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AGGRAVATION OF BABY BLUES SYMPTOMS AND ATTACHMENT STYLE IN MARRIAGE

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Purpose: The aim of the article is to present one of the most common disorders of the postpartum period, which is baby blues, and the quality of relationships in a marital relationship as a predictor of the severity of the symptoms of this disorder.
Design/methodology/approach: The study presents the results of research based on the analysis of dependencies between the aggravation of baby blues symptoms and attachment style in marriage. A group of 75 women who had given birth within less than six months took part in the study, which utilised Plopa's Questionnaire of Attachment Styles (KSP) and a Questionnaire on the Aggravation of Baby Blues Symptoms (KNOBB).
Findings: The study confirmed a negative relation between a secure attachment style and the intensification of maternal blues symptoms, and a positive relation where the anxious-ambivalent style is considered. The highest degree of correlation between attachment styles and postpartum blues symptoms was observed with respect to the social sphere and, further, to the emotional sphere and maternal role competence.
Practical implications: The results presented point to the significance of the relationship with the life partner (father of the child) as an adjustment resource. The knowledge gained may serve for practitioners who develop informational, preventive and intervention programs for women who experience difficulties in adjusting to parenthood.
Originality/value: The problem of postpartum disorders fits into the general category of mental health. Dealing with it is important from the standpoint of proper diagnosis and treatment. The presented content is intended to raise the level of social awareness and inspire to search for other factors important from the point of view of the process of adapting to the maternal role.

Keywords: maternal blues in women, baby blues, maternity, attachment style.

1. Introduction

From the life-span developmental perspective, giving birth to a child and taking on a parental role is treated as a natural subsequent stage of a long-term developmental process. It is one of the developmental tasks that are typical of early adulthood. The personal and social significance of this event and the series of changes arising from it altogether enable us to categorise childbirth as an event of fundamental significance, referred to in psychology as a developmental crisis or critical event (Kubacka-Jasiecka, 2010; Trempała, 2011). As a turning point of major importance from the perspective of an individual woman's lifetime, maternity is a series of strongly emotional experiences incomparable to any other, which fits into the woman's course of life as an event that is an expected watershed moment in its nature (Budrowska, 2000; Bartosz, 2002; Kuryś, 2010). Since it radically destabilises how an individual functions in their environment and requires mental adjustment, it is also described as a readjustment life event (Sobolewski, Strelau, Zawadzki, 1999). The sudden transformation into a different role than the one fulfilled up to a given moment always yields a spectrum of diverse and often ambivalent experiences, the intensity and complexity of which is determined by the novelty of the situation (Mercer, 1986; Deave, Johnson, Ingram, 2008; Kuryś, 2010; Javadifar et al., 2016).

The disruptive nature of childbirth is emphasised especially when it concerns the birth of the individual's first child, which involves the transition to parenthood (i.e. a transition from a married to a parental couple) (Matuszewska, 2003; Kornas-Biela, 2009; Plopa, 2011; Bakiera, 2013)[1]. It is in that moment that the dynamic of developmental changes is the highest, and the experiences that accompany them are the most difficult, as evidenced by mothers' and fathers' reports alike (Matuszewska, 2003; Nyström, Ohrling, 2004; Deave, Johnson, Ingram, 2008; Plopa, 2011; Sousa e Silva, Carneiro, 2014). Most first-time parents experience difficulties relating to their lack of knowledge of various aspects of parenthood. This especially pertains to the rules and requirements of daily childcare and (with time) the necessity of taking routine action oriented at satisfying the infant's needs (Turner, Helms, 1999; Fillo et al., 2015). Especially in mothers' perception, this leads to them feeling that they have a limited ability to enjoy free time, and, consequently, feeling tired, tense, and exhausted (Nyström, Ohrling, 2004).

[1] With births of subsequent children, gaining knowledge and embedding behaviours with time becomes a more structured activity, which is favourable for the creation of specific cognitive and action schemes. Thus, subsequent transitions into parenthood should themselves constitute more stable periods of parental functioning and should inhibit the determined functional balance less than the initial transition to parenthood (Matuszewska, 2003).

