ISSN: 2643-6892
Iris Journal of Nursing & Care
DOI: 10.33552/IJNC.2025.05.000611
Iris Publishers

Research Article

Copyright © All rights are reserved by Minoru Kabashima

Parents' Coping Processes for Infant Nighttime Crying in Japan: A Grounded Theory Approach Based on Maternal Perspectives

Minoru Kabashima*

Faculty of Nursing, Josai International University, Japan

***Corresponding author:** Minoru Kabashima, Faculty of Nursing, Josai International University Gumyo, Japan

Received Date: January 30, 2025

Published Date: February 07, 2025

Abstract

Objective: Nighttime crying during infancy poses significant challenges for parents, leading to anxiety, uncertainty, and frustration in mothers, while fathers may resort to shaking their children in despair, increasing the risk of abuse. While individual coping strategies have been documented, the specific processes that parents use to navigate and overcome nighttime crying remain unclear. This study aimed to explore how parents cope with and adapt to this issue.

Methods: Data were collected through semi structured interviews with 15 mothers of infants aged ≥5 months who demonstrated nighttime crying, residing in Tokyo and Chiba in Japan. Participants described their responses to nighttime crying and changes in their marital relationships or roles before and after its onset. A grounded theory approach was adopted, utilizing coding and comparative methods.

Results: Parents' coping processes for nighttime crying emerged in the following themes: (1) preparation and practice of coping strategies, (2) division of roles between partners, (3) utilization of external support and social resources, (4) psychological and physical burdens on mothers, (5) mothers' conflict toward fathers, (6) mutual understanding between spouses and support from fathers, and (7) overcoming nighttime crying, leading to family growth and change. Recognition of differences between spouses emerged as a key factor in the coping process, influencing how couples managed these challenges.

Conclusions: Marital differences shaped the division of roles and increased the psychological and physical strain on mothers at the onset of nighttime crying. However, navigating maternal emotional struggles and engaging in communication fostered deeper mutual understanding within couples and enhanced paternal support. Ultimately, couples overcame nighttime crying challenges, contributing to both personal and familial growth.

Keywords: Nighttime crying; Parents' coping; Maternal and child health; Grounded theory approach

Introduction

Infant nighttime crying refers to episodes of excessive crying or frequent awakening during the night in infants, and poses a common challenge for parents in the early stages of child-rearing [1,2].

It is also defined as "episodes of inconsolable crying and fussing during the night in otherwise healthy infants, often occurring at the same time every night, intermittently, or throughout the night for no apparent reason" [3].

This work is licensed under Creative Commons Attribution 4.0 License

By approximately six months of age, most infants develop self-soothing abilities that allow them to return to sleep independently after naturally occurring nighttime awakenings [4]. However, 20–30% may experience difficulties falling and staying asleep during their first year [5-10]. In Japan, the prevalence of such issues is estimated to be 30–40% [11,12].

Nighttime crying has significant implications for both infants and their parents. In infants, persistent nighttime crying is associated with adverse emotional, social, cognitive, and behavioural developmental outcomes [13-15]. Parents may experience sleep disruption, fatigue, and a reduced capacity to provide effective care [9,16]. Furthermore, it is linked to poor maternal mental health outcomes, including depression and physical exhaustion [17-19]. Fathers also face stress related to caregiving, which is associated with an increased risk of child maltreatment [20,21]. Thus, addressing the impact of nighttime crying on both parents and developing strategies to mitigate its effects are critical.

Several intrinsic infant factors have been identified as potential causes of nighttime crying, including sensitivity to cow's milk protein [22,23], difficult temperament [24], developmental maturation, and certain medical conditions [25]. Behavioural strategies such as graduated extinction (wherein parents progressively delay their response to the infants' crying) and establishing positive bedtime routines have been shown to be particularly effective in managing sleep issues in children aged six months and older [26,27]. These strategies—collectively referred to as "sleep training"—aim to promote independent sleep initiation in infants [28]. Their benefits include improved daytime functioning (e.g., reduced crying and better mood) in children, and enhanced mood and stress levels, improved sleep quality, and increased marital satisfaction in parents [29,30].

However, given the complexity of the causes of nighttime crying, it is unlikely that any single intervention can completely resolve it. Although various coping strategies such as behavioural approaches have been examined, their effectiveness remains inconsistent and inconclusive. Therefore, understanding how parents cope with nighttime crying is arguably more important than attempting to eliminate it entirely because nighttime caregiving often falls solely on parents who typically lack external support during these hours. Despite the importance of this issue, research focusing specifically on parents' coping processes is scarce. Gaining insights into these processes could enhance our understanding of parenting dynamics and the roles within family structures.

This study aims to explore how mothers and fathers in Japan cope with infant nighttime crying, with a particular focus on the strategies and processes employed. By shedding light on these coping mechanisms, this research seeks to contribute to the fields of maternal and child health, and family nursing, by providing new insights to support parenting and strengthen spousal support.

Materials and Methods

Design

This study adopted the grounded theory approach (GTA) developed by Corbin and Strauss [31]. Understanding the evolution of parents' coping mechanisms as they navigate and manage nighttime crying requires an analysis of their interactions within the caregiving context. Grounded theory—rooted in symbolic interactionism—is designed to explain psychosocial processes and was thus deemed an appropriate methodological framework for this study.

Sample and recruitment

Mothers of infants aged 5 months or older who had experienced nighttime crying and resided in Tokyo or Chiba, Japan were considered. Based on previous studies indicating that nighttime crying typically begins around 5–6 months of age, the target group was defined as "mothers with infants aged 5 months or older" and nighttime crying was defined as "crying that starts suddenly in the middle of the night with no identifiable cause, does not stop, and is not followed by immediate sleep."

Participants were recruited using purposive and snowball sampling methods. For purposive sampling, posters detailing the study's purpose and outline were displayed at health centres and commercial facilities in Tokyo and Chiba. Mothers who met the inclusion criteria were invited to participate. Additionally, participants were encouraged to introduce others who might meet the criteria and provided with an email to share that explained the study.

Recruitment continued until data saturation, defined as the point at which no new information emerged from the data. Of the 15 mothers approached, all agreed to participate. The researcher had not personally engaged with any of the participants prior to the interviews.

Data collection

Between April 2020 and March 2022, the researcher conducted individual semi-structured interviews, either face-to-face, in a designated room at the researcher's facility, or online via conferencing platforms such as Microsoft Teams or Webex Meetings, partly because of COVID-19 restrictions. In both face-to-face and online settings, privacy was carefully maintained to ensure that neither the participant nor the interview content could be overheard by third parties. Only the participant and the researcher were present during the interviews.

