The Transition to Parenthood: Exploration of Systemic Changes and Implications for Future Treatment

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THE TRANSITION TO PARENTHOOD: EXPLORATION OF SYSTEMIC
CHANGES AND IMPLICATIONS FOR FUTURE TREATMENT

by

David B. Jenks

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

of

DOCTOR OF PHILOSOPHY

in

Human Development and Family Studies

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2021
ABSTRACT

The Transition to Parenthood: Exploration of Systemic Changes and Implications for Future Treatment

by

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Utah State University, 2021

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This multi-paper dissertation consists of three chapters related to the transition to parenthood. Chapter two provides a general overview of the transition to parenthood and explores how the biopsychosocial-spiritual model and family systems theory can help to better understand this transformative transition. The purpose of chapter three is to explore the treatment that may be received by families during the transition to parenthood. A discussion on the treatment that may be received in a primary care setting is provided. Solution-focused brief therapy is identified as a therapy model that should be considered by medical family therapists and other health providers as they work with families during this transition to overcome the challenges they are experiencing. A hypothetical case vignette was also used to demonstrate how solution-focused brief therapy could be used by a collaborative care team. Chapter four explores how spiritual fortitude influences the development of perinatal anxiety and depression. A sample of 161 couples completed a questionnaire composed of measures exploring the biopsychosocial-spiritual
aspects of the transition to parenthood. From that questionnaire, measures exploring attitudes towards parenthood, spiritual fortitude, and perinatal anxiety and depression were used to complete an actor partner interdependence mediation model analysis investigating the mediating effect of attitudes towards parenthood on the interaction between spiritual fortitude and perinatal anxiety and depression. Findings suggest that although attitudes towards parenthood do not provide a mediating effect, spiritual fortitude and attitudes towards parenthood are important aspects to explore related to the development of perinatal anxiety and depression. The present work provides additional insight into the development of perinatal anxiety and depression and how providers can intervene to help families identify and achieve a more desired outcome.

(210 pages)
The transition to parenthood is change that alters the very structure of the family system. Families who engage in this transition are often in need of assistance as they navigate and attempt to manage the changes and challenges that arise. The biopsychosocial-spiritual model is a modality that helps providers more holistically examine the biological, psychological, social and spiritual realms of life’s experiences. This model provides a valuable way to look at the transition to parenthood and understand some of the interactions taking place that may contribute to the development of challenges such as mental health concerns. The present dissertation was designed to examine the relationship between the biopsychosocial-spiritual aspects and the transition to parenthood in order to identify ways to help families in need during this transition. A model of therapy, solution-focused brief therapy, is identified and explored as a helpful technique to be used by providers tasked with working with families during the transition to parenthood. A vignette is then used to explore how solution-focused brief therapy can be used by providers working in a collaborative care setting with a couple navigating the transition to parenthood.

Additionally, a sample of 161 couples aged 21 to 44 ($M = 31.52$, $SD = 4.48$) who have given birth or are currently pregnant during the perinatal period completed a questionnaire exploring the biopsychosocial-spiritual aspects during the transition to
parenthood. An Actor-Partner Interdependence Mediation Model was used to explore the relationship between spiritual fortitude and depression and anxiety during the perinatal period as mediated by attitudes towards parenthood. Present findings highlighted the influence that spiritual fortitude has on the development of perinatal depression and anxiety as well as the relationship between attitudes towards parenthood and depression and anxiety during the perinatal period. Although not a mediating effect, this study identified the importance of examining how spiritual fortitude could serve as a buffer against mental health concerns during the perinatal period.
DEDICATION

To my amazing wife, your courage and determination as we have welcomed children into our lives has been awe-inspiring. The things you do for our family are never left unnoticed, you are my greatest support, my ally, and my best friend. I would be nowhere without you.

To all the couples currently or who will in the future engage in the transition to parenthood in some way. I hope that you are able to find solace and comfort in this transformative transition and that if needed you will seek out and receive the care that you need and deserve.
ACKNOWLEDGMENTS

I want to first thank my entire family, both the one I was born to and the one I married into. I have been blessed with wonderful role models and I am grateful for the support and encouragement they have all given me as I have sought to achieve this goal.

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Additionally, I want to thank the Marriage and Family Therapy cohorts I have been able to work with during my time at Utah State University. Their support, humor, guidance, and friendships have contributed to my abilities as a therapist, supervisor, and teacher. I also want to give a special thanks to my fellow doctoral students, especially those in the MFT emphasis, as their unwavering support, encouragement, and willingness to hear me vent was instrumental.

Finally, I would like to thank my wonderful wife and fellow partner in the transition to parenthood, Amanda. Without her support I never would have been able to get to where I am today. Her guidance and patience in these past several years were crucial in my ability to succeed.

David B. Jenks
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CHAPTER ONE

DISSERTATION OVERVIEW

The transition to parenthood (TtP) is an experience that completely transforms the lives of those engaged in it. During this transformative experience, parents may need various resources to help them manage the challenges that come up. By researching the TtP, the needs of those engaging in this transition can be identified. This exploration can lead to a greater understanding of the systemic nature of this transition, which can help providers tasked with caring for these families more holistically treat the challenges they are experiencing, and provide the care and resources they are looking for.

The present dissertation is designed to explore the TtP and present some important considerations to help providers engaged in helping families manage and overcome the challenges they run into as they progress through this transition. The TtP is an experience that the whole family has, not just the mother and the new baby. The purpose behind chapter 2 is to explore the TtP as a systemic experience. To further demonstrate this, family systems theory (Bowen, 1978; Broderick, 1993; von Bertalanffy, 1968) will be used to identify how the whole family is affected by the TtP. Chapter 2 will also explore the transition in relation to the biological, psychological, social, and spiritual aspects of life and how the use of a BPSS assessment (Robinson & Taylor, 2016) will further help providers working with families during this transition to more fully conceptualize the treatment that the family needs.

Chapter 3 is intended to demonstrate how solution-focused brief therapy (SFBT: de Shazer et al., 1986, 2007) can be used in a collaborative care settings to treat and help couples manage the issues that could develop as they navigate the TtP. SFBT is a model
of therapy developed by Insoo Kim Berg and Steve de Shazer that is future-focused and goal-directed (de Shazer et al., 2007). Research has demonstrated the effectiveness of brief interventions utilized in SFBT (Franklin et al., 2017; Gingerich & Peterson, 2013; J. S. Kim, 2008). Research has also explored the possibilities of the use of SFBT in medical settings (Zhang et al., 2018b). Therapists working with couples going through the TtP could use a brief strengths-based perspective, like SFBT, to explore the various facets of a family’s life that may contribute to a loss of functioning or the development of issues. This chapter will also present a case study demonstrating the implementation of SFBT in a collaborative care setting.

Spirituality has been identified as an important coping mechanism during stressful situations (Koenig, 2009). Chapter 4 presents the concept of spiritual fortitude, defined as the overall sense and belief that one can utilize spiritual resources to overcome stressors (Van Tongeren et al., 2019), and is designed to investigate how spiritual fortitude influences the experience families will have during the TtP. Specifically, this study will provide an opportunity to examine how negative attitudes toward parenthood serve as a mediator between spiritual fortitude and perinatal depression and anxiety and potentially buffer the effect that the TtP has on the prevalence of depression and anxiety during the perinatal period. By examining how spiritual fortitude influences the transition, providers can identify ways that the challenges during the TtP could be lessened or made easier to manage by using spiritual coping mechanisms.

The purpose of this dissertation is to bring attention to certain aspects of the TtP that have been neglected in the larger body of research surrounding this transition and how providers can more effectively help families during this transition. By examining the
TTP systemically, providers are more holistically able to treat the entire family and provide the family system with some much-needed resources during this challenging transition. Collectively, these chapters will inform researchers, therapists, and other providers as they work with and help families manage this critical family milestone.
CHAPTER TWO

GENERAL INTRODUCTION TO THE TRANSITION TO PARENTHOOD

With approximately 3.7 million births in the United States in 2018 and 2019 (Martin et al., 2019, 2021) the transition to parenthood (TtP) is a pivotal life stage that many couples are trying to navigate. The TtP may also be seen as one of the most profound transitions experienced and is identified as an important milestone not only for the parents, but also for infant development (Deave & Johnson, 2008). The birth or addition of a child is often an exciting and joyful time, but also brings with it a series of challenges and structural changes (Bost et al., 2002) which the family must adapt to in order to negotiate and establish a sense of balance. If the family system is not able to successfully adapt to these challenges, they may be at increased risk for developing issues or various forms of dysfunction during their transition such as stress related to difficulties managing roles, caring for themselves, psychological fatigue, and relationship strain (Lévesque et al., 2020).

While traditionally viewed as a heterosexual experience, the TtP is not an event solely experienced by heterosexual couples. Research identifies that roughly three million LGBTQ+ Americans have had a child, as well as an estimated six million Americans have an LGBTQ+ parent (Gates, 2013). LGBTQ+ adults transition to parenthood in varying ways including, adoption and foster care (Mallon, 2004), surrogacy (Kim, 2017), within the context of previous heterosexual relationships (Richards et al., 2017), and reproductive technologies (Reczek, 2020). Engaging in the TtP as a heterosexual or LGBTQ+ couple presents different but also similar challenges such as role identity challenges, and stressors associated with the nature of the TtP (Farr & Tornello, 2006).
With the addition of a new family member and as family relationships change, the TtP requires the family to restructure and reorganize (Lindblom et al., 2014). This restructuring is often accompanied by a variety of changes within the family system. As the system attempts to adapt to the changes that take place, they may develop forms of positive functioning. As well, due to their inability to adapt to the changes and restructuring that take place, may also experience a loss of functioning within the family system. Research has identified a variety of changes that take place during the TtP, such as the effect that the transition has on marital satisfaction and quality (Christopher et al., 2015; Doss et al., 2009, 2014; Lawrence et al., 2008; Nourani et al., 2019; Trillingsgaard et al., 2014), the development of postpartum/perinatal anxiety and depression (Don et al., 2014; Figueiredo & Conde, 2011; Goodman, 2004; Matthey et al., 2003; Mitchell et al., 2019; Parfitt & Ayers, 2014), and the influence that parenthood has on work ethic and work related stress (Entricht et al., 2007; Kaufman & Uhlenberg, 2000).

Although excited, parents may often feel unprepared and even apprehensive about managing the changes and potential challenges that occur during the TtP (Deave et al., 2008). Not all families going through the TtP experience issues and many may actually adapt quite well to the new roles they take on (Lévesque et al., 2020; Petch & Halford, 2008). Families who do experience challenges during the TtP may require various forms of treatment. Treatment can refer to any form of outside assistance or professional help that is sought, such as therapy or medical interventions that are used to counteract any forms of dysfunction or issues that develop during the TtP. With the TtP being a normative transition that many families experience, providers need to better understand this transition and how this transition influences individual and family functioning. By
facilitating this understanding, the treatment that is received will be systemically informed, addressing those unique changes and challenges that each member of the family is experiencing.

**Family Systems Theory**

Family Systems Theory (FST: Bowen, 1978; Broderick, 1993; von Bertalanffy, 1968) is a valuable resource in understanding the complex experience of the TtP. FST “is a theory of human behavior that views the family as an emotional unit and uses systems thinking to describe the complex interactions in the unit” (Kerr, 2003, p. 1). This theory identifies that just like a system is composed of a set of objects working together (Hall & Fagen, 1956), the family is composed of a set of individuals connected by relationships. Figure 2.1 represents the core of FST, how each person in a family is connected and often

Figure 2.1

*Family Systems Interactions*

Note. This figure demonstrates the core beliefs regarding FST. All members of the system are interconnected and influence each other.
times influences each other in many ways. These interconnected relationships create a
family system, and emphasize the importance of looking at the whole system, not just
individual parts (Bavelas & Segal, 1982). This framework facilitates an understanding of
the complexity of interpersonal relationships, and provides a unique lens to examine the
TtP. Systemic thinking posits the family as a circular relationship, where the problems of
one individual are connected to another individual and the problems they may be
experiencing (Johnson & Ray, 2016). This implies that issues or difficulties experienced
by one partner during the TtP will contribute to the development of difficulties in the
other partner as well. When families come in to see providers, they bring in complex
interconnected relationships and issues. If providers are unable to adequately see these
relationships, the care or treatment that is provided will not fully address the core of the
presenting problems.

The goal of any system is to maintain a healthy sense of balance, referred to as
homeostasis, and rid the system of disruptions preventing the system from maintaining
that healthy level of homeostasis (Seshadri, 2019). During the TtP, new parents strive to
find that balance as they work within the changes that occur in the family (Lévesque et
al., 2020). In any situation, the family interacts and reacts to external and internal stimuli,
such as the birth of a child, pushing the family to either stay stagnant or adapt and change
(Smith & Karam, 2018). That input then causes the system to change or adapt in some
way demonstrating the ever-changing nature of the family (Becerra & Coffey, 2016;
Smith & Karam, 2018). Depending on the boundaries established by the system, the input
may potentially contribute to a disruption of the system’s homeostasis. Input may come
in a variety of formats and does not necessarily consist of verbal exchanges, but may
refer to “energy, information, or communication flow received from other systems” (Zastrow & Kirst-Ashman, 2007, p. 139). Forms of input could include specific stressor events, social experiences, interpersonal interactions, and even personal or internal changes, all of which may cause some sort of change in the system. The TtP is one of those times where the family is forced to adapt to a change that occurs. In the course of that adaptation and due to the reciprocal nature of the family system, the issues that arise influence everyone in the family.

The TtP changes the ways couples interact (Cox et al., 1999). During this transition, family interactions are altered as preexisting roles are forced to change. With that change, new subsystems are created within the family forcing them to adapt to the structural changes that are taking place. As the family adapts and reorganizes, boundaries separating different subsystems within the family will need to be redrawn in order to integrate the new addition to the family (Lindblom et al., 2014). Roles will also need to be explored as the family adapts with the additional responsibilities related to parenthood (Kerig, 2005).

By recognizing and exploring how each member of the family interacts with and influences every other part of the family, providers could explore and identify some of the contributing factors that cause the family to develop dysfunctions and a less than ideal level of homeostasis. It is important to examine each person in the family to identify how they may affect the presenting problem, and to explore the relationships between each individual and identify how these relationships perpetuate the identified issue.
Biopsychosocial-Spiritual Model

In order to understand why systems experiencing change may develop issues or challenges, providers need to explore what may be contributing to the issues in the first place. One systemic modality that helps providers identify areas that may contribute to the prevalence of issues during the TtP is the Biopsychosocial-Spiritual (BPSS) model (Engel, 1977, 1980; Prest & Robinson, 2006). The BPSS model is an approach that helps therapists and providers more holistically assess the challenges experienced by individuals, families, and any other person that may seek assistance. The BPSS model helps professionals understand the biological, psychological, social, and spiritual aspects of the family’s life and how each part of the family system is interconnected, demonstrating how something that changes or disrupts one part of the system will in turn affect the rest of the system. In the following section, the four BPSS dimensions will be discussed in relation to some of the things an individual may experience during the TtP. For ease of understanding, the four BPSS aspects will be described separately with the hopes that one can see how they are interconnected and significantly relate to each other during the TtP. Figure 2.2 represents the interconnected nature of the BPSS model and identifies some of the things that may be going on in each of these areas.

Biological Issues in the Transition to Parenthood

Families and couples experiencing the TtP go through a wide variety of physical changes. Unsurprisingly, as their body changes to facilitate the growing fetus, the TtP biologically affects mothers giving birth more than anyone else in the family. Pregnancy contributes to a variety of physiological and anatomical changes in mothers that have
significant effects on the their body (Soma-Pillay et al., 2016). Weight gain is one physical change that often occurs during the TtP, not just for mothers but also for fathers (Umberson et al., 2011). Additionally, as the body adjusts, pregnant mothers experience a sudden and dramatic increase in hormones that assist in providing a suitable environment for the development of the fetus (Bhatia & Chhabra, 2018; Venning, 1955). These hormones also influence various physiological changes that the mother goes through (Motosko et al., 2017). Fathers may also experience a shift in hormones during the TtP such as a decline in testosterone (Edelstein et al., 2017). Depending on the stage of
pregnancy, the mother will experience physical changes ranging from backaches, swollen limbs, gastrointestinal issues, changes in breast tissue, weight gain, nausea, fatigue, and sleep problems (Murkoff & Mazel, 2016; The American College of Obstetricians and Gynecologists, 2016). In a normal pregnancy these changes often go away or diminish after birth with minimal lasting effects (Soma-Pillay et al., 2016). As the body changes, women may begin to feel uncomfortable in their bodies, which may result in the development of depression, anxiety and self-esteem issues (Duncombe et al., 2008), which may also influence the development of the same issues in fathers (Goodman, 2008).

In assessing the biological aspects of a client’s life, it is important to look at current and past health issues, as well as various health behaviors such as diet, exercise, sleep and substance use (Robinson & Taylor, 2016). These components can have a large impact on the outcomes related to the TtP. In no way is this an exhaustive list, but some of the questions that could be asked to both partners when assessing the TtP could include:

- What physical symptoms are you most concerned about right now?
- Has there been a history of health concerns in any other pregnancies?
- Have there been any health concerns that have come up because of the transition to parenthood or pregnancy with either you or your partner?

**Psychological Issues in the Transition to Parenthood**

The psychological dimension of the BPSS model is often the most prevalent and it is because of these issues that clients typically seek help from mental
health professionals. Psychological issues may include a number of issues involving cognitive, emotional, motivational, attitude related, and behavioral systems all that affect health in some way (Lehman et al., 2017). Though often experienced individually, the psychological challenges that come up during the TtP can also influence the entire system as well as the BPSS areas of other members in the system. In the exploration of these challenges, it is important to explore not only mental health but also personality, mood, levels of hope, and stressors. In addition to these emotions, there is also a need to explore the psychological states of each member of the family and how they interact with each other in the system (Robinson & Taylor, 2016). During the TtP, psychological issues can come up in a variety of ways. Although many parents adapt well to the changes that occur during the TtP, it may still take a toll on the mental health of these parents (Parfitt & Ayers, 2014). Parents may develop a number of concerns including depression and anxiety (Fairbrother et al., 2015). Depression and anxiety have also been found to contribute to poor outcomes in children (Feinberg et al., 2016; Skouteris et al., 2009), paternal adjustment problems and negative paternal attitudes (Pinto et al., 2020), and have been found to influence marital quality during the TtP (Christopher et al., 2015).

When assessing the psychological dimension of the TtP, the provider explores how the psychological well-being of the family system affects the TtP and how the TtP affects the psychological health of the system. Due to the sensitive nature of the psychological issues clients bring up, providers also need to be aware of and understand potential warning signs that may necessitate crisis management or intervention. During the assessment a provider will explore areas such as personality, mood, current and previous mental health conditions, stressors, levels of hope, and other mental, emotional,
and behavioral areas related to the client’s TtP. Possible questions include:

- Tell me about some of the recent events that have brought you in today.
- Have you experienced any mental health concerns in the past?
- How do you think the current issues have impacted you emotionally and mentally?
- What emotions seem to be coming up the most for you during this experience?
- Have you noticed any changes in how your partner handles daily stressors since this change?

