Exploring the Lived Experiences of Couples Making the Transition to Parenthood and the Meaning They Ascribe to Brief, Couple-Focused, Preventative Interventions

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EXPLORING THE LIVED EXPERIENCES OF COUPLES MAKING THE TRANSITION TO PARENTHOOD AND THE MEANING THEY ASCRIBE TO BRIEF, COUPLE-FOCUSED, PREVENTATIVE INTERVENTIONS

by

Dolores D. Michael

A thesis submitted in partial fulfillment of the requirements for the degree of

MASTER OF SCIENCE

in

Family, Consumer, and Human Development (Marriage and Family Therapy)

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UTAH STATE UNIVERSITY
Logan, Utah

2014
ABSTRACT

Exploring the Lived Experiences of Couples Making the Transition to Parenthood and the Meaning They Ascribe to Brief, Couple-Focused, Preventative Interventions

by

Dolores D. Michael, Master of Science
Utah State University, 2014

Major Professor: Dr. W. David Robinson
Department: Family, Consumer, and Human Development

A descriptive, phenomenological research design was used to gain a deeper understanding of the nature and meaning of couples’ experiences as they made the transition to parenthood. Specifically, this study examined what is the lived experience of couples making the transition to parenthood and what meaning do they ascribed to the experience of brief, couple-focused, preventative interventions? Five couples who were expecting their first baby participated in this study. From the data provided, two major categories emerged. The first was the couples’ experiences with becoming new parents and the second was the couples’ experiences with therapy. Under the first category, five major themes emerged: (1) physical and emotional challenges, (2) bonding with baby, (3) satisfaction in roles and new identity, (4) impact of social support, and (5) stability of relationship satisfaction. Three themes were discovered under the category related to the couples’ experience with therapy: (1) facilitated communication, (2) stress management,
and (3) preparation for the transition. This study concluded by discussing the essence of the phenomenon of couples’ experiences with the transition to parenthood and the meaning they ascribed to therapeutic interventions along with clinical implications of these findings.

(101 pages)
PUBLIC ABSTRACT

Exploring the Lived Experiences of Couples Making the Transition to Parenthood and the Meaning They Ascribe to Brief, Couple-Focused, Preventative Interventions

Dolores D. Michael

The objective of this research study was to investigate how meaningful it would be to provide relationship therapy from a marriage and family therapist to couples going through the transition to parenthood. The participants in this study all received four therapy sessions before the baby was born and one therapy session after the birth. A total of five couples participated in this study. Data was gathered from the assessments they took before each therapy session and at the final interview.

As a result, the participants in this study all remained stable or increased in their marital satisfaction when measured four to seven weeks after the baby was born. Furthermore, the couples reported in a final interview that therapy helped them to improve communication skills, stress management skills, and overall preparation for handling the challenges of becoming new parents. New parenthood for these couples brought about physical and emotional challenges, a need for social support, bonding with the baby, and satisfaction in roles and their new identity. This research was important because it demonstrated how brief, couple-focused therapy, provided by a trained marriage and family therapist, could benefit couples going through the transition to parenthood.
DEDICATION

I would like to dedicate this work to the man who accompanied me through my personal transition to parenthood and all of the adventures that came as a result, Sean Michael. What an absolute pleasure it is to share in this life journey with you.

I also want to dedicate this to my children who have patiently put up with me pursuing this degree, Colene, Corbin, Caeli, and Cassidy. You are all the best!
ACKNOWLEDGMENTS

What an amazing journey graduate school has been! I am so grateful for having been given the opportunity to learn from the faculty at Utah State University. Dave, Ryan, and Megan have all been truly instrumental in my development as a therapist and a scholar.

I would like to especially thank Dave Robinson, my committee chair, for his support and encouragement throughout this entire thesis process. Thank you for your time in reading and rereading multiple drafts of this document and encouraging me along the way.

Huge thanks also go to my other committee members, Ryan Seedall and Linda Skogrand. Both of you were always willing to listen and offer advice when I needed it, and most of all, you believed in me. Your support has been a huge reason why I made it to this point of completion.

Dolores Michael
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CHAPTER I
INTRODUCTION

Although much is known about the stresses and challenges for couples going through the transition to parenthood, little is known about the lived experience of both the man and woman as they make this transition and how they would ascribe meaning to utilizing therapy including brief couple-focused, preventative interventions. Research is needed in this area of family therapy to demonstrate how interventions done from a systemic biopsychosocial perspective can add meaning to couples experiences as they make their journey to parenthood.

Researchers first became interested in the challenges of this life cycle transition after a hallmark study done by LeMasters (1957), a sociologist, who claimed that 83% of new parents had a “moderate or severe crisis” in the first few years after the birth of their first child. Belsky and Rovine (1990) examined marital relationships from late pregnancy to three years postpartum and found that 30% to 59% of the participants showed a decline in their marital quality, whereas 10% to 30% showed a positive increase in marital quality. A more recent longitudinal study of couples found that the transition to parenthood led to a decrease in marital satisfaction over and above the declines in satisfaction experienced by a matched control group who voluntarily were childless (Lawrence, Rothman, Cobb, & Bradbury, 2010). In addition to marital quality, other factors affecting the transition to parenthood include: postpartum depression in women (Barnes, 2006) and men (Condon, Boyce, & Corkindale, 2004), role changes (Barnes, 2006), and trauma related affects of pregnancy and birth (Yampolsky, Lev-Wiesel, & Ben-Zion, 2010).
Current scholarly researchers have found that interventions to help ease the transition to parenthood have been mostly based on individual treatment of symptoms instead of the systemic component of couple interventions (Hunt, 2006; Pinquart & Teubert, 2010). Specifically, postpartum depression has been treated with cognitive behavior therapy, interpersonal psychotherapy, counseling, and social and peer support groups (Murray, Cooper, Wilson, & Romaniuk, 2003). Although the effectiveness of various psychotherapies for postpartum depression are effective, specific studies on the effectiveness of systemic family therapy for postpartum depression have not been researched (Hunt, 2006).

Research investigating interventions for couples that are geared towards marital quality include: support groups, educational programs, and couple workshops that have been designed to help couples in their relationship to expect the stresses associated with the birth of a first child and to then move to healthy responses by accepting changes in roles and responsibilities (Petch & Halford, 2008). Likewise, in a meta-analytic study of couple interventions during the transition to parenthood, researchers integrated results from 21 couple-focused interventions and found statistically small effect sizes on couple adjustment, couple communication, parenting, and psychological well-being. However from this same study, interventions that included a trained interventionist such as a family therapist showed stronger effects on couple adjustment to the transition to parenthood (Pinquart & Teubert, 2010). While educational programs and support groups have been the focus of intervention during this life change time, couple-focused interventions including a family therapist, need further investigation (Pinquart & Teubert, 2010).
Researchers have also shown that unmet attachment needs for couples may cause marital satisfaction to decrease (Feeney, 2003; Meredith & Noller, 2003; Sable, 2000) and a sense of hopelessness and depression to increase (Barnes, 2006; Carnelley, Pietromanaco, & Jaffe, 1994; Dozier, Stovall, & Albus, 1999). In contrast, couples who are securely attached will have a higher capacity to communicate their needs and have the belief that their partner will be reliable and responsive when needed (Whiffen & Johnson, 1998). By adding the attachment perspective to interventions, the family therapist has the opportunity to enrich the therapeutic interventions with the couples.

In conclusion, in this study I identified the core experiences that gave meaning to the phenomenon of men and women making the transition to parenthood. Furthermore, I explored the couples’ perception of the benefits of therapeutic interventions with a marriage and family therapist (MFT). Moreover, I sought to discover how an MFT’s lens of the biopsychosocial framework influences this transitional time in a couple’s life. Specifically I looked to answer the question, “What is the lived experience of couples making the transition to parenthood and what meaning do they ascribe to the experience of brief, couple-focused, preventative interventions?”
CHAPTER II
LITERATURE REVIEW

Although the topic of the transition to parenthood has been well documented in scholarly literature, this phenomenological study will explore a relatively new area of research looking specifically at the utility of integrating couple-focused, preventative interventions in a therapeutic setting. The following review of literature regarding the transition to parenthood and interventions will address four topics: (1) family systems theory, (2) biopsychosocial framework and interventions; (3) the family life cycle, including impact on couples, women, and men; (4) use of attachment theory; and (5) current therapeutic interventions.

Family Systems Theory

Family Systems Theory offers a framework for working with couples going through the transition to parenthood by providing a lens to view the whole as greater than the sum of the parts (von Bertalanffy, 1968). With this framework, one can better understand the nature of a couples’ relationship as the complexity of changes occur when the couple become parents. As the originators of the theory explain, a change in one part of the system causes change in other parts of the system (Bateson, Jackson, Haley, & Weakland, 1956). For the purpose of this study, the following concepts of systems theory will be discussed: circular causality, family rules, family cohesion, and flexibility.

Circular causality is the concept that there is cyclic view of behavior as opposed to linear cause and effect of behavior (Palazzoli, Boscolo, Cecchin, & Prata, 1988).
Circular causality allows the clinician to see what is transpiring, not why it is occurring (Becvar & Becvar, 2009). Clinicians practicing under family systems theory focus on the process of how couples interact as opposed to the content and, therefore, look at what can be done to change the pattern in order to improve the interactions. The stress associated with new parenthood can start a cyclic pattern of behavior that leads to isolation and emotional separation if left unchecked. By bringing awareness prenatally to the negative interaction patterns couples may go through, couples are better able to communicate and maintain emotional closeness (Johnson, 2004).

The next assumption of systems theory is that “rules result from the redundancy principal and are critical in defining a family” (Smith & Hamon, 2012, p. 148). Furthermore, rules can be both overt and unspoken (Jackson, 1965). As couples begin to create the rules of their relationship, their repetitive patterns of interaction will become the rules by which the family lives. Rules can be made overt by helping couples’ find personal meaning and understanding behind the rules they bring into their relationship and parenthood.

Family cohesion and flexibility as defined by Olson (2000), identifies the degree to which a family has emotional closeness and the family’s adaptability to new and/or stressful events. Healthy family functioning, according to Olson (2000), is when a family is able to balance both separateness and togetherness and have flexibility in leadership, roles and rules. According to Olson’s Circumplex Model, there are five principles of stress related change that a couple goes through during life cycle changes (Olson & Gorall, 2003). Under stress, such as becoming new parents, couples tend to (1) move
towards chaos or enmeshment, (2) increase in communication, (3) return to a similar, but usually not identical, pre-stress system after the stressful event, (4) take six months to a year to adjust to the stressful event, and (5) become unbalanced during stress but return to balance if they were balanced to begin with. To summarize, relational systems that are balanced in their flexibility and cohesion are better able to adjust to the stresses associated with the life cycle transition of becoming new parents.