Even though the (first) child undeniably and fundamentally transforms and restructures the lives of both partners (Belsky, Rovine, 1990; Cowan, Cowan, 2000; Belsky, Kelly, 1994; Ostoja-Zawadzka, 1999; Guttmann, Lazar, 2004; Ahlborg, Strandmark, 2006; Sousa e Silva, Carneiro, 2014), it disproportionately and even more radically disturbs the balance and reorganises the lives of mothers. Women experience a larger number of changes, which are more pervasive for them than for men. We can also observe more areas of life that these changes pertain to, from physical aspects, through different social and professional situations, to the redefinition of the woman's identity (Mercer, 1986; Notman, Lester, 1988; Cowan, Cowan, 2000; Gurba, 2003; Matuszewska, 2003; Kuryś, 2010; Bakiera, 2013; Javadifar et al., 2016). Already when pregnant, women invest more in adjusting themselves to their parental role, anticipating larger changes in many areas of their lives (Pancer, 2000). These changes cause a psychological transformation which results in a specific attitude that is necessary for the development of a mother identity together with emotions and behaviours related to maternity (Cowan, Cowan, 2000). The woman's desire to go through this transformation and become a mother may be strong and deeply felt, but may, simultaneously, give rise to concern and ambivalence towards the impending changes. Prospective mothers therefore experience a range of positive emotions, but also feelings of anger, fear, sadness, or hostility (Trad, 1990). In the first moments after giving birth, happiness, elation, relief, calm and interest in the newborn child are accompanied by fatigue, pain, fear, and sometimes also a feeling of guilt if a child is born ill or premature (Ronin-Walknowska, 2010). We may thus see that there are two sides to the challenges a new mother has to face. On the one hand, adjusting to changes initiated by childbirth is a positive disintegration (Kornas-Biela, 2009) that improves the general wellbeing of an individual and also that of a married couple, and leads to a new quality of attitude towards oneself, others, and the world; on the other hand, the adjustment in question is a source of problems and difficulties, being also one of the most stressful and demanding changes in one's life (Alizade, 2006; Kubacka-Jasiecka, 2010; Kuryś, 2010; Fillo et al., 2015; Deave, Johnson, Ingram, 2008).

The relationship between women's wellbeing and mental health, and their sex and gender roles has been empirically confirmed (Russo, Green, 2002). Therefore, stress is closely related to the role of a mother, and is an integral element of the maternal experience through various stages of a child's development (Mercer, 1986; Deave, Johnson, Ingram, 2008). Women are particularly vulnerable to its consequences during the postpartum period, which is a period of dynamic morphological and functional changes in a woman's body that occur six to eight weeks after childbirth (Ronin-Walknowska, 2010).

Pregnancy and childbirth have an immense impact on the body and mentality of new mothers, making them less mentally resilient and more prone to stress. Potential stressors that women experience in early maternity include the biological changes in their bodies, such as the somatically burdensome physical effort of labour and delivery, sudden hormonal changes, lactation, breast engorgement and related ailments, as well as fatigue, lack of sleep or changing

circadian rhythms. Another group of (mental) stressors covers women's emotional lability, irritability, breastfeeding stress and anxiety, as well as changes in how women experience events, and changes pertaining to their sexuality. In turn, social stressors result from the necessity to take on new responsibilities, a new role in the family, and the mothers' social, financial, and professional situation (Makara-Studzińska, Prażmowska, Iwanowicz-Palus, 2009; Krzyżanowska-Zbucka, 2010).