**Social Issues in the Transition to Parenthood**

The social dimension of the BPSS model includes individuals who the family may turn to for support, both inside and outside the family (Robinson & Taylor, 2016). As such, social issues during the TtP may refer to a disruption in social engagement whether between partners, family members, friends and acquaintances, or even a disruption in one’s ability to be social. The couple relationship is also a social relationship that is influenced during the TtP in a variety of ways (Redshaw & Martin, 2014). Oftentimes what couples need during the TtP are effective ways to cope with the changes that are taking place whether that is with psychotherapy, medication, self-help, or other forms of treatment and aid that help to alleviate the stress and difficulties (Cowan & Cowan, 1995; Deave et al., 2008; Parfitt & Ayers, 2014).

Parents may find that they can’t live the life they previously did due to the increased responsibility when children enter the system. Research has explored the effect of social and cultural factors on teenage pregnancies, implying that an individual’s
environment may contribute to teenage pregnancies (Akella & Jordan, 2015). Research has also identified that babies born to mothers with low social support are smaller and born at lower birth weights (Elsenbruch et al., 2007). Mothers with low social support or those who were dissatisfied with the prenatal support they received were also more predisposed to developing mental health issues such as depression (Collins et al., 1993). Social support is believed to be a variable that influences various outcomes in pregnancy (Omidvar et al., 2018). Social sources may also affect the choices that parents need to make during the transition regarding a variety of aspects such as how to feed the baby, what clothing is best, what brands to use, and even the best way to birth the baby. The advice that is received may also affect the mother in different ways, potentially resulting in shame or even guilt because of the choices they have made.

Examining the social support that individuals, families, and couples have is an important part of determining what resources could be utilized to help them manage issues that come up. Low social support has been linked to psychological distress and health related problems (Collins et al., 1993). Traditionally, it is believed that with the announcement of a pregnancy or an impending birth, social support may increase due to the excitement of the event. By examining each of these areas, providers can determine the effect that social factors have on the TtP and how best to intervene in times characterized by dysfunction.

Assessment of the client’s social dimension includes examining where the family turns for support, and how those supports have been affected by the current issues, whether negatively or positively. These social supports may include relationships, friends, colleagues or coworkers, community, sociopolitical environment, and culture
In order to assess this area, the provider may ask some of the following questions:

- Who are members of your support system who you feel are the most supportive right now?
- How have you seen your support system change during this experience?
- How has your current experience influenced your relationship with your partner?

**Spiritual Issues in the Transition to Parenthood**

The final aspect of the BPSS model is spirituality. In order to better understand how spirituality fits into the TtP, it is first necessary to define what spirituality is. Spirituality can refer to a wide variety of things that evoke some sort of impactful response. Spirituality can refer to the religious aspects of an individual’s life or belief in a higher power, but may also include meaning making, level of connection with society, overall experience, respect for nature, and spiritual practices used by the family (Carver & Ward, 2007; Robinson & Taylor, 2016). It has been found that spirituality serves varying purposes during the TtP and during the child’s birth, especially in coping (Bélanger-Lévesque et al., 2016) and meaning making (Klobučar, 2016). It has also been identified that spiritually minded individuals have more access to social support (Hatala, 2013), thus influencing the prevalence of negative outcomes associated with the TtP. Additionally, spirituality is something that has been found to be particularly important to many mothers as they make the TtP (Carver & Ward, 2007). This indicates that spirituality may have important implications in successfully transitioning to parenthood, and may potentially have a large effect on whether or not other facets of family life
contribute to the development of issues during the TtP.

The spirituality aspect of the BPSS assessment may be a challenging aspect to explore due to the individual and unique nature of this dimension. It is important for the provider to understand that the spirituality of the patient refers to more than just religiosity, and may focus more on meaning making around the current event or how they make sense of the experience they are going through. As this portion of the assessment is completed, it may also be helpful to allow the patient to identify their perceptions regarding spirituality. The provider should ensure that the questions asked take the client’s spiritual beliefs and experiences into account. Potential questions could consist of:

- How would you describe your spiritual beliefs?
- What meaning has this transition to parenthood given to your life?
- How has this experience influenced your views on your spirituality?
- How has your spirituality helped you in this current experience?

**Additional Considerations**

In each dimension of the assessment, it is important to develop an understanding of the various beliefs of the patient in order to be more sensitive regarding the questions that are asked and how they may have an influence on their current functioning. Additionally, providers working with LGBTQ+ couples in their TtP, will need to be aware of the unique challenges that are presented to LGBTQ+ parents and understand how to navigate and help them manage the challenges that arise as well as the effect that types of questions may have. The BPSS assessment should be adapted according to the
needs of those seeking care as well as incorporating the various issues that they may be experiencing. The BPSS assessment will help therapists and other providers holistically understand the presenting problems that arise during the TtP and how they could more fully address the needs of the clients and their system. Furthermore, it is also important to explore how the biological, psychological, social, and spiritual facets are interconnected and affect each other. As this is done, the provider gains a clearer picture of how each area plays a part in the presenting problems. This exploration can be facilitated by simply inquiring as to how each aspect may play a part in or is affecting the prevalence of issues experienced in that particular dimension. The following questions may serve as a guide to develop specific questions that explore the interconnected effect of each of the BPSS dimensions.

- How has your spirituality been affected by the physical, psychological, and/or social challenges you are currently experiencing?
- How has your support system been affected by the physical, psychological, and spiritual dimensions of your life?
- How have the physical conditions you are experiencing played a part in the psychological, social, and spiritual dimensions of your life?
- How have the psychological issues you are experiencing impacted the physical, social, and spiritual dimensions of your life?

**Biopsychosocial-spiritual Model and Systems Perspective**

Recognizing the complex interrelated parts that play a direct role in individual functioning contributes to an understanding of how issues could be corrected. The BPSS
model emphasizes that there are a variety of aspects of life that intersect and correlate providing a more holistic view of the factors contributing to the presenting problem (Robinson & Taylor, 2016). For example, an individual’s physical health concerns can also affect them socially, psychologically, and spiritually. By utilizing FST, providers gain an understanding of the importance of examining the family system as a whole, especially in times of dysfunction. As dysfunctions are explored, the BPSS model provides an in depth understanding of specific areas to examine that will help to improve the functioning of the system being explored. As demonstrated in Figure 2.3, the BPSS model is a systemic model that can be used to help understand more specific interactions that are taking place in a family.

**Figure 2.3**

*Systemic Interactions of the Biopsychosocial-Spiritual Aspects*

*Note.* This figure demonstrates how the BPSS model is systemic in nature and the interconnected effects of each BPSS dimension.
Exploring the Transition to Parenthood

During the TtP, the family system is altered in ways that many couples are unprepared for. This experience potentially causes the system to be overwhelmed and stressed as the family system attempts to adapt. The TtP is a very different transition for each parent (Cowan et al., 1985; Moller et al., 2008). Due to individual expectations and sociocultural pressures, each parent may take on different roles during the TtP and may also develop certain behaviors to fit those roles. Katz-Wise et al. (2010) identified in heterosexual couples that “men and women undergo psychological change based on the degree to which their social roles are altered” (p.2). As women give birth, they experience a greater biological role, and with societal expectations regarding motherhood, they may also have a different parenting role (Katz-Wise et al., 2010). Although the father’s role is different, within heterosexual relationships there are still marked societal and relationship pressures for men to fulfill their duties well, typically in the form of breadwinning (Katz-Wise et al., 2010). LGBTQ+ couples planning to begin the transition to parenthood are often faced with similar challenges in adapting to new roles as their heterosexual counterparts (Farr & Tornello, 2006). However, these roles are often discussed and agreed upon and are often more egalitarian in nature (Patterson et al., 2004). Every parent, regardless of gender identity or sexual orientation, experiences a shift in roles that creates a unique and individual experience during the TtP. With the different roles that each parent holds, and with the different experiences that they have, they are in need of different resources during the TtP to make the transition as smooth as possible (Deave et al., 2008; Deave & Johnson, 2008). By recognizing this, providers can develop a treatment plan that takes into account those unique experiences and addresses
the issues that each parent is experiencing.

Utilizing FST and a BPSS assessment, the biological, psychological, social and spiritual areas of a family system can be examined during the TtP to determine how they affect the family as a whole. Although the effect of the TtP may be felt individually in many of these areas, understanding the systemic effect can help inform the treatment used to resolve the presenting issues. Furthermore, it is vital that therapists and other providers work closely with other professionals involved in the client’s care to ensure that the client receives optimal treatment and minimal harm.

**BPSS Treatment During the Transition to Parenthood**

Although typically viewed as a positive experience, the development of issues such as depression, anxiety, and relationship problems can cause the TtP to be a very difficult experience. Every pregnancy and birth are different and may necessitate different resources based on various contextual factors in order to successfully navigate the TtP. It is expected that at some point during the transition, parents and families will feel a degree of stress and distress, which in turn will affect the relationships in the family. This stress could amplify preexisting stressors that are already plaguing a family causing more hazardous issues (Cowan & Cowan, 1995). With a variety of issues that may present during the TtP, the BPSS model and assessment helps providers key in on some of these issues and how they may influence other members of the family system. Once the issues are known, treatment can be provided in a way that best addresses the needs of the client. The treatment may also vary depending on the professionals providing care. With the variety of problems that may come up, treatment needs to be
informed so that it appropriately and adequately resolves the presenting complaints as efficiently as possible.

**Medical Family Therapy**

By identifying the systems that clients belong to and exploring their roles in these systems, the biological, psychological, social, and spiritual realms will naturally be explored. During the TtP, systemic thinking helps caring professionals see how the structural changes to the family system affect both parents. The BPSS model provides a unique way of examining facets of the family’s life that may contribute to the perpetuation of a problem and helps inform how providers can intervene and resolve the issues preventing the family from maintaining homeostasis. Medical Family Therapy (MedFT) is a field within Marriage and Family Therapy that examines the intersectionality of mental health and physical conditions. MedFT often utilizes a BPSS assessment which can be used to explore the biological, psychological, social, and spiritual aspects of the TtP (Doherty et al., 1994; Linville et al., 2007). Oftentimes clients find themselves stuck or confused regarding what they should do to best handle their stressors. These experiences may affect individuals and families in both positive and negative ways. MedFT is unique in that it utilizes the BPSS model and systems perspective as a way to treat individuals and families that struggle with health-related issues (Doherty et al., 1994; Falke & D’Arrigo-Patrick, 2015). Medical concerns are not always addressed in therapy due to a mind-body split that is believed to be the best way to work with clients. This means that therapists typically focus on the psychosocial aspects and leave the medical field to work in the biological realm (McDaniel et al., 1999).
Assessment in therapy is an important component of the client’s experience, and allows the provider to accurately identify what may be perpetuating the presenting problem. Providers need to fully understand what is going on in order to provide the best possible care and to determine the most appropriate treatment plan. The BPSS model provides a holistic way to assess both individuals and families (Robinson & Taylor, 2016). The BPSS assessment helps caring professionals expand their assessment abilities to more than just mental health, it helps them to explore how a client’s biological, social, and spiritual beliefs influence the psychosocial well-being, and how each is interconnected (Hodgson et al., 2016).

A BPSS assessment facilitates the gathering of information regarding aspects of a client’s life in order to understand the issues they are having and how those aspects affect the presenting problem (Robinson & Taylor, 2016). Questions that are asked are specifically tailored to the areas of the BPSS model and focus on each aspect to gather information that can help the provider understand the family, the issues they are going through, and how each dimension is interconnected. During the assessment process, it is important that questions are not just used to assess one partner but both in order to explore the systemic impact of the TtP.

With treatment providers often focused on optimizing and improving the health of the baby and the mother, the treatment that is provided is rarely systemic. Treatment that is provided, in whatever form it takes, needs to take into account the entire system and identify ways to assess and treat the family system as a whole in order to prevent problems from reappearing and disrupting the family system once again. Research conducted on the TtP for LGBTQ+ parents is not as extensive as research on heterosexual
parents, and often focuses on child outcomes, family formation, and stigmas associated with LGBTQ+ parenting. The TtP is just as stressful for all parent dyads regardless of sexual orientation, gender identity, and sexual preference (Farr & Tornello, 2006). The research that has been completed on the TtP for LGBTQ+ parents identifies they are in need of similar forms of support as their heterosexual counterparts (Farr & Tornello, 2006). Furthermore, Farr & Tornello, (2006) identifies that the majority of LGBTQ+ couples need to overcome certain barriers and make certain decisions before becoming a parent. LGBTQ+ parents’ roles are often more egalitarian and they may each be equally impacted by the changes that occur during their TtP (Farr & Patterson, 2013). However, it has been found that the partners who give birth in LGBTQ+ couples experience a greater mental burden than their partners (Lévesque et al., 2020).

In heterosexual partnerships, the father is often neglected in treatment even though both parents are equally affected by the TtP (Deave & Johnson, 2008). The parent who does not give birth can often be a great support for new mothers. Deave and Johnson (2008) identified that although they felt a part of the pregnancies of their partners, men want to be included and often felt excluded from classes and appointments. They also identified the desire for services aimed at them to provide additional support as they made their way through the TtP with their partners. Oftentimes, fathers are told that it is not necessary for them to attend appointments and as previously identified often felt excluded in important decisions. While there is the potential that it is not necessary for fathers to be included in every aspect of prenatal and postnatal care, couples should be encouraged to attend classes and be engaged in the care that takes place before and after the birth due to its systemic influence on the family (Deave et al., 2008).
By systemically examining the TtP and utilizing the BPSS model and assessment, providers gain an understanding of the impact of the TtP on the family. They are also better informed regarding the best treatment approaches to take, and recognize that all individuals involved in the TtP need to be included in treatment. Figure 2.4 demonstrates how the TtP is an experience that greatly influences the BPSS areas of one’s own life as well as those that they are directly in contact with. These interactions should be looked at in order to better understand the effect that the TtP has on the family and how these BPSS areas and interactions can and should be examined in order to better inform treatment.

Figure 2.4

*Biopsychosocial-Spiritual Informed Treatment During the Transition to Parenthood*

By working with the system as a whole, each aspect that potentially contributes to dysfunction in the system can effectively be addressed and worked on. This will help to
promote a system conducive to healthy development and homeostasis. Family
functioning can greatly affect the outcomes that a child experiences (M. J. Cox & Paley,
1997). Improving the system as a whole is better for children in the long run as it helps
parents create a stable foundation that children are then able to grow from regardless of
the effect that the TtP has on the family. The TtP is a complex change that needs to be
studied and examined in order to help families more fully navigate this transition.
Providers can help families work through the issues that arise by recognizing the effect
that the TtP has on the entire family and how issues intersect with and affect the system
as a whole. Although the TtP is often seen as an individual transition for mothers, it also
affects partners, siblings in the family, and even extended family members.

Services that are provided, whether by medical professionals or other providers
need to take into account the whole system and provide care that sufficiently manages all
aspects of the issue. With the TtP being a very common transition for families, it will
always be something that could potentially cause families to struggle as they work
through the challenges that come up. Providers need to be more aware of the
interconnected nature that the TtP has on all aspects of family life in order to more
holistically provide care to patients, clients, and families. Utilizing a BPSS assessment,
providers are able to understand how the TtP systemically impacts various facets of the
family’s life. Then using that information, those providers are able to more effectively
address and treat the presenting problems in a way that accounts for the reciprocal
interconnected nature of the issues experienced during this transition.
CHAPTER THREE

THE USE OF SOLUTION-FOCUSED THERAPY IN COLLABORATIVE TREATMENT DURING THE TRANSITION TO PARENTHOOD

The transition to parenthood (TtP) can be a challenge not only for those engaged in the transition but also for those tasked with assisting and caring for the millions of families that engage in this transition each year. The unique experiences and challenges that each family member has presents the need to identify specific ways for providers to intervene and help in the quickest most effective way possible. The focus of this paper is to inform providers regarding a common treatment modality used by behavioral health specialists called Solution-Focused Brief Therapy (SFBT: de Shazer et al., 2007). An overview of SFBT will be provided, and some of the challenges related to the TtP and the treatment of behavioral health disorders in primary care will be identified. A hypothetical case vignette will be used to provide an example of how behavioral health specialists may use SFBT in a collaborative care setting working with a family during the TtP. Finally, implications for primary care providers will be identified and examples will be offered to demonstrate how they can implement or adapt this modality to their current care practices.

The TtP can be an overwhelmingly difficult, but also enjoyable experience for the majority of couples who participate in this transition (Gottman & Notarius, 2000). During the TtP, it is not uncommon for parents to develop issues such as biological challenges and changes (Edelstein et al., 2017; Soma-Pillay et al., 2016; Umberson et al., 2011), perinatal mental health concerns (Condon et al., 2004; Don et al., 2014; Figueiredo & Conde, 2011; Parfitt & Ayers, 2014), and marital distress, decline, or dissatisfaction.
Collaborative Care

During the TtP families, couples, and individuals experiencing difficulties often approach their primary care providers (PCPs) for assistance. PCPs are often confronted with a myriad of illness, disease, and issues. Many patients who present to primary physicians with physical ailments or issues, including those that may be experienced during the TtP, are also found to have psychological struggles (Blount, 2003). Even though their symptoms are often psychosocial in nature, patients usually seek help from their PCPs first (Goodrich et al., 2013; Grumbach et al., 1999). It is estimated that approximately 70% of patients are diagnosed and treated in primary care settings for some of the most prevalent mental health conditions (Goodrich et al., 2013). Due to the insurmountable amount of additional knowledge and skills they are expected to master in order to provide the best care to their patients, primary care providers may experience burnout or fatigue (Bodenheimer, 2006). These providers often feel overwhelmed due to the additional demands placed on them, which can contribute to longer wait times and subpar care for patients (Bodenheimer, 2006). To counteract this, PCPs have begun to integrate behavioral health specialists into a collaborative care setting (Blount, 2003). It is vital that providers collaborate and work with other specialists who have a background in
behavioral health issues. These behavioral health specialists are then able to work with the PCPs to coordinate care, which may also mean working with a psychiatrist to facilitate psychiatric medicinal needs (Eghaneyan et al., 2014; McDaniel et al., 2014).

Collaborative care is defined as continuous communication between clinicians, such as behavioral health professionals and medical providers, with the purpose of creating a shared treatment plan for patients (McDaniel et al., 2014). A critical part of collaborative care is the establishment of cooperative relationships that facilitate open communication between professionals, structured organization and follow-up, and occasionally working in the same location (Rugkåsa et al., 2020; Young & Skorga, 2013). In order to achieve this collaborative relationship, behavioral health specialists need to develop skills in joining, networking, consulting, and providing larger systemic assessments and interventions (McDaniel et al., 2014). Additionally, collaboration with behavioral health specialists can help medical providers understand what services behavioral health specialist can provide, increasing their skills and abilities to address the psychosocial concerns that may come up as they work with their patients (Blount, 2003).