In the past 10 years there has been a plethora of research articles written about the transition to parenthood yet there are only a handful of articles that mention family systems theory. None of the prominent journals in marriage and family therapy mention using systems theory as a foundation in working with couples going through this life transition. This study will fill this gap in the research by showing how marriage and family therapists can apply the concepts of systems theory when working therapeutically with couples going through this transition.

The Biopsychosocial Framework

Crucial to the understanding of the uniqueness of this research study is my utilization of the biopsychosocial (BPS) model, as first theorized by George Engel (1977). Holistically gaining understanding of individuals as biological, psychological, and social beings allows for more informed care of clients. Furthermore, researchers have expanded this model to include the spiritual or belief systemic component to give a broader understanding of the individual and thus using the term biopsychsocial-spiritual (BPSS) model (Prest & Robinson, 2006). From the BPSS model, the marriage and family therapist not only sees the systemic components of the relationship but the even more
complex system resulting from the influences of the biological, mental, and emotional health of the individual along with their socially constructed belief system (McDaniel, Hepworth, & Doherty, 1992). According to Ross, Sellers, Evans, and Romach (2004), biological variables (e.g., health of mother and baby) and psychosocial variables (e.g., life stress, relationship quality, and social support) have to be considered when working with women during the prenatal period. Thus, this study will integrate the BPSS model of care into working with couples during the transition to parenthood for the purpose of gaining a more holistic understanding of the complexity of systems and issues interplaying and affecting this life transition.

To illustrate the complexity of issues from a biopsychosocial perspective, McDaniel et al. (1992) explained how “there are no biological problems without psychosocial implications, and no psychosocial problems without biological implications” (p. 2-3). Thus, the biological condition of pregnancy has psychosocial implications and the psychosocial implications surrounding pregnancy can lead to biological health-related issues. In particular, several studies have shown that biological and psychosocial risk factors during the prenatal time contribute to postpartum depression (Beck, 2001; Lancaster et al., 2010; Ross, Evans, Sellers, & Romach, 2003; Skouteris, Wertheim, Rallis, Milgrom, & Paxton, 2009). The psychosocial risk factors that increase the risk of postpartum depression include: lack of social support, domestic abuse, life stress, maternal anxiety, history of depression, unintended pregnancy, lower income, lower education, smoking, single status, poor relationship quality, and Medicaid insurance (Lancaster et al., 2010). Ross and colleagues (2004) looked at the biological
and psychosocial factors affecting mood changes of women both in the prenatal and postnatal time periods and found that these factors did have an indirect affect on symptoms of anxiety and thus concluded that both biological and psychosocial factors must be considered when working with prenatal women.

To illustrate further, biopsychosocial factors that have been associated with preterm delivery are general anxiety, pregnancy-related fears, lack of emotional understanding of partner, non-ideal relationship with partner, lack of feeling of acceptance by female friends, and smoking (Rauchfuss & Maier, 2011; Zachariah, 2009). Researchers have concluded that improved predictions of pregnancy complications can be obtained through a joint risk factor assessment using both biomedical and psychosocial factors (Rauchfuss & Maier, 2011). Further research is needed in the area of exploring the utility of providing preventative, biopsychosocial-focused care to couples making the transition to parenthood.

**Biopsychosocial Preventative Interventions**

Researchers have focused on the biological and psychosocial determinants that predict pregnancy and postpartum outcomes, yet research is lacking in preventative measures that improve these outcomes (Austin, 2003; Dennis, 2005). In a study of the effectiveness of antenatal interventions on postpartum depression, Clatworthy (2012) found that all successful interventions with the exception of one (Lara, Navarro, & Navarrete, 2010) included a component that addressed interpersonal relationships (Clatworthy, 2012). Interestingly, the preventative interventions that included an interpersonal relationship component did not necessarily include the woman’s partner as
part of the intervention sessions. Knowing the importance of relational factors as a cause and maintenance of depression (Grigoriadis & Ravitz, 2007) interventions focusing on the couple’s relationship is critical in preventing or lessening the effects of postpartum depression. Furthermore, results from a study looking at the biopsychosocial factors related to preterm deliveries found that lack of support, poor emotional understanding by the partner, and additional stress, fear, and anxiety were significantly associated with preterm delivery (Rauchfuss & Maier, 2011). Therefore, further research is needed to demonstrate how including a marriage and family therapist trained in the biopsychosocial model and interventions will have an impact on postpartum outcomes for couples.

The Family Life Cycle

Foundational to the understanding of working with couples making the transition to parenthood, one must begin with the concept of the family life cycle (McGoldrick, Carter, Carter, & Preto, 2010). The family life cycle represents transitions from one life stage to the next. Specifically, the transition to parenthood represents a period when families must restructure and change. According to Menaghan (1983), the transition to parenthood is one of the most challenging life transitions a couple will go through. Many factors affect this transition not only at the individual level, but clearly, a family system has to adjust to new and sometimes unforeseen stressors (Cowan & Cowan, 1995). Furthermore, during the transitional times of the family life cycle when families need to pull together, there becomes an internally directed cohesiveness (Rolland, 1994) that is needed in order for the transitioning family system to successfully navigate the shift of roles and needs.
Impact on Couples

According to the hallmark study of Cowan and Cowan (1995), the transition to parenthood stage of the family life cycle constituted a period of stressful and sometimes maladaptive change for a significant proportion of new parents. For some young couples, the stress and changes in roles caused a significant drop in marital satisfaction (Cowan & Cowan, 1995; Shapiro, Gottman, & Carrère, 2000). A more recent longitudinal study of couples found that the transition to parenthood led to a decrease in marital satisfaction over and above the declines in satisfaction experienced by a matched control group who voluntarily were childless (Lawrence et al., 2010). Similarly, researchers conducting an 8-year longitudinal study found that this deterioration in relationship satisfaction was sudden and tended to persist (Doss, Rhoades, Stanley, & Markman, 2009). Factors that have been found to contribute to a decrease in marital satisfaction after the birth of a baby included a failure to renegotiate roles and clarify assumptions (Petch & Halford, 2008), and conflict frequency (Kluwer & Johnson, 2007).

In contrast, according to some researchers, not all couples become less satisfied with their marriages during the transition to parenthood. Cowan and Cowan (1995) found that 18% of couples not participating in their intervention group increased in marital satisfaction as they became new parents. Couples who had sought out support and had more experiences coping with small stressors early in marriage reported better marital adjustment following the birth of a child (Kluwer & Johnson, 2007). Shapiro et al. (2000) conducted a 6-year longitudinal study to identify the common factors that predicted stability versus decline in marital satisfaction over the transition to parenthood. These
researchers found that for mothers, stable or increasing marital satisfaction was predicted by (1) the husbands expression of fondness toward her, (2) the husband’s high awareness for her and their relationship, and (3) her awareness for her husband and their relationship. By understanding the factors that predict marital satisfaction increase and stability during the transition to parenthood, a marriage and family therapist can take a strengths-based approach to providing therapeutic interventions that build a strong, close relationship. This study will attempt to fill the gap in research regarding how couple-focused preventative interventions can impact relationships and thus keep stable or improve marital satisfaction as couples transition to parenthood.

**Impact on Women**

For women, parenthood is envisioned as a natural transition in the family life cycle where they immediately know how to care for their babies, find fulfillment in the role of nurturer, and are happy (Choi, Henshaw, Baker, & Tree, 2005). Admitting to wanting or needing help produces feelings of inadequacy as women describe feelings of distress when others offer to help (Cronin & McCarthy, 2003). From the feminist perspective, Choi and colleagues (2005) described how women reported that they should not only be able to cope as new mothers, but also should be able to take care of household tasks and take care of others. Choi and colleagues (2005) further illustrated the important components of women’s transition to parenting, and that the socially constructed ideology of motherhood, often led to postnatal depression, distress, and sometimes anger when reality did not meet the expectations of motherhood. In spite of
what appears to be a bleak reality of being a mother, in a study of 1285 women, 72% had no disappointments about motherhood (Green & Kafetsios, 1997).

One of the most significant factors affecting women during the transition to parenthood is postpartum depression. Major postpartum depression is estimated to be 13% (Beck, 2001) and as high as 35% to 40% for Latinas (Gage & Kirk, 2002), and 23.4% for impoverished, inner-city women (Hobfoll, Ritter, Lavin, Hulsizer, & Cameron, 1995). The systemic implications for the disruptions caused by postpartum depression include maternal-infant attachment (Murray et al., 2003) as well as consequences for the emotional health of a woman’s partner (Goodman, 2008) and the quality of the marital relationship (Barnes, 2006). Studies searching for a predictor of postpartum depression have proposed that postpartum depression is a result of unmet attachment needs (Whiffen & Johnson, 1998), while Feeney, Hohaus, Noller, and Alexander (2001) found that it is a combination of attachment insecurity and the stresses of parenthood. In a meta-data-analysis study done by Knudson-Martin and Silverstein (2009), researchers showed how the “good mother” constructions of motherhood contributed to postpartum depression and isolation due to a lack of support and validation of their experiences from their interpersonal relationships.

However, studies have shown how relationship quality and social support are highly related to resilience during the postpartum period (Philipps & O’Hara, 1991; Roux, Anderson, & Roan, 2002; Zelkowitz & Milet, 1996). Knowing the importance of the interpersonal contexts in postpartum depression, emphasizes the need for
interventions that include a trained therapist to facilitate communication and relational connection with couples prenatally.

In a review of eight self-report measures used to assess for depressive symptoms in the postpartum period, researchers found that the Edinburgh Postnatal Depression Scale (EPDS) to be the most reliable and valid screening instrument (Boyd, Le, & Somberg, 2005). The EPDS has also been validated in studies to assess for depression in the prenatal period and, therefore, has been used as a preventative measure for identifying women who are at higher risk of developing postpartum depression (Bunevicius, Kusminskas, Pop, Pedersen, & Bunevicius, 2009; Fernandes et al., 2011; Gibson, McKenzie-McHarg, Shakespeare, Price, & Gray, 2009). Therefore, a number of studies have advocated for psychosocial assessments and interventions to be done prenatally in order to better determine risk factors for postpartum depression (Buist et al., 2002; Matthey, Kavanagh, Howie, Barnett, & Charles, 2004; Priest, Austin, Barnett, & Buist, 2008). Therefore, this study utilizes a marriage and family therapist who has the unique perspective of adding the psychosocial component of assessment along with tools such as the EPDS (Cox, Holden, & Sagovsky, 1987) to improve identification of women who are at risk for postpartum depression.

