous abortion in some women, especially during the first trimester.
- If there is bleeding from the vagina, the woman should refrain from sexual activity and consult her physician or midwife at once.
- If the insertion of the penis into the vagina causes pain that is not easily remedied by a change of position, the couple should refrain from intercourse.
- Pressure on the woman's abdomen should be avoided, especially in the final months of pregnancy.
- During oral sex, care should be taken not to blow air into the vagina, as there is a possibility of causing an embolism (an air bubble in the bloodstream).
- Late in pregnancy, an orgasm is likely to induce uterine contractions. Generally this is not considered harmful, but the pregnant woman may want to discuss it with her practitioner. (Occasionally, labor is begun when the waters break as the result of orgasmic contractions.)

A couple, especially during their first pregnancy, may be uncertain as to how to express their sexual feelings. The following guidelines may be helpful (Strong and DeVault 1997):

- Even during a normal pregnancy, sexual intercourse may be uncomfortable. The couple may want to try positions such as side by side or rear entry to avoid pressure on the woman's abdomen and to facilitate more shallow penetration.
- Even if intercourse is not comfortable for the woman, orgasm may still be intensely pleasurable. She may wish to consider masturbation (alone or with her partner) or cunnilingus.
- Both partners should remember that there are no rules about sexuality during pregnancy. This is a time for relaxing, enjoying the woman's changing body, talking a lot, touching each other, and experimenting with new ways—both sexual and nonsexual—of expressing affection.

Men and Pregnancy

Obviously, pregnancy is something men do not experience directly. It is the woman's body that carries the fetus and undergoes profound change along the way. For men, pregnancy is only accessible vicariously. Still, how men navigate the pregnancy process has consequences for their later conceptualization of and involvement in fathering (Marsiglio 1998).

During pregnancy, men experience changes in their sexual relations with their partners, especially in the amount and nature of fantasies, and alterations in their

patterns of dreams. In their sexual fantasies, they reported feeling as if they were fertilizing, nurturing, or "feeding" their fetuses or their wives, thus revealing the connection they draw between pregnancy and sexuality (Marsiglio 1998).

Early in their partner's pregnancy, men's dreams occasionally take on qualities of mystery and awe, later shifting to dreams of being neglected or rejected by their partners (Marsiglio 1998). Men's anxieties during pregnancy cover a number of areas, including the health of both fetus and partner, whether they will be a good father, how fatherhood will affect their lives, and how well they will manage their economic responsibilities, especially given new expenses and reduced spousal income. Although a man's traditional role as father centered on providing, the concern over competence as a provider is not the major source of men's pregnancy anxieties. Men whose employment is unstable or whose incomes are insufficient will experience more provider anxiety than will men who simply take for granted that they can meet their financial responsibilities (Cohen 1993).

The roles men play in supporting their partners, participating in the preparation for parenthood, and at the birth also are significant. Not all men act in similar ways. Some may be relatively detached, others fully involved, and still others practical in their participation in the pregnancy (Marsiglio 1998). The way men act during pregnancy (reading material, attending prenatal classes, involving themselves in the birth process, and so on) may affect how they later relate with their newborns. Of particular note is the experience of witnessing the birth of their children, which reportedly opens men to a depth of emotional experience often otherwise absent from conventional cultural expressions of masculinity. Men are "feminized"; they speak poignantly, occasionally poetically, about what that experience was like or meant to them (Cohen 1987; Gerson 1993).

Contested Viewpoints on Childbirth

Women and couples planning the birth of a child have decisions to make in a variety of areas—birthplace, birth attendants, medications, preparedness classes, circumcision, and breastfeeding, to name but a few. The "childbirth market" is beginning to respond to consumer concerns, so it's important for prospective parents to fully understand their options.

The Critique against Medicalization: Hospital Birth

Through the last decades of the twentieth century, there was much criticism directed at what was seen as excessive and intrusive institutionalized control of women's birth experiences. The concept of the **medicalization of childbirth** depicts women receiving impersonal, assembly line–quality care during labor and delivery and lacking much input or control over their childbirth experiences. It is illustrated in the following comment from one woman describing her initial feelings in the hospital (Leifer 1990):

> When they put that tag around my wrist and put me into that hospital gown, I felt as if I had suddenly just become a number, a medical case. All of the excitement that I was feeling on the way over to the hospital began to fade away. It felt like I was waiting for an operation, not about to have my baby. I felt alone, totally alone, as if I had just become a body to be examined and not a real person.

During one of the most profound experiences of her life. a woman may find herself surrounded by strangers to whom birth is merely business as usual.

Central to the critique of medicalization is the idea of control: women have less say and control over the process than they should. This is illustrated in this second comment, this from another woman, describing the way she was treated (Leifer 1990):

> And then this resident gave me an internal [examination], and it was quite painful then. And I said: "Could you wait till the contraction is over?" And he said he had to do it now, and I was really upset because he didn't even say it nicely, he just said: "You'll have to get used to this, you'll have a lot of this before the baby comes."

The critique of medicalization also takes into account the environment and medical procedures used. Lighting, noise, routine use of monitoring devices, routine administering of enemas, rates of episiotomies (a surgical procedure to enlarge the vaginal opening by cutting through the perineum toward the anus), rates of Cesarean-section deliveries, use of forceps or vacuum suction to assist in pulling the fetus from the

Exploring Diversity Couvade: How Men Give Birth

Throughout the world, men envy and imitate both pregnancy and childbirth. In our culture, there are sympathetic pregnancies in which a man develops physical characteristics similar to those of his pregnant partner. If she has morning sickness, so does he; if her belly begins to swell, so does his. Also, men often use images of pregnancy and childbirth to describe their creative work. A man "conceives" an idea. He is in a "fertile" period in his artistic development.

Other cultures have the ritual of **couvade.** The word comes from the French *couver,* meaning "to hatch or brood." Among the Hopi, for example, a man is required to be careful not to hurt animals. If he does, his child may be born deformed.

The Huichol of Mexico traditionally practiced a ritual of couvade in which the husband squatted in the rafters of the house or the branches of a tree above his wife during labor. When the woman experienced a contraction, she pulled on ropes attached to his scrotum. In this way, the man shared the experience of childbirth.

The couvade is a dramatic symbol of the man's paternity and his "magical" relation to the child. By pretending he is pregnant, he distracts evil spirits from harming his baby. Describing the magical effect of the couvade, Arthur and Libby Colman (1971) write: "The couvade phenomena have the important side effects of helping a husband play an important part in pregnancy and childbirth. . . . They help a man cope with the envy and competitiveness which he may feel at his wife's ability to perform such a fundamental and creative act."