Collaborative care occurs in a variety of locations including hospitals, clinics, behavioral health centers and in specialty clinics such as cancer clinics, rehabilitation centers, fertility centers, and many other medical locations (McDaniel et al., 2014). The degree of collaboration may also vary depending on the location the services are provided, the abilities and willingness of the behavioral health specialist and medical providers to collaborate, the reception of the other health professionals involved, and also the structure of the agencies involved in the collaboration (McDaniel et al., 2014). There are several models of collaborative care that have been adopted by different
organizations, all of which focus on creating and facilitating communication between behavioral health specialists, case managers, psychiatrists, and PCPs to ensure the proper care of the patients or clients who are seeking help (Eghaneyan et al., 2014; Gask, 2005; Young & Skorga, 2013).

Collaborative care is successful in settings where providers are located in the same clinic, however this is not the only way collaborative care occurs. It can also take place via effective communication between providers who work at different clinics. Communication between specialists is associated with positive patient outcomes (Foy et al., 2010). As the various providers communicate cooperatively, the needs of the patients can be adequately addressed, whether or not providers are in close proximity to one another. The most important elements that ensure effective collaborative care are effective communication and a sense of “commitment to team-based care in which providers have an in-depth understanding of each other's roles and cultures and a shared language” (McDaniel et al., 2014, p. 60). Team-based care is an integral part of collaborate care, and behavioral health specialists are essential members of care teams when working with primary care doctors and other specialists (McDaniel & Fogarty, 2009).

In instances where a behavioral health specialist is not available, PCPs can refer them out to an off-site behavioral health specialist. However, this is not as ideal as having a specialist on-site, since patients may not start treatment if asked to go off-site to receive it (Auxier et al., 2012). A referral to a behavioral health specialist can help patients get much-needed care for the psychosocial challenges they are experiencing. When these referrals take place, communication is vitally important in order to ensure the success of
the referral. Occasionally, physicians have identified that they often receive no follow-up communication from the off-site therapist who received the referral (Ruddy et al., 2008) and therapists identify that at times it can be a challenge to get a hold of the referring physician (McDaniel et al., 2014). Successful collaboration with off-site therapists involves effective communication between the PCP and the behavioral health specialist.

**Medical Family Therapy**

Medical family therapists (MedFTs) are behavioral health specialists who often work in a collaborative care setting and recognize and use “systemic family principles to understand and treat problems” (McDaniel et al., 2014, p 11). Within a healthcare setting, MedFTs work with medical providers as specialists, who often confront unique cultural and contextual factors, as well as the biopsychosocial-spiritual (BPSS) challenges that are often more acute and severe than those faced in conventional behavioral health settings (Trudeau-Hern et al., 2014). Medical family therapy (MedFT) is a systemic, holistic approach that emphasizes that physical health is affected by and interacts with one’s mind, body, relationships, and community (McDaniel et al., 2014). MedFT identifies that there is a connection between health and relationship problems. These problems usually involve the biological, psychological, social, and spiritual aspects of life recognizing that “there are no psychosocial problems without biological features, and there are no biomedical problems without psychosocial features” (McDaniel et al., 2014, p.5).

Exploring the BPSS areas allows the therapist or provider to explore more than just the apparent mental health or physical concerns they are presented with.

Understanding the interconnected nature of the biological, psychological, social, and
spiritual areas of the presenting problem, MedFTs can more fully identify the needs of
the patients and establish a more holistic treatment plan. When MedFTs work in a
collaborative care setting they are able to collaborate with other providers to ensure
clients and patients receive the care they require. When this collaboration occurs,
treatments are more effective and outcomes more positive as the BPSS dimensions are
examined and addressed simultaneously (Bischoff et al., 2012).

**SFBT Overview**

When families present to a medical or collaborative care clinic, due to the varying
severity of the issues, time available, and the needs of families it is necessary to identify
brief forms of treatment that can be used (Lachmar et al., 2019). Examining the effects of
a brief intervention focused on coparenting and the couple relationship Doss et al. (2014)
found promising results indicating that brief focused interventions can be effective in
buffering against some of the stressors associated with the TtP. Additionally, brief
therapy methods have been identified as being a good fit for use in primary care settings
(Giorlando & Schilling, 1997). One brief form of therapy that has been identified to be
particularly effective in the resolution of issues is SFBT (Franklin, 2015; Gingerich &
Peterson, 2013; A. Zhang et al., 2018). Within medical research, SFBT has been
identified and accepted as a collaborative counseling model that works well with the busy
family practice (Greenberg et al., 2001). In this paper, SFBT will be explored to identify
how it could be utilized to more fully assess individuals and couples navigating the TtP.
First, some of the major points of SFBT will be examined and then a hypothetical case
study will be used to further demonstrate how SFBT may be used to treat issues during
the TtP in a collaborative care setting.

SFBT is a therapy model that was developed by Steve de Shazer and Insoo Kim Berg (de Shazer et al., 1986). SFBT is a strength-based approach to mental health that emphasizes strengths and resources (Corcoran & Pillai, 2009), and has been shown to work well with a variety of mental health issues (Franklin, 2015; A. Zhang et al., 2018). SFBT assumes several things, mainly that those receiving services are capable, resourceful, and have the abilities to succeed as they have in the past, meaning they are able to repeat that success (de Shazer et al., 2007). Solution building is one of the most important aspects of SFBT. In SFBT the interventions that are used focus on establishing goals and identifying solutions by finding exceptions (de Shazer et al., 2007; Stermensky & Brown, 2014). When clients generate their own solutions, it helps them to recognize their own abilities as well as see the past solutions that they have been able to utilize.

Although difficult when working with medical concerns, identifying past solutions can be helpful as they explore the current concerns and how past solutions can help them in their current struggles. One way this is facilitated is by reflecting the complaints that come up as goals. A therapist will try to help the client focus on their abilities and the resources they have as well as amplifying those resources to remind the clients of what they are able to accomplish (Chromy, 2007). Additional assumptions include; 1) beliefs that change are facilitated by emphasizing solutions, positives, and possibilities; 2) there is always an exception to the problem; 3) families are competent and are experts in their choices of goals and solutions; 4) there is no one right way to view things because what may seem wrong to one family may be right to another; 5) if it isn’t broken, don’t fix it; and 6) you do not need to know a lot about the problem in order
to solve it (Dermer et al., 1998). With these assumptions, a therapist would traditionally work with the client to help establish their therapeutic goals and the accompanying solutions. As the client progresses in therapy, the therapist starts to adopt an enabling role in helping the client to see that they can solve their problems and issues on their own. During the TtP, a strengths-based approach can be very beneficial to help the family identify how they can succeed and appropriately manage the stressors they experience during this transitional stage.

The acronym MECSTAT developed by Greenberg et al., (2001), adapted from the acronym MED-STAT developed by Giorlando & Schilling, (1997), can be used to assist providers in remembering specific steps when applying a SFBT approach in a healthcare setting. The acronym identifies seven key SFBT interventions and strategies that can be used in brief meetings as well as in ongoing sessions to assist clients or patients in identifying and creating specific goals that will help them overcome their presenting complaints. These interventions include the miracle question, exception questions, coping questions, scaling questions, time-outs, accolades or compliments, and tasks (Table 3.1). The following section will explore these interventions and how they could be used in a collaborative care setting by providers and therapists to assist those navigating the TtP, as well as with any other concerns they may present. In the following, patient and client are used interchangeably to refer to someone receiving help from either a medical provider or a therapist.

**The Miracle Question**

The miracle question is a valuable intervention that could be asked in many different ways. The basic premise is that once the patient goes home, at the end of the day
Table 3.1

**MECSTAT Acronym**

<table>
<thead>
<tr>
<th>M</th>
<th>Miracle Question</th>
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<tbody>
<tr>
<td>E</td>
<td>Exception Question</td>
</tr>
<tr>
<td>C</td>
<td>Coping Question</td>
</tr>
<tr>
<td>S</td>
<td>Sealing Question</td>
</tr>
<tr>
<td>T</td>
<td>Time-out</td>
</tr>
<tr>
<td>A</td>
<td>Accolades or Compliments</td>
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<td>T</td>
<td>Tasks</td>
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they go to bed and while they are sleeping a miracle happens, that miracle is that the problems they have been describing have suddenly been solved. However, once they wake up, they have no idea that the problem has been solved. At this point providers would ask the patient what specifically would clue them in that the miracle has occurred and what would be different because of it (de Shazer et al., 2007). By using the patient’s own imagination, they are able to envision their preferred future and describe what it looks like or even feels like. Adding a BPSS lens to a miracle question could entail asking about each of the BPSS areas and how those areas would be different once the miracle occurred. This would further help the patient to envision and see their future but also how they would be feeling or what they would be experiencing once it was attained.

**Exception Questions**

A common tool used in SFBT is helping patients find exceptions to the problems or issues they are experiencing. Finding exceptions is key in helping move the patient
towards their identified miracle (Giorlando & Schilling, 1997). As the therapist helps patients look for exceptions, the patient is better able to recognize solutions that may already be achievable. Exceptions are usually found through asking the patient to identify a time when the problem or issue would typically be there but was not (Reiter, 2010). By answering this question, the patient is able to recognize instances when they did not have the problem and explore the solutions that they used. They are then able to utilize the identified solutions to help them with their current issues. As exceptions are identified, therapists can assist the patient in creating goals for treatment; “In SFBT, there are no deficient, unchangeable clients, only exceptions and solutions yet to be discovered” (Seedall, 2009, p. 99). Once exceptions and solutions are discovered the patient may feel more capable to implement those solutions.

A therapist needs to be careful and considerate using this intervention in a MedFT setting. When a patient comes in experiencing a health concern, it may be particularly distressing to be asked when there was a time when they didn’t experience that particular health condition because that is their current life circumstance. However, examining and looking for exceptions to health issues may also help to dissipate the hopelessness they feel in their current situation (Giorlando & Schilling, 1997). When working with families navigating the TtP, clinicians can examine previous experiences they have had and identify past coping skills that could be of use in the current moment. An example of how a therapist could format this question is:

Therapist/Medical Provider: Given that life has changed with the new baby, I am curious if there was a time when you may have felt similar stressors and you were able to implement something that helped you to resolve those issues?
The therapist can also be more specific and ask if there was a time when they were previously experiencing physical issues and they were able to resolve them. This can help point them to previous resources they had available to them that could currently help them as well.

**Coping Questions**

Coping questions are especially useful when a patient reports that nothing has changed. This gives providers an opportunity to focus on the positive and inquire as to what they have done in order to prevent the problem from getting worse. Sometimes it is easier to realize that things are good because they have not gotten worse, despite the problem not being solved. When patients feel that they have not made any progress or that their issues have not changed, they may start to have a negative response to the treatment process. Coping questions can also help to uncover concrete actions taken by individuals to help them manage their current predicaments (Greenberg et al., 2001). By postulating that they have actually been able to actively prevent the problem from getting worse, the patient may start to sense a feeling of accomplishment that in turn helps them develop a stronger sense of hope in the future. These emotions can help patients feel that they are at least somewhat in control of the challenges they are experiencing.

**Scaling Questions**

A scaling question is useful when trying to gauge the severity of the presenting problem. The question starts by asking the patient to identify on a scale, typically zero to 10, where they are at in the current moment. Where zero might mean the worst ever and 10 might be the best ever. If the patient says they are at a two or a three the provider may
then be able to ask what they would need to do in order to get to a four or a five, thus finding more solutions. Scaling questions are also valuable because they can give providers a starting point to identify where the patient is now, where they were in the past, and where they want to be in the future. According to de Shazer et al., (2007) there are two main components to scaling questions; first, as an assessment device which can be used in each session to provide ongoing measurement of progress, and second, as a way to focus on exceptions, previous solutions, and a way discover new changes as they occur. This intervention can be used in each session to keep track of how the patient is doing. If the patient rates higher on the scale than they previously did, providers can point out that success and figure out what they did to make that change, however small it may be.

**Time-outs**

Time-outs in a therapy session or an appointment can be very helpful for physicians or therapists to gather thoughts and consult with other professionals, but also for patients to ponder things discussed in the appointment or even to identify additional concerns to bring up after the break. Time-outs also offer the provider a chance to identify and think about the final two steps, especially for formulating compliments or accolades (Giorlando & Schilling, 1997; Greenberg et al., 2001).

**Compliments**

Compliments are an effective way to positively reinforce the changes that patients are making in their lives. It also provides opportunities to emphasize and focus on the positive. Compliments should be used any time the patient describes something they are
doing that is positive or solution building (O’Hanlon & Weiner-Davis, 1989). By nature, patients tend to focus on the negative, not necessarily on purpose, but it is a lot harder to notice the positive things that they are doing when they are confronted by challenges and other concerns. Compliments bring about a positive response, helping the patient feel proud of their accomplishments. A medical or mental health provider can use brief intervention of a compliment in the following way:

Therapist/Medical Provider: That is awesome that you have been able to make so much progress in such a short amount of time. How does it feel to be at this point?

Patient: It feels really good.

Therapist/Medical Provider: Great job! I want you to pay attention to that feeling and recognize that you were able to get here. It was not anything that anyone else did but through your own efforts that it happened.

Tasks

Tasks or homework are commonly used in therapy to help a clinician assess a patient’s readiness to change. Tasks may be assigned in a variety of ways and may ask patients to focus on a specific aspect throughout the assigned timeframe. For example, the clinician can ask the patient to identify exceptions that take place throughout the week, or integrate some part of the scaling or miracle questions used in the session. A common task used in SFBT is the formula first-session task. This task is typically assigned at the end of the first session and commonly directs the patients to be aware and watch for things that are working, as opposed to paying attention to what is not working (Cade & O’Hanlon, 1993).
Although this intervention is traditionally used at the end of the first session, it can be adapted and used in other sessions as a way to help the patient make the mental shift from focusing on the negative to focusing on the positive. Focusing on the positive allows the patient to see the resources that they have and what other positive things they are incorporating into their lives (Adams et al., 1991). During the TtP when parents experience difficulties, it may be hard for them to focus and identify what is going right. This task can help them recognize there may be some good things happening that they were not recognizing before.

Vignette

The following vignette is intended to facilitate a better understanding of how providers on a collaborative care team can work together and how they might use SFBT in their collaborative work with a patient navigating the TtP and experiencing perinatal mental health concerns. The following vignette is meant to demonstrate some of the interventions that can be utilized as various providers work collaboratively with a family going through the TtP and any resemblance to actual persons is purely coincidental.

Trisha is a 28-year-old Caucasian female visiting her provider, Dr. Richardson, for a 6-week follow-up visit after the birth of her first child. Previous to this, Trisha had seen Dr. Richardson and brought up some concerns regarding some symptoms of depression. At that time, she was prescribed 25 mg of Zoloft, increasing to 50 mg after one week to help manage her depression. During the 6-week follow up visit, Dr. Richardson had Trisha fill out a number of questionnaires, a standard practice at their clinic after birth, in order to assess for various complications she may be experiencing.
One assessment that was filled out was the Edinburgh Postnatal Depression Scale (EPDS). Trisha’s EPDS score was 18, which indicated a moderate level of postpartum depression, it also indicated an increase in symptoms since the last time she saw him. Dr. Richardson utilized some SFBT techniques in the following interaction.

**Dr. Richardson**- Trisha it looks like your depressed mood has gotten a little worse since the last time I saw you. Can you tell me how you have been doing?

**Trisha**- I am not really sure, things just feel a little bit worse.

**Dr. Richardson**- I am wondering, if you had to rate the intensity of your depression on a scale of 1 to 10, where 1 means not bad at all, and 10 is the worse it could ever be, where would you rate it on that scale now *(scaling question)*?

**Trisha**- I think maybe a 7. It has definitely gotten worse, last time I would have said it was at like a 4.

**Dr. Richardson**- Wow a 7! That is pretty high. Why do you think it is not an 8 or a 9?

**Trisha**- I think it could definitely get there, but I guess right now I am trying to stay positive, like I am doing better than I could be.

**Dr. Richardson**- That is definitely true. Things could always be worse, but that is amazing that you are trying to staying positive, great job *(compliment)*. Now I am also wondering if you would be interested in talking to my colleague, Carli, who could help you address ways for you to cope a bit better with all of the recent transitions you have gone through? We will work closely
together to address your needs *(referring to behavioral health specialist).*

**Trisha**- I wouldn’t be opposed, and actually I think that might be really helpful.

**Dr. Richardson**- Awesome, Carli is right here in our clinic that makes it really nice because we are able to collaborate together to make sure all your concerns are being addressed.

By using a **scaling question**, Dr. Richardson was able to assess where Trisha was emotionally. This information can be used in future appointments to identify and track changes in her depressed symptoms. By using a **compliment**, Trisha could begin to feel hopeful in her treatment plan and feel more optimistic about her future. After their visit concluded, Dr. Richardson introduced her to Carli, a MedFT working in the clinic as part of their **collaborative care** team. Carli regularly sets aside time to consult with patients in the clinic at the request of their providers if behavioral health issues come up, as well as meeting regularly with those providers in order to discuss the needs of the patients they are treating collaboratively.

Carli met with Trisha for 15 minutes following her visit with Dr. Richardson in order to check in briefly regarding her mental health symptoms and to perform a safety assessment. Trisha reported that she was not currently having suicidal ideation, thoughts of self-harm, or of harming her child and that if those thoughts came up, she was aware of who she could call and what she needed to do to make sure she and her child were safe if she started feeling worse. In this meeting, Trisha disclosed that she had a relatively easy pregnancy in the beginning, but began to feel her emotions getting the best of her later on in the pregnancy, which is when she initially received her prescription for 50 mg
of Zoloft, and continued to see those emotions getting worse after their daughter was born. She reported that when she was initially placed on Zoloft, she felt really good and it really helped but after she had given birth things were just different. At first, she thought it was just baby blues, so she didn’t think much about it, believing that it was a normal part of pregnancy or a reaction to the changing hormones. She identified that she now feels that it is more concerning than she initially thought. The following is how part of their meeting went.

**Trisha**- This is all a lot harder than I thought it would be, I thought I was supposed to be happy and enjoy having a baby, it is just too hard.

**Carli**- I hear you! Your experience with becoming a parent has not been what you expected, and that it has been surprisingly hard. I am wondering if there has been a time since the birth when you have actually felt happy *(exception question)*?

**Trisha**- yeah, I guess there have been times that have been really enjoyable. Sometimes she looks at me with her big eyes and it just hits me, like this is what I have been wanting, and I can tell she loves me and we just connect. But other times it isn’t there.