The emotions experienced in early maternity are also the effect of the inevitable confrontation with the applicable archetype of the woman as a mother (Alizade, 2006). The degree in which society values maternity affects how mothers are perceived by women and how other people react to them (Redshaw, Martin, 2011). Culturally, maternity is treated as a nominal trait of a woman, a condition of deeming her (socially) normal. As an expression of social ennoblement, it is, therefore, a kind of pressure that allows women to enjoy social life, support, and privileges (Budrowska, 2000). At the same time, Budrowska (2000) observes that maternity is often glorified, both in media and intergenerational discourse. This is because it is a common conception that women do not have significant difficulties in fulfilling themselves in the role of a mother due to the fact that having a child is biologically natural for them (Bielewska-Batorowicz, 2006). In line with generally understood criteria, maternity involves ensuring love and reliability, maintaining the child's trust, meeting their needs with affection, and being constantly available for them at one's own cost (Alizade, 2006). Consequently, the expectations and mental pictures that new mothers have with respect to maternity are often far removed from their real experiences. Each pregnancy and childbirth are different, as are the situations respective families find themselves in. These discrepancies affect experiences in early parenthood (Lilja, Edhborg, Nissen, 2012). Comparing one's situation after childbirth with an idealised image of maternity circulated in the media may lead to disappointment and frustration (Krzyżanowska-Zbucka, 2010). Studies show that the inadequacy of expectations with respect to real parental experiences increases depressive symptomatology and causes worse adjustment in the relationship (Harwood, Mc Lean, Durkin, 2007).

The social pressure for manifesting solely the positive emotions towards a newborn baby might render it impossible for women to express contrary and ambivalent impulses, as such are regarded as unacceptable and improper for new mothers (Trad 1990). It turns out, however, that these are common, and sometimes regarded as normative due to their frequency.

The most considerable emotional changes occur in the first few days and weeks after childbirth. In this period, the risk of serious mental disorders, and especially that of emotional disorders of various intensity, becomes several times higher (Wasielewska-Pordes, 2000; Makara-Studzińska, 2009; Krzyżanowska-Zbucka, 2010; Ronin-Walknowska, 2010). A postpartum emotional change may display itself as an innocuous and temporary depressed mood but may also amount to a permanent disorder or even mental illness.

Interest in postpartum mood disorders is nothing new. Instances of such disorders have been indicated already in antiquity, thereby conditioning the historically grounded perception of women as beings that are at the mercy of their fluctuating reproductive cycle. The 19th century saw first scientific studies devoted to postpartum mood disorders (Snow, 2010), whereas the 1980s were a decade of growing interest in women's mental health during pregnancy, childbirth, and the postpartum period (Hanley, 2009). Brockington (2004) listed over 30 different postpartum disorders. It is generally assumed that disorders related to pregnancy and childbirth are those mental changes that occur up to one year after childbirth, although such changes are sometimes diagnosed after a longer period (Hanley, 2009). Postpartum mental disorders are most often distinguished into three categories, by type, intensity, and symptom duration: baby blues (25-85%), postpartum depression (10-20%), and psychosis (0.1-0.25%) (Makara-Studzińska, 2009).

The most common and most observed disorder is baby blues, also called postpartum or maternity blues. On average, it is experienced by 80 to 85% of mothers (Wasielewska-Pordes, 2000; Henshaw, Foreman, Cox, 2004; Burt, Hendricks, 2005). The term describes a mild self-limiting affective disorder, which is, as such, a part of the woman's physiological reaction to childbirth. It is sometimes treated as the final response to the stressful situation of pregnancy and childbirth. Baby blues develops between the first and the fourteenth day after pregnancy, reaching its peak by day 3 to 7. It lasts around ten days to two weeks, and sometimes a month (Krzyżanowska-Zbucka, 2008), although some women experience baby blues for as long as three months (Jaeschke, Siwek, Dudek, 2012).