In his activities to deceive the evil spirits, a man may also find a reasonable outlet for his own desire to take on something of the female role in life.

womb—all of these reflect what critics have suggested is society's increasing dependence on technology and medical control. Critics of medicalization contend that episiotomies, the use of forceps, and vacuum extraction are employed more for the convenience and control of the obstetrician than due to medical necessity. In general, critics recognize and value the potential lifesaving use of such interventions *when needed* but question procedures that seem to place medical convenience above women's interests or needs.

The Feminist Approach

The question of what women most want or need is central to a feminist critique of childbirth. Along with consumer advocates and government policymakers, feminists and activists in the "women's health movement," have raised concerns and objections about the medicalization of childbirth. For feminists, a woman's rights—"to be informed, fully conscious, and to experience childbirth as a 'natural' process" are paramount (Treichler 1990). Feminists question how much medical intervention and control are necessary to reduce risks associated with the "normal, natural physiological process" of childbirth. They assert that most pregnant women are essentially healthy and require minimal medical management during the birth process.

Writing in 1990, Treichler spoke of a "crisis in childbirth" intensifying around such criticisms and the medical profession's defense. Many of the above criticisms have been heard and addressed by hospitals and medical practitioners. For example, most hospitals have responded to the need for family-centered childbirth. Fathers and other relatives or close friends typically participate today. "Birthing rooms," with softer lighting and more comfortable birthing chairs, are increasingly common. Some hospitals permit rooming-in (the baby stays with the mother rather than in the nursery) or a modified form of rooming-in.

What Mothers Say

With the preceding critique of medicalization in mind, we might predict women to express high levels of discontent with their experiences and treatment during pregnancy, while in labor and giving birth, and after they give birth. We see quite the opposite from data collected in the Listening to Mothers survey, conducted by Harris Interactive and the Maternity Center Association. Billed as "the first national U.S. survey of women's childbearing experiences," the report is based

on telephone interviews and online surveys with a combined sample of 1,583 women who gave birth during the 2-year period between May 2000 and June 2002. If anything, the results suggest positive experiences and assessments of treatment and care received. Some key findings are as follows:

1. By far, most mothers felt "quite positive" about their birthing experiences:
   - 95% felt that they generally understood what was happening to them.
   - 93% felt comfortable asking questions.
   - 91% felt that they had received the necessary amount of attention.
   - 89% felt as involved as they desired in decision making about their deliveries.
2. Nearly all women (97%) reported giving birth in a hospital, and 80% were attended to by obstetricians. (10% used midwives, 4% were attended to by family physicians, and 5% by nurses or physician's assistants).
3. Qualitative assessments of the overall care and treatment women received from their physicians were quite positive. Approximately nine out of ten women reported that their doctor or midwife had been polite, supportive, and understanding. The biggest complaint was that physicians or midwives seemed "rushed."
4. Women reported experience with the following medical interventions during labor and delivery that included the following:
   - 93% reported being monitored by an electronic fetal monitor.
   - 86% were given an intravenous (IV) drip.
   - 63% were given epidural analgesias to relieve pain, 30% were given a narcotic pain reliever, and 5% were given general anesthesia.
   - 78% of the recipients of epidurals and 66% of those who were given general anesthesia reported those techniques to be "very helpful."
   - 61% reported trying to use breathing as a means of controlling or minimizing pain, and 30% reported using "mental strategies." Only about one in five women who used either of these two approaches considered them "very helpful."
   - One in four women had Cesarean sections. Only 11% of women had "assisted vaginal deliveries" in which either forceps or vacuum extraction was used.
   - More than a third of women received episiotomies.
5. Nine out of ten women reported receiving "supportive care" or attention during labor and delivery from their spouses or partners. Medical personnel were also supportive; 83% of women reported that they received support from nurses, and 53% said they received support from their doctors.

Although critics may still question how much medical necessity accounts for the previously mentioned rates of pain medication, episiotomies, and fetal monitoring, it is hard to ignore the high rates of satisfaction expressed by women about their experiences giving birth.

Pregnancy Loss

One additional aspect of dependence on technology is feeling omnipotent and that we should be able to solve any problem. Thus, if something goes wrong with a birth—if a child is stillborn or has a disability, for example—we look for something or someone to blame. We have become unwilling to accept that some aspects of life and death are beyond human control.

The loss of a child through miscarriage, stillbirth, or death during early infancy is a devastating experience that has been largely ignored in our society. The statement "You can always have another one," although it may be meant as consolation, is particularly chilling to the ears of a grieving mother. In recent years, however, the medical community has begun to respond to the emotional needs of parents who have lost a pregnancy or an infant.

Spontaneous Abortion

Spontaneous abortion (miscarriage) is the most common form or type of pregnancy loss. Most occur during the first trimester, with only 3% of all intrauterine deaths occurring after 16 weeks of pregnancy (Layne 1997). The rate of miscarriage is lowest among women 20–24 years old and increases steadily to a high among women 35–39 years old. The estimated *rate* of pregnancy loss is nearly double among women of color compared to non-Hispanic white women, but white women suffer most miscarriages (Layne 1997).

About one out of four women is aware she has miscarried at least once (Beck 1988). Studies indicate that at least 60% of all miscarriages are caused by chromosomal abnormalities in the fetus (Adler 1986). Furthermore, as many as three-fourths of all fertilized eggs do not mature into viable fetuses (Beck 1988). One study found that 32% of implanting embryos miscarried (Wilcox et al. 1988).

Most miscarriages occur between the sixth and eighth weeks of pregnancy. Evidence is increasing that certain occupations involving exposure to chemicals or high levels of electromagnetism increase the likelihood of spontaneous abortions. Miscarriages may also occur because uterine abnormalities or hormonal levels are insufficient for maintaining the uterine lining.

Infant Mortality

The rate of **infant mortality** in the United States remains far higher than the rates in most of the developed world. The U.S. Public Health Service reported 6.8 deaths for every 1,000 live births in 2001 (National Center for Health Statistics 2002). Nevertheless, among developed nations, the United States does not fare well in low infant mortality. In 1999, the United States ranked 28th of 37 countries with populations of at least 1 million for which complete counts of live births and deaths were compiled. (This means that 27 countries had *lower* infant mortality rates than the United States.) In the same comparison in 1990, the United States ranked 11th (http://www.cdc.gov/nchs/data/hus/tables/2003/03hus025.pdf.). In comparison with many developing countries, the rate in the United States is quite low (UNICEF State of the World's Children 2001). Still, the U.S. rate is on par with the rate in Cuba, Malaysia, and Slovakia, all of which are far less wealthy than the United States (Ruane and Cerulo, 2004). Within the United States, the nation's capital has a higher infant mortality rate than any of the 50 states, at 12.5 per 1,000 live births (U.S. Census Bureau 2001, Table 104).