**Carli**- hmm, what do you think is different about those times where you feel that connection and times that you don’t?

**Trisha**- I don’t know. I guess maybe the times that I feel happy and that connection I am not feeling as stressed.

**Carli**- WOW, so stress may really play a part in those feelings of connection. I am wondering what you have been able to do to not feel stressed in those
moments that you have that connection with your daughter (coping question)?

Trisha- I guess in those moments I have tried not to focus on all the fears I have, or the frustrations that come up. It is really hard to do at times but I kind of just push those things aside.

Carli- That is really awesome that you are able to do that. It really can be hard to not focus on all the hard stuff that comes up (compliment). I am wondering if I can ask you an interesting question? Let’s say that tonight after you get ready for bed, you fall asleep and at some point, while you are sleeping a miracle happens. What that miracle is, is that the emotions, frustrations, and fears you have expressed today have been resolved. But since you were asleep you don’t know that that miracle occurred. However, when you wake up, I am curious what you think the first thing you would notice might be that would clue you in that a miracle occurred? What would tomorrow look like? (miracle question)

Trisha- I think I would just feel happier, I wouldn’t feel like the only thing I was feeling was fear. I think I would also feel a little more support at home, and I would be able to sit down and relax maybe with a book, or feel up to going for a walk.

Carli- That sounds like it would be really nice! It seems like having a little extra help at home would be really nice and being able to relax would definitely help you handle everything that is coming up. Reading or going for a walk would be so nice. Now, it sounds like some of those things may not be
available to you right now, but which of those things might be attainable?

Trisha- Maybe I could go on a walk; I could probably take my baby too. I could also sit down and read while she is sleeping.

Carli- Do you think that is something you could try between now and the next time we meet? I am also wondering if between now and the next time we meet you could pay attention to all the things that are going well throughout the week that you want to keep happening (task).

In this interaction, Carli assigned Trisha the task to go home and go on a walk or read for 30 minutes on her own, she reported that she would complete that task before their next session, in addition to looking for the positive things that are going on that she would want to keep happening. They scheduled another session later on the next week and Carli informed Trisha that she would also follow up with Dr. Richardson when they concluded. After consulting with Dr. Richardson regarding some of the concerns Trisha brought up and how her symptoms had gotten worse, he suggested that it may be helpful to increase Trisha’s dose of Zoloft. Dr. Richardson’s nurse called Trisha to discuss his recommendations and Trisha agreed that it would be worthwhile to try, so Dr. Richardson increased Trisha’s Zoloft to 100 mg daily.

Before their next session Carli called Trisha to check in regarding the past week and how things had been going. Trisha reported that she experienced some frustrations regarding her partner Peter and not feeling like he was helping as much as she needed. Carli discussed with Trisha the importance of addressing the whole system in therapy especially with an event such as having a baby, which affects their whole family unit. Carli invited her to bring in her partner to their next session, and she agreed that it would
be a great idea since she has started noticing some changes in her husband since they had their baby as well.

In the brief meeting that they were able to have following her appointment with Dr. Richardson, Carli wanted to make sure that Trisha was able to do something that helped her to manage some of the symptoms she was experiencing. By using the miracle question, Carli was also able to explore Trisha’s preferred or dream future. In addition to this, by assigning a task Carli was able to help Trisha focus on working and moving toward that preferred future and not focusing on the problems she was experiencing. An important part of the next session is that Peter was invited to attend therapy as well. In order to explore the systemic nature of the issues, it is very beneficial for the immediate system to be present. At times patients may choose to attend sessions individually. If this happens it is important to adapt questions in order to also explore how the other individuals in the system are also affected.

At the beginning of their next scheduled session which was the first session with Trisha’s husband, Carli requested that Trisha and Peter talk a little about their family and how they met. Trisha and Peter reported that they met attending college, while working on completing their bachelor’s degrees. They met through mutual friends and were married a year later. Trisha and Peter reported that they had always wanted a large family because it was an enjoyable experience for each of them growing up, but that they were not sure if they still wanted that now. As Carli asked questions regarding their pregnancy, it was identified that early on Trisha had experienced mood swings and started to have pervasive thoughts regarding something bad happening to the baby and was increasingly concerned that she would hurt the baby. This was when she initially was put on Zoloft.
She reported that she didn’t see a therapist then because it wasn’t a big priority at that
time. They also reported that they have been getting in more frequent arguments
regarding everyday things. Carli continued to inquire about some of their current
concerns and how the mental health concerns were affecting their relationship. Trisha
reported that she felt really lost at times and also felt really inadequate to be able to care
for their daughter. Peter reported that he would begin to feel frustrated and lost, not
knowing how he could help, often resulting in Peter developing similar anxieties and
worries. Due to Trisha’s worries she seemed to prefer to stay indoors and avoided contact
with friends. Peter identified that he was often busy with his schooling and was not able
to be around when Trisha needed him, which seemed to exacerbate some of the issues
they were experiencing. During this same time, Peter started to feel himself withdraw
from interacting with Trisha, the baby, and from social gatherings. He often found it
difficult to focus and concentrate on various tasks, get out of bed in the morning, feel
confident in his abilities, and to generally feel happy. They discussed Peter’s PHQ-9 and
found out that he scored a 14. In this session Carli also began to implement some SFBT
techniques to help identify some of the specific goals that Peter and Trisha want to work
on in therapy:

Carli- It sounds like the past few months have been really difficult for you as
you both have tried to adapt to having a little baby at home, and it hasn’t just
affected you each individually, but also how you interact with others and
maybe even how you are feeling physically. I am wondering if you can think
of a time when you had stressors on the same level as the ones you currently
have, but were able to manage them in an effective way (exception
question)?

Peter- Yeah. I think there have definitely been times where we have managed better. I know for me it seems like I go through periods where it's not as rough and easier to handle. I think the times that I notice that it is easier is when I feel like Trisha is less stressed.

Carli- So it sounds like your mood and abilities to manage some of those stressors and emotions that you are experiencing really relate to how Trisha is feeling.

Peter- Yeah, I can definitely see that.

Trisha- I think I can see that also. There are times when I feel like we are both able to manage it better together, mostly when I feel like we are on a team and really working together to keep everything organized at home.

Carli- So maybe finding a way to work more as a team would help with everything that is going on. On a scale of 1 to 10, where 10 is working as a team all the time and 1 is not being on a team at all and doing your own thing, where is the problem today (scaling question)?

Trisha- I think right now it would feel like a 4 or a 5.

Peter- I think it would be closer to a 5 to me maybe like a 4.5.

Carli- So it’s about right in the middle, not like a 2 or a 3, so that is awesome. What will you need to do to go from a 4 to a 5?

Following this question Trisha and Peter identified specific things that would let them know there had been a change. For example, Trisha said Peter would help her more around the house with chores that she often felt she had to do on her own. Carli worked
with Trisha and Peter to identify if this would be an appropriate goal to work on and how they would know they had accomplished that goal. Additional goals that were identified in this session consisted of Trisha getting her EPDS score down from an 18 to a 10. Trisha also identified that she would feel up to spending time with friends. Additionally, Peter identified that he would feel more connected to Trisha and the baby and would feel more excited about spending time with them instead of feeling stressed. He also identified that he would want to decrease his PHQ-9 score from a 14 to an 8. They both identified that they would spend more time together and work on their relationship.

In subsequent sessions, Carli utilized various types of SFBT questions to check in on their goals and gauge the progress they were having. As Carli identified these successes, she used compliments to help Peter and Trisha recognize the progress that they were making. She also began to use SFBT to help explore how the BPSS areas were interconnected and how they might be affecting the presenting concerns. Carli also assigned tasks at the end of sessions to help Trisha and Peter make progress toward their goals. Carli also checked in with Dr. Richardson regularly to make sure he was aware of changes in Trisha’s symptoms. Both Carli and Dr. Richardson were able to start collaborating with Peter’s doctor, who helped Peter get on some medication to help him manage some of his depressive symptoms. Additionally, when Trisha went to follow up appointments with Dr. Richardson, especially in relation to her medications, he asked scaling questions to check in on how her symptoms had worsened or improved. He also used other techniques, like coping questions and exception questions, to identify successes as well as needs. He then communicated pertinent information to Carli so that these successes or concerns could be addressed in future therapy sessions.
For Peter and Trisha, the TtP was not what they expected it to be. They saw an increase in the amount of conflict they experienced in their relationship regarding everyday things that they may not have argued about before. They avoided contact with each other for fear of being triggered by the actions and emotions the other was exhibiting. Initially seeking care from her doctor, Trisha was able to receive the care she needed as Dr. Richardson collaborated with Carli, the MedFT at the clinic. In addition to receiving therapy, Peter and Trisha were able to receive medication which has been found to be more effective when combined with psychotherapy (Cuijpers et al., 2014). When Trisha and Peter started couples therapy, Carli used SFBT to identify specific goals that would help them reach their envisioned miracle (Franklin, 2015). SFBT utilizes targeted interventions that help clients recognize current and past resources and successes that can be used to uncover future hopes, goals, and solutions (Franklin, 2015). This allowed Peter and Trisha to feel more optimistic regarding their future by helping them recognize their own abilities to reach their desired miracle. The continued collaboration between providers ensured that Peter and Trisha were receiving the care they needed at each step of their treatment.

**Implementation of Interventions**

The vignette used in this paper emphasizes the use of SFBT by a MedFT working in a collaborative care setting, as well as how a provider can use some of these same techniques. The ideas and interventions presented in this paper can also easily be revised and implemented into treatment provided by medical providers. Additionally, by collaborating with behavioral health specialists, medical providers can more effectively
refer to a behavioral health specialist for additional help as needed. SFBT is a model of therapy that has been determined to be particularly beneficial for use in medical settings. This does not mean that SFBT is the only useful model for working with patients in a collaborative care setting, but its brief nature lends it to be particularly helpful in medical settings. SFBT helps the patient shift from a problem mindset to a solution mindset, moving from negative thinking to focusing more on the positive. When patients are in a stressful state, it is difficult to see the positive in their lives. Essentially, the goal in SFBT is to help a client or patient more readily recognize and utilize the positives around them. A MedFT working from a SFBT lens can help patients identify and revisit the positive things that they have in their lives that could help them overcome the current stressors.

When feasible, collaboration with specialists who are able to provide care within their specific domains is ideal. If a patient seeing a primary care physician brings up concerns regarding their ear, nose, or throat, the PCP will refer them to an otolaryngologist in order to help them get the best possible care. Likewise, if a patient brings up concerns regarding mental health issues, they need to be referred to a behavioral health specialist to get appropriate treatment. This may be more practical if there is a behavioral health specialist working in the same clinic or location as the primary care providers. However, at times there may be a need for PCPs to provide some sort of brief behavioral health intervention designed to help patients manage symptoms until they are able to meet with a behavioral health specialist.

SFBT is a great option for providers to implement in their care practices to quickly gauge and identify goals regarding presenting issues. All too often, treatment
planning in medical settings focuses on the problems associated with the presenting concerns, and not the good patients are experiencing as well. By identifying positives and creating goals in relation to the change the patient wishes to achieve, providers can identify the professional collaboration that needs to take place. As well, the information obtained in these brief assessments can be very useful to the behavioral health specialist when collaboration occurs.

As patients meet with their medical providers, especially in the first visit, the MECSTAT acronym can be helpful in identifying how to implement these techniques. Using the example of a new mother coming in for an appointment with concerns surrounding perinatal anxiety, stress, fatigue, and body aches, interventions can be implemented in the following ways. Table 3.2 further outlines the following examples.

The **miracle question** can be used to quickly identify the health goals that the patient has. The miracle question could be used by asking:

- “Let’s say a miracle occurs while you are sleeping and that miracle is that the stress and anxiety you are experiencing are gone. What is the first thing you would notice when you woke up to clue you in that the miracle occurred?”

Using the miracle question the provider is able to give the patient the opportunity to quickly ascertain their preferred future concerning the health issues they are experiencing. This information will help them identify what they would want to be happening instead of the issues they are experiencing. Their preferred future can then be used to develop a treatment plan or identify additional professionals that should be involved in the care that is received.

**Exception questions** can be asked at almost every part of the visit. If a patient
<table>
<thead>
<tr>
<th>Example</th>
<th>Exclamation</th>
<th>Confirmation</th>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>The eggs were dropped today.</td>
<td>The paint was chipped off the wall.</td>
<td>You're supposed to be at work, aren't you?</td>
<td>Where are you?</td>
<td>You're supposed to be at work, aren't you?</td>
</tr>
<tr>
<td>We left the door open.</td>
<td>I saw the cat in the window.</td>
<td>I'm late because of the traffic.</td>
<td>Why are you late?</td>
<td>I'm late because of the traffic.</td>
</tr>
<tr>
<td>I've been working all day.</td>
<td>I'm going to the store.</td>
<td>It rained all day.</td>
<td>Why didn't you go outside?</td>
<td>It rained all day.</td>
</tr>
<tr>
<td>They're not here.</td>
<td>She's coming soon.</td>
<td>I'm going to the store.</td>
<td>Why are you going to the store?</td>
<td>She's coming soon.</td>
</tr>
<tr>
<td>There was a fire.</td>
<td>He's coming soon.</td>
<td>She's coming soon.</td>
<td>Why are you coming soon?</td>
<td>There was a fire.</td>
</tr>
<tr>
<td>The lights are on.</td>
<td>The lights are on.</td>
<td>She's coming soon.</td>
<td>Why are you coming soon?</td>
<td>The lights are on.</td>
</tr>
</tbody>
</table>

Explain a new method to resolve an argument with consensus supporting pertinent matrixes, show graphics, and pose your

The law of laps: Always be ready to

Table 2
feels like the purpose of them coming to the office is to discuss the problems they are having, they may forget the things that they are already doing that help them manage their present concerns. The exception question can be formatted in the following way:

- “Was there a time during the past week or so when you would normally feel fatigued but you didn’t?”

This question allows the patient to identify when they were not troubled by or experiencing a symptom, which opens the door to exploring why they weren’t experiencing that symptom at that time and identify ways to utilize that solution in the future. Part of this may entail examining past treatments they have received that may also be helpful at the current time. If they are unable to identify an exception or if they feel like things haven’t gotten better, a provider can utilize a **coping question** to identify what they have done to prevent the issue from getting worse. For Example:

- “You identified that your anxiety hasn’t gotten worse. What have you been able to do to accomplish that?”

When ailments are experienced, coping skills and techniques can be a valuable resource in alleviating the effect of whatever symptoms are being experienced.

**Scaling questions** may already be in use as providers evaluate symptoms, such as the common, “On a scale of 1 to 10, how would you rate your pain?” Scaling questions can be a great resource to identify and track how symptoms have gotten better or worse. Providers could use scaling questions to gauge troublesome symptoms associated with the TtP such as:
• “On a scale of 1 to 10, where 1 means none at all and 10 means worst imaginable, how would you rate the severity of your body aches (anxiety, stress, fatigue) right now?”

By identifying a baseline and checking in on the rating scale from time-to-time, providers can know if the treatments they are prescribing are helping or if another approach is needed.

As previously identified, time-outs or breaks may or may not be feasible depending on the setting that the session or appointment is taking place. Providers need to use discretion and identify if taking a break will benefit the patient in their current setting or if it would be more of a hinderance. Time-outs can be implemented when medical providers need to collaborate with behavioral health specialists by using a statement such as:

• “You mentioned you would be interested in meeting with a therapist. I want to step out really quickly and see if we could have our behavioral health specialist come in and meet you. While I am gone could you think about some of the concerns you would want to bring up with them?”

An important part of the break is giving some sort of task or assignment to work on while the provider is gone. This helps ensure that time is not wasted and gives patients time to think about aspects discussed in the appointment.

Compliments can be helpful at every point of a session or appointment. Patients need to feel hope regarding their future, especially during the TtP. By validating and acknowledging the positive things they have accomplished, patients will begin to be more confident in their abilities to accomplish their goals, health related or not. An example
would include:

- “How were you able to not let your stress get you down this past week? That is really great, awesome job!”

This example not only commends the patient for the success they had but also helps to acknowledge what they are doing well, motivating them to continue using these tools in the future.

Finally, **tasks** can be used in a number of ways. Essentially the goal behind a task is to get patients to do something that will help them progress towards their goals. When a patient sees their medical provider, they may be assigned health related tasks. For example, if a new mother comes in to an appointment to address fatigue and pain, their doctor might identify things she can do to manage her pain and fatigue. A task that could be assigned is:

- “Between now and the next time I see you, I want you to try to implement some of the coping strategies we identified today that could help you manage the fatigue and pain you are experiencing.”

Additionally, a task may be to have the patient check in with a referral to a pain specialist if deemed appropriate. It is also helpful to give the patient the opportunity to identify or assign themselves a specific task or assignment. When patients are able to identify their own tasks, the likelihood they will actually complete them increases. The tasks they assign themselves will also be directly related to their concerns which will help them stay on track and focused on achieving their goals. An effective question may be:

- “Is there something you want to work on between now and our next appointment related to the topics we discussed today?”
When a provider asks a coping question, the coping mechanisms that are reported can be used as future tasks/homework or even “prescribed” to be used as needed when symptoms arise. Furthermore, if a referral to an off-site behavioral health specialist is provided, a task can be used to assign the patient to follow-up and make a visit with the behavioral health specialist.

While PCPs should not be expected to conduct mental health therapy as a major part of the care they provide for their patients, SFBT presents some techniques that could be implemented to offer more effective aid to their patients (Brimblecombe, 1995; Park, 1997). When patients seek out help, they often focus on the negative, or what is going wrong. By shifting focus to the positive and looking for new or existing solutions, patients are able to identify the resources they need to achieve the change they are looking for (Greenberg et al., 2001). Furthermore, by using some of the basic counseling skills of SFBT, providers can more effectively and efficiently assess the needs of the patients in their offices (Giorlando & Schilling, 1997). Behavioral health specialists may also benefit from using SFBT in therapy if not already doing so.

**Conclusion**

The TtP can be a very challenging experience. As the couple evolves from couple life to parent life, this transformation contributes to a variety of challenges and changes in multiple aspects of their relationship (Nourani et al., 2019). As couples seek help for the challenges associated with the TtP, medical providers and MedFTs have a unique opportunity to provide collaborative care in a variety of ways. They are able to work with families and play a vital role in conceptualizing what is happening in the family’s life that
may be impacting the biological issues as well as the psychological. SFBT presents a unique way of approaching health related challenges and collaboratively working with the patient to help them achieve the goals that they have in regard to their present concerns. The collaborative nature of SFBT can help patients feel heard and understood. By using SFBT and exploring the goals that the patient wants to achieve, patients begin to feel like they have a say in their treatment and the outcomes related to their care.
CHAPTER FOUR

MAKING MEANING IN THE TRANSITION TO PARENTHOOD: THE INFLUENCE OF SPIRITUAL FORTITUDE, ATTITUDES, AND MENTAL HEALTH

The TtP is an important life stage characterized by the preparation to become a parent. During pregnancy and early parenthood, partners have different experiences concerning the roles and expectations that come with this transition (Kline et al., 1991). Research suggests that the TtP for fathers has been ignored in literature, but exploring the TtP for fathers in conjunction with mothers could provide valuable insight (Condon et al., 2004). The perinatal period is a term used to describe the time frame from pregnancy to one year postpartum (Garcia & Yim, 2017; Helfer, 1987). During the perinatal period, couples frequently experience various challenges and stressors as their lives adapt to changes within the system.