Clinically speaking, baby blues is a subdepressive mood. Epidemiological studies show that typical symptoms include: a mild depressive mood, tearfulness, emotional lability, hypochondriactic attitude, fatigue, lack of energy, sadness, nervousness, irritability, embarrassment, hypersensitivity, a feeling of exhaustion, difficulties sleeping, loss of appetite, difficulties related to concentration, memory and logical thinking, confusion, feeling of being lost, concern, incorrect interpretation of children's behaviours, and sometimes the loss of interest in the child and a feeling of hostility towards the husband. These symptoms are mild and temporary, often subsiding on their own, and it is most often the case that they do not significantly disturb the manner in which a woman functions. The symptoms may, however, worsen the quality of a woman's life. In such cases, maternity does not yield the natural and expected gratification lying in the pleasure derived from being in contact with the child or breastfeeding. Mothers feel incompetent, lost, "degenerate", and guilty of not feeling the full scope of love towards their baby (Henshaw, Foreman, Cox, 2004; Krzyżanowska-Zbucka, 2008; Makara-Studzińska, 2009).

This state does not require pharmacological treatment. What often suffices is rest, understanding, support from the closest friends and family, and a sense of security provided. Educational efforts covering women and the closest family members serve as the basis of assistance for postpartum blues. The emotional, valuing, or informational support given makes

it possible to reduce the symptoms present or, in other cases, refer mothers to a psychologist. Due to the common nature of baby blues, the relatively small intensity of the condition, and its short duration, it is often neglected by midwifes and even mothers themselves. In general, the rule is to wait the baby blues out. However, the symptoms present should not be ignored, as there is a real risk that they may worsen, leading to a full-blown depression (Krzyżanowska-Zbucka, 2008; Makara-Studzińska, 2009). It has been empirically proven that women who experience extended cases of baby blues are almost three times as likely to fall into postnatal depression (PND), with depressive symptoms being more severe and lasting longer (Lilja, Edhborg, Nissen, 2012). 20% of women with baby blues go through considerable depression within one year of childbirth (Stewart, Robertson, Phil, Dennis, Grace, Wallington, 2003), which puts at threat the process of developing attachment, and opens up the possibility that the child might not undergo proper social and emotional environment (Makara-Studzińska, 2009; Behringer, Reiner, Spangler, 2011).

Physiological pregnancy and proper child delivery in themselves do not constitute the reason for perinatal mental disorders, although various factors leading to them may arise in their course (Kaźmierczak et al., 2014). The list of obstetric risk factors includes psychiatric conditions (e.g. a personal or family history of mental disorders or alcohol/drug use), factors related to the pregnancy (the pregnancy being unwanted or endangered, traumatic experiences in past pregnancies, difficult birth or birth injury), and psychosocial factors unrelated directly to the pregnancy or childbirth (e.g. dysfunctional family relationships or a poor financial situation) (Krzyżanowska-Zbucka, 2010).

The proneness to develop baby blues is not directly related to the history of mental disorders, environmental stressors, cultural context, or the question of breastfeeding, but these may have effect on whether baby blues leads to significant depression. The largest risk group includes women who tend to cope with events passively, display difficulties in adjusting to and accepting themselves in the role of a mother, plan on returning to professional activity shortly after childbirth, and report a lack of satisfaction in their relationship with their partner (Ehlert, et al., 1990). The applicable psychological and social context determines, after all, the meaning and results of procreative efforts, including the state of the parents' mental health (Russo, Green, 2002).

Researchers have indicated that the marital relationship/partnership is one of the potentially sensitive areas that modify the process of adjusting to maternity, including the issue of perinatal mood disorders (Green, Kafetsios, 1997; Pilkington et al., 2015). This is illustrated by, among others, Jay Belsky's process model of determinants of parenting, and Christoph M. Heinicke's parenthood model (Kaźmierczak, 2015), both of which treat the quality of marriage as significant as far as functioning as a parent is concerned.

Development-wise, adjusting to changes initiated by childbirth is a sensitive period for the whole family system. Entering into parenthood is one of the most considerable challenges, as childbirth may strongly impact the family dynamic and family ties (Ahlborg, Strandmark,

2006). It is currently assumed that the relationship between the quality of parenthood and that of marriage is circular in nature. The manners in which the man and woman function in both subsystems at the same time are interdependent, and affect the development of the child. Satisfying relations between spouses serve as the foundation for the family, and are a necessary resource in coping with the requirements of parenthood (Plopa, 2005, 2011; Bakiera, 2006).