Looking at combined data, for 1995–2002, the U.S. infant mortality rate of 7.1 per 1,000 live births, represented more than 225,000 infant deaths during that period. The rate varied by race and ethnicity, from a low of 5.0 among Asians to a high of 13.9 among African Americans. The United States has targeted a goal rate for 2010 of 4.5, as well as an objective to eliminate racial and ethnic disparities (http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5422a1.htm).

Of the thousands of American babies less than 1 year old who die each year, most are victims of the poverty that often results from racial or ethnic discrimination. Up to a third of these deaths could be prevented if mothers were given adequate health care (Scott 1990).

The United States is far behind many other countries in providing health care for children and pregnant women. In France, Sweden, and Japan, for example, all pregnant women are entitled to free prenatal care. Free health care and immunizations are also provided for infants and young children. Working Swedish mothers are guaranteed 1 year of paid maternal leave, and French families in need are paid regular government allowances (Scott 1990). One in six children born in the United States, is born to mothers who received no prenatal care through the first trimester of pregnancy. Almost one in eight children have no health insurance (Ruane and Cerulo, 2004).

Although many infants die of poverty-related conditions, others die from congenital problems (conditions appearing at birth) or from infectious diseases, accidents, or other causes. Sometimes, the causes of death are not apparent. Data from the Centers for Disease Control and the National Center for Health Statistics for 2001 attribute 2,234 infant deaths to **sudden infant death syndrome (SIDS),** a perplexing phenomenon wherein an apparently healthy infant dies suddenly while sleeping (http://www.cdc.gov/nchs/fastats/pdf/mortality/nvsr52_03t32.pdf).

A study from Australia identified four factors that appear to increase the chances of SIDS (Ponsonby et al. 1993): (1) a soft, fluffy mattress, (2) the baby being wrapped in a blanket, (3) the baby having a cold or other minor illness, and (4) allowing the baby to become too warm. Exposure to secondhand smoke also has been implicated (Klonoff-Cohen et al. 1995). It is also important that an infant not be placed to sleep on its stomach until it is strong enough to turn over ("Sleeping on Back Saves 1,500 Babies," 1996).

Coping with Loss

The depth of shock and grief felt by many who lose a child before or during birth is sometimes difficult to understand for those who have not had a similar experience (Layne 1997). What they may not realize is that most women form a deep attachment to their children even before birth. The loss of the child must be acknowledged and felt before psychological healing

can take place. Instead, however, women typically find that friends, relatives, and coworkers want to pretend that "nothing has happened" (Layne 1997).

Equally problematic are the common reactions from medical personnel and midwives. Medical personnel, especially physicians, may perceive pregnancy loss as "medically unimportant" and as evidence of normal and natural processes at work. Midwives, who typically try to "demedicalize" pregnancy, tend to stress problems that result from overmedicalization. Thus, "nonmedically caused problems" (for example, naturally occurring spontaneous abortion) may remain beyond the domain of midwives. Finally, most "preparation for childbirth" literature and education glosses over or leaves out miscarriage. Thus, women who miscarry are likely to feel and be invisible to those involved in reproductive medicine and childbirth instruction and assistance (Layne 1997).

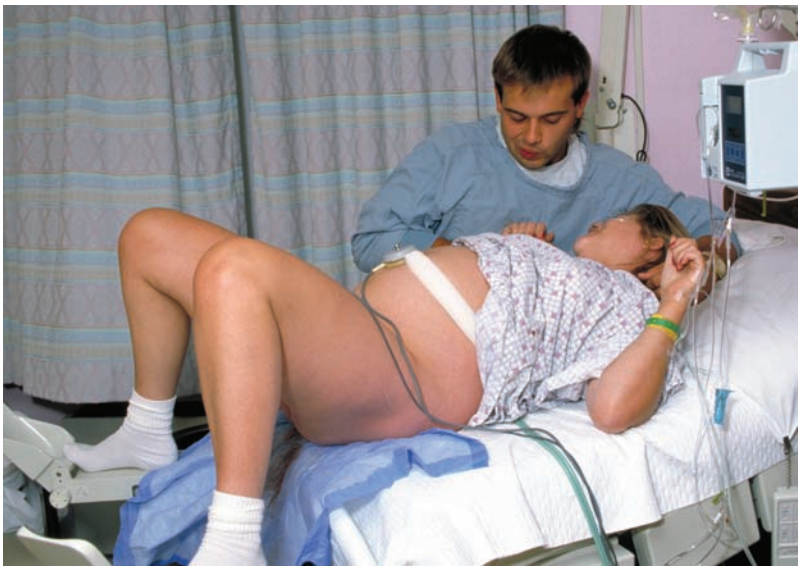
Women (and sometimes their partners) who lose a pregnancy or a young infant generally experience similar stages in their grieving process. Their feelings are influenced by many factors: supportiveness of the partner and other family members, reactions of social networks, life circumstances at the time of the loss, circumstances of the loss itself, whether other losses have been experienced, the prognosis for future childbearing, and the woman's unique personality. Physical exhaustion and, in the case of miscarriage, hormone imbalance often compound the emotional stress of the grieving mother.

The initial stage of grief is often one of shocked disbelief and numbness. This stage gives way to sadness, spells of crying, preoccupation with the loss, and perhaps loss of interest in the rest of the world. It is not unusual for parents to feel guilty, as if they had somehow caused the loss, although this is rarely the case. Anger (toward the physician, perhaps, or God) is also a common emotion.

Experiencing the pain of loss is part of the healing process (Vredevelt 1994). This process takes time—months, a year, perhaps more for some. Support groups and counseling are often helpful, especially if healing does not seem to be progressing or depression and physical symptoms do not appear to be diminishing. Planning the next pregnancy may be curative, too, although we must keep in mind that the body and spirit need some time to heal.

Giving Birth

Sociologist Karin Martin conducted intensive interviews with a small sample of first-time mothers. The twenty-six mostly white heterosexual women, ranging in age from 20 years to over 40, were interviewed within 3 months of having given birth. Instead of exploring the macro-level and institutional dimensions of childbirth, Martin wanted to know how women experienced childbirth and how their experiences were



Family-centered childbirth allows fathers to participate alongside mothers in the birth process.

shaped by "internalized technologies of gender," those "aspects of the gender system that are in us, that become us" (2003, 56). These internalized ideas and practices help determine "how we think about and understand ourselves as men and women" (57).