The TtP can be a demanding experience for mothers, fathers, and members of the entire family system. Understanding how the family functions as a system helps providers see the reciprocal nature of the stressors that are experienced during the TtP. Furthermore, examining the TtP systemically and exploring how each parent is influenced can help point to various resources that could help the family more effectively transition to becoming parents. The unique experience of the TtP signifies that each parent may be in need of different resources to help them manage and cope as they progress through the TtP (Deave et al., 2008). It is vital to identify which resources or coping mechanisms each parent needs.
As parents engage in the transition to parenthood (TtP), they may face several challenging situations. When stressors and struggles occur, people are often drawn to religious and spiritual sources as a way to cope (Zhang et al., 2021). Spirituality is a broad term that refers to the belief in a higher power, a belief in something bigger than oneself, and a connection to the world, or elements found in nature (Sulmasy, 2002). An individual going through the TtP may find solace in their spirituality, which helps them cope and handle the changes they are experiencing (Amadeo & Sofield, 2006). They may also recognize that specific experiences have the potential to cause them to question their beliefs, lose the beliefs they had, or experience a loss of meaning in life (Swinton, 2001). Just as one’s identity is established through interactions with the environments in which they are found, spirituality plays a role in shaping identity (Pedersen, 2000). Suffering brings about a perceived need or curiosity that may be healed by examining spiritual components (Beng, 2004). During the TtP, spirituality may also bring about a sense of purpose, which helps parents manage during the TtP. The coping mechanisms developed during this transition may help cultivate a sense of spiritual fortitude.

Spiritual fortitude refers to the confidence that an individual has the spiritual resources, or spiritual coping skills, needed to grow and face the stressors they are confronted with (Van Tongeren et al., 2019). Spiritual fortitude is more than just a belief that one has the resources needed. It refers to one’s ability to engage with and utilize their spiritual resources as needed (Van Tongeren et al., 2019). Spiritual fortitude is a trait that compels individuals to engage in positive religious coping, meaning how individuals engage with their spirituality as a form of support (McElroy-Heltzel et al., 2018; Van
Tongeren et al., 2019). Positive religious coping has been identified as a resource that can help individuals restore a sense of meaning in life and improve their overall spiritual well-being (McElroy-Heltzel et al., 2018). Positive religious coping is also related to positive outcomes during stressful events (Ano & Vasconcelles, 2005; Pargament et al., 2001). Spiritual fortitude has been identified as a valuable coping resource in various instances, such as mental health issues related to the COVID-19 pandemic (Zhang et al., 2020) and natural disasters (McElroy-Heltzel et al., 2018; Zhang et al., 2021).

Van Tongeren et al. (2019) identified that people with higher levels of spiritual fortitude show more positive psychological adjustment to significant life stressors. Furthermore, spiritual fortitude may also help individuals engage in meaning-making processes, which can help promote positive religious coping. Their study indicates that spiritual fortitude was positively related to positive religious coping, meaning in life, and spiritual well-being (Van Tongeren et al., 2019). Spiritual fortitude is a distinct construct that may play an essential part in one’s psychological well-being following adversity (McElroy-Heltzel et al., 2018). During the TtP, spiritual fortitude is a potential resource that can help buffer the impact of various challenges on new parents, especially in regards to psychological well-being. Until now, research has not specifically examined the relationship between TtP and spiritual fortitude. Research has examined spirituality and the TtP but has focused on unordinary situations (Bélanger-Lévesque et al., 2016). The potential influence that spiritual fortitude has on the TtP needs to be examined to identify how spiritual fortitude can serve as a resource and coping mechanism for families during the TtP.
Attitudes Towards Parenthood

Attitudes toward parenthood entail beliefs regarding roles, responsibilities, and cognitions that are influenced by the experience the couple is having (Sockol et al., 2014). Parents often experience a number of stressors that contribute to the views and attitudes they have regarding parenthood (Sockol et al., 2014). When attitudes regarding parenthood become more negative and dysfunctional, parents are at increased risk for developing emotional challenges during the TtP (Sockol et al., 2014; Sockol & Allred, 2018). Spiritual fortitude is something that could help prevent negative attitudes towards parenthood from developing. Furthermore, the changes, challenges, and new tasks associated with the TtP may increase the amount of perceived stress that is felt (Doss et al., 2009). Stress has a particularly detrimental effect on the body and birth outcomes during pregnancy and childbirth (Bussières et al., 2015; Chen et al., 2020; Paykel et al., 1980; Witt et al., 2014). The stress that is felt can also influence how a parent views the transition and the attitudes they have regarding the TtP.

Negative attitudes towards parenthood have been shown to influence the development of maternal depression and anxiety during the perinatal period (Sockol et al., 2014). Fathers with negative attitudes towards parenthood also experience high levels of depression and anxiety (Sockol & Allred, 2018). Experiencing problems regarding the infant’s general health, sleeping patterns, colic, feeding, crying, and irritability, as well as vulnerable personalities and previous history of depression, have also been found to influence rates of postpartum depression (Church et al., 2005). While the influence of negative attitudes toward parenthood on depression and anxiety in the perinatal period has been examined, the potential relationship between spiritual fortitude and negative
attitudes towards parenthood has not.

**Perinatal Depression and Anxiety**

During the TtP, the challenges parents experience may contribute to the development of stress, frustration, disappointment, and even feelings of failure, which can contribute to mental health issues during the TtP (Matthey et al., 2000). One of the most common psychological challenges that occurs during the TtP is the development of postpartum depression (PPD). PPD is a common mood disorder that impacts new and experienced mothers alike. PPD can refer to depressive symptoms that develop during pregnancy or are present following the birth of a child into the first year postpartum (Gaynes et al., 2005). It is estimated that 1 in 9 mothers will experience symptoms related to PPD nationwide (Ko et al., 2017). Symptoms of PPD can range from minor depressive symptoms to major depressive symptoms, indicating the unique experience that each mother has following the birth of a child. In addition to typical depressive symptoms, individuals experiencing PPD may also experience: crying more often than usual; feelings of anger; withdrawing from loved ones; feeling numb or disconnected from their baby; worrying that they will hurt the baby; feeling guilt and shame about not being a good parent; doubting their ability to care for the baby; or ambivalence towards the baby and other individuals in the family (Centers for Disease Control and Prevention, 2019).

Most commonly seen in the mothers who gave birth, PPD can also affect fathers. During the perinatal period, approximately 24% to 50% of men whose partners experienced PPD were also found to be experiencing PPD (Goodman, 2004), demonstrating the reciprocal nature of interactions during the TtP. Although there is a
link between maternal PPD and the development of paternal PPD, how maternal PPD affects paternal PPD is still unclear. Additionally, rates of paternal PPD may be higher than many realize (Ly, 2010). Typically, the treatment of PPD focuses on the mother who gave birth or the mother-child relationship (Forman et al., 2007). This neglects the other partner and their potential need for mental health treatment. Including the whole system in treatment is imperative since the birth of a child is a change that impacts the whole family system.

An additional challenge that may occur during the TtP is perinatal anxiety (PA). Compared to PPD, PA has received very little attention (Manassis et al., 1995). Approximately 28.8% of adults will suffer from an anxiety-related disorder in their lifetime (Kessler et al., 2005). Frequently co-occurring with depression, it is believed that individuals may also experience clinically significant levels of anxiety when they report depressive symptoms in the postpartum period (Wenzel et al., 2005). Like depression, anxiety can disrupt life and day-to-day activities and influence various adverse outcomes during the perinatal period (Bauer et al., 2016). PA has also been linked to unfavorable pregnancy-related outcomes such as low birth weight, preterm birth, development of mental health issues, including postpartum depression (Bayrampour et al., 2016; Hay et al., 2010; Heron et al., 2004; Kingston et al., 2012; Narayanan & Nærde, 2016). Mental health challenges during the perinatal period are extremely common. In order to identify how to provide proper care for those experiencing these challenges, the systemic experience of the TtP and mental health concerns needs to be understood.
Biopsychosocial-Spiritual Model

The stressors experienced during the TtP come in a variety of forms and are often unanticipated. Research has identified several different ways the TtP has affected individual aspects such as physical and physiological changes (Edelstein et al., 2017; Motosko et al., 2017; Soma-Pillay et al., 2016), perinatal anxiety and depression (Bauer et al., 2016; Bayrampour et al., 2016; Demontigny et al., 2013; Gillis et al., 2019; Ko et al., 2017; Matthey et al., 2000, 2003), dyadic coping and romantic attachment (Alves et al., 2019), changes in social support (Bost et al., 2002), relational satisfaction (Nourani et al., 2019; Rauch-Anderegg et al., 2020), the spiritual needs of mothers during pregnancy (Carver & Ward, 2007), and meaning-making during the TtP (Klobučar, 2016; Redelinghuys et al., 2014). These examples pertain to the biological, psychological, social, and spiritual aspects of life, which play an essential part in the successful transition to parenthood (Engel, 1977, 1980; Prest & Robinson, 2006).

The BPSS model was developed to help identify how the biological, psychological, social, and spiritual facets of an individual’s life impact the manifestation of a problem in the system (Robinson & Taylor, 2016). An individual or even a family experiencing some sort of change in their lives, such as the TtP, is affected biologically, psychologically, socially, and spiritually. Given the systemic nature of this transition, those experiencing it need to negotiate these aspects in their own life and negotiate these facets with other family members. As providers work with families during the TtP, they need to understand how the biological, psychological, social, and spiritual factors impact the presenting problems with which they are confronted.
The biological, psychological, and social aspects of the TtP have been researched significantly. Each individual in the family goes through biological changes as the TtP progresses. Psychologically, individuals may experience a variety of issues such as sadness, euphoria, anhedonia, fatigue, worry, excitement, and even feelings of worthlessness, guilt, and overwhelm (Baldoni et al., 2020; Mitchell et al., 2019). These symptoms can affect the prevalence of psychological symptoms in their partners (Perren et al., 2005). Socially, the system interacts with and is influenced by other systems during the TtP. For example, if one of the psychological symptoms they are experiencing is depression, it may come with social changes, such as isolation, a common side effect of depression (Yozwiak, 2010).

Couples are also impacted socially within their intimate partner relationships. For example, Doss et al. (2009) identified that both mothers and fathers experience a similar decline in relationship satisfaction following the birth of a child. Thus, the birth of a child inevitably affects how they interact socially with each other, which can influence the connection or lack of connection they develop with family members, neighbors, and other important people. There has not been much research completed exploring spirituality during the TtP. Due to limited research surrounding spirituality and the TtP, the present study aims to gain a better understanding of the relationship between spirituality, negative attitudes towards parenthood, and the prevalence of depression and anxiety during the perinatal period.

**Present Study**

The TtP is a crucial life transition that a large majority of the population may
choose to experience (Martin et al., 2019; White & Booth, 1985). Given the identified interconnection between the psychological states of parents (Goodman, 2004) and the importance of examining the dyadic interactions in a relationship (Kenny et al., 2006), the TtP is one experience that needs to be explored dyadically. The present study aims to fill a crucial gap in the literature by exploring the potential mediating role of negative attitudes towards parenthood on the relationship between spiritual fortitude and depression and anxiety during the perinatal period in mothers and fathers. Spiritual fortitude is a strength that can serve as a buffer or coping mechanism, and can help people more effectively cope in the face of stress (Zhang et al., 2021). While the impact that spiritual fortitude and negative attitudes towards parenthood has on depression and anxiety in parents have been explored separately, the potential interplay of these constructs has not yet been examined.

Research is needed that examines possible antecedents of negative attitudes toward parenting, such as spiritual fortitude, to gain a different understanding of how attitudes might be formed. Furthermore, this study will examine if spiritual fortitude can serve as a buffer during the TtP as it has been for other stressful experiences. This study adopted a dyadic approach using the Actor-Partner Interdependence Mediation Model (APIMeM; Ledermann et al., 2011). Whereas research has explored the TtP for LGBTQ+ parents (e.g., Farr & Tornello, 2006; Gates, 2013), the chosen analysis for this study necessitates distinguishable dyads (Kenny et al., 2006; Ledermann et al., 2011). Distinguishable dyads refer to the ability to distinguish the two dyad members from each other in some way (Kenny et al., 2006). In heterosexual couples/parents, this can easily be done by gender or parental identity (i.e., mother or father). When examining same-sex
couples, distinguishability becomes more difficult because same-sex dyads cannot be
distinguished based on gender (Umberson et al., 2015). The nature of research questions
in this study necessitates the examining of differences between parents during the TtP.
For this reason, heterosexual parents were recruited for the study, however, it is my hope
that future studies will focus on LGBTQ+ couples in their transition to parenthood.
Doing so will find ways to help with the unique challenges faced by LGBTQ+
individuals and partners during the TtP.

Based on the research discussed earlier, the hypotheses that guided this study
were as follows:

**H1:** One’s level of spiritual fortitude will have a significant negative association
with reported levels of depression and anxiety during the perinatal period in mothers and
fathers.

**H2:** One’s partner’s level of spiritual fortitude will have a significant negative
association with their own reported levels of depression and anxiety during the perinatal
period.

**H3:** Negative attitudes toward parenthood will significantly mediate the
relationship between spiritual fortitude and depression and anxiety for mothers and
fathers, respectively, during the perinatal period (actor-oriented mediation effects). This
means that spiritual fortitude will explain depression and anxiety during the perinatal
period through its effect on negative attitudes towards parenthood.

Overall, it is anticipated that this study will help caring professionals understand
the individual and relational dynamics regarding the impact of spiritual fortitude on
depression and anxiety during the perinatal period. As well as how negative attitudes
towards parenthood influence depression and anxiety during the TtP.

**Methods**

**Recruitment**

The target population for this study were partnered mothers and fathers (18 years and older) currently in the perinatal period, identified as conception to 1 year postpartum, with their biological child. Recruitment was done primarily through fliers posted across various websites, social media platforms, and community locations. These fliers informed potential participants of this research study. They also provided participants with a web address where they could complete an assessment focused on the biological, psychological, social, and spiritual aspects of the TtP.

**Participants**

There were 2,101 responses collected from the survey. Of these participants, 1,042 completed the survey in its entirety. The dataset used in this study contained various questions designed to prevent computer bots from adding fraudulent entries to the data. Additionally, participants could remove themselves from the study at the beginning of the survey. As part of the data cleaning process, all responses deemed to be fraudulent were removed, as well as the responses from participants who identified that they did not want to complete the survey. After cleaning the data and linking dyadic responses, the final sample consisted of 161 matched dyads. Participants were asked to create a unique identifier, and they were asked what their partner’s identifier was. These identifiers were compared and linked together, resulting in 161 matched dyads.

Participants were included in the study if they were over 18, currently in the
perinatal period identified as conception to 1 year postpartum, currently pregnant, or had given birth to their biological child, and had completed all of the required measures needed for the analysis. The analysis used in this study necessitated distinguishable dyads. For this purpose, only participants identified as being in a heterosexual relationship were included in the sample. Participant’s ages ranged from 21 to 44 ($M = 31.52$, $SD = 4.48$). The sample consisted of 322 participants (161 dyads) with 74.8% of the sample identifying as Caucasian/White, 13% as American Indian or Alaska Native, 7.8% as African-American/Black, 2.2% as Mexican-American/Hispanic, 1.6% as Asian or Pacific Islander, and .6% as biracial. Participants were able to select different relationship statuses; however, only three were selected, 96.6% of our sample reported being in a first marriage, 3.1% as cohabitating, and .3% as later marriage (widowed, divorced).

Additionally, approximately 79.5% of fathers and 78.3% of mothers reported that the current or recent pregnancy/birth was of their first child. In comparison, about 20.5% of fathers and 21.7% of mothers said that it was their second or third child. Furthermore, 54.4% of the sample reported currently being pregnant, and 45.6% reported being within one year postpartum. Complete demographic characteristics can be found in Table 4.1.