How parents cope with the new situation is directly related to mutual attachment, treated as one of the psychological dimensions that describe the subjective assessment of a marriage. Attachment is defined as a state where a person experiences a strong desire to remain close in contact with another, specific individual (Plopa, 2005). Referring to John Bowlby's theory (2007), we have to assume that the ability to create close relationships and emotional ties lies in the nature of every human being, and attachment in childhood is, in itself, a matrix of ties manifest in adulthood (Rostowski, 2003; Plopa, 2005; Józefik, Iniewicz, 2008; Liberska, Suwalska, 2011). The subject of attachment in adults are, most of all, spouses. Attachment displays itself most often when adults experience intense emotions and stress (Marchwicki, 2004), childbirth being an example of such a situation.

Cindy Hazan and Phillip Shaver (1987) (Rostowski, 2003; Liberska, Suwalska, 2011) observed analogies between attachment relations in childhood and adulthood, determining relations in romantic relationships that are key for attachment theory. Focusing on the emotional and behavioural aspect, like Ainsworth, they distinguished the following attachment styles: secure, anxious-ambivalent, and avoidant.

From the perspective of changes initiated by childbirth, it is assumed that the secure attachment style allows treating the relationship between the partners as a resource that facilitates adjusting oneself to the applicable critical event. This adjustment is easier when the relationship is based on the feeling of security, trust and self-confidence, when it is characterised by a high degree of openness, affection, good communication and satisfaction derived from the relationship with the partner, who is seen as available and supportive in difficult and highly significant situations. In turn, as can be assumed, this adjustment is much more difficult if the relationship is based on the lack of security, as is the case with the anxious-ambivalent attachment style. This style is characterised by worrying about such matters as sustaining the relationship and losing the partner. Experiencing an excessive need to be close to the partner causes the individual to idealise their environment and set unrealistic expectations. In situations where they are distant from their partner, they excessively experience jealousy, suspicion, anger, sadness, and fear. They display strong and ambivalent tendencies for controlling their own emotions, and, at the same time, exaggeratedly engage themselves in the relationship. For them, love is obsessive in nature. It is characterised by expectations of unity and unconditional reciprocity. Difficulties in adjustment to parenthood may also be expected where the relationship is based on the lack of tendency to develop close and open relationships with the partner, which is what characterises the avoidant attachment style. The source of mental comfort in this style is a clear delineation of boundaries (also with respect

to intimacy and emotionality), the lack of which causes irritation and embarrassment. Distance in the relationship is reflected by the need to have rational and controlled communication, deprived of spontaneity and openness to intimate dialogue (Plopa, 2005, 2005a, 2008, 2014; Łoś, 2010; Byra, Parchomiuk, 2015).

Based on the conclusions reached in the studies and the theoretical assumptions, we may therefore assume that there is a significant relation between the quality of marriage and how women adjust themselves to the changes initiated by childbirth in the very earliest phase of maternity (i.e. the postpartum period). Aggravation of baby blues symptoms is considered here as an indicator of adjustment to changes (dependent variable), while the attachment style in marriage is the indicator of marriage quality (independent variable). Therefore, the aim of this study is to prove the relationship between the worsening of baby blues symptoms and the various attachment styles in marriage.

2. Methodology of own research and results

75 women in a marital relationship (N = 61; 81.3%) or partnership (N = 14; 18.7%) with their most recent (only or subsequent) child born almost four months before the study (*M* = 3.97 months, *Min* = 0.40; *Max* = 6.00, *SD* = 1.66) took part in the research. These were mothers of either one child (N= 48; 64%) or from two to five children (N = 27; 36%). The vast majority of them (N = 67; 89.3%) planned their most recent pregnancy and considered their wellbeing during pregnancy to have been good or average (N = 72; 94.7%), giving a similar assessment with respect to labour and delivery (N = 63; 84%). The average age in the test sample was *M* = 29.6 years (*Min* = 22.00; *Max* = 42.00, *SD* = 4.10). The study participants were well educated, with three in four (N = 57) having obtained a tertiary degree. The women were inhabitants of cities (N = 59; 78.7%) and rural areas (N = 16; 21.3%) of the Upper Silesian Urban Area, which was the area where the study was conducted.