Each participant was interviewed once, with each session lasting approximately one hour. Interviews followed a structured guide, beginning with questions regarding participants' demographic =characteristics (e.g., age, number of children, age in months of the infant at nighttime crying onset, and marital status). The discussion then transitioned to questions such as, "Can you describe the situation when the crying started?" and "What led you to identify the crying as nighttime crying?" When necessary, additional questions were asked to clarify or deepen participant responses, while ensuring alignment with the research objectives.

As the study progressed, the interview guide was revised and refined based on the emerging theories and key categories identified by the researcher. Throughout the interviews, the

researcher minimized personal input to encourage participants to express themselves freely. Observational notes were taken to capture participants' physical appearances and facial expressions, alongside the researcher's reflections on the interview process.

All interviews were recorded using a digital voice recorder. Efforts were made to enhance reporting quality by adhering to the Standards for Reporting Qualitative Research (SRQR).

Data analysis

Data collection and analysis were conducted simultaneously. Audio recordings of the interviews were transcribed verbatim to create detailed transcripts. Data analysis followed the GTA outlined by Corbin and Strauss [31] and was performed by one primary researcher and two research assistants.

In the first phase, open coding, the transcripts were carefully and repeatedly reviewed to identify concepts. Data were segmented into meaningful units (fragmentation) and categorized based on their properties and dimensions. Labels that best captured the underlying concepts were assigned to each data segment. Throughout this process, the researcher recorded their insights and reflections in memos that informed subsequent sampling and interview content.

In the second phase, axial coding, the labels developed during open coding were further refined. Similarities and differences among the labels were compared, and the relationships between their properties and dimensions were examined. This process led to the identification of additional abstract subcategories and categories. During this phase, the core category or central theme of the study was identified. All categories and core categories were systematically organized to clarify their interrelationships, and a diagram created.

The data collection and analysis processes were iterative, involving constant comparison of the data, categories, and their interconnections. Data saturation was deemed to have been reached after 15 interviews as no new categories or concepts emerged.

Research rigor

To ensure rigor, we applied the principles of credibility, dependability, confirmability, and transferability outlined by Guba and Lincoln [32]. Credibility was enhanced through member checking, wherein participants reviewed summaries of their responses during and after the interviews to verify the accuracy and validity of the interpretations. Dependability was achieved through collaborative discussions among the research team to resolve discrepancies in coding and ensure consistency in data interpretation. This process was supported by rigorous training in interview techniques and regular peer debriefing. Confirmability was reinforced by external validation: qualitative research experts independently reviewed a sample of the coded transcripts and provided feedback to ensure that the emergent categories aligned with the raw data. Transferability was supported by a detailed description of the research context, including participant demographics, interview settings, cultural considerations, and findings supplemented with verbatim quotes.

Ethics

This study was approved by the Ethical Review Board of the author's affiliated university (07M180010). Participants were fully informed about the purpose and design of the study, their right to withdraw at any time, protection of their personal information, strict handling of data, and use of a digital voice recorder for recording the interviews. Verbal and written consent were obtained from all participants prior to the interviews. Personal data were securely stored in the archives of the researcher's institution to ensure confidentiality and compliance with the ethical standards.

Results

The average (standard deviation [SD]) age of the 15 mothers interviewed was 29.9 (5.1) years. The mean (SD) number of children of the participants was 1.6 (0.6). The mean (SD) age in months of the infants when nighttime crying began was 5.6 (0.6) months. All the participants had spouses (Table 1).

Table 1: Participants Characteristics (n=15).

Age in years, mean ± SD	29.9 ± 5.1
The number of children, mean ± SD	1.6 ± 0.6
Age in month of infant when nighttime crying began, mean ± SD	5.6 ± 0.6
Marital status, n (%)	Married 15 (100%) Single 0 (0%)

SD: standard deviation.

Analysis of the data obtained from the interviews led to the extraction of 7 main categories and 23 subcategories. The core category of the parents' coping processes for infant nighttime crying as perceived by mothers was "Recognition of differences between spouses" (Table 2).

Table 2: Main categories and subcategories regarding parents' coping processes for infant nighttime crying.

Main categories	Subcategories
Preparation and practice of coping strategies	Shifts in mindset and awareness toward nighttime crying
	The need for strategies to address nighttime crying
	Gathering information on nighttime crying solutions
	Conventional caregiving methods for managing nighttime crying
	Adjusting the environment and daily routines to prevent nighttime crying
	Sleep-training as a method to address nighttime crying
	Realization of individualized approaches to nighttime crying
	Tips for implementing nighttime crying strategies
Division of roles between partners	Dividing roles between spouses
	Separate sleeping arrangements for spouses
Psychological and physical burdens on mothers	Anxiety over prolonged nighttime crying
	Stress and physical burden related to nighttime crying
	Mothers feeling overwhelmed by nighttime crying
Utilization of external support and social resources	Utilization and limitations of public support
	Roles of relatives and friends of the mother
Mothers' conflict toward fathers	Expectation toward fathers' understanding
	Disappointment toward uncomprehending fathers
Mutual understanding between spouses and support from fathers	Differences in spouses' perspectives on nighttime crying and parenting approaches
	Solace through differences in spousal personalities
	Communication between spouses leading to the fathers' support
Overcoming nighttime crying, leading to family growth and change	Resolution of managing nighttime crying
	Growth and increased resilience gained from experiencing nighttime crying
	Changes in spousal and family dynamics through nighttime crying experiences

Core category: Recognition of differences between spouses

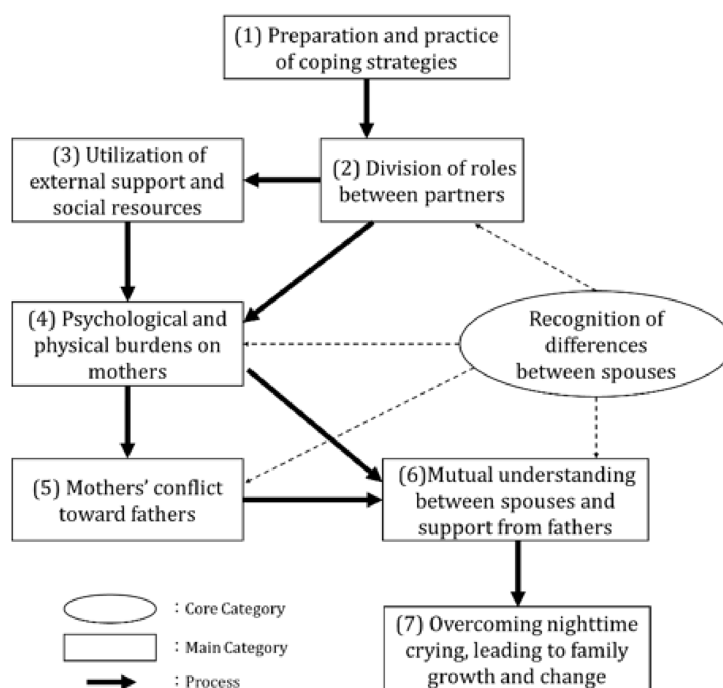

Figure 1: Model of parents' coping processes for infant nighttime crying.