Deep within us, even in "seemingly natural experiences like birth," are our culturally constructed gender identities (57). Even during childbirth, women are "doing gender," acting compliant, nice, and kind. Martin's informants recalled trying not to "bother" strangers in adjoining rooms, remembered trying hard to remain attentive during conversations, and described doing things that indicated they were putting the needs of others ahead of their own. Even though they had to impose on others (doctors, nurses, midwives, husbands, and so on) for things (backrubs, quiet, patience, information, and so on), they recalled feeling badly about doing so. They found it hard not to feel "rude" or "selfish" for making the demands and imposing on others.

Other ways in which women selflessly "acted like a girl" include allowing—indeed looking to—male partners to "describe, define and decide about their experiences during labor, even their bodily ones" (63). This included using their partners' experiences and views of the birth as definitive of what happened during birth. This was worsened by their inability to "see" the birth. Then, "at the height of labor's physical demands . . . just before an epidural . . . or when pushing the baby out," the women described "acting out," referring to themselves with words like "nasty," "crabby," and "out of control." Even though we might consider it understandable for women to yell, curse, or whine, in their own minds these reactions were neither understandable nor justified. They describe "feeling bad" when they "lost control," by which they mean when they were "not nice." They recall, both during and after giving birth, apologizing to their partners and medical providers. These apologies seem to validate Martin's contention that women were consciously trying to regulate their behavior, even amid the physically and emotionally demanding process of childbirth.

Martin suggests that the feminist critique of the medicalization of childbirth may be correct in highlighting how institutional control over birth shapes the experience. But it is only part of the story, but women's birth experiences are also regulated and controlled "from within," by internalized gender identities. Even when "given permission" to depart from gender expectations, to act in gender deviant ways, they found themselves at odds with such behavior. It was not "how they are" or "who they are" (Martin 2003).

Choosing How: Adoptive Families

Parenthood is not only entered biologically. Although adoption is being examined here as the traditionally acceptable alternative to pregnancy for infertile couples, it may also include the adoption of stepchildren in a remarriage, the adoption of a child by a relative, the adoption of adolescents, the adoption of two or more siblings, and the adoption of foster children who have been removed from their parental homes (Grotevant and Kohler, in Lamb 1999). Many people—married and single, with or without biological children—choose to adopt, not because they are unable to conceive or bear their own children but because they are ideologically committed to adoption. Perhaps they have concerns about overpopulation and the number of homeless children in the world. They may wish to provide families for older or disabled children. Thus, the population of adoptive families is diverse in terms of both motivation and circumstances.

Until recently, it has been difficult to say with certainty how common adoption is in the United States, given the relative absence of dependable or comprehensive data (Grotevant and Kohler, in Lamb 1999). The Center for Adoption Research and Policy estimated that more than 1 million children are currently in adoptive families and more than 5 million adults and children have been adopted (Grotevant and Kohler, in Lamb 1999). More recently, however, the U.S. Census Bureau undertook, for the first time, an effort to count and construct a profile of adoptive families (Kreider 2003). According to the census data, there are more than 2 million adopted children residing in 1.7 million households.

Table 10.3 shows other characteristics of households with adopted children. Nearly 2% of households with children have adopted children only. Another 1.8% have adopted and biological children together in the household, and 0.1% have adopted children with stepchildren or adopted, biological, and stepchildren together.

Census data further reveal the following:

- Adopted children are more likely to be female than male, which Kreider suggests results from both

Real Families — Men and Childbirth

I remember thinking, "Nobody else cares." My wife was knocked out, everybody else in the room was taking care of my wife and the baby, and the baby was wet, cold, red, really an ugly looking thing. And yet, it was like your first puppy. No one else cares—no one else is going to take care of it at that moment. Truthfully, I was instantly bonded; it was like a marriage. She [my daughter] opened her eyes a little bit and I immediately began to relate to what she saw. . . . I was thrilled. I followed her after she opened her eyes and tried to imagine what she saw and what she might be seeing. . . . It was real exalting.

Mark, 37-year-old father of one

My wife had the shakes and couldn't hold the baby. I held her [my daughter] and sang her a lullaby. She was looking at my face, wasn't focusing, but I could see something going on. She could obviously hear too. I got to hold her for like fifteen minutes. It was all so exciting and incredible . . . and strange.

Bill, 36-year-old father of one

The preceding comments are the recollections of two fathers to having witnessed the births of their daughters. Told to sociologist Theodore Cohen, they reveal how deeply some men are moved by their involvement at birth. In the United States and many other countries, it is now commonplace for fathers to attend, witness, and often even actively assisting in the birth of their children. It may be so common that we forget how relatively recent it is for men to enjoy such access. In 1960, only about 15% of fathers attended the birth of their child in the delivery room. Although estimates vary, by the first years of the twenty-first century, between 75% and 80% of fathers were present at childbirth (*Washington Post* 2006).

We see the same trend elsewhere. In the United Kingdom, fathers are now in attendance at 80% of births (Johnson 2002). Similar trends have been observed in other European countries and in Canada. Attendance at birth offers fathers an opportunity to feel part of the birth process and to offer support to their partners. It may or may not lead to greater involvement in subsequent childrearing. Although some research speculates that it does, other research finds no such effect (Palkovitz 1985).

Among men in the United Kingdom, the most frequently cited motivations for attendance at birth are out of support for their partners, out of curiosity, or because of pressure. In the United States and Canada, there is a fourth reason: men often play the role of "coach," assisting their partners to implement what they have been taught in prenatal classes (Johnson 2002, 167):

> Here it is the man's responsibility to help his partner practice the procedures learned in prenatal classes, requiring the acquisition of some knowledge and training.

Where once hospital practice and cultural expectations kept men out of the delivery room, now they are expected to be present. To illustrate this coercive element, in Martin Johnson's exploratory study of 53 British fathers, 57% of the men said they felt pressured to be there through labor and delivery. For example, "You don't get a choice, not really. It is assumed that you want to be there; I mean I did, but that is not the point. It's like not having a choice."

Finally, in Johnson's study, men's reactions to what they saw and experienced were both positive and negative.

On the negative side, 56% of the men identified as their most overwhelming memory the pain they witnessed their partners suffering. One man, Ben, claimed he felt as though he ought to be experiencing pain himself: "In a strange way, when she dug her nails into my hands, I wanted to embrace the pain; it was like my share."

On the positive side, and unsurprisingly, men were deeply moved by the birth and awed by their partners' strength and resilience.