The scientific tools used were for the purposes of this research were the Questionnaire of Attachment Styles (*Kwestionariusz Stylów Przywiązaniowych* or *KSP*) as devised by Mieczysław Plopa (2005, 2008), and the Questionnaire on the Aggravation of Baby Blues Symptoms (*Kwestionariusz Nasilenia Objawów Baby blues* or *KNOBB*). KSP consists of 24 statements which include subscales (8 items each) for the respective three attachment styles (secure, anxious-ambivalent, and avoidant). The reliability of the questionnaire was determined by measuring its internal consistency with Cronbach's alpha, which amounted to 0.729-0.845, depending on the attachment style. *KNOBB*, in turn, consists of 36 self-assessment statements which include subscales (12 items each) for three areas: the emotional sphere, the social sphere, and maternal role competence. These statements describe feelings, attitudes and behaviours of mothers present within a few weeks after delivery. The reliability of the questionnaire was

determined by measuring its internal consistency with Cronbach's alpha, which amounted to 0.915-0.923, depending on the areas of baby blues symptoms, and to 0.963 for the general score. A personal questionnaire was used to obtain details on the social, demographic, and procreative situation of the participating mothers.

IBM SPSS Statistic 22 was used for statistical calculations. To verify whether the variables are characterised by normal distribution, the Kolmogorov–Smirnov test was carried out. The results show that secure and anxious-ambivalent attachment styles have normal distribution as variables (from $p < 0.060$ for the secure style to $p < 0.064$ for anxious-ambivalent), whereas the other variables are not characterised by normal distribution. Because of this, further analyses were carried out using nonparametric statistical methods, and the Spearman's rank correlation test was applied. All results with a bilateral significance of $p < 0.05$ were deemed statistically important. Those in the range of $p < 0.051$ to $p < 0.09$ were considered as being within the statistical trend.

3. Research results and discussion on the results

The results of this research are presented in the Tables below.

Table 1 contains results illustrating the relation between the secure attachment style and the worsening of baby blues symptoms.

Table 1.
The relation between the secure attachment style and the aggravation of baby blues symptoms (N = 75)

Worsening of baby blues symptoms	**r_s**	**p**
Emotional sphere	-.256	.027
Social sphere	-.486	.000
Maternal role competence	.227	.050
General score	-.348	.002

A statistically significant relation between the secure attachment style in marriage and the aggravation of baby blues symptoms has been evidenced. There is a low correlation between the attachment style and symptoms regarding the emotional sphere and maternal role competence, as well as for the general score. A medium correlation with respect to social (relationship-related) sphere can be observed.

Table 2 contains results illustrating the relation between the anxious-ambivalent attachment style and the worsening of baby blues symptoms.

Table 2.
The relation between the anxious-ambivalent attachment style and the aggravation of baby blues symptoms (N = 75)

Worsening of baby blues symptoms	**r_s**	**p**
Emotional sphere	.468	.000
Social sphere	.629	.000
Maternal role competence	.412	.000
General score	.553	.000

A statistically significant relation between the anxious-ambivalent attachment style in marriage and the aggravation of baby blues symptoms has been evidenced. There is a moderate correlation between the attachment style and symptoms regarding the emotional sphere and maternal role competence, as well as for the general score. A high correlation with respect to social (relationship-related) sphere can be observed.

Table 3 contains results illustrating the relation between the avoidant attachment style and the worsening of baby blues symptoms.