The analysis revealed that the recognition of differences between spouses played a critical role in the coping processes of parents addressing infant nighttime crying (Figure 1). In the early stages of nighttime crying, mothers often assumed responsibility for managing the situation, reasoning that "fathers need to work," "only I can breastfeed," and "it's enough if fathers play with the child or help with household chores." These statements reflect mothers' acknowledgment of differentiated roles within marital partnerships.

However, as the crying episodes became prolonged and increasingly intense, the psychological and physical burden on the mothers grew. This led to conflicting emotions: while they hoped for empathy from their spouses, expressing desires such as "I want him to understand how hard this is for me," they also struggled with scepticism, thinking, "What can a father, who isn't used to dealing with a crying baby, really do?"

The differences between spouses extended beyond role division, encompassing perspectives on nighttime crying, parenting approaches, and personality traits. For instance, while mothers aimed to ensure their child's growth and maintain a consistent routine, stating, "I want to put the baby to bed to avoid disrupting their rhythm" or "I want to follow the parenting guidelines," fathers often adopted a more relaxed attitude, saying, "Let them cry until they're tired from it" or "There's no point in overthinking it."

Through continued communication, these differences became clearer and eventually facilitated improvements in paternal support and marital relationships. Upon recognizing their spouses' distress, fathers demonstrated support by "respecting the mother's efforts," "working together as a couple to resolve the situation," "expressing gratitude," and "soothing the child without being prompted."

Initially, differences between spouses were a source of tension, reinforcing fixed roles and contributing to maternal stress. However, as the coping process unfolded, the partners understood and appreciated each other's perspectives and personalities. Ultimately, this mutual understanding fostered a more collaborative and communicative relationship, wherein the differences between spouses became a source of strength for mothers, driving growth and positive change in the family.

Main category: Preparation and practice of coping strategies

Parents recognized the onset of nighttime crying when a previously well-sleeping child began waking and crying persistently for consecutive nights. During this process, mothers experienced shifts in their mindset and awareness, realizing the need to address the situation. Consequently, they adopted various coping strategies. This category comprises eight subcategories.

Shifts in mindset and awareness toward nighttime crying

At a certain point, infants began to wake and cry during the night or struggled to fall asleep. Initially, mothers attempted to address the crying by resolving its perceived causes, such as changing diapers or breastfeeding. However, when these measures failed to alleviate the crying, mothers' perceptions and preparedness regarding nighttime crying began to shift.

At first, I thought my baby was a relatively good sleeper. But then, at some point, even after breastfeeding or changing diapers, the crying wouldn't stop. The baby just wouldn't sleep. That's when I thought, "Is this what they call nighttime crying? It's finally starting." I remember preparing myself, thinking, "This is going to be harder than I expected."

The need for strategies to address nighttime crying

Although mothers began to adjust their mindset toward nighttime crying, the need to address it was often compounded by their living environment. Mothers, particularly those living in apartments or in close proximity to neighbours, were concerned about the potential for their child's crying to disturb others. One participant shared her experience of receiving complaints from a neighbour.

We lived in an apartment, and with neighbours nearby, I couldn't just let my baby cry it out until they stopped. When we first moved into the apartment, I introduced myself to the neighbour, explaining that we had a small child. They made a displeased face and told me, "I'd be disturbed if it gets noisy." That really stuck with me, and I thought, "I can't cause trouble for them."

Gathering information on nighttime crying solutions

Faced with the challenge of managing nighttime crying, mothers recognized their limited knowledge and began seeking effective solutions. They turned to resources such as books and the Internet to explore causes and coping strategies.

It was harder than I imagined, and I had no idea what to do. I didn't have any ideas, like, "Why are they crying? What should I do?" So, I went to the library to borrow books, used the Internet, and researched the causes and ways to handle nighttime crying.

Conventional caregiving methods for managing nighttime crying

In the early stages of nighttime crying, mothers relied on previously used conventional caregiving methods to soothe their child. These included changing diapers, breastfeeding, holding and walking the baby, singing, or co-sleeping. While both parents could participate in some tasks, such as changing diapers or holding the baby, breastfeeding naturally fell solely to the mother, which often shaped the division of roles within the couple.

Before nighttime crying started, I could usually guess the reason for the crying—whether it was hunger, a dirty diaper, or wanting to be held. But with nighttime crying, none of those worked. So, I tried co-sleeping or breastfeeding while lying down. My husband helped with holding the baby, but breastfeeding was something only I could do. Naturally, putting the baby to bed became my responsibility.

Adjusting the environment and daily routines to prevent nighttime crying

While mothers initially addressed nighttime crying using conventional methods, they also began implementing preventive measures. These included optimizing the sleeping environment by dimming lights and turning off the television, adjusting the infant's daily routine to increase activity during the day (e.g., outdoor play), and establishing bedtime routines such as reading picture books.

I made sure not to let my baby nap after 4 p.m. During the day, we would go out and play as much as possible. Before bedtime, I dimmed the lights and turned off the TV. I tried to eliminate any stimulation that could interfere with sleep.

Sleep-training as a method to address nighttime crying

When conventional and preventive measures failed to improve nighttime crying, some mothers turned to sleep-training techniques inspired by parenting books. These methods included night weaning (avoiding breastfeeding at night), letting the baby cry during the day without immediate intervention, and adjusting the timing of the baby's activities to encourage nighttime sleep.

With my husband's help, we tried night weaning. I breastfed the baby sufficiently before bedtime but avoided feeding them during the night, even if they cried. The first four days were really tough, but by the fifth day, the baby started sleeping. For the next two weeks, they only woke up once or twice a night. That was a huge improvement for us—it felt like a breakthrough.

I couldn't let my baby cry during the night because of the neighbours, so I tried preparing during the day. I let them cry as much as they wanted during the day, waiting until they stopped on their own without breastfeeding or holding them. It was like daytime training to help them sleep through the night.

Realization of individualized approaches to nighttime crying

Through trial and error, mothers eventually discovered their children's specific tendencies and characteristics regarding crying and sleeping. For instance, they noticed patterns such as falling asleep immediately after breastfeeding or being difficult to soothe once they started crying. Based on these observations, mothers adapted their strategies to suit their children's individual needs rather than strictly following parenting guides.