**Table 4.3**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Fathers (n = 161)</th>
<th>Mothers (n = 161)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Race</strong></td>
<td>N (% )</td>
<td>N (%)</td>
</tr>
<tr>
<td>African-American/Black</td>
<td>14 (8.7%)</td>
<td>11 (6.8%)</td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>22 (13.7%)</td>
<td>20 (12.4%)</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>3 (1.9%)</td>
<td>2 (1.2%)</td>
</tr>
<tr>
<td>Biracial</td>
<td>2 (1.2%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Caucasian/White</td>
<td>117 (72.7%)</td>
<td>124 (77%)</td>
</tr>
<tr>
<td>Category</td>
<td>Mexican-American/Hispanic</td>
<td>Other Latinx</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td></td>
<td>3 (1.9%)</td>
<td>4 (2.5%)</td>
</tr>
</tbody>
</table>

**Age**

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Mexican-American/Hispanic</th>
<th>Other Latinx</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-24</td>
<td>8 (5%)</td>
<td>13 (8.1%)</td>
<td></td>
</tr>
<tr>
<td>25-30</td>
<td>43 (26.7%)</td>
<td>56 (34.8%)</td>
<td></td>
</tr>
<tr>
<td>31-35</td>
<td>70 (43.5%)</td>
<td>69 (42.9%)</td>
<td></td>
</tr>
<tr>
<td>36-45</td>
<td>40 (24.8%)</td>
<td>23 (14.3%)</td>
<td></td>
</tr>
</tbody>
</table>

**Relationship Status**

<table>
<thead>
<tr>
<th>Status</th>
<th>Mexican-American/Hispanic</th>
<th>Other Latinx</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cohabiting</td>
<td>4 (2.5%)</td>
<td>6 (3.7%)</td>
<td></td>
</tr>
<tr>
<td>Married: first marriage</td>
<td>156 (96.9%)</td>
<td>155 (96.3%)</td>
<td></td>
</tr>
<tr>
<td>Married: Later marriage (Widowed, divorced)</td>
<td>1 (0.6%)</td>
<td>0 (0%)</td>
<td></td>
</tr>
</tbody>
</table>

**Relationship Length**

<table>
<thead>
<tr>
<th>Length Range</th>
<th>Mexican-American/Hispanic</th>
<th>Other Latinx</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-5 years</td>
<td>80 (49.7%)</td>
<td>80 (49.7%)</td>
<td></td>
</tr>
<tr>
<td>6-10 years</td>
<td>64 (39.8%)</td>
<td>64 (39.8%)</td>
<td></td>
</tr>
<tr>
<td>11-15 years</td>
<td>11 (6.8%)</td>
<td>11 (6.8%)</td>
<td></td>
</tr>
<tr>
<td>16-20 years</td>
<td>5 (3.1%)</td>
<td>5 (3.1%)</td>
<td></td>
</tr>
<tr>
<td>21+ years</td>
<td>1 (0.6%)</td>
<td>1 (0.6%)</td>
<td></td>
</tr>
</tbody>
</table>

**Number of Children**

<table>
<thead>
<tr>
<th>Number of Children</th>
<th>Mexican-American/Hispanic</th>
<th>Other Latinx</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st child</td>
<td>128 (79.5%)</td>
<td>126 (78.3%)</td>
<td></td>
</tr>
<tr>
<td>2-3 children</td>
<td>33 (20.5%)</td>
<td>35 (21.7%)</td>
<td></td>
</tr>
</tbody>
</table>

**Perinatal Period**

<table>
<thead>
<tr>
<th>Period</th>
<th>Mexican-American/Hispanic</th>
<th>Other Latinx</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 2 months</td>
<td>5 (3.1%)</td>
<td>5 (3.1%)</td>
<td></td>
</tr>
<tr>
<td>2-4 months</td>
<td>13 (8.1%)</td>
<td>11 (6.8%)</td>
<td></td>
</tr>
<tr>
<td>5-6 months</td>
<td>43 (26.7%)</td>
<td>44 (27.3%)</td>
<td></td>
</tr>
<tr>
<td>7-9 months</td>
<td>27 (16.8%)</td>
<td>27 (16.8%)</td>
<td></td>
</tr>
<tr>
<td>Birth to 1 month</td>
<td>4 (2.5%)</td>
<td>4 (2.5%)</td>
<td></td>
</tr>
<tr>
<td>2-4 months postpartum</td>
<td>22 (13.7%)</td>
<td>24 (14.9%)</td>
<td></td>
</tr>
<tr>
<td>5-6 months postpartum</td>
<td>27 (16.8%)</td>
<td>28 (17.4%)</td>
<td></td>
</tr>
<tr>
<td>7-8 months postpartum</td>
<td>12 (7.5%)</td>
<td>11 (6.8%)</td>
<td></td>
</tr>
<tr>
<td>9-10 months postpartum</td>
<td>4 (2.5%)</td>
<td>3 (1.9%)</td>
<td></td>
</tr>
<tr>
<td>11-12 months postpartum</td>
<td>4 (2.5%)</td>
<td>4 (2.5%)</td>
<td></td>
</tr>
</tbody>
</table>

**Education Level**

<table>
<thead>
<tr>
<th>Education Level</th>
<th>Mexican-American/Hispanic</th>
<th>Other Latinx</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>High School or equivalent</td>
<td>5 (3.1%)</td>
<td>5 (3.1%)</td>
<td></td>
</tr>
<tr>
<td>Vocational/Technical School (2 year)</td>
<td>8 (5%)</td>
<td>7 (4.3%)</td>
<td></td>
</tr>
<tr>
<td>Some College</td>
<td>16 (9.9%)</td>
<td>19 (11.8%)</td>
<td></td>
</tr>
</tbody>
</table>
College Graduate (4 year) 77 (47.8%) 102 (63.4%)
Master's Degree (MS) 48 (29.8%) 22 (13.7%)
Doctoral Degree (PhD) 5 (3.1%) 2 (1.2%)
Professional Degree (MD, JD, etc.) 2 (1.2%) 2 (1.2%)
Other 0 (0%) 2 (1.2%)

**Employment Status**
Employed full-time 143 (88.8%) 66 (41%)
Employed part-time 14 (8.7%) 25 (15.5%)
Homemaker 1 (0.6%) 65 (40.4%)
Student 2 (1.2%) 1 (0.6%)
Unemployed 1 (0.6%) 4 (2.5%)

**Income**
less than $10,000 0 (0%) 6 (3.7%)
$10,000 - $24,999 3 (1.9%) 7 (4.3%)
$25,000 - $39,999 26 (16.1%) 17 (10.6%)
$40,000 - $54,999 46 (28.6%) 47 (29.2%)
$55,000 - $69,999 23 (14.3%) 24 (14.9%)
$70,000 - $84,999 32 (19.9%) 32 (19.9%)
$85,000 - $99,999 12 (7.5%) 8 (5%)
$100,000 or more 19 (11.8%) 20 (12.4%)

Note: Demographics table contains only the characteristics of participants used in current study, not the entire dataset from which it was taken.

**Procedures**

**Data Collection**

Before data collection began, the study was reviewed and approved by the Utah State University Institutional Review Board (IRB). Approved flyers were posted and shared on social media outlets such as Instagram, Facebook, and Twitter. They were also posted in medical centers related to pregnancy and birth after receiving approval from these agencies. These flyers contained a QR code that directed participants to Qualtrics.com to complete the survey. The initial question of the survey served as the
letter of information and participant consent for the project. This question provided an overview of the study and provided them with two options: to opt out of or opt into the research study. If participants selected to opt-out, they were sent to a page thanking them for their interest. If they decided to participate, they were sent to the beginning of the survey, which consisted of several demographic questions and measures exploring the biological, psychological, social, and spiritual dimensions of the TtP. In addition to these measures, some quality control items were added to the survey designed to identify and prevent spam and fraudulent responses. Data were collected in a way that allowed for couple assessments to be linked so that dyadic responses could be analyzed.

Measures

Data used in this analysis were part of a more extensive data set collected by the research team, which looked at the BPSS experience of couples and individuals engaged in the TtP and is included in Appendix A. Measures used in the current analysis focused on postpartum depression, perinatal anxiety, spiritual fortitude, and negative attitudes towards parenthood. In addition to these, demographic information consisting of gender, age, race, sexual orientation, parental role (i.e., mother or father), relationship status, relationship length, income, employment status, TtP type, number of children, and the stage of the perinatal period were collected in order to understand the population and participants who consented to participate in the study.

Perinatal Mental Health

The outcome variables for this analysis were an individual’s level of perinatal anxiety (PA) and postpartum depression (PPD).
**Anxiety.** PA was assessed using the Perinatal Anxiety Screening Scale (PASS) (Somerville et al., 2014). The PASS is a 31-item scale that explores various symptoms associated with anxiety in the perinatal period (Somerville et al., 2014). Respondents are asked to report how often they experience a specific symptom within the past month by selecting *Not at all, Sometimes, Often,* or *Almost Always* to items such as: “worry about the future”; “needing to be in control of things”; “feeling jumpy or easily startled” and “a sense of dread that something bad is going to happen”. Scores range from 0 to 93, with higher scores indicating more severe anxiety. The PASS has demonstrated excellent reliability with a Cronbach’s α of .96 (Somerville et al., 2015). For the present study, Cronbach’s α was .98 for mothers and fathers combined, .98 for fathers, and .98 for mothers.

**Depression.** PPD was assessed using the Edinburgh Postnatal Depression Scale (EPDS), which is used to screen for postnatal depression in women (Cox et al., 1987) and has also been used to screen for postnatal depression in men (Matthey et al., 2001). The EPDS is a 10-item measure that assesses various depressed symptoms, validated for pregnant and postpartum women (Kheirabadi et al., 2012). Respondents are asked to select a response that describes how they have felt in the past seven days. Sample items include: “I have been able to laugh and see the funny side of things”; “I have felt sad or miserable”; and “I have been so unhappy that I have been crying”. Each item is rated on a four-point scale, with a few of the questions being reverse coded. Possible scores range from 0 to 30, with scores above 10 indicating the potential for a depressive diagnosis (Cox et al., 1987). The original study reported that the split-half reliability was 0.88, and a standardized α-coefficient of 0.87 (Cox et al., 1987). Additional studies found the
internal reliability for the EPDS to vary across studies ranging from .77 and .86 (Kheirabadi et al., 2012; Montazeri et al., 2007). McBride et al. (2014) suggest sufficient evidence to support the validity and reliability of the EPDS as a screening tool for postnatal depression. For the present study, Cronbach’s $\alpha$ was .89 for mothers and fathers combined, .89 for fathers, and .88 for mothers.

**Spirituality**

The predictor variable used in this analysis is spirituality, as determined by participants’ reported levels of spiritual fortitude. Spiritual fortitude was assessed using the Spiritual Fortitude Scale (SFS-9) (Van Tongeren et al., 2019). The SFS-9 is a 9-item measure that gauges spiritual fortitude using three subscales; spiritual endurance, spiritual enterprise, and redemptive purpose. Each of the questions in the measure pertains to one of the subscales and is rated on a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree), with higher scores signifying more spiritual fortitude during difficult situations. Sample items assessing spiritual fortitude include: “My faith helps push me to overcome difficult tasks in life”; “My faith helps me stand up for what is right during challenging times”; “Hardships give me a sense of renewed purpose”; and “I find meaning in my struggles”. Internal reliability was determined to be excellent, with a Cronbach’s $\alpha$ of .85 (Van Tongeren et al., 2019). For the present study, Cronbach’s $\alpha$ was .89 for mothers and fathers combined, .90 for fathers, and .89 for mothers.

**Attitudes Towards Parenthood**

The mediating variable for this analysis consisted of participants’ attitudes towards parenthood. Attitudes towards parenthood were assessed using two scales; the
Attitudes Towards Motherhood Scale (AToM: Sockol et al., 2014) and the Attitudes Towards Fatherhood Scale (AToF: Sockol & Allred, 2018). Both measures are very similar, with the only difference being that the questions for the AToM are directed towards the attitudes of the mother, and the questions for the AToF are the same questions from the AToM but modified to assess the beliefs of the father. The AToM and the AToF are both 12 item assessments that explore three different areas regarding attitudes towards parenthood; beliefs related to others’ judgments, beliefs related to parental responsibility, and beliefs regarding parental role idealization. Respondents answer on a 6-point Likert scale (always disagree to always agree), with higher scores representing more negative forms of parental attitudes (Sockol et al., 2014; Sockol & Allred, 2018). Sample items on each measure include: “People will probably think less of me if I make parenting mistakes”; “If I love my baby, I should want to be with him/her all the time”; “It is wrong to feel disappointed by motherhood/fatherhood”; and “Negative feelings towards my baby are wrong”. Internal reliability for the AToM and the AToF were both found to be good, with Cronbach’s α found to be .86 (Sockol et al., 2014) and .82 (Sockol & Allred, 2018), respectively. For the present study, Cronbach’s α was .89 for mothers and fathers combined, .89 for fathers, and .88 for mothers.

Data Analysis

Descriptive statistics, including means, standard deviations, and frequency distributions, were used to summarize the demographic characteristics for all study variables. Correlations were also calculated between all study variables. To test the hypotheses, an APIMeM was used within the structural equation
modeling framework using the Lavaan package (Rosseel, 2012) in R (R Core Team, 2017). APIMeM was used to investigate whether mothers’ and fathers’ spiritual fortitude predicted their own (actor effects) and their partner’s (partner effects) perinatal anxiety and depression directly and indirectly through the mediation of their own and their partner’s attitudes towards parenthood. APIMeM allows for direct and indirect actor effects as well as direct and indirect partner effects to be examined (Ledermann et al., 2011). Therefore, the model that was used consisted of two predictor variables (mothers’ and fathers’ spiritual fortitude), four outcome variables (mothers’ perinatal depression, fathers’ perinatal depression, mothers’ perinatal anxiety, and fathers’ perinatal anxiety), and two mediator variables (mothers’ and fathers’ negative attitudes towards parenthood).

The hypothesized structural model was a fully saturated model with zero degrees of freedom, which eliminates the ability for nested model comparisons. Therefore, I did not constrain actor and partner effects to equality across partners to test for empirical distinguishability, as has been recommended by Ledermann et al. (2011). Additionally, bootstrapping was used with 10,000 samples, as recommended by Preacher & Hayes (2008), to determine the significance of the indirect effects in the APIMeM model. Several potential covariates were also controlled for, including relationship length, educational level, race, age, where participants were in the perinatal period, and total number of children. All covariates except age were omitted from the model due to non-significance between the covariates and the outcome variables.
Results

Descriptive statistics

Bivariate correlations and descriptive statistics were obtained for all study variables and are provided in Table 4.2. Each significant correlation was found to be significant at $p < .01$. All correlations were found to be significantly correlated with all other variables with exception of the correlations between fathers’ attitudes towards parenthood and mothers’ perinatal anxiety ($r = .134, p = .090$), fathers’ spiritual fortitude ($r = -.050, p = .525$), and mothers’ spiritual fortitude ($r = .052, p = .516$), and the correlations between mothers’ attitudes towards parenthood and fathers’ perinatal anxiety ($r = .145, p = .067$), fathers’ spiritual fortitude ($r = -.026, p = .744$), and mothers’ spiritual fortitude ($r = -.013, p = .873$). Additionally, all significant correlations were found to be positive associations except for the correlations between fathers’ spiritual fortitude and fathers’ perinatal anxiety ($r = -.320$), mothers’ perinatal anxiety ($r = -.397$), fathers’ perinatal depression ($r = -.481$), and mothers’ perinatal depression ($r = -.523$), as

Table 4.4
Descriptive statistics and Bivariate Correlations of Study Variables

<table>
<thead>
<tr>
<th>Variables</th>
<th>M</th>
<th>SD</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Father’s Perinatal Anxiety</td>
<td>20.546</td>
<td>19.660</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Mother’s Perinatal Anxiety</td>
<td>32.484</td>
<td>21.420</td>
<td>0.605**</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Father’s Perinatal Depression</td>
<td>8.981</td>
<td>5.812</td>
<td>0.742**</td>
<td>0.445**</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Mother’s Perinatal Depression</td>
<td>11.478</td>
<td>5.816</td>
<td>0.506**</td>
<td>0.784**</td>
<td>0.590**</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Father’s Attitudes Towards Parenthood</td>
<td>43.354</td>
<td>10.873</td>
<td>0.254**</td>
<td>0.134</td>
<td>0.357**</td>
<td>0.239**</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Mother’s Attitudes Towards Parenthood</td>
<td>44.701</td>
<td>10.578</td>
<td>0.145</td>
<td>0.343**</td>
<td>0.239**</td>
<td>0.365**</td>
<td>0.602**</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Father’s Spiritual Fortitude</td>
<td>35.925</td>
<td>6.242</td>
<td>-0.320**</td>
<td>-0.397**</td>
<td>-0.481**</td>
<td>-0.523**</td>
<td>-0.050</td>
<td>-0.026</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>8. Mother’s Spiritual Fortitude</td>
<td>35.565</td>
<td>6.522</td>
<td>-0.244**</td>
<td>-0.359**</td>
<td>-0.372**</td>
<td>-0.497**</td>
<td>0.052</td>
<td>-0.013</td>
<td>0.742**</td>
<td>-</td>
</tr>
</tbody>
</table>

Note. * $p < 0.05$, ** $p < 0.01$, n = 161

Age was also included in the model with each perinatal depression and anxiety outcome regressed on to it, however, it is not depicted in this figure.
well as the correlations between mothers’ spiritual fortitude and fathers’ perinatal anxiety ($r = -.244$), mothers’ perinatal anxiety ($r = -.359$), fathers’ perinatal depression ($r = - .372$), and mothers’ perinatal depression ($r = -.497$). All measures used in the study demonstrated good to excellent Cronbach’s $\alpha$ reliability coefficient, and all correlations were in the expected directions.

**Actor-Partner Interdependence Mediation Model**

The structural version of the APIMeM model that was used examined actor and partner effects for both mothers and fathers in couple dyads. The model was a fully saturated model and therefore demonstrated perfect model fit, $\chi^2 \ (0) = 0.00, p < .000$, CFI=1.000, TLI=1.000, RMSEA=0.000, and SRMR=0.000, (Figure 4.1).

Nonindependence was also examined to explore the similarity between parents/partners’ scores. High levels of nonindependence among partners was found between negative attitudes toward parenting, $r(159) = .61, p < .001$, spiritual fortitude, $r(159) = .74, p < .001$, and perinatal anxiety, $r(159) = .56, p < .001$, and moderate levels of nonindependence or similarity was found with respect to depression, $r(159) = .41, p < .001$. These results signify that partners in parental dyads were more similar in their scores on study measures than scores of any other person in the sample they could have been paired with. This similarity is therefore due to being in a relationship with one another, illustrating a relationship level or systemic dynamic.

**Actor Effects**

Hypothesis one proposed that both fathers’ and mothers’ levels of spiritual fortitude would have a significant negative association with their own reported levels of
depression and anxiety during the perinatal period (actor effects). Results from the structural model demonstrated that there were significant negative actor effects of spiritual fortitude on perinatal depression for both mothers ($\beta = -.225$, $p < .001$) and fathers ($\beta = -.363$, $p < .001$), indicating that the higher fathers’ and mothers’ spiritual fortitude, the lower we expect their levels of anxiety and depression to be. Results also identified positive actor effects of negative attitudes towards parenthood on perinatal depression for both mothers ($\beta = .188$, $p < .001$) and fathers ($\beta = .172$, $p < .001$), and on perinatal anxiety for both mothers ($\beta = .854$, $p < .001$) and fathers ($\beta = .458$, $p < .001$).
This implies that negative attitudes towards parenthood contribute to higher levels of anxiety and depression during the perinatal period, which corroborates prior research on negative attitudes towards parenthood (e.g., Sockol et al., 2014; Sockol & Allred, 2018).

**Partner Effects**

Hypothesis two was that spiritual fortitude levels of the respective partner would have a significant and negative association with fathers’ and mothers’ own reported levels of depression and anxiety during the perinatal period (partner effects). Results demonstrated significant negative partner effects of fathers’ spiritual fortitude on mothers’ perinatal depression ($\beta = -.296, p < .001$) and also on mothers’ perinatal anxiety ($\beta = -.979, p < .001$). This means that the higher a father’s spiritual fortitude, the lower we expect the respective mother partner’s levels of depression and anxiety to be. Age was also included as a covariate in this analysis. Results demonstrated significant negative effects on fathers’ perinatal anxiety ($\beta = -.836, p < .05$) and mothers’ perinatal anxiety ($\beta = -.806, p < .05$). All other structural paths/effects were found to be nonsignificant.

**Mediation Effects**

Hypothesis three stated that negative attitudes toward parenthood would significantly mediate the relationship between spiritual fortitude (predictor) and depression and anxiety (outcomes) for mothers and fathers, respectively, during the perinatal period. That is, negative attitudes toward parenthood were expected to explain any significant associations between spiritual fortitude and depression and anxiety during the perinatal period (both actor-oriented and partner-oriented indirect pathways were examined). Our structural APIMeM model was rerun using 10,000 bootstrapped samples
to construct confidence intervals for each examined indirect effect as a determination of statistical significance. This method is currently considered a best practice for structural modeling that examines mediation (Preacher & Hayes, 2008). Regarding the indirect effects, results of the 95% bias-correcting bootstrapping did not reveal any significant indirect effects. These results, therefore, did not support the hypothesis of negative attitudes towards parenthood mediating the relationship between spiritual fortitude and perinatal depression and anxiety.