Table 3.
The relation between the avoidant attachment style and the aggravation of baby blues symptoms (N = 75)

Worsening of baby blues symptoms	**r_s**	**p**
Emotional sphere	.445	.000
Social sphere	.653	.000
Maternal role competence	.410	.000
General score	.540	.000

A statistically significant relation between the avoidant attachment style in marriage and the aggravation of baby blues symptoms has been evidenced. There is a moderate correlation between the attachment style and symptoms regarding the emotional sphere and maternal role competence, as well as for the general score. A high correlation with respect to social (relationship-related) sphere can be observed.

The results obtained confirm the correlation between the quality of marriage and the worsening of baby blues symptoms, a correlation made by the women participating in the study through a subjective assessment. In line with the assumptions, it has been shown that women with high scores for the secure attachment style experience baby blues symptoms in a less aggravated way than those whose attachment style is non-secure. For them, high scores for the anxious-ambivalent and avoidant attachment styles are positively correlated to a high degree of aggravation of baby blues symptoms in all three highlighted aspects of functioning (i.e. the emotional sphere, the social sphere, and maternal role competence) as well as with respect to the general score. Thereby, the value of marriage as a resource that makes it easier to adjust to changes caused by childbirth has been confirmed. The new mothers' experiences of postpartum blues symptoms are lesser in relationships that are based on the feeling of security and satisfaction derived from the partner being available, especially in situations which are seen

as fundamental and difficult. Mutual openness, affection, and support lower the tension, facilitating the adjustment to changes that occur. The lack of security that is common for the other (anxious-ambivalent and avoidant) attachment styles enables, in turn, the aggravation of baby blues symptoms.

The Results of research available in the literature show links between attachment styles and ways of coping in difficult situations. Adults who display a secure attachment style have the competences to cope with emotional difficulties more efficiently. Especially in women, the activation of this attachment style manifests itself in having more thoughts about intimacy and love, which builds up the feeling of autonomy and independence, as well as lowers stress levels. In turn, the anxious-ambivalent attachment style involves a passive way of coping with stress, which is concentrated on emotions and the internal experience of distress. This manifests itself in negative ruminations, emotions, and memories. This attitude fosters the conviction of not being accepted by others, and intensifies the pressure related to the emotions felt (Mikulincer, Orbach, 1995). Anxiety related to abandonment stops the development of autonomy and leads to a dependent attitude. Consequently, the marital relationship and family do not constitute a source of satisfaction and self-esteem. This makes it more difficult to take on and fulfil developmental tasks (Kozińska, 2013). Women with the avoidant attachment style display a mechanism of compulsive self-reliance. They emphasise their autonomy at the cost of rejecting support and relationships based on closeness and love. They tend to stifle and force out pessimistic thoughts, depreciate the role of the stress source, and inhibit the expression of bleak experiences. At the same time, they present a heightened level of anxiety and a considerable feeling of loneliness (Kozińska, 2013). They do not have a non-ambiguous and consistent way of coping, particularly with respect to negative emotions and stress. They may display ambivalence towards others (aggressiveness or withdrawal), and are especially prone to disorders and dissociation (Żechowski, Namysłowska, 2008). Those who are characterised by a non-secure attachment style tend to process information negatively (i.e. read more negative than positive signs, and expect more negative social interactions) (Dykas, Cassidy, 2011). This seems to explain why they tend to experience baby blues symptoms, especially with respect to their emotions and the way they function in a relationship.

Among the three areas distinguished, in which baby blues symptoms become manifest, relatively the strongest links have been observed between both the secure and the non-secure attachment styles and the social (relationship-related) sphere, with correlations being moderate and high, correspondingly. This sphere describes the experiences of the new mother in relationships with the people closest to her, and especially with her partner, the father of the child. Contrary to women with a secure attachment style, those with a non-secure (i.e. anxious-ambivalent or avoidant) style view their partners as unsupportive and unwilling to understand and empathise with them to a larger degree. In their perception, these partners are responsible for their malaise, and are insufficiently engaged in nursing and caring for the child. Mutual relations are seen as strained, with quarrels and misunderstanding being more likely to