At some point, I realized my baby always fell asleep right after breastfeeding. It hit me—that's their habit. Then I thought, "Maybe they've associated breastfeeding with falling asleep." So, I decided to separate the two—breastfeeding at one time and sleeping at another.

My baby wouldn't stop crying once they started. I tried the cry-it-out training, but it didn't work for us. Maybe I couldn't bear to wait it out, but at the time, I just thought, 'This doesn't suit my child.' So, I stopped immediately.

Tips for implementing nighttime crying strategies

While some approaches improved the situation, others showed no effect or even exacerbated nighttime crying. Through this process, mothers developed strategies to successfully implement and sustain coping measures. These included identifying the reasons behind failures (e.g., unfounded optimism), observing the child's responses, and prioritizing their own feelings and preferences.

I thought, "We've been consistent for two weeks, so it should be fine now. The baby must've forgotten about breastfeeding at night." But it didn't work that way. Looking back, I think I stopped too soon because I was so tired and couldn't think clearly.

The key to success is consistency—sticking to the same approach and adjusting based on what happens. It's all about connecting one step to the next.

I focused on methods that I genuinely wanted to try. It had to feel right for me. Otherwise, I'd be half-hearted, and even if it worked, I'd think it was just a coincidence. And if it didn't, I'd feel even more discouraged.

Main category: Division of roles between partners

Faced with nighttime crying, parents divided their responsibilities and assumed specific roles. Rather than jointly addressing nighttime crying, mothers—who already cared for the child throughout the day—handled putting the child to bed and managing nighttime crying. This division was not only due to the mother's ability to breastfeed but also because fathers needed rest for work, had early morning schedules, or were already managing other household tasks. Additionally, to accommodate differing sleep schedules and ensure adequate rest for the father, couples often slept in separate rooms. This category comprised two subcategories.

Dividing roles between spouses

In managing nighttime crying, mothers typically assumed the role of putting the child to bed and responding during the night, whereas fathers engaged in playtime with the child or completed household chores. This division of roles was not explicitly discussed but naturally evolved based on the couple's lifestyle. The mother, as the primary daytime caregiver, continued to handle nighttime duties (partly due to breastfeeding), while the father, as the working partner, focused on tasks such as laundry or dishes. Mothers often felt a sense of responsibility to handle nighttime crying, believing it was fair, given fathers' contribution in other areas.

I never thought about asking him to take over. I've seen other families where the moms do everything—cooking, childcare, all of it. In our case, my husband cooks and helps with housework, so I felt like I should at least handle the nighttime routine.

For our child, my husband is the "fun one," so if he steps in, it just excites the baby and makes it harder for them to settle down. Plus, he willingly does the housework and prioritizes my sleep, which I really appreciate.

Separate sleeping arrangements for spouses

Couples often opted for separate sleeping arrangements after their child was born. This decision stemmed from the father's late return from work, which risked waking the baby, and the need to ensure his uninterrupted sleep because of his work schedule. Despite being sleep-deprived themselves, mothers viewed this arrangement as a practical solution to prevent exhaustion in both partners.

Before our baby was born, we used to sleep together. But after the baby arrived, we started sleeping in separate rooms. My husband comes home after the baby is already asleep, and his return would

wake them up. That, plus the noise, made it easier to keep separate spaces.

It's mainly because he hates being woken up in the middle of the night. He has early mornings and long workdays, and if he can't sleep properly, it's hard for him. I mean, I'm not sleeping much either, but I figure it's better than both of us being completely burned out.

Main category: Psychological and physical burdens on mothers

Mothers dealing with nighttime crying gradually developed psychological symptoms, including stress caused by the crying and anxiety about its persistence. One mother described feeling a sense of dread, saying, "Night time crying is coming again tonight." These challenges were compounded by the inability to secure adequate sleep, leading to accumulated fatigue, irritability, and frustration with their own harsh tone when interacting with their infants. In addition, sleep deprivation exacerbated physical issues such as fatigue, susceptibility to cold, and general health deterioration. This category comprises three subcategories.

Anxiety over prolonged nighttime crying

Mothers expressed significant anxiety over the lack of improvement and the indefinite duration of nighttime crying. For some, nighttime crying became an unending "battle," leaving them emotionally drained.

Every night feels like the start of another battle against crying. It just goes on and on, and I think it will never stop.

I never imagined it would last over a month. I kept asking myself, "How long will this go on? What will happen to me?"

Stress and physical burden related to nighttime crying

Often handling nighttime crying alone, mothers experienced sleep deprivation, accumulated fatigue, and physical health problems such as susceptibility to colds and lethargy. Lack of sleep robbed mothers of emotional resilience and impacted their interactions with their infants. Many mothers described feelings of guilt, helplessness, and an inability to enjoy parenting.

I couldn't sleep, so the fatigue built up. I felt lethargic, irritable, and had no energy to celebrate my child's growth or even find them cute.

The sleep deprivation made me sick more often, and I found myself snapping at my child over small things. I hated seeing myself like that.

Mothers feeling overwhelmed by nighttime crying

Out of consideration for their working husbands, mothers often refrained from asking for help and instead managed nighttime crying alone. This led to feelings of isolation, an inability to share emotions, and a sense of being overwhelmed. Mothers also described the importance of external support, such as support centres, in alleviating their loneliness.

My husband never noticed the nighttime crying. I couldn't bring myself to wake him and ask for help when I knew he was exhausted from work.

I felt completely alone. I wondered if every mother experiences this, but I couldn't talk to anyone. Maybe it's just my personality, but I kept thinking that everyone else has their struggles, and sharing mine would burden them.

Later on, I started going to a support centre, and I wish I had gone earlier. At home, I was alone—day and night. My husband came home late, so having someone else around made such a difference.

Main category: Utilization of external support and social resources

Mothers sought support outside their immediate family, including public resources such as health check-ups and child support centres, as well as from relatives and friends such as their own mothers or "mom friends." While they actively utilized public services, their expectations cantered less on finding solutions and more on emotional support, such as having someone listen to them or temporarily mind their children. Despite their desire to rely on relatives and friends, few "mom friends" shared the same struggles with nighttime crying, limiting opportunities for problem-solving or empathy. This category included two subcategories.

Utilization and limitations of public support

Mothers attended prenatal classes to learn about pregnancy, childbirth, and childcare. While these classes provided information on nighttime crying, it was often forgotten as the focus of expectant mothers was on safely delivering a healthy baby. Some participants also felt that discussing negative aspects, such as nighttime crying, was discouraged to avoid overwhelming expectant mothers.