**Impact on Men**

In contrast to the numerous studies and research into the woman’s life cycle transition to motherhood, the experience of men during the transition to fatherhood is scant (Halle et al., 2008). Halle and colleagues (2008) suggested that the dilemma that men face is that they still feel the role of ensuring economic stability and yet they are
expected to provide a high level of physical and emotional support to their partner during this transition. Conflicting roles of responsible provider and nurturing father has led to misunderstood expectations between partners (Barnes, 2006). Barnes (2006) further explained that fathers often believed the myth that the woman should instinctually know how to comfort and nurture the baby and mothers believed that the father would shift his focus to family roles. Fathers have identified that they want information to help prepare them for fatherhood and this preparation for fatherhood has the potential to enhance maternal, child, and family health (Gage & Kirk, 2002). More research is needed in the area of the lived experience for men making the transition to parenthood.

Studies have revealed that not only do women suffer from postpartum depression, but men also have shown symptoms of paternal postpartum depression (Condon et al., 2004; Kim & Swain, 2007). In general, the incidence of self-reported depression in fathers is consistently lower than in mothers. One study found the rate of diagnosed depression in new fathers at six weeks postpartum to be around 2% to 5% (Fletcher, Matthey, & Marley, 2006). Correlational studies on depressive symptoms in new fathers found that having a depressed partner, or a partner with a high level of depressive symptoms was a strong correlate of elevated symptoms of depression in fathers during the postpartum time period (Goodman, 2008; Schumacher, Zubaran, & White, 2008; Wee, Skouteris, Pier, Richardson, & Milgrom, 2011). In summary, research is needed in the area of assessing for the predictive indicators of postpartum depression in men so that therapists can provide interventions that provide preventative measures to postpartum depression in men (Ross et al., 2004).
Attachment Theory

This study will utilize attachment theory to inform the couple-focused interventions. Based on Bowlby’s (1988) theory on attachment, researchers have expanded his framework of the emotional bond between a mother and her infant to explain interaction styles in adult relationships (Cassidy & Shaver, 1999). In adults, self-report measures describe attachment security in the categories of secure, avoidant, or anxious-ambivalent. These measures indicate the adults’ ability to feel comfortable with closeness in relationships or in contrast, anxiety with relationships. Furthermore, studies have found a relationship between attachment security and coping strategies (Mikulincer & Florian, 1998; Ognibene & Collins, 1998). Specifically, Mikulincer and Florian (1998) found that secure attachment in adults corresponds with problem-solving behavior and turning to others for advice and support. In addition, avoidant attachment (discomfort with closeness) corresponds with distancing behaviors and ambivalent attachment (anxiety with relationships) corresponds with affect-laden strategies such a self-blame and wishful thinking.

Attachment needs in adults, are brought to the surface during the stressful and uncertain times during the transition to parenthood (Barnes, 2006). Some studies indicate a link between insecurity and less constructive responses to stress (Feeney, Noller, & Roberts, 2000).

In addition, Barnes (2006) suggested that individuals who are insecure may continue to be unsure of the reliability and responsiveness of their partner. Therefore, the transitional time of becoming new parents can cause a time for emotional vulnerability
for both new mothers and new fathers. Moreover, the initial demands of bringing home a newborn can cause couples to base their own insecure attachment needs being met on how they perceive the responsiveness and reliability of the other (Whiffen & Johnson, 1998). Consequently, unmet attachment needs for couples may cause marital satisfaction to decrease (Feeney et al., 2001; Meredith & Noller, 2003; Sable, 2000) and a sense of hopelessness and depression to increase (Barnes, 2006; Dozier et al., 1999).

Assessing for attachment styles prenatally for both partners can open up opportunities for preventative therapeutic treatment for couples making the transition to parenthood. Measures such as the Experiences in Close Relationships (ECR) can be utilized as a self-report measurement of attachment demonstrating security or discomfort in close relationships or fear of abandonment (Brennan, Clark, & Shaver, 1998). Couples who are securely attached will have a higher capacity to communicate their needs and have the belief that their partner will be reliable and responsive when needed (Whiffen & Johnson, 1998). By taking a strengths-based approach, these couples can be encouraged to take the positive features related to their couple interaction and develop similar secure attachments in their child. On the other hand, couples who have unmet attachment needs would benefit from prenatal, couple treatment to address communicating attachment needs, role changes and flexibility needed to navigate successfully the transition to parenthood (Barnes, 2006). Preventative, therapeutic treatment that is informed by attachment theory has the potential to improve a couple’s marital satisfaction, decrease postpartum depression, and increase the couples’ ability to communicate and meet each other’s needs.
**Therapeutic Interventions During the Transition to Parenthood**

Knowing the needs of couples during the transition to parenthood has led to a variety of interventions. Support groups, educational programs, and couple workshops have been designed to help couples in their relationship to expect the stresses associated with the birth of a first child and to then move to healthy responses by accepting changes in roles and responsibilities (Petch & Halford, 2008). Likewise, in a meta-analytic study of couple interventions during the transition to parenthood, researchers integrated results from 21 couple-focused interventions and found statistically small effect sizes on couple adjustment, couple communication, parenting, and psychological well-being. However from this same study, interventions that included a trained interventionist such as a family therapist showed stronger effects on couple adjustment to the transition to parenthood (Pinquart & Teubert, 2010). While educational programs and support groups have been the focus of intervention during this life change time, couple-focused interventions including a marriage and family therapist, need further investigation (Pinquart & Teubert, 2010).

In another meta-analytic study of 17 interventions for postpartum depression ranging from the use of cognitive behavior therapy, interpersonal psychotherapy, counseling, and social and peer support groups, researchers found moderate effects of these interventions on depression in women with postpartum depression (Murray et al., 2003). Although the effectiveness of various psychotherapies for postpartum depression are effective, specific studies on the effectiveness of systemic family therapy for postpartum depression have not been researched (Hunt, 2006).
In a recent two-part study by Gambrel and Piercy (2014a, 2014b), researchers applied a 4-week relationship enhancement program based in mindfulness practices with couples expecting their first baby. Their phenomenological and mixed methods study looked specifically at the couples’ experiences with the program in a final interview conducted before the baby was born. The themes that emerged from their study were that the couples experienced positive changes for self, described improvements in their couple relationship, felt prepared for baby, and males were involved with partner in pregnancy. Additionally, the authors found that the program especially was beneficial for the men, with significant improvement in relationship satisfaction, mindfulness, and negative affect. While this study has shown that couples did have positive experiences with the mindfulness program, more research is needed to explore couples’ experiences after the baby is born when having received couple-focused, relationship enhancing therapy.

In conclusion, as a systems theorist, an MFT has the unique training required to see and work within the BPSS system of the expecting couple. By applying this lens to the study of the phenomena of the transition to parenthood, the researcher is able to uncover the rich meanings and stories of the participants while they make their journey to parenthood. A variety of interventions have been used and researched, but there still seems to be a paucity of research on capturing the lived experience of couples making this transition while receiving brief, couple-focused, preventative therapeutic interventions, from a biopsychosocial-spiritual model of therapy. This study will fill this gap, giving voice to both mother and father as they make this transition to parenthood and the meaning they attribute to couple-focused therapeutic interventions as they make the
transition to parenthood.
CHAPTER III

METHODS

A descriptive, phenomenological, research design was used to gain a deeper understanding of the nature and meaning of couples experiences as they made the transition to parenthood. The purpose of using phenomenology in research is to describe and interpret the meaning of the participants lived experience in order to understand the essence of the experience from the viewpoint of the participants (Dahl & Boss, 2005). In this study, the phenomenon was the life cycle transition to parenthood with couples receiving brief, couple-focused therapeutic interventions. The couples’ language and meaning from the final interview, along with the descriptive data from the assessments, demographics, and therapist’s topic outline, highlighted each couple’s journey throughout this transition. As a result, this study explored the research question of “What is the lived experience of couples making the transition to parenthood and how do they ascribe meaning to the utility of brief, couple-focused, preventative interventions.”

Epistemological Stance

As a marriage and family therapist using the phenomenological approach to research, it is important to understand the social constructionist, postmodern perspective of a family’s reality, how we obtain knowledge, and how the researcher becomes a part of the phenomena of study (Dahl & Boss, 2005). According to Dahl and Boss (2005), from the postmodern perspective, the researcher is interested in how couples experience their everyday worlds and how their perceptions of what they experience leads to differing
meanings. This meaning, or knowledge, is socially constructed and, therefore, truth is derived from the meaning generated through language and relationships (Anderson, 1997). Therefore, a researcher using the phenomenological approach acknowledges that “we are not separate from the phenomena we study” and this “everyday knowledge is shared and held by researchers and participants alike” (Dahl & Boss, 2005, p. 67). The phenomenological approach from the social constructionist, postmodern perspective, allows family therapy researchers to gain understanding of the meanings in participants’ experiences.

**Participants**

A total of five couples pregnant with their first baby participated in this research study. All participants were heterosexual, married, and reported satisfaction with their relationship as demonstrated by Couple Satisfaction Index scores above 104 at the time of the first session. The Couple Satisfaction Index is a 32-item scale designed to measure one’s satisfaction in a relationship. The range of how long they had been in a relationship was 1 to 9 years (Mean = 4.4, SD = 3.38). The participants all identified as Caucasian and ranged in age from 20 to 26 (Mean age = 23.3, SD = 2.05). Three of the participants were college graduates and the rest had some college. Five of the participants were full-time students, four worked part-time and one worked full-time.

Inclusion criteria used to participate in this study was that the participants needed to be English-speaking, heterosexual, in a committed relationship and pregnant with their first child. The women self-reported that they were between 29 and 33 weeks pregnant.
with their first child. Committed relationship was defined as married or living together for at least six months.

Exclusion criteria included any history of interpersonal violence, problematic substance abuse, or dissatisfaction in their relationship. Only one couple was not eligible to participate in the study due to the fact that she was pregnant with her second child.

**Procedures**

The participants were recruited on a western university campus and through childbirth classes at a local hospital after gaining approval from the hospital (see Appendix A). Recruitment Flyers (Appendix B) were handed out and the participants self-selected by calling the phone number on the flyer to see if they qualified. The flyer briefly described the study and explained the gift card incentives that were given at each session. The couple received a $15.00 gift card at each therapeutic session and then a $25.00 gift card at the final interview. The total value of the incentive was $100.00. Funding for the incentives came from a grant received from local university’s graduate school.

Participants were first screened by phone with the questions, “Are you between 29-33 weeks gestation?” “Are you in a committed relationship as defined as married or living together for at least six months?” “Has there been any violence in the relationship in the past six months as defined as hitting, punching, or pushing?” To screen for substance abuse each partner was asked, “Does your partner have a problem with substance abuse?” To screen for satisfaction in the relationship, each partner was asked, “Overall, are you satisfied with your relationship?”
Participants first read and signed the informed consent (Appendix C) then attended 4 prenatal therapy sessions and 1 postnatal therapy session and a final interview. Prenatal sessions were scheduled on a weekly basis starting around 34 weeks gestation. The postnatal session was scheduled 2-3 weeks after the baby was born. Therapy sessions were structured after a therapy topic outline and schedule (Appendix D) that I developed based on the review of literature and Gottman and Gottman’s (2008) work in their book, *And baby makes three: The six-step plan for preserving marital intimacy and rekindling romance after baby arrives*. Before the first therapy session and before the final interview, the participants answered demographic questions through an online program. Please refer to the appendices for the initial demographic questionnaire (Appendix E) and final interview demographic questionnaire (Appendix F). Assessments were sent to the participants through the same online program 1-2 days before each therapy session. They had until the time of their session to complete the assessments. These assessments provided descriptive data for each couple in regard to their emotional health and relational topics to be used in therapy.