Two of Johnson's informants, Ken and Bill, made the following comments:

> For the first time in a long, long time, I had tears rolling down my face. (Ken)
>
> When her head came out, I thought, I did this, she is half me, I have given the world a part of the future. (Bill)

desirability and availability. Specifically, "women in general express a preference for adopting girls, and single women more frequently have adopted girls than boys" (2003, 8). In addition, with regard to international adoptions, more female children are available for adoption from those countries that are "leading sources for adopted children" (8).

- Higher proportions of adopted children than biological children are African American and Asian; 16% were black (compared to 13% of biological

Table 10.3 ■ Households by Type of Children and Number of Adopted Children

	Number	Percent
Households by type of children	**45,490,049**	**100.0**
Adopted children only	816,678	1.8
Stepchildren only	1,485,201	3.3
Biological children only	40,657,816	89.4
Adopted and biological children	808,432	1.8
Adopted children and stepchildren	29,575	0.1
Biological children and stepchildren	1,659,924	3.6
Biological children, adopted children and stepchildren	32,423	0.1
Households with adopted children	**1,687,108**	**3.7**
One	1,383,149	3.0
Two	247,600	0.5
Three or more	56,359	0.1

SOURCE: http://www.census.gov/prod/2003pubs/censr-6.pdf

children) and 7.4% were Asian (more than double the 3.5% of biological children). A slightly smaller percentage of adopted children than biological children are Hispanic (14% versus 16%).

- Economically, families with adopted children are somewhat better off than those without. Smaller percentages of adopted children than biological children are poor (11.8% vs. 16%). "Adoptive households" had higher median incomes than households with only biological children ($56,138 compared to the $48,200) and a third of adopted children as opposed to 27% of biological children lived in households with incomes of $75,000 or more.
- Adopted children were more likely to have some disability than were biological children (15% versus 7% of boys, 9% versus 4% of girls). "Mental disabilities" were the most common disability, consisting of "difficulty learning, remembering, or concentrating."
- More adopted children (78%) than biological children (74%) lived in two-parent households.

Of the 1.7 million households with adopted children, about 308,000 (18%) contained members of different races. This is twice the proportion found among the 43.8 million households with no adopted children, where 4.1 million had members of different races. Kreider notes that this is largely a result of the adoption of foreign-born children by U.S. residents.

The costs of adoption can be quite steep. The Child Welfare Information Gateway, provides the following estimates of adoption-specific costs. Such costs vary, depending on the type of adoption, the type of agency used, whether they adopt domestically or internationally, and so on. The costs from range from a low of $0 to $2,500 for foster care adoption, from $5,000 to $40,000 for domestic infant adoption, and from $7,000 to $30,000 for international adoption, plus travel costs.

If there is a need for a home study to determine the suitability of prospective adoptive parents, costs may exceed $3,000 (Child Welfare Information Gateway, http://www.childwelfare.gov/pubs/s_cost/s_costa.cfm).

Adoption laws vary widely from state to state; some prohibit private adoption, and other states have laws that are considered quite supportive of it.

With confidentiality no longer the norm, the trend is toward **open adoption** in which there is contact between the adoptive family and the birth parents (McRoy, Grotevant, and Ayers-Lopez 1994). This involvement can be either mediated (through an adoption agency) or direct, where the birth mother and adoptive family have contact with each other. Many adoption experts agree that some form of open adoption is usually in the best interests of both the child and the birth parents.

Adoptive families face unique problems and stresses. They may struggle with physical and emotional strains of infertility; endure uncertainty and disappointment as they wait for their child; and may spend all their savings and then some in the process. They often face insensitivity or prejudice. For example, an adopted child may be asked, "Who is your *real* mother?" or "Are you their *real* daughter?" Adoptive parents may be congratulated by well-meaning folks—"Oh, you're doing such a good thing!"—as though

Popular Culture Covering Adoption

When you think about adoption, what comes to mind? Would you guess that most adoptions are successful? Do you consider adoptive families to be "real families"? What impressions of adoptees do you have? Researchers Susan Kline, Amanda Karel, and examined the role of broadcast journalism in shaping attitudes about adoption.

Looking at 292 adoption-related news stories that aired on morning news programs, news magazine programs, and evening news programs on either NBC, CBS, or ABC between 2001-2004, they found somewhat mixed coverage.

More than half (162 stories, 56%) of all adoption related stories contained "problematic depictions" of adoptees, such as portraying them as having emotional difficulties, health problems or engaging in antisocial behavior. In 121 stories (41%) adoptees were portrayed in socially desirable ways. In 34% of the stories (99), there were both positive and negative depictions, as in the case of an adoptee who had been "out of control," but bonded with adoptive parents. Stories with solely negative portrayals (63; 22%) were almost three times as common as stories with only positive depictions (22; 8%).

Almost half the stories contained nothing about biological parents. Of the 53% (156) that did feature birth parents, more negative than positive portrayals were found. In 68 stories (23%) only negative portrayals of birth parents were conveyed; conversely, 29 stories (10%) conveyed only positive images. Overall, more stories contained problematic depictions (44%; 127 stories) than contained positive portrayals (30%; 88 stories) of birth parents. The negative portrayals featured such issues as abandonment of one's children or food stamp fraud. Interestingly, the tone of the coverage shifted when considering adoptive parents.

Interactions in adoptive families were featured in 91% of the 292 stories. Positive depictions (for example, showing family cohesion, support, love, accomplishments) were somewhat more common than negative (for example, critical, aggressive, or abusive) ones (62% vs. 57%). Only 27% of the stories featured solely negative depictions of adoptive family interactions, while 41% portrayed such interactions in solely positive ways.

Kline, Karel and Chaterjee recommend that more news coverage focus on "solely positive portrayals of adoptees" and pay greater attention to birth parents' views of the adoption experience. They also warn practitioners who work with prospective adoptive parents to be aware of the following. Given the problematic tone of the portrayals of adoptees, the limited coverage of why birth parents place children for adoption, and the tendency for news stories to stigmatize or stereotype adoptees and birth parents, prospective parents may hold negative images, have limited knowledge of what motivates birth parents to place their children for adoption, and misunderstand adoption and adoptive family life. Thus, it is important to consider the slant of news coverage of adoption, as especially in the absence of direct interaction with adoptees and adoptive families, mass media images can help reduce stigma.

they had made a sacrifice of some kind in choosing to build a family in this way. Even grandparents may reject adopted grandchildren (at least initially), especially if the adoption is interracial. The idea that adoption is not quite "natural" is all too common in our society.