arise. There is distance and lack of interest regarding intimate relations, and a sense of lower physical attraction. The non-secure attachment style is also correlated with the aggravation of those symptoms that pertain to the mothers' relationships with other people from their closest environment. The mothers in question are more irritated by visits from guests and interferences in childcare on the part of their family members (e.g. their mother or mother-in-law). They also feel not understood by their closest friends and family members, and overburdened by domestic responsibilities. Apart from the social sphere, statistically significant correlations for all three attachment styles have also been observed with respect to the emotional sphere and maternal role competence. It has been shown that non-secure attachment styles cause certain symptoms to manifest themselves in a more aggravated manner. These include: lack of optimism and hope for the future, withdrawal into oneself, feeling of loneliness, sadness and blues, apathy and indifference, concern and anxiety, tearfulness, fear, unsubstantiated panic, tiredness and fatigue caused by day-to-day responsibilities, irritability, emotional lability, and a lack of control over one's life. In turn, with respect to maternal role competence, women with an anxious-ambivalent or avoidant attachment style indicated greater difficulties in adjusting to the role of the mother. The participants experienced helplessness and doubt regarding their ability to nurse and care for their baby. They also had lower self-esteem, and a lower perception of their resources and competences. They miss the life before pregnancy, show a lack of the expected happiness and satisfaction derived from taking on a maternal role, and experience difficulties in establishing contact with the child, as well as reflecting and understanding their needs and emotions. They are also more worried about their child's wellbeing – this being connected to the feeling of guilt that they are not sufficiently good as a mother, not as good a mother as others.

Researchers who have preoccupied themselves with attachment show that the attachment style has an impact on the perception of parenthood and on satisfaction derived from it (np. Lubiewska, Derbis, 2016). Women with an anxious attachment style derive less satisfaction from being a parent (Kohn et al., 2012). Both during pregnancy and within one year from giving birth, they experience considerable stress and worry about their child, as do women with an avoidant attachment style, who also see high parental stress (Trillingsgaard et al., 2011). Women with a developed secure style have it easier to accept the fact that they become mothers and to adjust to changes arising from that role (Chrzan-Dętkoś, Łockiewicz, 2015). There is furthermore evidence confirming a neurobiological basis that differentiates women and their relations with their child by attachment style (Zdolska-Wawrzkiewicz, Bidzan, Chrzan-Dętkoś, 2018).

Researchers are more and more often taking interest in the subject of attachment in reference to procreation, also in the context of romantic relations (Zdolska-Wawrzkiewicz, Bidzan, Chrzan-Dętkoś, 2018). The results presented in this article point to the significance of the relationship with the life partner (father of the child) as an adjustment resource. Women's perception of their relationship as based on security is a factor that facilitates

adjustment to parenthood. Considering the context of the quality of marriage is incredibly important in the early stages of transition to maternity. This is because the partner plays a significant role in generating and mitigating postpartum disorders. The quality of the relationship may therefore be treated as a factor that allows predicting baby blues symptoms. As indicated in reference books, the intensity and duration of those symptoms is key for the emerging relationship between the mother and the newborn, and determines both the presence of postpartum depression and (*vice versa*) the quality of the relationship (Chrzan-Dętkoś, Kalita, 2019; Bakiera, 2006).

The knowledge gained may serve for practitioners who develop informational, preventive and intervention programs for women who experience difficulties in adjusting to parenthood, pointing to areas of the relationship with the partner that require more attention and potential changes. At the same time, it shows that early maternity is a time where women give themselves the right to emotional ambivalence, and do not try to build their own image based solely on an idealised picture of the maternal role, free of any weaknesses or flaws.

The problem of postpartum disorders fits into the general category of mental health. Dealing with it is important from the standpoint of proper diagnosis and treatment. The basis for potential efforts lies, however, in proper education that raises social awareness of how common the difficulties experienced are, and in the search for factors that are important when it comes to women's adjustment to the maternal role.

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