I conducted the prenatal therapy sessions at the university’s site for marriage and family therapy. The sessions lasted approximately 45 minutes to 1 hour. The participants had the option of having the postnatal therapy session at their home or at the university’s clinic. I conducted therapy based upon common factors known to affect the transition to parenthood in conjunction with the individual needs of the couple as revealed through their assessments.
To further explain how therapy was conducted, the following will describe my approach to providing therapy. All therapy sessions were semi-structured using a therapy topic outline (Appendix D) based on past literature and conducted using a model of systems theory that included a biopsychosocial and attachment perspective. In addition, assessments were used to individually guide the treatment goals based on the needs and symptoms presented by each couple. The following will describe how the aforementioned concepts and tools were used in this study.

First, the initial assessments of the CSI, ECR, DASS, PHQ9, and EPDS were used to guide treatment goals for each couple. These goals were individualized to the needs of the couple. For example, if a participant scored high on anxiety or depression, specific techniques such as mindfulness were utilized to decrease symptoms. Additionally, as a systemic therapist, the patterns of interactions that triggered anxiety and depression were explored so that new interactional patterns could be utilized in and out of session. For the couples who presented with low couple satisfaction and high attachment anxiety or avoidance, Emotionally Focused Therapy (Johnson, 2004) was utilized to get to underlying attachment needs and through enactments the participants learned positive ways to recognize and express attachment needs.

As a systemic therapist using a biopsychosocial perspective, I brought into therapy two handouts titled, “How to Connect with Your Baby” (Appendix G) and “The Transition to Parenthood: What the Research Says” (Appendix H). The purpose of these handouts was both educational and to raise awareness of realistic expectations of the biopsychosocial factors that contribute to depression and relationship satisfaction decline
after becoming new parents. Both handouts were discussed systemically during therapy sessions using circular questioning. Additionally, the socially constructed meaning of the topics surrounding becoming new parents was discussed for the purpose of helping the couples create a shared meaning of their new role changes.

My committee chair, who is experienced in phenomenological methodology, then conducted a semi-structured final interview. He used a semi-structured final interview guide (Appendix I) to elicit rich descriptions of experiences of the couples making the transition to parenthood. All interviews took place between four and seven weeks after the birth of the baby. The conversational nature of the in-depth interviewing allowed the researcher to elicit the perceptions of the participants’ experiences through their language and stories (Fontana, 2002). Each interview was semi-structured to gain information about both the man and the woman’s perspective regarding the transition to parenthood and the meaning they ascribed to therapeutic interventions. The data from the final interview was transcribed for qualitative analysis. The data from the demographic questions and therapist’s topic outline were used for descriptive purposes of the participants and of therapy.

**Measures**

Measures were taken at every session, including the final interview. The following section will describe the measures given. Before the first session the following assessments were given: the Couple Satisfaction Index (CSI-32) to assess the quality of the couple relationship (Funk & Rogge, 2007), the Depression, Anxiety, Stress Scale (DASS21) to assess the negative emotional states of depression, anxiety, and stress.
(Lovibond & Lovibond, 1995), the Experiences in Close Relationships (ECR-12) to assess for adult attachment anxiety and avoidance (Brennan et al., 1998), and the Edinburgh Postnatal Depression Scale (EPDS-10) to assess for severity of depressive symptoms in women (Cox et al., 1987), and the Patient Health Questionnaire (PHQ-9) to assess for severity of depressive symptoms in men (Kroenke, Spitzer, & Williams, 2001).

Ongoing assessment of couple satisfaction, as measured by the CSI-32 was given at each therapy session to both partners. Severity of depressive symptoms was assessed at each therapy session through the EPDS for the women and the PHQ-9 for the men. Two days before the semi-structured interview the following assessments were given to each participant: DASS-21, ECR-12, CSI-32, EPDS-10 (for women), and the PHQ-9 (for men).

**Data Analysis**

The first method of data analysis was descriptive information from the initial demographic questionnaire (Appendix E), the final demographic questionnaire (Appendix F), and the therapist’s topic outline and schedule (Appendix D). The demographic questions were compiled to describe the participants as a whole and the therapist’s topic outline and schedule was used to describe therapy.

This phenomenological study followed the data analysis method of template analysis as described by Crabtree and Miller (1999), with the goal of capturing broad categories of information. The first step was to develop a priori themes based on past research and the assumptions of this study. The a priori themes were the nine questions that guided the final, semi-structured interview. These a priori themes were set up in an
excel worksheet for the coders to use as they analyzed the transcripts for themes. According to template analysis methodology these themes were tentative and subject to redefinition or removal.

The next step was to organize and train a coding team. Two undergraduates and one graduate student along with myself made up the coding team. After completing a training session on qualitative data analysis, the coding team followed the template analysis guidelines.

First, the team members individually made repeated readings of the transcript until each team member gained a general sense of the whole experience for each couple. Once there was an understanding of the sense of the whole experience, each team member individually re-read the text to highlight the part of the transcripts that were relevant to the a priori themes established from the final interview questions. Second, the team members individually pulled out meaning units for each theme from each participant and put them into a separate document where they were analyzed to identify a central theme for males, females, and their overall themes. Third, the data analysis team met to integrate through a consensus the male, female, and overall themes that emerged from the data. Finally, the original template was revised to fit the data. When the text revealed inadequacies in the template, modifications and revisions were made and the meaning units were reexamined to produce a revised theme. For example, the template had the section titled, positive experience of motherhood/fatherhood in the original template but after analysis of the meaning units, the coding team changed it to bonding with baby was experienced.
During the data analysis process, I journaled any preconceptions, impressions, insights, and questions experienced to avoid bias of findings and countertransference of the researcher. In addition, the researcher used member checking to report back the findings to the participants to allow them to confirm the findings.

**Validation**

Strategies for evaluating qualitative research were put forth by Lincoln and Guba (1985) to demonstrate credibility, dependability, and confirmability. *Credibility* refers to whether the concepts and themes accurately describe the experience of the participants. To address credibility, the researcher used member checking (Lincoln & Guba, 1985) to report back the findings to the participants who are experts in their own experiences to allow the participant/expert to confirm or correct the interpretation of the data found in the concepts and themes. The researcher/therapist contacted each participant by email to report the essence of the themes discovered in order to get his/her feedback on the accuracy of the statement. See Appendix J for a copy of the email sent to each participant. The researcher asked each participant if the results fit with their experience. As a result of the member checking process the participants agreed with the findings and said that they fit well with their experience.

In addition, the coding team provided credibility through their independent evaluations and their process of agreement or disagreement in the concepts and themes. *Dependability* refers to the ability for other researchers to understand how decisions were made in establishing the themes and their ability to replicate this study. To address dependability, a journal of the decision-making process was used as a record of the
analysis procedural decisions made by the data analysis team. Moreover, a copy of the interview guide was given for future researchers to use, yet it should be expected that new and different meanings should result from the lived experiences of couples in another time and setting. Confirmability refers to the extent to which the findings are based on the data rather than the researcher’s personal constructions (Lincoln & Guba, 1985). To address confirmability, the researcher kept a journal that documented and addressed preconceptions, impressions, insights, and questions during the data analysis.
CHAPTER IV

FINDINGS

The stated purpose of this study was to understand the meaning couples ascribed to making the transition to parenthood with a marriage and family therapist providing brief, couple-focused therapeutic interventions. Their participation included attending five therapy sessions, a final interview, taking assessments, and providing demographic information. The following section will draw together how the participants gave meaning to this transition and their experience with therapy. In addition, I, as therapist, will provide the reader with information gleaned from the therapy sessions to further explain the therapy process and to describe the participants. In the following section are the final demographics describing the participants as a whole and the descriptions of each of the categories and themes along with the words of the participants. Pseudonyms are used to maintain the confidentiality of the participants. To illustrate the categories and themes, quotes from the participants were pulled from the final interview and questions asked in the final survey.

The following will describe the participants as a whole based on the demographic questions from the initial therapy session and the final interview. Due to the small $N$, this data is used for descriptive purposes only, not as statistically relevant data and cannot be generalized to the population.

To illustrate how the couples described their experience, two scaling questions captured how they felt they adapted individually and as a couple. From a question on the final survey, participants were asked, “Using a scale of 0-10, with 10 being extremely
well-adapted and 0 being extremely not well-adapted, how well have you adapted to the transition to parenthood?” The mean was 8.2 ($SD = .79$). With the same scaling question, except for asking how they feel they have adapted as a couple, the mean was slightly higher at 8.6 ($SD = 1.07$).

To illustrate how helpful the participants rated working with a marriage and family therapist, the following scaling question was used in the final survey, “Using a scaling question of 0-10 with 10 being extremely helpful and 0 being extremely not helpful, how helpful has it been to work with a marriage and family therapist through the transition to parenthood?” The mean was 8 ($SD = 1.7$).

From the final assessment using the Couple Satisfaction Index (CSI), 90% of the respondents remained satisfied or slightly increased in their relationship satisfaction. The mean CSI score at intake was 145.2 ($SD =12.44$). At the time of the final interview the mean was 147.5 ($SD = 12.33$). Scores above 104.5 indicate satisfaction in the relationship.

Couples also reported through the Experience in Close Relationships (ECR) assessment a decrease in attachment anxiety and unchanged attachment avoidance. This assessment indicated that the participants felt more secure about the availability and responsiveness of their partners. The mean attachment anxiety score at intake was 3.03 ($SD = 1.02$). At the final interview the attachment anxiety mean was 2.72 ($SD = .69$). Attachment avoidance mean at intake for all participants was 3.95 ($SD = .28$). Attachment avoidance mean scores at the final interview was 3.93 ($SD = .21$). ECR scores are based
on a scale of 1 to 7 with higher scores indicating higher attachment anxiety and avoidance.

To capture how depression, anxiety and stress changed over time the DASS 21 was used at the initial therapy session and at the final interview. For the mean depression score for all participants at the initial session was 5.8 ($SD = 4.76$). By the final interview it had dropped to 3.2 ($SD = 2.70$). Mean anxiety scores at the initial session was 2.8 ($SD = 4.24$) and at the final interview it had dropped to mean .8 ($SD = 1.93$). Mean stress scores at the initial session was 10.8 ($SD = 7.67$) and at the final interview it had dropped to mean 6.6 ($SD = 7.31$). On the DASS 21, depression, anxiety, and stress scores range from 0 to 42. Higher scores indicate a higher degree of symptoms. All mean scores from the initial therapy session and the final interview were in the normal range.