At the same time, adopted children may feel uniquely loved. Suzanne Arms recalling her son Joss's explanation to a friend, recounts, "When Joss was six, he was overheard explaining to a friend how special it was to be adopted. Apparently," she adds, "he made a good case for it, because when his friend got home, he told his mother he wanted to be adopted so he could be special too" (Arms 1990).

Reflections

Is the ability to create a child important to your sense of self-fulfillment? If you discovered that you were infertile, what do you think your responses would be? Would adoption be an option for you? Why or why not?

Becoming a Parent

The time immediately following birth is a critical period for family adjustment. No amount of reading, classes, and expert advice can prepare expectant parents

for the real thing. The 3 months or so following childbirth (the "fourth trimester") constitute the **postpartum period.** This is a time of physical stabilization and emotional adjustment.

New mothers, who may well have lost most of their interest in sexual activity during the last weeks of pregnancy, will probably find themselves slowly returning to prepregnancy levels of desire and coital frequency. Some women may have difficulty reestablishing their sexual life because of fatigue, physiological problems such as continued vaginal bleeding, and worries about the infant (Reamy and White 1987).

Both relationship satisfaction and postpartum depression are important predictors of the levels of sexual desire and satisfaction and of changes in sexual frequency following childbirth. Enjoyment returns gradually. According to research by Margaret De Judicibus and Marita McCabe, at 2 weeks postpartum, few new mothers report sexual intercourse as pleasurable; by 12 weeks, two thirds of women say that sex is "mostly enjoyable." Even then, however, 40% complain of some difficulties. Relationship satisfaction is at its lowest at this point. Nearly six out of seven couples report reduced frequency of intercourse at 4 months postpartum. By 6 months postpartum, many women continue to report significantly lower levels of desire, sexual frequency, and sexual satisfaction when compared to the levels before conception. By this point, the quality of the mother role was also strongly associated with sexuality, as was fatigue. Over the first few postpartum months, there is evidence of reductions in both reported love for the partner and affection expressed between partners (De Judicibus and McCabe 2002).

De Judicibus and McCabe identify each of the following as factors associated with reduced sexual desire, decreased frequency of relations, and lower levels of satisfaction:

- Adjustment to changes in social roles during transition to parenthood.
- Declining marital satisfaction. This has been reported in many countries. After a first-month "honeymoon" period, the trend toward lower levels of satisfaction becomes stronger by the third postpartum month.
- Postpartum mood or postnatal depression; 35–40% of women report *some* depressive symptoms.
- Fatigue.
- Physical changes with birth of a child. These can result in *dyspareunia,* or painful intercourse, the symptoms of which may include "a burning, ripping, tearing, or aching sensation associated with penetration. The pain can be at the vaginal opening, deep in the pelvis, or anywhere between. It may also be felt throughout the entire pelvic area and the sexual organs and may occur only with deep thrusting" (http://www.healthscout.com/ency/1/474/main.html).
- Breastfeeding.
- The demands imposed by infants.

The postpartum period also may be a time of significant emotional upheaval. Even women who had easy and uneventful births may experience a period of "postpartum blues" characterized by alternating periods of crying, unpredictable mood changes, fatigue, irritability, and occasional mild confusion or lapses of memory. For some, this can be truly devastating, leaving them feeling as though they are "losing their minds" as they struggle with postpartum reactions that include psychosis, depression, panic disorder, and obsessive compulsive disorder (Layne 1997). A woman may have irregular sleep patterns because of the needs of her newborn, the discomfort of childbirth, or the strangeness of the hospital environment. Some mothers may feel lonely, isolated from their familiar world. Infants of women suffering postpartum depression also suffer, as postpartum depression interferes with mothers' abilities to respond to their newborns' needs and may lead to poor emotional and cognitive development (Layne 1997).

Many women blame themselves for their fluctuating moods. They may feel that they have lost control over their lives because of the dependency of their newborns.

Biological, psychological, and social factors are all involved in postpartum depression. Biologically, during the first several days following delivery, there is an abrupt fall in certain hormone levels. The physiological stress accompanying labor, dehydration, blood loss, and other physical factors contribute to lowering the woman's stamina. Psychologically, conflicts about her ability to mother, ambiguous feelings toward or rejection of her own mother, and communication problems with the infant or partner may contribute to the new mother's feelings of depression and helplessness. Finally, the social setting into which the child is born is important, especially if the infant represents

a financial or emotional burden for the family. Postpartum counseling before discharge from the hospital can help couples gain perspective on their situation so that they will know what to expect and can evaluate their resources.

Although the postpartum blues are felt by many women, they may be especially problematic for young mothers. Donna Clemmens (2002) reports that as many as 48% of adolescent mothers suffer depressive symptoms, a rate more than 3.5 times that among adult mothers (13%). Clemmens identifies the following six themes as evident in depressive reactions of young mothers (19 years old or younger):

1. *Suddenly realizing motherhood.* Struck by the "sudden cold realization of being a mother, motherhood hits like a Nor'easter" (a severe storm that seems to come out of nowhere).
2. *Torn and pulled between two realities.* Mothers described being pulled and torn between the realities of new motherhood and being adolescents in school, sometimes leading to regrets over lives that "could have been."
3. *Constantly questioning and trying to explain the unexplainable.* Feeling depressed, participants had a difficult time explaining their depression. They reported feeling an emptiness, a state of "wanting to die," feelings that they couldn't shake but also feelings that they couldn't effectively explain to others.
4. *Feeling alone, betrayed, and abandoned by those that you need to love you.* This speaks to the feeling of abandonment by boyfriends and friends, leaving them feeling stressed and betrayed, as if they had nothing going for them.
5. *Everything is falling down on you and around you.* The sadness, anger, mood swings, fatigue, confusion, and crying symptomatic of depression felt like a heavy weight being carried around. Although they sometimes felt happy, their moods would drop for no apparent reason.
6. *You are changing and regrouping, seeing a different future.* Some mothers felt that having "survived the storm" they wanted to warn other teens about what early motherhood was really like. In this way they hoped to make something constructive of their hurt.

Clemmens notes that all the young women maintained warm feelings for and commitment to their children. They acknowledged regrets about having had sex so early and having become pregnant but not about having their children. There were also numerous statements about feeling stronger, more responsible, and reliable as a result of becoming mothers (Clemmens 2002).

Men, too, seem to get a form of postpartum blues. When infants arrive, many fathers do not feel prepared for their new parenting and financial responsibilities. Some men are overwhelmed by the changes that take place in their marital relationship. Fatherhood is a major transition for them, but their feelings are overlooked because most people turn their attention to the new mother.