I think they might have mentioned it in the prenatal class, but it didn't stick. Before giving birth, all you can think about is wanting to have a healthy baby, so things that might not even happen just don't register. Plus, I heard that it's better not to mention negative things beforehand because it could stress out some people.

Postpartum, some mothers sought advice about nighttime crying during health check-ups but often found the responses unhelpful or frustrating.

It felt like no matter who I talked to, I got the same answers—just the obvious stuff you could find anywhere. They'd say, "You're not feeding enough breast milk," and I'd be screaming in my head, "I am!" I eventually stopped asking for advice because I realized they couldn't give me solutions.

Conversely, mothers who sought help from child support centres appreciated the emotional and practical support they received, such as someone listening to their struggles or briefly caring for their child.

They didn't give me specific solutions, saying every child is different. But at the time, I was already trying different strategies, so what I needed most was someone to hear me out and respond to how I felt. Just being able to share my struggles gave me encouragement.

When they said, "Go ahead and rest, we'll watch your child," I felt so relieved. It gave me the assurance that it was okay to lean on

them. I couldn't sleep at night, and during the day, someone watching my child even for a short time allowed me to rest. I realized how important that kind of support is.

Roles of relatives and friends of the mother

In addition to public resources, mothers hoped to receive support from relatives, particularly their own mothers. However, since co-living arrangements with parents are rare, support for nighttime crying was limited to phone conversations during the day.

For the first few weeks after my child was born, my mom came to stay with us. But once things settled down, she went back home. So, there was no one to take over during the crying fits at night. All I could do was call her during the day and say, "This is what's happening," and have her listen.

Mothers also found it difficult to connect with "mom friends" who could empathize with their nighttime crying struggles. Many of these friends, often formula-feeding, did not face the same issues.

I felt lonely. Not many people were dealing with nighttime crying, so there wasn't anyone to share my struggles with or to empathize with me. I breastfeed, while most of my friends use formula. Their babies seemed to cry less because formula keeps them fuller longer.

Main category: Mothers' conflict toward fathers

While mothers handled nighttime crying alone, often through role division and separate sleeping arrangements, many eventually found themselves mentally and physically exhausted. They began to hope that their struggles would be acknowledged and shared by their partners. However, when fathers failed to notice the crying or appeared unsure of how to handle it, mothers felt disappointed. Torn between these expectations and disappointments, they struggled with whether to reevaluate their roles or return to sharing a sleeping space. This category comprises two subcategories.

Expectation toward fathers' understanding

Initially, mothers wanted fathers to focus on work and rest sufficiently. However, over time, they began to desire empathy and understanding of their struggles. Some mothers described this shift as a natural response to being the only one dealing with nighttime crying in a household of three—mother, father, and child.

I wanted him to experience nighttime crying with me, to really feel what it's like. But do I have to say it for him to understand? Shouldn't he realize it on his own? At night, when the baby's crying, it's just me, my husband, and our child. Isn't it natural to want him to understand eventually? I think that's just part of being a couple.

Disappointment toward uncomprehending fathers

Mothers were often disappointed by fathers who seemed unaware or uninvolved in addressing nighttime crying. Some fathers did not wake up at all, realize that the baby had cried during the night, or know how to help when they did wake. This led mothers to conclude that their partners were entirely unaware of the challenges of nighttime crying unless explicitly told.

Since we sleep in separate rooms, he probably doesn't hear anything, so I doubt he even knows the baby was crying. But even when we sleep in the same room, he never notices. Honestly, it's more frustrating that he doesn't wake up than the crying itself.

There are times when he does wake up during nighttime crying. But he'll just say, "I don't know what to do." Maybe he wasn't used to the idea of a crying baby yet, but I just thought, "Oh, really? That's it?"

Main category: Mutual understanding between spouses and support from fathers

Mothers who experienced frustration toward their partner recognized that different perspectives on nighttime crying and parenting approaches were at the root of their conflicts. While mothers tended to believe that following parenting books was the best approach, fathers were more inclined to allow their child to follow a natural rhythm. Although such differences initially appeared to worsen marital relationships, the fathers' perspectives and personality traits ultimately served as a source of comfort for mothers. These experiences improved spousal communication and fostered increased support from fathers. This category comprises three subcategories.

Differences in spouses' perspectives on nighttime crying and parenting approaches

Mothers strongly felt that the child "*must sleep*" to maintain a proper rhythm, ensure healthy development, and reduce their own additional stress. On the other hand, fathers believed that there was no need to force the child to sleep, revealing a different perception of nighttime crying. Similarly, while mothers viewed parenting books as essential to good parenting, fathers were more flexible, asserting that strict adherence was unnecessary.

Initially, these differences caused confusion and resistance in mothers. However, over time, mothers began to accept the fathers' perspectives as positive alternatives.

My husband would say, "Just let it be; they'll sleep when they want to." But I felt they had to sleep, or their rhythm would be disrupted, and I would have to deal with the aftermath. The more I fixated on this, the less it worked. One day, his words made me realize that this perspective could also be valid, and perhaps it's okay to have differences.

Solace through differences in spousal personalities

Differences in the spouses' personalities provided relief to mothers who felt overwhelmed. While mothers often felt the need to "improve the situation and find solutions," fathers approached the issue with an optimistic and laid-back attitude, believing that things would eventually work out. Although mothers were always somewhat aware of these differences, the challenges of nighttime crying amplified them. In these moments, fathers' optimism and accepting attitudes helped alleviate the emotional strain on mothers.

My husband never pressured me to "put the baby to bed," and that alone was a huge relief. Just knowing that he believed things would be

okay made me feel much lighter.

If we had both kept worrying together—"We have to make the baby sleep!"—it would have felt so much heavier. But even hearing him say, "It's okay" just once made all the difference.

Communication between spouses leading to the fathers' support

During the nighttime crying period, couples made intentional efforts to communicate effectively, not only by setting aside time together but also by sharing information and offering words of support. Through this communication, fathers gained a better understanding of the mothers' situations and determined the appropriate ways to support them.

After the baby slept, we always made time for the two of us. We would share what happened during the day, including updates on nighttime crying. I would talk about what I was trying to do. My husband didn't try to study with me but instead supported what I wanted to try. If he had given me constant advice or talked too logically, I probably would have found it frustrating.

He started speaking to me more—saying things like "Thank you" or "They cried again today, huh?" It stopped me from feeling like I was fighting alone. Indifference is the hardest thing to bear. Just hearing his voice and knowing he was there to listen was enough.

Main category: Overcoming nighttime crying, leading to family growth and change

Through collaborative efforts to address nighttime crying, couples deepened their mutual understanding and supported each other until the crying subsided. Mothers experienced personal growth and gained emotional resilience during this process. Additionally, changes in spousal roles and family dynamics led to the growth of the family as a unit. This category comprises three subcategories.