Depression for the women was measured using the Edinburg Postnatal Depression Scale (EPDS) to track risk for postpartum depression. Depression was measured at each session (total of 6 times) using the EPDS. Scores above 10 indicate possible depression. For all of the women depression scores over time went down or stayed the same. One participant had a score above the 10 cut-off, indicating possible depression. She scored 19 at the initial session and 13 at the final interview. When asked if depression fit for her, she said no. The mean at the initial session for all the women was 7.8 ($SD = 6.98$). The mean at the final interview was 4.8 ($SD = 5.45$). See Table 1 for mean scores at every session for the women.
Table 1

_Edinburgh Postnatal Depression Scale (EPDS) for Women_

<table>
<thead>
<tr>
<th>Session</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>7.8</td>
<td>6.98</td>
</tr>
<tr>
<td>Two</td>
<td>8.0</td>
<td>8.28</td>
</tr>
<tr>
<td>Three</td>
<td>7.4</td>
<td>7.70</td>
</tr>
<tr>
<td>Four</td>
<td>7.2</td>
<td>7.40</td>
</tr>
<tr>
<td>Five</td>
<td>5.6</td>
<td>5.59</td>
</tr>
<tr>
<td>Final interview</td>
<td>4.8</td>
<td>5.45</td>
</tr>
</tbody>
</table>

Depression for the men was measured using the Patient Health Questionnaire (PHQ9). Depression was measured at each session. A score of 1-4 is minimal depression; 5-9 is mild depression. For all the men, the scores stayed in the minimal signs of depression and scores came down over time. At the initial session the mean was 3.2 (SD = .84). At the final interview the mean was 2 (SD = 1.41). See Table 2 for mean scores at every session for the men.

Table 2

_Patient Health Questionnaire (PHQ9) for Men_

<table>
<thead>
<tr>
<th>Session</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>3.2</td>
<td>.84</td>
</tr>
<tr>
<td>Two</td>
<td>1.8</td>
<td>.84</td>
</tr>
<tr>
<td>Three</td>
<td>1.6</td>
<td>1.14</td>
</tr>
<tr>
<td>Four</td>
<td>1.4</td>
<td>1.14</td>
</tr>
<tr>
<td>Five</td>
<td>2.8</td>
<td>1.79</td>
</tr>
<tr>
<td>Final Interview</td>
<td>2.0</td>
<td>1.41</td>
</tr>
</tbody>
</table>
From the data provided by the final interviews, the final survey, and therapist’s topic outline, two major categories emerged. The first related to the participants’ experiences of becoming new parents, and the second related to their experiences with therapy. Under the first category of the couples’ description of becoming new parents, five major themes emerged: (a) physical and emotional challenges, (b) bonding with baby, (c) satisfaction in roles and new identity, (d) impact of social support, and (e) stability of relationship satisfaction. Three themes were discovered under the category related to the couples’ experience with therapy: (a) facilitated communication, (b) stress management, and (c) preparation for the transition. See Table 3 for categories and themes.

Table 3

*Major Categories and Themes*

<table>
<thead>
<tr>
<th>Category</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>(1) Physical and emotional challenges</td>
</tr>
<tr>
<td></td>
<td>(2) Bonding with baby</td>
</tr>
<tr>
<td></td>
<td>(3) Satisfaction in roles and new identity</td>
</tr>
<tr>
<td></td>
<td>(4) Impact of social support</td>
</tr>
<tr>
<td></td>
<td>(5) Stability of relationship satisfaction</td>
</tr>
<tr>
<td>II</td>
<td>(1) Facilitated communication</td>
</tr>
<tr>
<td></td>
<td>(2) Stress management</td>
</tr>
<tr>
<td></td>
<td>(3) Preparation for the transition</td>
</tr>
</tbody>
</table>
Category I: Experience and Description of Becoming New Parents

All of the couples had a challenging yet satisfying experience making the transition to parenthood. The new parents faced biological challenges such as lack of sleep, hormone changes due to pregnancy and birth, healing from the birthing process, and breastfeeding. Additionally, they had psychosocial challenges due to life stress, role changes, relationship quality, and social support. The following section will illustrate the themes related to this first category of the participants’ experience and description of becoming new parents.

Theme One: Physical and Emotional Challenges That Occurred During the Transition

Seven out of the 10 participants identified lack of sleep as the biggest challenge they had during the transition. A couple of the women had trouble with breastfeeding resulting in the baby not thriving at first. The men felt challenged with trying to balance work and being home, and then feeling guilty because they did not feel they were helping enough with the baby. These physical and emotional challenges were highlighted in the following quotes:

Gavon: We are definitely tired a lot and then sometimes we get a little short-tempered compared to before, but I think that’s how we’ve learned to recognize more of our issues. [Our therapist] kind of helped us get a little list of tools to help solve our problems quicker or even recognize them and so that’s been helping us a lot.
Marie also echoed what many of the women said; “Probably sleep has been the most challenging thing for me.”

Difficulty with breastfeeding was not only stressful for the women but the men also felt the stress and the extra burden of not being able to help beyond offering support. Allison said, “[Breastfeeding] has been just really frustrating for me because I wanted to just breastfeed her and not have to supplement. . . . You know that it is really better for the baby. It [having to supplement] was just really frustrating.” Allison’s husband, Blake, described the dilemma of wanting to help with the breastfeeding issue but not being able to. Blake stated: “Sleeping has been a challenge. . . . with the whole breastfeeding thing there really isn’t a whole lot I can do to help, and seeing her struggle with it and knowing there isn’t much I can do about it has been really challenging for me.”

Landon and Tyler expressed the challenge they were having with trying to find balance in their roles as father, husband, and provider. Landon said, “I think . . . the work thing is really hard. . . . Looking back I feel guilty because [Marie] is doing a lot on her own during the day, I’m really proud of her too, it is pretty incredible.”

Tyler stated, “I think for me [the most challenging thing] is trying to balance everything. Trying to balance going to school and working almost 40 hours a week, and then trying to spend time with Megan and with the baby. So that’s been a little overwhelming.”

Overall, the biological challenges of healing after the birth and functioning on less sleep compounded with the emotional challenges of hormonal adjustments and feelings of guilt were apparent in the participants. However, the participants were able to
verbalize the reality of the biopsychosocial factors that made the transition challenging. By acknowledging these factors, the couples were able to pull together as a team and support each other through the challenges.

**Theme Two: Bonding to Baby was Experienced**

A common theme emerged from both mothers and fathers in their expression of love for the baby and satisfaction out of meeting the baby’s needs. In the last session before the baby was born we discussed a psycho-educational handout, “How to Connect with Your Baby” (Appendix I) based on the compilation of research done by Gottman and Gottman (2008). The handout was used to encourage discussions in therapy regarding their individual and relational responsibility to create a safe and secure attachment to their child. Topics included the brain research regarding emotional regulation development in a baby, how to engage and be with the baby, and how to recognize signs of overstimulation. These themes emerged in the final interview from the question asking what had been a positive aspect of becoming a new mother/father. The majority of the participants responded in a way that spoke of their love and bonding to the baby. Connor said, “I had been worried beforehand that I wouldn’t feel an attachment to the baby. . . . but over a few days the attachment came.” Gavon also expressed how it was for him to become a new father, “For me it’s just being able to find a new person to love, you know . . . and feeling her love you back.”

The parents expressed a satisfaction of motherhood and fatherhood that included being the ones taking care of the baby and meeting his/her needs. Tammy said, “It’s kind of . . . just this overwhelming love for another person is just really, it’s a neat thing. This
baby relies on me and so I’m important. Landon also stated similarly, “I love the time we spend with [our baby] and just together . . . . I really like that we have someone to take care of . . . and we can take care of him.”

Heather verbalized what it meant to her to see the bonding she saw between her husband and the new baby, “I have loved watching Gavon, how much he loves her . . . that’s super positive for me to see him how much he cares about her. I love that.”

Overall, motherhood and fatherhood was a positive experience for the participants as exemplified by their responses of love and bonding with the new baby. Both mothers and fathers expressed satisfaction with his/her ability to meet the needs of the baby.

**Theme Three: Satisfaction in New Identity**

In this sample, the participants all took on traditional roles of the mother being the primary caregiver and staying home with the baby, and the fathers providing the financial support by working outside the home and/or going to school. A couple of the moms were still in school so they did leave for classes and had to balance doing schoolwork, being a mom, and being a wife. Likewise, the dads were learning to balance work, being a father, and being a husband. In the third session of therapy we discussed realistic expectations of role and identity changes that happen after the birth of the first child. The following quotes from the final interview demonstrate how the participants felt about their new identities and roles after making the transition to parenthood. Megan stated it this way, “Just being home with her [has been a positive aspect of becoming a mother]. . . . I’m not working right now so that’s been awesome.”
For the fathers, the addition of the new role gave them more purpose and meaning in life. Tyler stated, “I feel like it’s made me stronger and grow up more. I feel like it’s helping me to work more . . . do better in school . . . more determined in life.” Blake expressed similar thoughts, “It gives me another . . . purpose. Taking care of [our baby] makes me feel like I am doing meaningful things. It’s been really nice. . . . it’s kind of fun.”

Finding personal meaning in their new roles after becoming a parent benefited these couples as they discovered their socially constructed new identities. These social constructions of roles were discussed and explored during the therapy sessions to help in the communication of role expectations.

**Theme Four: Social Support was Appreciated**

Participants identified friends and family support as a meaningful part of their transition to parenthood. This theme emerged in the final interview when the participants were asked what advice they would give to others going through the transition and what will make the next time easier if they chose to have another child.

Tammy was thankful that she “had a lot of family support.” Her husband, Connor, echoed that sentiment and gave the advice to “let other people help you.” Marie said, “For me it was helpful to turn to people who had already had babies. . . . it was nice to call [friend] . . . and know that there are people who know what you are going through.”

Overall, the participants felt that family and friend support played a helpful part in easing the stresses related to becoming new parents. Family helped with watching the
baby while the parents slept or went out on a date. Friends helped to normalize their experience and the frustrations and stresses associated with being a new mom/dad.

**Theme Five: Relationship Satisfaction Increased or Remained Stable**

To best exemplify how the participants felt their relationship satisfaction fared through the transition to parenthood, Megan stated at the final interview, “Yeah, I think it’s been hard definitely. It’s a huge transition, but I think it’s definitely brought us closer together instead of farther apart . . .” Heather echoed the same acknowledgment of the difficulties and yet how the transition has made them stronger. “It’s like in a lot of ways it has made us stronger and like it has still like been an adjustment. . . . Yeah, I think we are stronger because of it. Having a baby has made me love Gavon more.” Gavon agreed with his wife Heather and added, “We talk about what I can do better and things so we are still keeping the communication open and trying to work together as a team for the baby so it’s been good.”