The transition to parenthood can be made somewhat easier if the new parents understand in advance that a certain amount of fatigue and stress is inevitable. They need to ascertain what sources of support will be helpful to them, such as friends or family members who can help out with preparing meals or running errands. They also need to keep their lines of communication open—to let each other know when they are feeling overwhelmed or left out. It's also important that they plan time to be together, alone or with the baby—even if it means telling a well-meaning relative or friend they need time to themselves.

For many women and men, the arrival of a child is one of life's most important events, filling mothers and fathers alike with a deep sense of accomplishment. The experience itself is profound and totally involving. A father describes his wife (Kate) giving birth to their daughter (Colleen) (Armstrong and Feldman 1990):

> Toward the end, Kate had her arms around my neck. I was soothing her, stroking her, and holding her. I felt so close. I even whispered to her that I wanted to make love to her—It wasn't that I would have or meant to—it's just that I felt that bound up with her.
>
> Colleen was born while Kate was hanging from my neck. . . . I looked down and saw Mimi's [the midwife's] hands appearing and then, it seemed like all at once, the baby was in them. I had tears streaming down my face. I was laughing and crying at the same time. . . . Mimi handed her to me with all the goop on her and I never even thought about it. She was so pink. She opened her eyes for the first time in her life right there in my arms. I thought she was the most beautiful thing I had ever seen. There was something about that, holding her just the way she was. . . . I never felt anything like that in my life.

Taking on Parental Roles and Responsibilities

Even more than marriage, parenthood signifies adulthood—the final irreversible end of youthful roles. The irrevocable nature of parenthood may make the first-time parent doubtful and apprehensive, especially during the pregnancy. Despite the many months of pregnancy, the actual transition to parenthood happens in the instant of birth. Such an abrupt transition from a nonparent to a parent may create considerable stress. Parents take on parental roles literally overnight, and the job goes on without relief around the clock. Many parents express concern about their ability to meet all the responsibilities of childrearing.

There have been a number of important analyses of the transition to parenthood (Rossi 1968; LaRossa and LaRossa 1981; Cowan and Cowan 1992). An early and influential analysis of what parents experience as they enter the new social reality of parenthood was offered by Alice Rossi (1968). According to Rossi, entering parenthood is stressful because of the nature of the role of parent and the characteristics of the parental role transition.

Rossi singled out the following features of entering parenthood:

- *Irreversibility.* Unlike nearly any other role, once we enter parenthood we cannot easily leave without incurring significant social or legal repercussions. Even "deadbeat parents," who have left their children and ceased to support them, are still considered responsible for their children's welfare.
- *Lack of preparation.* There is almost nowhere and no way to practice parenting. Parenting books, childbirth classes, and babysitting experience, pale in comparison to the reality we face upon having children. Furthermore, little systematic effort is made to equip people with more realistic understanding or even practical skills to more effectively parent.
- *Idealization and romanticization.* Related to the lack of preparation are the expectations we have about what parenthood, which are often unrealistic and overly idealized. If and when reality turns out to be less than ideal, we become frustrated and disappointed.
- *Suddenness.* Despite what might be 8 months of awareness of impending parenthood, the actual transition is sudden. There is no opportunity for expectant parents to ease into the role; we go from nonparent to parent in the moment of childbirth and assume all of the role responsibilities with that same suddenness.
- *Role conflict.* The parental role affects all of the other roles we play, encroaching upon time spent with a spouse or partner and complicating paid employment.

Based on their research on new parents, Ralph and Maureen Mulligan LaRossa suggested that the major

■ *Although becoming a parent is stressful, the role of mother or father is deeply fulfilling for many people.*

adjustment new parents face is *temporal.* Like a hospital or fire station, new parenthood is a **continuous coverage system;** infants must have someone available to care for them 24 hours a day, 7 days a week. When direct care is not needed (for example, during naps or nights when infants sleep), someone must at least be "on call" (a secondary level of accessibility), ready to move to more direct interaction. Finally, when at least two competent caregivers are present, one may move to a state of "downtime" (tertiary level), wherein one is free to pursue other activities without concern for the infant's needs. The LaRossas suggest that new parents (in a two-parent household) compete with each other and experience conflict over downtime. Much of the LaRossas' analysis follows from that, looking at who has more downtime (fathers), who does most of the primary parenting (mothers), and why. In answering the latter question, they note some wider cultural beliefs that value mother care, as well as some relationship and individual-level factors that press mothers toward more of the work associated with children and turn fathers into "helpers" and "playmates" (LaRossa and LaRossa 1981).

Still more recently, Carolyn and Phillip Cowan identified five domains in which new parents experience change as a result of the arrival of children (1992, 2000):

- *Identity and inner-life changes.* New parents discover that they no longer think of themselves the same way they did before their children were born. Their priorities and personal values also change. Issues that previously seemed remote, unimportant, or abstract become personal, meaningful, and real.
- *Shifts within the marital roles and relationship.* Parenthood alters how couples divide tasks or allocate responsibilities. Because they are also experiencing fatigue (from reduced sleep and more work), their relationship quality may diminish.
- *Shifts in intergenerational relationships.* Becoming parents alters—often improving and intensifying, sometimes straining—the relationship between new parents and *their* parents.
- *Changes in roles and relationships outside the family.* New parenthood, especially new motherhood, may force changes in other nonfamily roles and relationships, such as at work or in friendships. Although some of these changes may be temporary (for example, leaving work only for the length of a parental leave), they nonetheless compound other things to which new parents are adjusting.
- *New parenting roles and relationships.* New parenthood means that a couple must arrive at an agreeable division of childcare. New parents learn how difficult it is to maintain equal and/or equitable divisions of childcare. One parent may feel put upon or taken advantage of in the way the couple allocates their individual time and energy to childcare tasks.

The Cowans suggest that the difficulties associated with the parental transition are more difficult for contemporary parents because of some major features of the social climate in which they parent. First, contemporary parenthood is more discretionary or optional, making decisions about whether and when to have children subject to more discussion, negotiation, and potential dispute. Second, many new parents, especially middle-class parents, are relatively isolated, geographically, from their wider kin groups and other long-term social supports. Third, changes in women's roles have introduced more role conflict for new mothers and have increased women's need and legitimate demand for more sharing by their partners. Fourth, the social policies that address the needs of parents are weak to nonexistent. Fifth, there are few enviable or attractive role models for effective parenting; *Leave It to Beaver* families are unrealistic, and yet there is no equivalent cultural model of dual-earner parents to draw upon. If we cannot parent like our own parents did, who can we emulate? Sixth, today's families are supposed to fulfill all of our emotional needs. Parenting is stressful and requires mutual effort and sacrifice. But effort and sacrifice don't fit compatibly with individual emotional fulfillment.