Resolution of managing nighttime crying

At the onset of nighttime crying, mothers felt an intense sense of urgency to help their children fall asleep quickly. However, by the time the children reached approximately 14 to 18 months of age, nighttime crying decreased or ceased. Mothers reflected that the reduction in crying could be attributed to the natural developmental process of the child or their own verbal interventions. One participant described how, following the birth of a second child, she repeatedly communicated the end of nighttime breastfeeding, which the older child gradually began to understand.

When my second child was born, I could no longer breastfeed as much. So, I kept telling my older child, "It's time to stop breastfeeding at night." Gradually, I felt like they started to understand.

Growth and increased resilience gained from experiencing nighttime crying

The experience of nighttime crying helped mothers develop emotional resilience and the ability to respond calmly to their child's cries. While they initially felt anxiety and urgency during these episodes, they eventually learned to reassure themselves by recognizing that "it's not a life-threatening situation." This shift allowed them to respond with greater composure.

Now I can tell myself it's okay even if they cry a little. At first, I would panic, but now I have the space to calmly observe the situation.

Mothers' growth through these experiences influenced how they approached subsequent parenting challenges. Having overcome the difficulties of nighttime crying, mothers felt better equipped to face new challenges with a positive mindset.

Looking back, it was hard, but I feel like I overcame it. I think I did well. But now I'm facing different challenges, and I've already switched my mindset to focus on those.

Changes in spousal and family dynamics through nighttime crying experiences

At the onset of nighttime crying, couples tended to hold back from expressing their thoughts because of their busy schedules and pre-existing roles, which created a sense of cautious "testing" in their relationship. However, by jointly addressing nighttime crying, couples grew into a relationship wherein they could freely share their thoughts and opinions.

At first, we were testing the waters, and it felt like we couldn't say what we really wanted to. But as we faced nighttime crying together, we gradually came to understand each other's thoughts and were able to speak openly.

Initially, fathers were not very proactive in addressing nighttime crying. However, they gradually began to understand the burden on mothers and took on responsibilities such as putting the child to bed and managing nighttime care. Fathers' empathetic attitudes and supportive actions improved the quality of marital relationships.

My husband started holding the baby during nighttime crying and sometimes took over for me. Gradually, it felt like we were doing it together.

The establishment of cooperative partnerships between spouses led to changes in family roles and dynamics. As fathers' behaviour and perspectives evolved, mothers gained new insights and became more positive in their approach to nighttime crying.

When my husband said, "It's okay; we'll get through it somehow," I felt much more at ease. Nighttime crying was tough, but overcoming it helped us grow as a family.

Even after nighttime crying subsided, the quality of communication between spouses continued to improve, strengthening their partnerships in parenting and family management.

Discussion

Based on Corbin and Strauss's GTA [31], this study explored how Japanese parents, particularly mothers, cope with infant

nighttime crying and grow with their families through this process. The parental care process in response to nighttime crying identified Recognition of differences between spouses as the core category, supported by seven main categories. These findings complement and extend existing research by illustrating how differences between spouses during episodes of nighttime crying influence the coping process, how parents address the stress of nighttime crying, and the role of external public support systems.

Recognition of differences between spouses: From conflict to growth

Different perceptions and parenting approaches to nighttime crying initially emerged as factors that defined roles within couples and contributed to maternal conflict. However, as couples engaged in continued communication, these differences eventually fostered mutual understanding and promoted cooperation. Mothers generally adopted a rational and routine-oriented approach to managing nighttime crying, characterized by thoughts such as "If the baby doesn't sleep now, I'll have more work to do" and "I want to follow the parenting guide." Conversely, fathers often exhibited an optimistic and flexible attitude, summarized as "Things will work out." While these differences initially caused tension and conflict, positive communication enabled mothers to gradually accept their partners' differing perspectives. Over time, they began to reassess their own actions and approaches, adapting more flexible strategies to effectively address nighttime crying.

These findings align with previous research indicating that fathers' flexibility and optimism encourage mothers and contribute to fostering positive relationships between parents and their children [33]. Furthermore, viewing couples as a "team tackling a shared problem" supports earlier findings that diverse teams outperform homogenous ones over time in overcoming challenges and achieving higher performance [34,35]. While personality and value differences can lead to conflict [36], diversity can serve as a strength in contexts where it is respected, particularly in smaller teams, such as families [37].

Although previous studies have reported that couples with similar values and attitudes tend to have higher marital satisfaction [38,39], this study suggests that couples with differing perspectives on nighttime crying and parenting can also succeed. While such differences may initially lead to conflict, mutual respect, consideration, and gratitude foster intimacy, allowing individual identities to merge into a collective "*team*" identity. This dynamic may enable couples to address and overcome challenges such as nighttime crying more effectively.

Moreover, the process by which mothers gradually accept their partners' differing perspectives highlights the concept of self-differentiation within Bowen's family systems theory [40,41]. According to Bowen, self-differentiation refers to the ability to maintain autonomy and individuality while simultaneously fostering emotional connections and togetherness with others. Healthy individuals achieve a balance between these two aspects. In this study, mothers maintained their individuality by addressing nighttime crying using their own thoughts and methods, while adapting to their partners' differing viewpoints. This process contributed to their emotional resilience. Fathers' optimism and support provided emotional relief for mothers experiencing anxiety due to nighttime crying, ultimately reducing the associated psychological burden. These findings reinforce the notion that different parental coping styles do not necessarily lead to conflict but rather complement each other, enhancing the family unit's overall resilience.

Parental coping with stress from nighttime crying: Dyadic coping

Nighttime crying primarily placed mental and physical burdens on mothers, who were often the primary caregivers. Initially, mothers felt anxious and overwhelmed by the unpredictable and prolonged nature of nighttime crying. However, repeated exposure and trial-and-error led to the recognition that their child's crying did not indicate life-threatening situations. This understanding allowed them to develop a calmer approach to manage nighttime crying. To alleviate the stress experienced by fathers who were often fatigued from work, mothers took on the fixed role of addressing nighttime crying, thus reducing the fathers' exposure to this stress.

Fathers initially left caregiving responsibilities to the mothers. However, they eventually began to perceive nighttime crying as a shared issue. Fathers not only contributed to nighttime care but also provided emotional support by expressing gratitude and respecting mothers' decisions. These findings align with the processes of dyadic coping (DC), which involve mutual interaction between partners to manage stress [42-44].