As a result, the final assessments matched what the participants were saying in the final interview in regards to their relationship satisfaction staying steady or slightly increasing. The participants were able to express how there were challenges yet, from their perspective, the challenges made them grow stronger and closer together.

In sum, the participants in this study all experienced the emotional and physical challenges of becoming new parents and, yet, they felt comfortable using social support from family and friends to help. Additionally, as they took on traditional roles with their new identity of motherhood or fatherhood they felt satisfied and were able to welcome in
the new baby with expressions of love. Finally, satisfaction in the relationship stayed stable for these couples.

**Category II: Experience and Description of Therapy**

Overall, the participants described their experience with couples’ therapy as a helpful and a positive experience. The three themes under the category of experiences and description of therapy included: (1) facilitated communication, (2) stress management, and (3) preparation for the transition. To illustrate the experiences and descriptions of therapy, the following illustrative quotes were provided from the final interviews.

**Theme One: Therapy Facilitated Communication**

The participants identified how communication was enhanced in their interpersonal relationship and how communication encouraged conversations both in and outside of therapy that would not have happened otherwise.

Using emotionally-focused therapy techniques (Johnson, 2004), I facilitated relational communication by exploring the negative interactional patterns, exploring underlying emotions and attachment needs, and enacting new interactional patterns in session. To best illustrate this theme, Megan and Tyler were able to gain understanding into their pattern of Megan holding in stress and anxiety and then exploding in an “outburst” towards Tyler. Tyler would feel attacked and would usually respond in defense. Megan was also able to identify how this pattern was demonstrated in her family of origin and, therefore, gave her more resolution to “not be a yeller like my mom when
the new baby comes.” By raising awareness for both of them to the negative interactional pattern, their underlying needs, and their part in the pattern, this couple was able to explore new ways of interacting in therapy and then transferred that to their interactions at home. Megan said, “There were things I didn’t even realize I needed but then [I learned] . . . to communicate my needs and wants better.”

In addition, therapy was a catalyst for encouraging further communication outside of therapy. From the therapy topic outline (Appendix D) I, as therapist, would ask questions surrounding family of origin relationships, family of origin parenting, fears, and roles that sparked the participants to talk further outside of session regarding how they envisioned and wanted their family culture to be. Connor in the final interview demonstrated this best when he said:

Connor: [I liked] the first couple of sessions when [the therapist] asked kind of deeper questions . . . things that we don’t normally communicate, like some things from our past and family that we really hadn’t talked about . . . . Our communication got bigger and it gave us something to go home and talk about.

Gavon: I think with a few more years we would have figured a lot of that stuff out without counseling but the counseling sped up our maturity with how we look at things and our arguments and where they come from and just our levels of communication and our tools to communicate. It’s just given us a lot more.

Tyler said that it was nice to have someone “initiate . . . conversations because otherwise we wouldn’t because we just get lost talking about everyday things.” Megan likewise articulated how therapy helped her: “I think it’s been great. It kind of brought up things . . . that we wouldn’t have necessarily thought much about. I really liked it a lot.”

Overall, therapy facilitated communication both in and outside of therapy. The participants benefited from awareness of communication patterns and underlying needs and how to communicate those needs through more positive interactions. In addition,
deeper conversations were started in therapy and continued at home due to the therapist initiating topics such as family of origin relationships, family of origin parenting, fears, and role expectations.

**Theme Two: Therapy Taught Us Tools to Deal with Stress**

As true with many couples, becoming new parents is just one of many stressors that are the reality of a couples’ life. Most of the participants in this study were students who were trying to balance school, finding or maintaining jobs, and preparing to be parents all at the same time. They were all going to childbirth preparation classes. Some took additional breastfeeding classes and attended therapy sessions with me while going to college classes and working. Tools such as mindfulness were taught and used in session with the couples. “Mindful relating holds that an open and receptive attention to the present moment (mindfulness) promotes a more accepting and less experientially avoidant orientation to challenging emotions such that more responsive and relationally healthy modes of responding become possible” (Wachs & Cordova, 2007, p. 464). From the final interview, some of the participants reflected on how mindfulness was a skill that they were continuing to use and find helpful. Tyler stated: “. . . we talked about (mindfulness) and how we can think through the stress. That is something I still kind of use. Just thinking it, instead of freaking out.”

Landon: All of the things we learned helped in a lot of ways, like mindfulness. I’ve been using a lot of the things we talked about like [noticing] how we are feeling and then talking about it is one of the biggest things we have kept using [from therapy]. The things I learned were for me, not specific for [the baby] being born . . . . it has been better for myself in general like the mindfulness stuff . . . and helping with [our communication].
In general, the participants found that they were able to apply the use of mindfulness to the everyday stresses after the baby was born. During the therapy sessions, mindfulness was taught as a tool to reduce anxiety and stress prenatally. After this introduction to the concept of mindfulness, the participants applied this method of awareness to other parts of their life.

**Theme Three: Therapy Prepared Us for What to Expect**

The respondents in the final interview stated that the advice they would give to couples about to go through the transition to parenthood would be to educate and prepare for what the challenges are going to be. Similarly, the participants stated that the topics that discussed challenges and what to expect after the baby was born were the most beneficial topics from the therapy sessions. As the therapist, I created a handout titled “What the Research Says” (Appendix J), based on information from the book, *And Baby Makes Three* (Gottman & Gottman, 2008). This handout was used in therapy as a psycho-educational piece and a conversation starter. The handout summarized and listed facts pulled from the research such as: Even though both parents are working much harder, they both feel unappreciated. During the first year after baby is born, the intensity of relationship conflict increases. Sex sometimes declines during the first year after baby is born. New moms become fatigued and have less to offer emotionally to their partners, but they become very involved with their babies. The best predictor of marital adjustment after baby arrives is the quality of friendship in the marriage. The following quotes illustrate how this component of therapy was meaningful to them:
Blake: Try to know the challenges that are going to come up. Because that’s been beneficial to me because with the first visit with (therapist’s name), she told us about some of the challenges that come up in relationships typically when a child is born. So I knew what to expect and so I started to feel this way. . . . and I knew what to expect and how to take care of it already. So I think that just learning about what to expect as far as your relationship with your spouse is huge.

From the final interview, Tammy expressed that the most beneficial topics for her were the ones discussing “expected relationship changes and expectations of bonding with baby.” Gavon also expressed similar thoughts: “Definitely to go to counseling because I don’t think we really needed it but . . . the education of it . . . helps you recognize your issues.”

In sum, even though all of the couples in this study started out with satisfaction in their relationship, they all felt that their relationship benefited from participating in therapy with a marriage and family therapist. Therapy provided not only a psycho-educational component about what to expect during the transition to parenthood, but therapy helped to improve communication and stress management skills.

The transition to parenthood is known to be a time of stress for most couples. In this study I looked at the phenomenon of five couples making this transition and the meaning they ascribed to receiving systemic, couple-focused therapy from a biopsychosocial perspective as they made this journey. While the stress and challenges were apparent, these couples found meaning in their experiences with therapy and the changes associated with the transition.
CHAPTER V
CONCLUSIONS AND OBSERVATIONS

Becoming new parents is typically the first challenging life cycle event that a couple experience. This study looked at the lived experience of couples making this transition to parenthood and the meaning they ascribed to receiving brief, couple-focused therapeutic interventions from a marriage and family therapist. The purpose of this chapter, then, is to discuss how these findings connect back to the literature and how this study adds to the current body of knowledge. Specifically, this section will look at the biopsychosocial framework, impact on couples, impact on fathers, impact on mothers, and impact of therapy. Additionally, limitations, implications, further research, and conclusions will also be discussed.

Biopsychosocial Framework

The participants in this study faced biological and psychosocial challenges during this transition. Biological factors included lack of sleep, hormone changes due to pregnancy and birth, healing from the birthing process, and breastfeeding. Psychosocial factors included life stress, relationship quality, and social support. According to the research, biological variables have an indirect effect on psychosocial stressors and symptoms of anxiety that lead to mood changes in women during pregnancy and the postpartum period (Ross et al., 2004). This study supported the conclusions made by Ross and colleagues (2004) that stated that both biological and psychosocial variables should be considered when working with women during pregnancy and postpartum. As a
result of using this biopsychosocial model in therapy, the therapist was able to gain a more holistic understanding and address in session the complexity of factors affecting this life transition. By using this biopsychosocial model of therapy, the couples in this study felt prepared to accept the biological challenges that they faced, they sought social support when needed, and communicated with each other how the stressors were affecting their mood.

**Impact on Couples**

The majority of the participants in this study fell into the 18% category of marriages that increased in their marriage satisfaction after becoming new parents (Cowan & Cowan, 1995). Shapiro and colleagues (2000) found that the predictors of stable marriage satisfaction over the transition to parenthood included: (1) the husband’s expression of fondness toward her, (2) the husband’s high awareness for her and their relationship, and (3) her awareness for her husband and their relationship. With research informed therapy, the therapist was able to build off of the participants’ strengths and increase their relational awareness and fondness in therapy. As a result, all of the couples remained stable or increased in their marriage satisfaction which is contradictory to findings that state that after the birth of the first child there is a sudden deterioration in marriage satisfaction (Doss et al., 2009).

Petch and Halford (2008) found that factors which contributed to a decrease in marital satisfaction after the birth of a baby included a failure to renegotiate roles and clarify assumptions. In this study, the participants were encouraged to communicate prenatally their assumptions regarding role changes and responsibilities during the
therapy sessions. The couples expressed how bringing up these topics prenatally opened up conversations that would not have happened otherwise.

**Impact on Fathers**

The fathers in this study expressed the challenges they had with trying to find balance in their new roles as father, husband, and provider. The male participants felt guilty for not being more available to take care of the baby and help their wife. This study supports the findings of Halle and colleagues (2008) who found a similar dilemma for men trying to be both the financial provider and physical and emotional supporter to their partner. Other research suggested that this dilemma leads to misunderstanding in role expectations and that men want information to help prepare them for fatherhood (Barnes, 2006). This study added to this research and showed how, as stated earlier, fathers benefited from the prenatal discussions of roles and role expectations and that they felt prepared for the changes and challenges associated with the transition.

**Impact on Mothers**

Two factors affecting women during the transition to parenthood are postpartum depression (Beck, 2001) and women’s socially constructed ideology of motherhood (Choi et al., 2005). In this study, the women at four to seven weeks after the birth had reportedly not experienced postpartum depression. A couple of the mothers did report normal signs of the “baby blues” such as sadness and anxiety that lasted a few days, yet depression symptoms went down over time. These results contradict the literature saying that 13% of women experience major postpartum depression (Beck, 2001).
In addition, the new mothers in this study had realistic expectations and felt prepared for the role and identity changes that accompany the birth of the first child and felt satisfied and well adjusted to the transition. This finding supports the research by Green and Kafetsios (1997) who found that 72% of women had no disappointments about motherhood. Also, the women in this study actively sought out social support from friends and family. This finding contradicts the study done by Cronin and McCarthy (2003) who found that women feel distressed when others offer to help and admitting to wanting or needing help produces feelings of inadequacy. The women in this study not only accepted social support from friends and family, but they recommended that new moms should also actively seek and receive help from others as a way to positively use resources to help during this transition.