**Discussion**

The present study extended the research on the TtP by exploring the influence that spiritual fortitude has on the development of perinatal mood disorders such as anxiety and depression and the mediating effect of negative attitudes towards parenthood on the relationship between spiritual fortitude and anxiety and depression during perinatal periods. Regardless of the joy and excitement that can be experienced during the TtP, conditions such as depression and anxiety act as perceptual filters, meaning experiences are viewed through a lens affecting overall experience (Church et al., 2005). During the TtP, the changes and challenges the couple goes through can significantly affect outcomes after their transition. Dyadically examining the TtP also provides an understanding of the relational/systemic interactions that take place during this critical transition.

The first hypothesis posited that one’s spiritual fortitude would have a significant negative association with reported levels of postpartum depression and anxiety in mothers and fathers. Results indicate that there were significant negative actor effects
between father’s spiritual fortitude and their own reported levels of depression and anxiety. Results also demonstrate significant negative actor effects between mother’s spiritual fortitude and mother’s levels of perinatal depression. These results show that spiritual fortitude provides some sort of buffer against depression for mothers and fathers and anxiety for fathers during the perinatal period. These results align with previous research examining the effect that spiritual fortitude has on depression and anxiety during stressful experiences such as natural disasters (McElroy-Heltzel et al., 2018; H. Zhang et al., 2020, 2021). Up to this point, spiritual fortitude has not been examined in relation to the TtP. These results further identify the need for research exploring spiritual fortitude and additional ways it may help families during the TtP.

Results also identified significant positive actor effects between negative attitudes towards parenthood and anxiety and depression in both mothers and fathers. Dysfunctional or negative attitudes toward parenthood may contribute to the prevalence of issues during and after the TtP (Fonseca & Canavarro, 2018). As previously discussed, the influence that negative attitudes towards parenthood have on depression and anxiety has been documented (Sockol et al., 2014; Sockol & Allred, 2018). Although Spiritual fortitude was not found to predict negative attitudes towards parenthood, it may still be important to examine how spiritual fortitude and negative attitudes towards parenthood influence each other.

Religious beliefs and spirituality provide a sense of meaning and purpose which can assist with managing the psychological challenges that come up during challenging experiences (Koenig, 2009). Spirituality is an essential resource for many people who often use spirituality or religiosity to better cope and handle stressors they are presented
with (Moreira-Almeida et al., 2014). The results from this study regarding the actor effect that spiritual fortitude has on mental health during the perinatal period help to identify spiritual fortitude as a crucial coping mechanism for families engaged in this transition. For providers working with individuals experiencing challenges associated with the transition to parenthood, it may be helpful to explore aspects related to spiritual fortitude to identify strengths and areas of growth that could help manage the presenting concerns more effectively.

Results also demonstrate a significant partner effect between father’s spiritual fortitude and mother’s reported levels of depression and anxiety, supporting hypothesis two, which theorized that one’s partner’s spiritual fortitude would have a significant association with their own reported levels of postpartum depression and anxiety. This identifies that the higher spiritual fortitude a father has, the lower the expected levels of depression and anxiety present in mothers. By contrast, mothers’ spiritual fortitude and attitudes towards parenthood were not found to influence levels of depression and anxiety in fathers. Fathers’ depression and anxiety were affected by their negative attitudes and spiritual fortitude, but were not influenced by their partner’s/a mothers’ spiritual fortitude. This indicates that mothers seem to be more influenced by fathers’ spiritual fortitude than fathers are affected by mothers’ negative attitudes and spiritual fortitude. As previously identified, spiritual fortitude impacts one’s levels of depression and anxiety, demonstrating the importance of spiritual fortitude for one partner. With the inclusion of these results, we can see a more complete picture of the influence that spiritual fortitude has on levels of depression and anxiety during the TtP.

As partners become parents, their relationship grows in many ways, including a
sense of togetherness, which is related to aspects of spirituality (Klobučar, 2016). One aspect of spiritual fortitude may include one’s ability to rely on their partner. Results indicate that fathers may be a valuable support for mothers. During the TtP, one aspect that is commonly overlooked is the amount of support that couples feel. Spousal support creates an environment that can foster trust, love, and interdependence in marital relationships, thus affecting outcomes of the TtP (Don & Mickelson, 2012). Spiritual fortitude may contribute to increased hope and support that could positively influence a couple’s views concerning the TtP and their outlook regarding the struggles they are experiencing.

Hypothesis three postulated that negative attitudes toward parenthood would significantly mediate the relationship between spiritual fortitude and depression and anxiety for mothers and fathers, respectively, during the perinatal period. The APIMeM concluded that attitudes towards parenthood did not mediate the relationship between spiritual fortitude and perinatal depression and perinatal anxiety. Although spiritual fortitude did not significantly predict negative attitudes toward parenting, which would have likely resulted in a significant mediating effect of negative attitudes, spiritual fortitude and attitudes, spiritual fortitude and attitudes towards parenthood are still important aspects that should be explored in relation to the development of depression and anxiety and the TtP overall.

Although no mediation was found, several findings should be examined. As mothers and fathers work together and rely on each other, spiritual fortitude can be strengthened. Increased spiritual fortitude has the potential to buffer families from challenges such as mental health concerns. Specifically, results from the study identify
the significant link between one’s negative attitudes towards parenthood predicting one’s levels of depression and anxiety. Findings demonstrate support for research regarding the effect that attitudes towards parenthood have on the development of perinatal mood disorders, and more specifically, that attitudes towards parenthood are strongly associated with symptoms of depression and anxiety in parents during the perinatal period (Sockol et al., 2014; Sockol & Allred, 2018). These results identify a critical consideration for those working with families engaged in the TtP. Parfitt & Ayers (2014) identified that approximately one-fourth of parents reported having ambivalent or negative feelings toward parenthood in pregnancy which were also linked to persistent negative feelings toward the baby, leading to more negative emotional responses. As families seek help for the challenges they face, especially regarding mental health concerns, exploring the thoughts, emotions, and attitudes they have regarding the TtP may be very beneficial in preventing or decreasing the prevalence of mental health concerns. Although more research is needed to fully understand the influence of spiritual fortitude on the TtP, this study has begun to fill the gap in the literature regarding its role in the TtP process.

As identified, spiritual fortitude may be an essential aspect to explore during the TtP. Spiritual fortitude may be a helpful coping mechanism that can help buffer against prolonged and detrimental changes and challenges that families experience. This study found a significant relationship between spiritual fortitude and depression and anxiety during the perinatal period, namely the more spiritual fortitude a person has, the lower the chance they, or in some cases their partner, will develop mental health concerns during the TtP. Spirituality has been found to help with mental health concerns and physical health (Cheadle & Dunkel-Schetter, 2017). As providers work with families to treat the
issues they are experiencing, aspects surrounding spirituality can be very beneficial to explore. Not only will this allow providers to better understand the patients they are caring for, but it will help them identify specific ways to intervene and assist them with the challenges they are going through (Unger, 2012).

Limitations and Future Directions

This study explored the potential mediating effect of negative attitudes towards parenthood on the relationship between spiritual fortitude and perinatal anxiety and depression. Despite some informative results that emerged from this study, it is important to acknowledge study limitations. One limitation of the mediation model used is that it was a fully saturated, just identified model. Ledermann et al. (2011) suggest that when using an APIMeM, actor and partner effects should be constrained across partners as a test of empirical distinguishability. However, due to the model being fully saturated, zero degrees of freedom, and therefore, perfect model fit, it did not lend itself to these recommended constraints and resulting model comparison. Future research that examines alternative models that allow for model comparison would be of benefit. This study was exploratory in the sense that previous research has not examined spiritual fortitude as an antecedent to negative attitudes towards parenthood. Even though no mediation was found, research needs to continue to identify ways to counteract negative and dysfunctional attitudes toward parenthood to help families more effectively manage the TtP. Furthermore, it may be beneficial for future research to explore different model orientations or adaptations of the current model, such as a potential moderating effect of attitudes on the relationship between spiritual fortitude and depression and anxiety.
Self-selection with respect to sampling method was also a limitation of this study. Couples actively chose to participate based on seeing the information about the study, the link to the survey, or having an interest in the topic. Individuals who did not have access to the social media posts or attending offices that posted the flyer were unaware of the study and were therefore unable to participate. This study also examined the experience that was had by heterosexual couples. Distinguishability was a vital aspect of the analysis, which necessitated limiting participants to heterosexual couples so that each partner’s responses could be identified and compared. It is important to realize that other couple orientations have alternative experiences regarding the TtP and it would be beneficial for future research to explore both similarities and differences in these experiences. Furthermore, this study examined the TtP at one point in time. In order to more fully understand what is happening during the entire TtP, a longitudinal study design would be helpful.

Regardless of the identified limitations, this study provides some important considerations regarding the interactions that take place during the TtP, especially for those working to help couples experiencing struggles. These interactions need to be further examined to identify ways to assist families navigating the TtP, taking into account the interconnected nature of this transition. It seems that this study was the first of its kind to explore the effect that spiritual fortitude has on the TtP. Recognizing the interactions between partners and how levels of spiritual fortitude influence depression and anxiety during the perinatal period, it is important to examine further the various relationship dynamics that occur between couples during the TtP. For example, in line with findings that supported hypothesis two, future research should explore further why a
father’s spiritual fortitude impacts a mother’s levels of depression and anxiety but not the other way around. This exploration will help identify why spiritual fortitude is a relational coping mechanism, how it influences each partner, and why it appears to be even more influential for mothers.

This study also points to the importance of examining relationship systems during the TtP. By examining relationship systems, it is possible to determine additional ways to help couples achieve more positive outcomes during the TtP. This examination could further be explored in future research by investigating the implementation of various interventions, especially brief ones, during the first part of the TtP as a way to buffer the couple against BPSS problems arising, which has been identified as a serious need in research (Welch et al., 2019). Furthermore, research might extend on this study by examining the entire family system, not just couples, to explore how family and relationship dynamics both are influenced by, as well as influence, the TtP.

Attitudes towards parenthood have been found to influence anxiety and depression and to affect the decision to engage in the TtP (Barber, 2001). Parents, especially young parents, are at increased risk for developing mental health concerns, so finding a way to detect those at risk early on is needed (Sipsma et al., 2016). The relationship between negative attitudes towards parenthood and perinatal depression and anxiety is an important interaction that could be very beneficial for providers. By assessing for negative attitudes towards parenthood, providers, clinicians, and other health professionals may be able to identify individuals at risk of developing perinatal depression and anxiety and implement certain interventions and treatments that will aid them during this difficult challenge.
Conclusion

This study examined the influence of negative attitudes towards parenthood on the relationship between spiritual fortitude and depression and anxiety in the perinatal period. While no significant mediating effects were found, the findings identified some significant associations between negative attitudes towards parenthood, spiritual fortitude, and depression and anxiety within the dyadic relationship during the TtP. The significant actor and partner effects observed in this study provided some important considerations surrounding the relationship that fathers’ spiritual fortitude has on their attitudes towards parenthood and anxiety and depression in themselves and their partners. When working with families navigating the TtP, spiritual fortitude may be an useful aspect to explore and develop with family members to help alleviate the effect that depression and anxiety have on the family during this life-changing experience.
CHAPTER FIVE

GENERAL DISCUSSION

The transition to parenthood (TtP) is a challenging and transformative experience for anyone who embarks on it (Saxbe et al., 2018). As more and more families begin this transition and experience challenges and stressors related to it, providers will need to identify more effective ways to treat and care for these families (Welch et al., 2019). The purpose of this dissertation was to identify the TtP as a systemic event and present some ideas for providers as they work with families struggling during this transitional stage.

In chapter 2, I presented the idea that the TtP is a systemic experience that not only affects the mother but all members of the family system. In addition to family systems theory (FST: Bowen, 1978; Broderick, 1993; von Bertalanffy, 1968), the biopsychosocial-spiritual (BPSS) model (Engel, 1977, 1980; Prest & Robinson, 2006) helps examine areas that may contribute to the development of challenges within the family system. In Chapter 3, I identified how Solution-Focused Brief Therapy (SFBT: de Shazer et al., 2007) can be used in a collaborative setting to help a couple going through the TtP in a collaborative care setting. Finally, in chapter 4, spiritual fortitude is explored as a potentially important aspect in relation to the development of perinatal anxiety and depression as families progress through the TtP. In this discussion some of the main points of this dissertation will be discussed, namely family systems theory and how it relates to the BPSS model, SFBT in collaborative care, and spiritual fortitude and the TtP. Implications for care providers, limitations, and future directions and will also be identified.
Family Systems Theory and the Biopsychosocial-Spiritual Model

FST is a theory of family interaction that explores and explains the reciprocal impact of interactions within families. By utilizing and understanding FST, providers are able to more fully comprehend the needs of those experiencing struggles during the TtP. By implementing this theory, clinicians are able to identify the rules that govern the system and implement interventions that promote constructive change, purging the system of the problematic behavior that torments them (Johnson & Ray, 2016). These constructive changes help establish a well-functioning relationship that is found to help families fare better during the postpartum period (Lindblom et al., 2014).

As identified, biologically, the family may experience a number of physical (Motosko et al., 2017; Murkoff & Mazel, 2016) and physiological changes (Bhatia & Chhabra, 2018; Edelstein et al., 2017) as they experience this transition. Psychologically, families navigating the TtP can experience a wide variety of issues including anxiety, depression, post-traumatic stress disorder, and obsessive compulsive disorder (Bayrampour et al., 2016; Fairbrother et al., 2015; Parfitt & Ayers, 2014). These disorders have been found to affect additional areas of the family system as well (Pearson et al., 2019; Pinto et al., 2020; Skouteris et al., 2009). Socially, the TtP has been found to influence the family in a number of ways. As parents embark on the TtP, it has been found that marital satisfaction declines over the course of the transition (Cox et al., 1999). It has been identified that satisfaction declines at a steeper rate when children are present then with non-parent couples (Don & Mickelson, 2012). Couple satisfaction is a vital part of any relationship. Couples who feel less satisfaction in their relationship may be at higher risk for conflict and eventual relationship dissolution (Hirschberger et al., 2009).
High levels of relationship satisfaction may prevent parents from developing postpartum mood disturbances, pointing to the effect that relational satisfaction has on PPD (Don & Mickelson, 2012).

Spirituality is an important aspect to explore in relation to the TtP. Spirituality can take on many different roles, and has been found to be connected to and impact areas such as meaning making, the couple relationship, emotions, how families interact with one another, and identity development (Klobučar, 2016). Spirituality has also been found to influence the overall experience had during childbirth (Bélanger-Lévesque et al., 2016). As a whole, there is still much that can be explored in relation to the relationship between spirituality and the TtP.

As providers work with families navigating the TtP, examining areas such as the biological, psychological, social, and spiritual experiences of the family can greatly improve the care provided (Bischoff et al., 2012). Providers can also help improve clinical outcomes by utilizing collaborative care (Kusnanto et al., 2018).

**Solution-Focused Brief Therapy in Collaborative Care**

Providers can examine the BPSS facets through the use of SFBT. SFBT is not the only form of brief therapy or intervention that can be used in a collaborative care setting. Other forms that can be useful include Cognitive Behavioral Therapy (e.g., Bogucki et al., 2021) and Motivational Interviewing (e.g., Rollnick et al., 2008). Clinicians can also adapt their own models of therapy to be brief while still focusing on the needs of their clients. SFBT was chosen due to its brief evidence-based approach to psychotherapy (Kim et al., 2019). SFBT is one modality used to help families struggling
during the TtP by facilitating brief solution-based interventions meant to aid families as they attempt to identify solutions for the problems that overcome them (Iveson, 2002). It has been identified that SFBT utilizes many valuable interventions that can help both the client and the therapist in their quest to achieve their therapeutic goals (e.g., Beyebach, 2014). SFBT appeals to providers due to its flexible nature and ability to facilitate change in a brief amount of time, which is seen as a valuable resource in their work (A. Zhang et al., 2018).

By pointing out strengths that clients may have forgotten, they are able to shift from a problem-focused mindset to a solution-focused mindset (Adams et al., 1991). This shift in thinking positively, helps clients see the positive encounters that they have and instill hope in their future (Giorlando & Schilling, 1997). Hope can be defined as the connection of the mental willpower someone has along with the plan the client has developed to achieve their goals (Reiter, 2010). It is through this positive focus and hope that clients are able to successfully discover goals and achieve their desired outcomes (Kondrat & Teater, 2012; Reiter, 2010). When experiencing a challenge like the TtP, hope can be a powerful, healing tool.

The interactions portrayed between Trisha, Peter, Dr. Richardson, and Carli demonstrated how a collaborative team can utilize SFBT with their clients or patients to explore their needs, goals, and desires surrounding their TtP. A major tenet of SFBT is the preferred future of the client. Solution-focused therapy works by envisioning a future when the client is not experiencing their presenting concerns, and then working to make that vision a reality or getting as close to it as possible (Langdridge, 2006). This happens through a series of questions; these questions focus on what is happening now or what
they want to happen in the future. The therapist helps clients let go of the present holds and frustrations that are preventing them from living their preferred lives, making changes, and more fully coping with issues they cannot change themselves, such as health concerns. By focusing on the future, clients are able to look past the current issues they are experiencing to more fully identify how they can work to resolve or cope with their current stressors. Trisha and Peter’s preferred future entails learning how to better handle the stress associated with the TtP, working with medical providers to manage medicinal interventions, and improving social interactions.

**Spiritual Fortitude and the Transition to Parenthood**

Spirituality is something that has not been thoroughly researched, especially in connection with the TtP. Spirituality can be a great asset to those experiencing struggles and stress. Stressors can be anything that causes tension in an organism (Amadeo & Sofield, 2006). The changes that occur during the TtP can contribute to an insurmountable amount of stress. When difficulties are experienced, one way to manage them is by embracing these stressful moments and identifying the lessons that can be learned from these experiences, even amidst the chaos (Amadeo & Sofield, 2006). These moments of learning can help manage and diminish the stress that is felt. Spirituality can be linked to religiosity, but can also refer to meaning making, connection with society, a sense of awe and wonder, and centering and mindfulness practices (Robinson & Taylor, 2016). Spirituality has also been defined as “the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or
Regardless of the definition, spirituality is something impacts everyone, but has not been examined much in relation to the TtP. Chapter 4 was designed to fill that gap and highlighted the effect that spiritual fortitude or the “confidence that one has sufficient spiritual resources to face and grow in the face of a stressor” (Van Tongeren et al., 2019, p. 589), has on perinatal depression and anxiety. Using an APIMeM, spiritual fortitude was examined in relation to the prevalence of depression and anxiety as mediated by negative attitudes towards parenthood. Results indicated that spiritual fortitude had a significant negative effect on one’s attitudes towards parenthood and their perinatal depression and anxiety. Signifying that the more confident someone is that they have the spiritual resources needed to get through and manage the challenge, negative attitudes, depression, and anxiety will all decrease. In addition, results pointed to the importance of a father’s spiritual fortitude as a buffering agent in the development of anxiety and depression in mothers. While this model identifies predictors, it is difficult to identify the cause of the relationships that were found. One potential explanation my refer to the nature of the relationships that were examined, it is possible that fathers could play an important role in helping mothers manage the stressors and challenges that come up. Results from this study can be a valuable starting point to further explore the TtP and how the biological, psychological, social, and spiritual aspects influence the experience that is had by couples engaging in this transition.