DC can be categorized as positive and negative. Positive DC includes supportive, common or shared, and delegated coping [44,45]. By contrast, negative DC encompasses hostile, superficial, and ambivalent interactions [44,45]. In this study, mothers engaged in delegated DC by independently handling nighttime crying, such as soothing the child and creating an optimal environment. Fathers employed supportive DC (e.g., assisting with daily parenting tasks and showing empathetic understanding) and common or shared DC (e.g., jointly finding solutions and tackling issues) to alleviate mothers' burdens. However, fathers were not observed to engage in delegated DC, such as taking over the responsibility for addressing prolonged nighttime crying or co-sleeping, which could have reduced maternal stress. Similarly, no instances of negative DC such as ignoring, blaming, or reluctantly supporting the mothers were observed.

Nighttime crying is one of the first challenges that couples face as new parents [1,2]. Since it occurs when external support is typically unavailable, couples must collaborate to address the issue, making spousal cooperation a critical factor. In addition to managing the care of a crying child, parents must support each other in mitigating their mutual stress. This requires the use of supportive DC, such as open discussions and sharing emotions [46], and the common or shared DC observed in this study, which is crucial for reducing maternal stress. Furthermore, fathers engaging in delegated DC, such as taking over nighttime caregiving or co-sleeping, would not only alleviate maternal stress but also help resolve the child's sleep

problems. Bendetta et al. [47] reported that "paternal involvement at bedtime reduces children's difficulties in falling asleep." Fathers' active involvement in bedtime routines enhances father–child interactions, promotes children's emotional stability, and improves sleep quality. These findings highlight the importance of fathers playing a more active role in bedtime routines and nighttime caregiving.

The Role of External Support Systems

Mothers sought assistance from external public support systems, such as health checkups, child support centres, and relatives and friends. While offering limited practical solutions, public support services played a crucial role in providing emotional support and reducing feelings of isolation. In Japan, prenatal classes for mothers and fathers offer guidance on newborn care and breastfeeding, whereas postnatal services include home visits mandated by the Maternal and Child Health Act (Article 11) and universal home visitation programs outlined in the Child Welfare Act (Article 6). The latter targets all families with infants up to four months old, providing consultations on parenting concerns, offering information on child-rearing, and coordinating with relevant organizations to deliver services to families in need. Regular health checkups and child support centres are available in various regions.

However, there are barriers to seeking external public support. For example, some mothers believed that they lacked the resolve to receive it or felt that parenting challenges were due to their own inadequacies or inability to cope [48]. Seeking support was perceived as an acknowledgment of personal shortcomings. Furthermore, cultural norms emphasizing self-reliance and personal responsibility made it difficult for mothers to seek external assistance [49]. In Japan, nearly half of the mother's report experiencing some form of difficulty, anxiety, or burden in the first year after childbirth [50,51].

Research indicates that mothers "prefer support from familiar environments and professionals they know" [48]. To address this, improving access to public support services and implementing culturally sensitive programs—such as having the same public health nurses or midwives provide guidance before and after childbirth—may make it easier for mothers to accept both practical and emotional support.

Strengths and limitations

This study focused on the process by which Japanese parents cope with nighttime crying, and is a novel investigation of how spousal differences can foster an evolution of their roles and relationships as a team. However, the study's focus on mothers' perspectives limits its direct understanding of fathers' experiences. Additionally, as the study exclusively targeted Japanese mothers, the findings may have limited applicability in other cultural backgrounds. Future research should include fathers to provide a more comprehensive understanding of the coping processes within families.

Conclusion

This study demonstrated how Japanese parents address the challenge of infant nighttime crying and transform it into an opportunity for growth. Mutual understanding between spouses, adaptive strategies, and the utilization of external support emerged as key factors contributing to the development of both parents and the family unit. These findings provide valuable insights for improving parenting support programs and policies, and underscore the importance of culturally sensitive approaches.

Acknowledgements

I would like to thank all the participants for their contributions to this study and N. Okubo, Ph.D., for her useful advice. This work was supported by JSPS KAKENHI (Grant Number 19K19652).

Conflict of interest

The author declares no conflict of interest related to this article.

References

1. Morris S, St James-Roberts I, Sleep J, Gillham J (2001) Economic evaluation of strategies for managing crying and sleeping problems. Arch Dis Child 84: 15-19.
2. Scott G, Richards M (1990) Night waking in infants: effects of providing advice and support for parents. J Child Psychol Psychiatry 31: 551-567.
3. Wang SC, Yu JE (2012) Pediatrics in Chinese Medicine (9th ed). People's Medical Publishing House, Beijing, China.
4. Owens JA, Mindell JA (2011) Pediatric insomnia. Pediatr Clin North Am 58(3): 555-569.
5. Bruni O, Baumgartner E, Sette S, Ancona M, Caso G, et al. (2014) Longitudinal study of sleep behaviour in normal infants during the first year of life. J Clin Sleep Med 10(10): 1119-1127.
6. Hysing M, Harvey A, Torgersen L, Ystrom E, Reichborn Kjennerud T, et al. (2014) Trajectories and predictors of nocturnal awakenings and sleep duration in infants. J Dev Behav Pediatr 35(5): 309-316.
7. Mindell JA, Sadeh A, Wiegand B, How TH, Goh DY (2010) Cross-cultural differences in infant and toddler sleep. SleepMed 11: 274-280.
8. Sadeh A, Tikotzky L, Scher A (2010) Parenting and infant sleep. Sleep Med Rev. 14: 85-89.
9. Wake M, Morton-Allen E, Zeffie P, Hiscock H, Gallagher S, et al. (2006) Prevalence, stability, and outcomes of cry-fuss and sleep problems in the first 2 years of life: prospective community-based study. Paediatrics 117: 836-842.
10. Goodlin-Jones BL, Burnham MM, Anders TF (2000) Sleep and sleep disturbances: regulatory processes in infancy. In: Sameroff AJ, Lewis M, Miller SM (Editors.), Handbook of developmental psychopathology (2nd ed.). Kluwer Academic, New York, US, pp. 309-325.
11. Hideki H (2006) Investigation of night-time crying during infant health check-ups. Jpn J Pediatr 59(7): 1655-1659 (Japanese).
12. Hitomi S, Hideya K, Michiko Y, Yoshimi N (2008) Investigation into the factors related to severity of night-time fussing and crying of infants. Bulletin of School of Health Science Akita University 16(2): 9-15 (Japanese).
13. Paruthi S, Brooks LJ, Ambrosio CD, Hall WA, Kotagal S, et al. (2016) Consensus statement of the American Academy of sleep medicine on the recommended amount of sleep for healthy children: methodology and discussion. J Clin Sleep Med 12(11): 1549-1561.
14. Sadeh A, Tikotzky L, Kahn M (2014) Sleep in infancy and childhood: Implications for emotional and behavioural difficulties in adolescence and beyond. Curr Opin Psychiatry 27: 453-459.
15. Gregory AM, O Connor TG (2002) Sleep problems in childhood: A longitudinal study of developmental change and association with behavioural problems. J Am Acad Child Psy 41: 964-971.