Finally, this study supports the importance of the relationship quality as a predictor for postpartum depression as also demonstrated by the meta-data-analysis study by Knudson-Martin and Silverstein (2009). This highlights the need for interventions that include a marriage and family therapist who is trained to facilitate communication and relational connection with couples prenatally.

**Impact of Therapy**

The couples in this study had a positive experience with therapy and found that it was helpful in their adaption to the transition to parenthood. This supports the findings of Pinquart and Teubert (2010) who found that interventions that included a trained interventionist such as a family therapist showed stronger effects on couple adjustment to the transition to parenthood. Specifically, the psycho-educational piece of therapy helped
participants prepare for what to expect in their relationship and how to connect and form
secure attachments with their baby. In therapy, the psycho-educational component was
personalized to each couple and the meaning that they attributed to the information. As a
result of the relational therapy, the couples felt that they adjusted well as a couple,
communication was improved, and psychological well-being was improved including
depression and anxiety decreasing over the transition.

Furthermore, in this study, mindfulness was taught as an intervention to help the
participants gain skills to regulate their emotions during times of stress or conflict. The
practice of mindfulness prenatally helped the couples in the adjustment time after the
baby was born. Using mindfulness as an intervention with couples during the transition to
parenthood has been supported in a recent study by Gambrel and Piercy (2014b). In their
study that specifically used a mindfulness-based relationship education program for
couples expecting their first child, they found similar results of improvements in the
couple relationship.

**Limitations**

The limitations of this study were anticipated from the onset of the design of this
study. First, the participants were recruited through a convenience sampling technique.
The participants self-selected for this study by responding to a research flyer handed out
on campus or at a childbirth class. Future researchers would benefit from obtaining a
broader sample. Second, the results of this research cannot be generalized to the general
population due to the small sample size and lack of diversity in the sample. All of the
participants were Caucasian and heterosexual, with at least some college education. This
limits the generalizability of this study due to the nature of the design of phenomenological research. Third, as assumed in phenomenological inquiry the researcher is not separate from the phenomenon of study and, therefore, it can be seen as a limitation that the research question is influenced by the researchers’ beliefs and experiences. As the researcher/therapist, however, continued self-reflexivity and self-questioning was used as recommended by Dahl and Boss (2005) when conducting this research.

**Implications**

This study provides implications for clinicians working with couples expecting their first child. Specifically, a marriage and family therapist is trained to provide a unique systemic lens to implement the biopsychosocial model to the complexity of issues these couples face. The following section will describe how clinicians can implement systemic theory, the biopsychosocial framework, and attachment theory when working with couples going through the transition to parenthood.

**Systems Theory**

Clinicians who employ systems theory to therapy while working with couples expecting their first child, view the couple as a constantly changing system of interconnected parts. By looking at families through the concept of wholeness, one can see that the addition of a baby to a family system can impact other parts of the system. This study has shown the importance of therapeutically intervening during this life cycle transition as couples explore their internal rules of transformation in regards to roles and
flexibility in the relationship. Furthermore, clinicians practicing under systems theory see the interactions of the couple as a process as opposed to the content and the location of pathology is not within a person. The assumptions of systems theory, therefore, fit well when working with couples going through the transition to parenthood.

**Biopsychosocial Framework**

The biopsychosocial framework provides a roadmap for clinicians to assess holistically, the complexity of factors that interplay during this transition. Biopsychosocial factors that should be assessed include: general anxiety, pregnancy-related fears, emotional understanding of partner, relationship satisfaction, social support, domestic abuse, life stress, history of depression, unintended pregnancy, lower income, lower education, smoking, and single status (Lancaster et al., 2010; Rauchfuss & Maier, 2011; Zachariah, 2009). In addition to assessing and therapeutically intervening, this study also provided psycho-education regarding the biopsychosocial challenges. Couples found that the educational piece prepared them for the reality of the challenges associated with the transition to parenthood.

**Attachment Theory**

Clinicians using attachment theory to inform therapeutic interventions, have the potential to improve couple’s marital satisfaction, decrease postpartum depression, increase the couples’ ability to communicate and meet each other’s need, and potentially create secure attachments in the child. In this study, attachment theory was used to inform the emotionally-focused (Johnson, 2004) therapeutic techniques implemented to improve marital satisfaction and communication skills. Additionally, the psycho-educational
handout titled How to Connect with Your Baby, (Appendix G), prepared couples on the important aspects of forming healthy and secure relationships in the family.

Understanding in attachment theory provides a systemic lens for clinicians to see how by creating secure connections in parents sets the stage for secure attachments in the child.

**Couples**

Prenatal therapy has the potential to improve relationship satisfaction, decrease depression, and positively impact a couples’ ability to adapt to the transition to parenthood. As demonstrated in this study, couples who are encouraged to have conversations prenatally regarding realistic expectations, role changes, ways to handle stress, and ways to improve communication, feel better prepared for the challenges of becoming new parents. The transition to parenthood is a huge transition in life for many couples.

**Latest Research**

This current study fits well with the latest research by Gambrel and Piercy (2014a, 2014b) who demonstrated the effectiveness of a mindfulness-based relationship education program for couples expecting their first child. This study adds to the previously mentioned study by showing how prenatal and relational interventions can have an impact on the outcomes couple going through this transition. Similar results from these studies show how prenatal intervention helped couples to feel prepared for the challenges associated with becoming new parents and improved relationship satisfaction.
Further research is needed in the area of understanding how therapy can assist couples making the transition to parenthood. The following is a list of possible areas where further research is needed.

(1) How would therapy affect couples that are in distress going through the transition to parenthood?

(2) What impact would therapy have on couples going through the transition to parenthood if a larger sample was measured using quantitative analysis?

(3) What would be the longitudinal impact of preventative therapy for couples going through the transition to parenthood?

(4) Are there specific interventions that have larger impact than others on couple adjustment to parenthood?

(5) Does prenatal, couple-focused therapy affect child outcomes such as preterm delivery, birth complications, and mood of baby?

(7) Does systemic therapy based on a biopsychosocial model affect women who are at risk for postpartum depression?

(8) Further research could develop a specific biopsychosocial model to assess couples going through the transition to parenthood.

(9) Knowing the impacts of birth and the immediate postpartum experiences, how effective would it be to use this time period as an assessment marker for how the couple handles stress?
(10) Would other therapists find similar results if a manualized approach was created for clinicians to use as a guide for therapy when working with couples going through the transition to parenthood?

**Conclusion**

This study examined the lived experience of couples making the transition to parenthood and the meaning they ascribed to receiving brief, couple-focused therapeutic interventions from a marriage and family therapist. The transition to parenthood has its challenges, yet therapeutic interventions from a biopsychosocial perspective can help couples facilitate communication, learn tools to deal with stress and prepare for what to expect from the challenges. Parents who have received couple-focused therapy have realistic expectations of the physical and emotional challenges associated with the birth of a first child and are better prepared to handle these stresses as a team. Finally, relationship satisfaction has the potential to remain stable for couples going through the transition to parenthood when preventative interventions with a marriage and family therapist are utilized.
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APPENDICES
Appendix A. Letter of Approval from Hospital
August 30, 2013

Utah State University
Institutional Review Board
4460 Old Main Hill
Logan, UT 84322-4460

To Whom It May Concern:

As the Coordinator of Prenatal Services at Logan Regional Hospital, I approve of the research study being conducted by Dolores Michael and Dave Robinson recruiting pregnant participants from our childbirth classes.

Logan Regional Hospital will not be responsible for any financial, legal, or any other responsibility except for what has been explained as to provide an avenue for recruiting participants for this research study.

Sincerely,

Margo

Margo Christensen RN, BSN, IBCLC
Lactation/Prenatal Services Coordinator
Intermountain Logan Regional Hospital
Intermountain Lactation Standards Team Lead
435-716-5698
margo.christensen@imail.org
Appendix B. Recruitment Flyer
Purpose of Research: To investigate the lived experience of couples making the transition to parenthood while receiving marriage therapy.

Time Requirements:
• 4-weekly therapy sessions prenatally, 1 postnatal therapy session, and 1 final interview

Eligibility:
• English-speaking
• In a committed relationship for at least 6-months
• Satisfied with relationship
• No violence in relationship
• Between 30-34 weeks pregnant

Benefits:
• Gift Cards (Valued at $100/couple) will be given to compensate for your time
• Relationship therapy services and assessments

For more information or to find out if you are eligible please contact:

Dolores Michael 435-881-7591
Appendix C. Informed Consent
INFORMED CONSENT

The Transition to Parenthood

Introduction/ Purpose: Dolores Michael, a master’s degree student in Marriage and Family Therapy and Dr. Dave Robinson in the Department of Family and Consumer Human Development at Utah State University are conducting a research study to find out more about the lived experience of couples as they transition to parenthood. You have been asked to take part because you are pregnant and anticipating the birth of your first child. There will be approximately 6-12 total participants in this research.

Funding: This research will be funded through a graduate research grant awarded through Utah State University.

Procedures: If you agree to be in this research study, you will be asked to complete 4 assessments before the first session through an online program. There will be a total of 5 couple-therapy sessions with a marriage and family therapist graduate student with each session lasting between 45-60 minutes. The location of each session will take place at the Clinic for Marriage and Family Therapy at Utah State University. All therapy sessions and the final interview will be video and audio recorded. The audio recording will be used to ensure the accuracy of information at the therapy sessions and final interview. The following time schedule for the therapy sessions will be used: 34-weeks gestation, 35-weeks gestation, 36-weeks gestation, 37-weeks gestation, (38-40 weeks therapy sessions are optional), and 3-weeks postpartum. At each of these sessions you will be completing two assessments through an online program. The time estimated to complete the assessments is 5-20 minutes. At the 5-6 weeks postpartum time period you will participate in a final interview regarding your experience.

New Findings: During the course of this research study, you will be informed of any significant new findings (either good or bad), changes in the procedures, risks or benefits
resulting from participation in the research, or new alternatives to participation that might cause you to change your mind about continuing in the study. If necessary, your consent to continue participating in this study will be obtained again.

**Risks:** Participation in this research study involves minimal risks. Therapeutic interventions may involve discussing relationships, psychological, and/or emotional issues that may, at times, be distressing. If you feel uncomfortable or become distressed, both researchers are trained to address psychological risks that may arise and they will provide referrals to appropriate psychological services upon request. There is a small risk of loss of confidentiality but we have measures in place to reduce this risk. More information is provided below under “Confidentiality.”