Thus, the difficulties may become sources of resentment and estrangement (Cowan and Cowan 1992, 2000).

Reflections

If you have children, did you plan to have them? What considerations led you to have them? What adjustments have you had to make? How did your relationship with your partner change?

Stresses of New Parenthood

Many of the stresses felt by new parents closely reflect gender roles. Overall, mothers seem to experience greater stress than fathers. Although a couple may have an egalitarian marriage before the birth of the first

child, the marriage usually becomes more traditional once a child is born. If the mother, in addition to the father, continues to work, or if the woman is single, she will have a dual role as both homemaker and provider. She will also probably have the responsibility for finding adequate childcare, and it will most likely be she who stays home to take care of a sick child. Multiple role demands are the greatest source of stress for mothers.

There are various other sources of parental stress. Fathers often describe severe stress associated with their work. Both mothers and fathers must be concerned about having enough money. Other sources of stress involve infant health and care, infant crying, interactions with the spouse (including sexual relations), interactions with other family members and friends, and general anxiety and depression (Harriman 1983; McKim 1987; Ventura 1987; Wilkie and Ames 1986).

Changes in marital quality and marital conflict were studied among a sample of Caucasian and African American spouses as they transitioned to parenthood (Crohan 1996). The results of this study showed a decline in marital happiness and more frequent conflicts among both Caucasian and African American spouses. Caucasian parents also reported higher marital tension and a greater likelihood to become quiet and withdrawn after the birth of their child. This increase in avoidance behaviors may be because of the limited time and energy that new parents have to devote to conflict resolution.

Although the first year of childrearing is bound to be stressful, the partners experience less stress if they (1) have already developed a strong relationship, (2) are open in their communication, (3) have agreed on family planning, and (4) originally had a strong desire for the child. Despite planning, the reality for most is that this is a stressful time. Accepting this fact while developing time management skills, patience with oneself, and a sense of humor can be most beneficial.

Having a child is unlike any other experience we undertake. The changes in our lives are wide ranging and irreversible, the potential rewards are great, and the sacrifices are many. Increasing numbers of women and couples are deciding to forego parenthood, largely to avoid its many and profound consequences. Most people, however, continue to decide to embark on the journey described in this chapter and take on the challenging tasks that we look at in Chapter 11.

■ *Becoming a parent introduces changes in intergenerational relationships.*

Summary

- With wider availability of effective contraceptives and access to legal abortion, and with increases in delayed parenthood and *child-free marriage,* parenthood may now be considered more a matter of choice.
- There were more than 4 million births in the United States in 2004.
- Both fertility and birthrates vary across such social and demographic characteristics as race, ethnicity, education, income, and marital status.
- A record number of unmarried women gave birth in 2004. There were nearly 1.5 million nonmarital births, representing 36% of all 2004 births.
- Between 8% and 9% of women 15–44 have an "impaired ability" to have children. Between 7 and 8% of couples are involuntarily childless. Each year, more than 2 million couples seek assistance for problems of infertility.
- Estimates suggest that between 6.6% and 9.3% of women of childbearing age do not expect to have children.
- A common pattern leading couples to child-free lifestyles is to initially postpone having children for a definite period, when that time lapses to extend it indefinitely, and ultimately to perceive more advantages than disadvantages to remaining childless.
- Even with greater acceptance of voluntary childlessness, women and men who forego parenthood experience social pressure to justify or change their statuses and suffer from negative stereotypes.
- The pattern of delaying or deferring parenthood is increasingly common.
- Having children both at younger and at older ages exposes women to greater health risks.
- Between 1990 and 2000 the pregnancy rate declined for unmarried and married women. Pregnancy rates are highest among 20- to 24-year-old women, followed by 25- to 29-year-old women.
- Teen pregnancy rates declined through the 1990s and in the first years of this century.
- Of the more than 6 million pregnancies in a year, there were more than 4 million births (63% of pregnancies), 1.3 million abortions (20% of pregnancies), and 1 million stillbirths or miscarriages (17%).
- Nearly a quarter of pregnancies carried to full term are unplanned. Babies born from unplanned pregnancies face greater health and social risks, and their mothers have greater risks of postpartum depression.
- A couple's relationship is likely to undergo changes during pregnancy, especially if the pregnancy was unanticipated. Both partners may have fears about the baby's well-being, the birth, their ability to parent, and how the baby will affect their relationship.
- Although indirectly and vicariously, men are affected by a partner's pregnancy. Men's involvement in the pregnancy and birth process may affect their later parenting.
- Feelings about sexuality are likely to change during pregnancy for both women and men. Sexual activity is generally safe during pregnancy unless there is a prior history of miscarriage, bleeding, or pain.
- Critics have alleged that the *medicalization of childbirth*—making this natural process into a medical "problem"—has caused an overdependence on technology and an alienation of women from their bodies and feelings.
- Research with new mothers documented positive experiences and assessments of treatment and care received.
- Miscarriages are the most common form of pregnancy loss. Most occur early, during the first trimester; only 3% occur after the 16th week of pregnancy.
- *Infant mortality* rates in the United States are higher than in other industrialized nations. Loss of pregnancy or death of a young infant is a serious life event, although pregnancy loss is often met by silence.
- Birth may be an occasion where women "do gender" as they attempt to maintain the niceness and politeness of femininity despite the physical and emotional stress of childbirth.
- According to the U.S. Census Bureau the more than 2 million adopted children, 2.5% of all children living with a parent. They are more likely to be female, are economically better off than those living with biological parents and, racially, adopted children are more likely to be African American or Asian compared to children who live with biological parents.

- Adoptive families face unique problems and stresses; nevertheless, most report feeling greatly enriched.
- The transition to parenthood is unlike other role transitions. It is irreversible and sudden, and it comes with little preparation.
- Reduced sexual desire and depression during the *postpartum period* are among the potential problematic reactions to childbirth. Teenage mothers are much more likely than adult mothers to suffer from postpartum depression.
- Parental roles can create considerable and multiple stresses. Both mothers and fathers face multiple role demands (parent, spouse, and provider). Other sources of stress are associated with not having enough money; worries about infant care and health; and interactions with spouse, family, and friends. The *continuous coverage* that infants require also introduces stress and potential conflict into the lives of new parents.

Key Terms

child-free marriages 364
continuous coverage system 382
couvade 371
crude birthrate 362
fertility rate 362
infant mortality 373
medicalization of childbirth 370
open adoption 377
postpartum period 379
spontaneous abortion 372
sudden infant death syndrome (SIDS) 373
total fertility rate 362

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