16. Bayer JK, Hiscock H, Hampton A, Wake M (2007) Sleep problems in young infants and maternal mental and physical health. J Paed Child Health 43: 66-73.
17. Hall WA, Clauson M, Carty EM, Janssen PA, Saunders RA (2006) Effects on parents of an intervention to resolve infant behavioural sleep problems. Pediatr Nurs 32: 243-254.
18. Tikotzky L (2017) Parenting and sleep in early childhood. Curr Opin Psychol 15: 118-124.
19. Hughes A, Gallagher S, Hannigan A (2015) A cluster analysis for reported sleeping patterns of 9-month-old infants and the association with maternal health: results from a population-based cohort study. Matern Child Heal J 19(8): 1881-1889.
20. Power E, Sharif F (2021) Period of Purple Crying program for the prevention of abusive head trauma/shaken baby syndrome. Ir Med J 114(7): 415
21. Reijneveld SA, van der Wal MF, Brugman E, Sing RA, Verloove-Vanhorick SP (2004) Infant crying and abuse. Lancet 364(9442): 1340-1342.
22. Howard CR, Lanphear N, Lanphear BP, Eberly S, Lawrence RA (2006) Parental responses to infant crying and colic: The effect on breastfeeding duration. Breastfeed Med 1: 146-155.
23. Garrison MM, Christakis DA (2010) A systematic review of treatments for infant colic. Paediatrics 106: 184-190.
24. Troxel WM, Trentacosta CJ, Forbes EE, Campbell SB (2013) Negative emotionality moderates associations among attachment, toddler sleep, and later problem behaviours. J Fam Psychol 27(1): 127-136.
25. Morrell J, Steele H (2003) The role of attachment security, temperament, maternal perception, and care-giving behaviour in persistent infant sleeping problems. Infant Ment Health J 24(5): 447-468.
26. Mindell JA, Kuhn B, Lewin DS, Meltzer LJ, Sadeh A (2006) Behavioural treatment of bedtime problems and night waking in infants and young children. Sleep 29: 1263-1276.
27. Ramchandani P, Wiggs L, Webb V, Stores G (2000) A systematic review of treatments for settling problems and night waking in young children. Br Med J 320: 209-213.
28. Honaker SM, Schwichtenberg AJ, Kreps TA, Mindell JA (2018) Real-world implementation of infant behavioural sleep interventions: Results of a parental survey. J Pediatr 199: 106-111.
29. Hiscock H, Canterford L, Ukoumunne OC, Wake M (2007) Adverse associations of sleep problems in Australian preschoolers: national population study. Paediatrics 119: 86-93.
30. Meltzer LJ, Mindell JA (2014) Systematic review and meta-analysis of behavioural interventions for paediatric insomnia. J Pediatr Psychol 39: 932-948.
31. Corbin J, Strauss A (2015). Basics of qualitative research: Techniques and procedures for developing grounded theory (4th ed.). Sage Publication, Los Angeles, US.
32. Speziale HS, Streubert HJ Carpenter DR (2011) Qualitative research in nursing: Advancing the humanistic imperative. Lippincott Williams & Wilkins. Philadelphia, US.
33. Oshima K, Suzuki K, Nishimura T (2022) The process of becoming a parent team: Qualitative research on couples with a preschooler. Jpn J Dev Psychol 33(1): 25-39 (Japanese).
34. Watson WE, Kumar K, Michaelsen LK (1993) Cultural diversity's impact on interaction process and performance: Comparing homogeneous and diverse task groups. Acad Manage J 36(3): 590-602.
35. Jackson SE (1996) The consequences of diversity in multidisciplinary work teams. In: West MA, Guzzo RA (Editors.), Handbook of work group psychology, John Wiley & Sons Ltd, New Jersey, US, pp. 53-75.
36. Horwitz SK, Horwitz IB (2016) The effects of team diversity on team outcomes: A meta-analytic review of team demography. J Manage 33(6): 987-1015.
37. Stahl GK, Maznevski ML (2021) Unraveling the effects of cultural diversity in teams: A retrospective of research on multicultural work groups and an agenda for future research. J Int Bus Stud 52: 4-22.
38. Acitelli LK (1992) Gender differences in relationship awareness and marital satisfaction among young married couples. Pers Soc Psychol Bull 18(1): 102-110.
39. Grant R (2006) Couple similarity and marital satisfaction: Are similar spouses happier? J Pers 74(5): 1401-1420.
40. Bowen M (1972) Towards the differentiation of a self in one's own family. In: Framo JL (Editor.), Family interactions: A Dialogue Between Family Researchers and Family Therapists. Springer-Verlag. New York, US.
41. Bowen M (1978) Family therapy in clinical practice. New York, US.
42. Bodenmann G (1997) Dyadic coping: a systemic-transactional view of stress and coping among couples: theory and empirical findings. Eur Rev Appl Psychol 47: 137-141.
43. Revenson TA, Kayser K, Bodenmann G (2005) Couples coping with stress: Emerging perspectives on dyadic coping, American Psychological Association, Washington, DC, US.
44. Falconier MK, Randall AK, Bodenmann G (2016) Couples coping with stress. A cross-cultural perspective (1st ed), Routledge, New York, US.
45. Bodenmann G (1995) A systemic-transactional conceptualization of stress and coping in couples. J Psychol 54: 34-49.
46. Badr H, Carmack CL, Kashy DA, Cristofanilli M, Revenson TA (2010) Dyadic coping in metastatic breast cancer. Health Psychol 29: 169-180.
47. Ragni B, De Stasio S, Barni D, Gentile S, Giampaolo R (2019) Parental mental health, fathers' involvement and bedtime resistance in infants. Ital J Pediatr 45: 134.
48. Shoko K (2022) The actual situation of restraining the use of child-rearing support and the need for child-rearing support. Journal of the Faculty of Nursing, Iwate Prefectural University 24: 13-22 (Japanese).
49. Emiko O (2014) Leaving the West, rejoining the East? Gender and family in Japan's semi-compressed modernity. Int Sociol 29(3): 209-228.
50. Setsuko K (2020) Postpartum difficulties and the support desired by mothers in the year after giving birth. Bull Aichi Pref Univ School of Nurs Health 26: 123-135 (Japanese).
51. Setsuko K (2021) Relationship between mother's feelings and basics in the year after giving birth. Bull Aichi Pref Univ School of Nurs Health 27: 55-64 (Japanese).