**Benefits:** You will receive relationship therapy and education to help prepare you and your partner for the challenges of having a new baby. This study may also help researchers learn how to provide marital therapy for future parents and have an impact on marital satisfaction.

**Explanation & offer to answer questions:** Dolores Michael has explained this research study to you and answered your questions. If you have other questions or research-related problems, you may reach Dolores Michael at (435) 881-7591 or Dave Robinson at (435) 797-7430.

**Payment/Compensation:** To thank you for participating in this study, each couple in the study will receive a $15 gift card at each of the 5 therapy sessions and a $25 gift card for the final interview for a total of $100.00.

**Voluntary nature of participation and right to withdraw without consequence:** Participation in research is entirely voluntary. You may refuse to participate or withdraw at any time without consequence or loss of benefits. Please contact Dolores Michael at 435-881-7591 if you wish to withdraw from this study.

**Confidentiality:** Study records that identify you will be kept confidential as required by law. Federal Privacy Regulations provide safeguards for privacy, security, and authorized access. Except when required by law, you will not be identified by name, address, telephone number or any other direct personal identifier in study records disclosed outside of Utah State University, except for an update after each session to your physician. Only the investigator and research team will have access to the data which will be kept in a locked file cabinet or on a password protected computer in a locked room to maintain confidentiality. To protect your privacy, personal, identifiable information will be removed from study documents and replaced with a study identifier. Identifying information will be stored separately from data. Audio and video recordings from the therapy sessions and final interview along with identifying information, study identifiers and therapy notes will be destroyed after 5 years. The researchers in this study will follow the code of ethics requirements set by the American Association of Marriage and Family Therapy (AAMFT) requiring therapeutic notes to be kept for 5 years and then destroyed that time period.
Authorization to Release Professional Information: The researchers in this study are working in therapeutic collaboration with the Cache Valley Community Health Center. By participating in this study the following information may be exchanged between the researcher/therapist and the medical provider: treatment summary, progress notes and/or client assessment. Your consent for this release of information is completely voluntary and you may withdraw this authorization at any time. If you decide to withdraw from the study, we will ask your permission to continue using all information about you that has already been collected as part of the study prior to your withdrawal. This consent will automatically expire 3 months after your final interview.

IRB Approval: The Institutional Review Board for the protection of human participants at Utah State University has approved this research study. If you have any questions or concerns about your rights or a research-related injury and would like to contact someone other than the research team, you may contact the IRB Administrator at (435) 797-0567 or email irb@usu.edu to obtain information or to offer input.

Copy of consent: You have been given two copies of this Informed Consent. Please sign both copies and keep one copy for your files.

Investigator Statement: “I certify that the research study has been explained to the individual, by me or my research staff, and that the individual understands the nature and purpose, the possible risks and benefits associated with taking part in this research study. Any questions that have been raised have been answered.”

_______________________________ ______________________________
Dave Robinson Dolores Michael
Principal Investigator Student Researcher
435-797-7430 435-881-7591
dave.r@usu.edu dolores.michael@aggiemail.usu.edu

Signature of Participant By signing below, I agree to participate.

_______________________________ ______________________________
Participant’s signature Date
Appendix D. Therapy Topic Outline and Schedule
Therapy Topic Outline and Schedule

**Session 1** 34 weeks gestation/prenatal

Assessments taken 0-2 days before first session:
- DASS-21
- ECR-12
- EPDS-10 (for women)
- PHQ-9 (for men)
- CSI-32 (for both)

Couple Therapy Topics:
- Address any relevant topics revealed from assessments (e.g. depression, unmet attachment needs) and therapeutic goals
- Review assessments and strengths of relationship
- What the research says – handout
- Family of origin
- Story of courtship and marriage

**Session 2** 35 weeks gestation/prenatal

Assessments taken 0-2 days before second session:
- EPDS-10 (for women)
- PHQ-9 (for men)
- CSI-32 (for both)

Couple Therapy Topics:
- Address therapeutic goals
- Showing appreciation: What has your partner done this past week that made you feel cared for and connected in the relationship?
- Needs
- How might your needs change after the baby is born?
- Realistic expectations for birth, any fears, what if situations

**Session 3** 36 weeks gestation/prenatal

Assessments taken 0-2 days before third session:
- EPDS-10 (for women)
- PHQ-9 (for men)
- CSI-32 (for both)

Couple Therapy Topics:
- Address therapeutic goals
- How to handle conflict in the relationship (softened start-ups, repair attempts, unsolvable problems, processing the aftermath of a fight)
- Supporting role changes/Motherhood/Fatherhood
- Views on roles of parenting a newborn
**Session 4** 37 weeks gestation/prenatal
Assessments taken 0-2 days before fourth session:
- EPDS-10 (for women)
- PHQ-9 (for men)
- CSI-32 (for both)

Couple Therapy Topics:
- Address therapeutic goals
- Intimacy/sex before and after birth
- Emotional closeness
- Ways to handle stress and anxiety – Mindfulness
- How to connect with baby-handout and discussion

**Session 5** 3-weeks/postpartum
Assessments taken 0-2 days before fifth session:
- EPDS-10 (for women)
- PHQ-9 (for men)
- CSI-32 (for both)

Couple Therapy Topics:
- Address therapeutic goals
- Signs of postpartum depression

**Final Interview** 5-6-weeks/postpartum
Assessments taken 0-2 days before final interview:
- DASS-21
- ECR-12
- EPDS-10 (for women)
- PHQ-9 (for men)
- CSI-32 (for both)
Appendix E. Initial Demographic Questionnaire
Initial Demographic Questionnaire

What is your gender?

How old are you?

What is your racial or ethnic origin?

Please indicate the highest level of education completed.

What is your current relationship status?

How long have you been in this current relationship?

Please indicate your current household income in U.S. dollars.

What is your employment status? Please write your occupation in the space provided.
Appendix F. Final Demographic Questionnaire
Final Demographic Questionnaire

At how many weeks gestation was your baby born?

Was the birth vaginal or cesarean?

Were there any medical complications for baby at birth? If yes, please explain.

Were there any medical complications for baby after the birth? If yes, please explain.

Were there any medical complications for mom during the birth? If yes, please explain.

Were there any medical complications for mom after the birth? If yes, please explain.

Using a scaling question of 0-10 with 10 being Extremely Helpful and 0 being Extremely Not Helpful, How helpful has it been to work with a marriage and family therapist through the transition to parenthood?

What topic or topics were most beneficial to you from the therapy sessions?

Was there a topic or topics not covered that you wish had been discussed?

Using a scaling question of 0-10 with 10 being Extremely Well Adapted and 0 being Extremely Not Well Adapted, how well have you adapted to the transition to parenthood?

Using a scaling question of 0-10 with 10 being Extremely Well Adapted and 0 being Extremely Not Well Adapted, how well have you adapted as a couple to the transition to parenthood?
Appendix G. Handout - How to

Connect with Your Baby
How to Connect with Your Baby

What we know from Brain Research:
- During the first 3 years of life the neural structures are being built that have to do with the Baby’s self-soothing, ability to focus attention, trust in parents’ love and nurturance and the security of attachment to mother and father.
- When people experience emotions related to withdrawal, like sadness, fear or disgust, their right frontal lobe lights up.
- When people experience emotions related to engaging with the world, like interest, amusement, affection, happiness and anger, their left frontal lobes light up.
- Studies show that depressed people have more brain-wave activity in the right frontal lobe.
- How you interact and respond to your baby now is setting neurological pathways for how your baby will interact with her world later in life.

Face-to-Face play
- Stay warm and connected
- Stay responsive to your baby’s cues

Signals that baby is overstimulated:
- Looking away
- Shielding face with hands
- Pushing away
- Clearly wrinkled forehead (middle above the nose)
- Arching the back
- Fussing
- Showing a mixture of emotion (joy and fear)
- Crying

What To Do when baby is overstimulated:
- Stay calm
- Let the baby suck on something
- Hold baby close
- Soften your voice

How to know if baby is ready to engage again:
- Calm face and breathing
- Relaxed body

Things NOT to do if baby is overstimulated:
- Don’t move your face in front of baby’s face wherever she moves her head or move baby’s torso to look at you.
- Don’t move your face too close to your baby’s face, so that it is difficult for her to look away.
- Don’t increase the pace of play or increase stimulation after your baby has signaled that she is overstimulated.

Appendix H. Handout - The Transition to Parenthood: What the Research Says
The Transition to Parenthood:
What the Research Says

- Even though both parents are working much harder, they both feel unappreciated.

- During the first year after baby is born, the intensity of relationship conflict increases.

- Sex sometimes declines during the first year after baby is born.

- New moms become fatigued and have less to offer emotionally to their partners, but they become very involved with their babies.

- Both moms and dads undergo major changes in their own identities. Values and goals may change as they now think of themselves as parents, partners, friends, brothers, sisters, daughters and sons.

- New parents often want to be better at parenting than their own parents were with them.

- Culturally in our society, women come in to take care of the new mom and new baby and consequently, new dads get crowded out. Dad’s often respond by withdrawing from their babies and partner, especially if conflict has increased.

- Babies withdraw emotionally from fathers who are unhappy with their relationship with their partners. But babies don’t withdraw from moms who are unhappy with their relationship. This withdrawal from dads can be tragic for the baby’s emotional development.

- The best predictor of marital adjustment after baby arrives is the quality of friendship in the marriage.

Appendix I. Semi-Structured Final Interview Guide
Semi-Structured Final Interview Guide

1. How would you describe your relationship before your pregnancy?

2. Overall, how would you describe your relationship quality as you have made the transition to parenthood?

3. What has been a positive aspect of becoming a new mother/father?

4. What has been the most challenging aspect of becoming a mother/father?

5. How have you supported each other during this transition?

6. What advice would you give to other couples going through the transition to parenthood?

7. Overall, how would you describe your experience working with a marriage and family therapist while making the transition to parenthood?

8. Overall, what did you find most helpful working with a Marriage and Family Therapist?

9. If you were to choose to have another child what do you know now that will make the next time an easier transition?
Appendix J. Member Checking Email
Member Checking Email

Hi,

Part of my qualitative research requires me to check back with the participants to report to them the general findings and themes that I found from my research. Please look through the themes below and share back with me if these themes fit or do not fit with you. Please feel free to add any thoughts or comments that you might have.

Thanks again for your time! I hope that you are all doing well. It was such a pleasure to work with you.
-Dolores

Category I: Experience and Description of Therapy
Description Overall:

Theme 1: Therapy facilitated communication
Theme 2: Therapy taught us tools to deal with stress both individually and as a couple
Theme 3: Therapy prepared us for what to expect

Category II: Experience and Description of Becoming New Parents
Description Overall:

Theme 1: There were physical and emotional challenges
Theme 2: Bonding to baby was experienced
Theme 3: Satisfaction in new role identity