Implications

The primary purpose of this dissertation was to identify important considerations
for providers as they work with couples experiencing challenges during the TtP. As families seek help regarding the TtP, their providers play the crucial role of gatekeeper. Gatekeepers serve as go-betweens, providing access to additional services that may be critical to the successful outcomes of families seeking their assistance. Through implementing and utilizing some of the principles and findings in these studies, providers can become more aware of what they can do to ensure success for families who may feel like success is a distant dream.

For Providers

Up to this point, there does not appear to be much research examining what providers can do to better care for families who are experiencing challenges such as mental health concerns during in the TtP. However, research has identified that those involved in the TtP are at risk of developing mental health issues (e.g., Fairbrother et al., 2015; Pearson et al., 2019). Research has also identified that parents are at high risk for anxiety, especially first-time parents (Teixeira et al., 2009). Providers need to make it a priority to fully assess the whole experience that is had and seek collaboration if issues arise outside of their specialties in order to improve outcomes related to pregnancy and birth. Suppose providers can view the TtP from a systemic lens, exploring the entire family, not just those seen in the office. In that case, they will more comprehensively address the potential factors that contribute to difficulties during this transition. Medical providers are not traditionally trained in therapy techniques. However, providers seeing patients in their office who do not have access to an onsite mental health professional can implement new methods of questioning and assessing. These new methods will allow them to explore the presenting concerns of their patients more holistically and refer out to
other providers as needed.

**Solution-Focused Brief Therapy**

Brief forms of therapy, such as SFBT, grant providers quick and direct ways to assess the needs of the individuals they are working with, and identify some of the contributing factors that cause issues to develop in the first place. When a patient comes into a provider’s office, they are typically asked about the present symptoms and what the issue is. Time constraints may force the focus of the appointment to be on resolving the symptoms and not on identifying what is contributing to the problem. Brief forms of therapy or quick interventions such as those associated with SFBT can help to quickly and concisely assess and address the issues that come up. How members of the system experience life and engage with their environment may be affected by health concerns they experience. Those health concerns frequently do not just affect the individual diagnosed with those specific concerns, but anyone who may interact with them. By exploring the patient’s whole system, providers can identify contributing factors for the issues and identify sources of support and coping that may not have been previously recognized. This examination can also help point to sources of support that are lacking. When there are no children present in a relationship, spousal support can freely be offered. However, with the arrival of children, the parenting role often becomes the priority. Parents then neglect their own needs, which can affect the well-being of their partners (de Goede & Greeff, 2016; Delicate et al., 2018).

**Spiritual Fortitude**

One form of support that has been identified in this dissertation is spiritual
fortitude. As specified, spirituality can be a great source of hope, meaning, and aid when problems arise. Spirituality does not need to focus on organized religion but can pertain to people’s significance as they endure the experiences they face. Patients and clients may also use spirituality to understand and address the issues that arise. It may also contribute to how they communicate, cope with, and treat the problems they are experiencing (Collier & James, 2021). At times it may be hard to bring up spirituality with patients and clients, but these topics can be explored in a way that focuses on hope and positive thinking, which can contribute to a spiritual experience. Providers can explore spirituality with patients and clients by uncovering the shared experience of the problem they are going through. Helping families turn towards each other can establish a sense of support that will help them manage and cope with whatever challenges come up, especially during the TtP.

**For Parents and Partners**

While the main focus of this dissertation surrounded identifying essential considerations for providers as they work with families during the TtP, this dissertation has identified some crucial thoughts for parents as well. Chapter 4 of this dissertation explored how spiritual fortitude influences the prevalence of depression and anxiety in parents during the TtP. As parents begin the TtP, they may seek various coping mechanisms to help them navigate their experience more effectively. Spiritual fortitude is one form of coping that can be implemented during the TtP to help parents cope with the challenges. Pregnancy and childbirth are stressful events that necessitate increased support behaviors by partners in the relationship. Dyadic coping refers to these types of supportive behaviors (Alves et al., 2018). Different forms of dyadic coping are typically
employed, either positive or negative, depending on how the stress expressed by one partner is interpreted by the other. Positive dyadic coping refers to emotional and problem-oriented support that focuses on either working together to overcome the stress, or taking a more directive approach with one individual requesting the help of the other verbally. Negative forms of dyadic coping include hostile, ambivalent, and superficial behaviors often expressed without empathy, willingness, or understanding of the effect of the stress on the other partner (Alves et al., 2018).

A couple’s ability to engage in positive forms of dyadic coping may also be affected by the additional stress the individuals are going through not related to the impending birth. That stress may contribute to the development of depressive symptoms in mothers, which may also contribute to the prevalence of depressive symptoms in fathers (Alves et al., 2018). Following the birth of a couple's first child, positive relationship behaviors such as positive communication, supportive and dyadic coping, and relationship self-regulation declined. Furthermore, research has found that negative behaviors such as negative communication and negative dyadic coping increased (Alves et al., 2019). These behaviors were also associated with current and future relationship satisfaction (Rauch-Anderegg et al., 2020). Spiritual fortitude is one form of positive coping that could be implemented and strengthened in relationships to help them manage the stressors associated with the TtP. By exploring this aspect in families, providers, partners, individuals, and therapists can identify ways to help increase this and other forms of coping.

The studies contained in this dissertation identified ways that providers can help families during the TtP. This information can also help to inform families currently in or
beginning their TtP. Suppose families understand and are aware of ways to protect themselves against some of these challenges. In that case, they will be better prepared and more likely to have positive outcomes associated with their TtP.

**Limitations and Future Directions**

Together, these studies provide an additional perspective of the care a couple receives during the TtP, and an additional view on spirituality which is an important consideration to examine in treatment. However beneficial this information is, it is also important to identify potential limitations that may affect future research endeavors into the TtP.

Starting with chapter three, one limitation to be considered is the hypothetical nature of the presented case study. I was not able to find an actual case study demonstrating the use of SFBT in a collaborative care setting specifically working with families navigating the TtP, which is why this was the focus of this chapter. The hypothetical case study provided ideas of how to implement SFBT into a collaborative care setting with families during the TtP. In order to better understand the implications for brief forms of treatment, it is necessary to examine the actual use of SFBT in a medical setting with individuals struggling with issues related to the perinatal period.

A limitation found in chapter four is that it focused on the experience of the TtP for heterosexual couples. While the nature of the analysis necessitated distinguishable dyads, one aspect that could also be explored is how the TtP is experienced by all relationship types. By allowing for more broad inclusion, results would be generalizable to the greater population. Furthermore, in addition to relationship types, research should
also explore couples who engage in the TtP through different means such as surrogacy, adoption, other reproductive technologies, and any other avenue taken to engage in the TtP. Regardless of how couples start the TtP, challenges will come up that necessitate assistance from various providers. These providers will benefit from research that more fully explores the different avenues taken by couples and the assistance that they need.

As identified in chapter 4, the measures that were selected may not fully capture all aspects of spirituality. Future research could focus on creating a universal definition of spirituality that captures various experiences. While the measures used regarding spirituality fulfill what was being explored surrounding the influence of spiritual fortitude, there are many different definitions and meanings associated with spirituality that could still be examined in relation to the TtP. Additionally, to better understand the influence that the TtP has on those experiencing it, studies need to examine the transition in a more in-depth way. One way to facilitate this is through the development of a new measure focused on the overall experience of those transitioning to parenthood.

**Conclusion**

These combined studies add to the growing body of literature surrounding the TtP and collectively these chapters identify some important considerations for therapists and providers as they work with couples and families navigating the TtP. As families progress through the TtP, they face a variety of challenges that affect not only how they interact with other family members but also with their surroundings. By utilizing a systemic approach when working with families, providers are able to identify a wide variety of variables that may affect the prevalence of issues such as mental health concerns. During
the TtP the changes and challenges that are confronted contribute to changes and challenges in other aspects of life as well. As the family welcomes a child, parents may interact differently with people around them. They may no longer find the time to focus on their relationship. The lack of sleep may contribute to increased stress which could contribute to various mental health concerns. These mental health concerns may contribute to a decrease in an active lifestyle which could contribute to various physical health problems. All in all, the TtP can affect every aspect of life for new parents, and providers can play a pivotal role in helping alleviate negative stressors.

The studies contained in this dissertation provide an important look into the TtP and help to identify some additional areas that need to be explored in order to better understand the needs of families during this transition and how to help them. Taking a cumulative view, these studies provide support for the need to further research endeavors within the TtP. While some gaps may be filled by this dissertation, there are still many more to examine. Research needs to focus not only on the experience that is had during the TtP, but also on the needs of families as they make this transition. By understanding these needs, research and interventions can be tailored to alleviate specific issues that come up during the TtP. This research will allow families from every background to engage in this transition with hope, knowing that there is understanding and assistance available to them.
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Appendices
Appendix A: Transition to Parenthood Survey
This survey will explore various aspects of the transition to parenthood. The survey consists of a number of assessments that explore topics such as physical changes, psychological challenges, social interactions, and spiritual beliefs. Please click the link below to obtain a copy for your records of the letter of information for this study.

By clicking 'I agree' you acknowledge that you have read and understand the "Study Letter of Information" (link above) and consent to participating in the study and wish to continue to the survey. You also acknowledge that you meet the minimum qualifications for the study which are: you are 18 years of age or older, you or your partner are currently pregnant, you or your partner have given birth within the past year, you and your partner are making the transition to parenthood in some way, you have a partner who is also willing to complete the survey, and you both have time to complete the survey in its entirety. You agree that you understand the risks and benefits of participation, and that you know what you are being asked to do. You also agree that if you have any questions about your participation, you know how to contacted the research team. If at any time during the survey you wish to withdraw from the survey please exit out of the survey.

☐ I agree **(This option admits participants to the survey)**

☐ I do not wish to participate **(This option exits out of the survey and displays the following message “We thank you for your time spent taking this survey. Your response has been recorded.)**

*This question serves as a screener for “bots” it is hidden from actual participants. Any option that is selected thanks them for their participation and ends the survey.*

Did you read the study letter of information?

☐ Yes

☐ No

Before you proceed to the survey, please complete the captcha below. **(Participants must complete this captcha in order to access the survey)**
Please create your unique ID by combining the LAST three letters of your last name and the last 3 digits of your phone number. For example, if my last name was 'Smith' and my phone number was '555-1234', my unique ID would be 'ith234'. This ID will also need to be shared with your partner and you will need to know their unique ID, if they have not taken the survey yet please have them create their ID by following the same instructions so you can include it below. This will allow us to link your survey responses with theirs.

What is your unique ID?

________________________________________________________________

What is your partner's Unique ID? This will be used to connect your responses to your partner's.

________________________________________________________________

Your Sex

○ Male
○ Female
○ Other

______________________________

Parental Identity

○ Mother
○ Father

______________________________

Your Date of Birth? (mm/dd/yyyy)

_____________________________________

Racial or Ethnic Identity

○ American Indian or Alaska Native
○ Asian or Pacific Islander
○ African-American/Black

______________________________
○ Caucasian/White
○ Mexican-American/Hispanic
○ Biracial (specify) ____________________________________________
○ Other (specify) ______________________________________________

Sexual Orientation

○ Heterosexual
○ Gay/Lesbian
○ Bisexual
○ Other (Specify) ______________________________________________

Current Relationship Status?

○ Dating
○ Cohabiting
○ Married: first marriage
○ Married: Later marriage (Widowed, divorced)
○ Single

Highest Level of Education Completed.

○ Grammar School
○ High School or equivalent
○ Vocational/Technical School (2 year)
○ Some College
○ College Graduate (4 year)
○ Master's Degree (MS)
○ Doctoral Degree (PhD)
Professional Degree (MD, JD, etc.)
Other

How long have you been in your current relationship? Please identify months or years.

Your Yearly Income (Please indicate your combined yearly income with your partner):
- less than $10,000
- $10,000 - $24,999
- $25,000 - $39,999
- $40,000 - $54,999
- $55,000 - $69,999
- $70,000 - $84,999
- $85,000 - $99,999
- $100,000 +

Employment Status. (Please write your occupation in the space provided).
- Employed full-time
- Employed part-time
- Unemployed
- Homemaker
- Retired
- Student

Was this a planned pregnancy?
- Yes
- No
What number of child is this for you?

- [ ] 1
- [ ] 2-3
- [ ] 4-5
- [ ] 6+

How did you or are you making the transition to parenthood?

- [ ] Birth with biological child
- [ ] Adoption
- [ ] Surrogacy
- [ ] Other (Specify) ________________________________________________

The perinatal period is identified as conception to 1 year postpartum. At what stage in the perinatal period are you?

- [ ] Less than 2 months pregnant
- [ ] 2-4 months pregnant
- [ ] 5-6 months pregnant
- [ ] 7-9 months pregnant
- [ ] Birth to 1 month postpartum
- [ ] 2-4 months postpartum
- [ ] 5-6 months postpartum
- [ ] 7-8 months postpartum
- [ ] 9-10 months postpartum
- [ ] 11-12 months postpartum
This question serves as a screener for “bots” it is hidden from actual participants. Any option that is selected thanks them for their participation and ends the survey.

What is your gender?

- Male
- Female
- Other

Are you currently experiencing any health problems or concerns?

- Yes
- No

Please list the current health problems/concerns you are experiencing.
During the past 4 weeks, how much have you been bothered by any of the following symptoms?

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Not bothered at all</th>
<th>Bothered a little</th>
<th>Bothered a lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stomach Pain</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Back Pain</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Pain in your arms, legs, or joints (knees, hips, etc.)</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Menstrual Cramps or other problems with your period</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Headaches</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Chest pain</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Dizziness</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Fainting Spells</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Feeling your heart pound or race</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Shortness of breath</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Pain or problems during sexual intercourse</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Constipation, loose bowels, or diarrhea</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Nausea, gas, or indigestion</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Feeling tired or having low energy</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>Trouble Sleeping</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>
OVER THE PAST MONTH, how often have you experienced the following? Please tick the response that most closely describes your experience for every question.

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Some Times</th>
<th>Often</th>
<th>Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worry about the baby/pregnancy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fear that harm will come to the</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>baby</td>
<td></td>
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<td></td>
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<tr>
<td>A sense of dread that something</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>bad is going to happen</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Worry about many things</td>
<td></td>
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<td></td>
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<tr>
<td>Worry about the future</td>
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<tr>
<td>Feeling overwhelmed</td>
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<tr>
<td>Really strong fears about things,</td>
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<tr>
<td>eg. needles, blood, birth, pain,</td>
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<tr>
<td>etc.</td>
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<tr>
<td>Sudden rushes of extreme fear or</td>
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<tr>
<td>discomfort</td>
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<tr>
<td>Repetitive thoughts that are</td>
<td></td>
<td></td>
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<tr>
<td>difficult to stop or control</td>
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<tr>
<td>Difficulty sleeping even when I</td>
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<tr>
<td>have the chance to sleep</td>
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<tr>
<td>Having to do things in a certain</td>
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<tr>
<td>way or order</td>
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<tr>
<td>Wanting things to be perfect</td>
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<tr>
<td>Needing to be in control of things</td>
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<tr>
<td>Difficulty stopping checking or doing things over and over</td>
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<tr>
<td>Feeling jumpy or easily startled</td>
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<tr>
<td>Concerns about repeated thoughts</td>
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<tr>
<td>Being 'on guard' or needing to watch out for things</td>
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<tr>
<td>Upset about repeated memories, dreams or nightmares</td>
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<tr>
<td>Worried that I will embarrass myself in front of others</td>
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<tr>
<td>Fear that others will judge me negatively</td>
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<tr>
<td>Feeling really uneasy in crowds</td>
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<tr>
<td>Avoiding social activities because I might be nervous</td>
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<td></td>
</tr>
<tr>
<td>Avoiding things which concern me</td>
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<td>----------------------------------</td>
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<tr>
<td>Feeling detached like you're watching yourself in a movie</td>
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<tr>
<td>Losing track of time and can't remember what happened</td>
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<tr>
<td>Difficulty adjusting to recent changes</td>
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<tr>
<td>Anxiety getting in the way of being able to do things</td>
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<tr>
<td>Racing thoughts making it hard to concentrate</td>
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<tr>
<td>Fear of losing control</td>
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<tr>
<td>Feeling panicky</td>
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<tr>
<td>Feeling agitated</td>
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</table>
Over the last 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things

- Not at all
- Several days
- More than half the days
- Nearly every day

Feeling down, depressed, or hopeless

- Not at all
- Several days
- More than half the days
- Nearly every day

Trouble falling or staying asleep, or sleeping too much

- Not at all
- Several days
- More than half the days
- Nearly every day

Feeling tired or having little energy

- Not at all
- Several days
- More than half the days
- Nearly every day
Poorest appetite or overeating

- Not at all
- Several days
- More than half the days
- Nearly every day

Feeling bad about yourself—or that you are a failure or have let yourself or your family down.

- Not at all
- Several days
- More than half the days
- Nearly every day

Trouble concentrating on things, such as reading the newspaper or watching television

- Not at all
- Several days
- More than half the days
- Nearly every day

Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual.

- Not at all
- Several days
- More than half the days
- Nearly every day

Thoughts that you would be better off dead, or of hurting yourself
○ Not at all
○ Several days
○ More than half the days
○ Nearly every day

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

○ Not difficult at all
○ Somewhat difficult
○ Very difficult
○ Extremely difficult
Over the last 2 weeks, how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th>Feeling nervous, anxious, or on edge</th>
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<tbody>
<tr>
<td>Not at All</td>
<td>o</td>
</tr>
<tr>
<td>Several Days</td>
<td>o</td>
</tr>
<tr>
<td>More Than Half the Days</td>
<td>o</td>
</tr>
<tr>
<td>Nearly Every Day</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Not being able to stop or control worrying</th>
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<tbody>
<tr>
<td>Not at All</td>
<td>o</td>
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<tr>
<td>Several Days</td>
<td>o</td>
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<tr>
<td>More Than Half the Days</td>
<td>o</td>
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<tr>
<td>Nearly Every Day</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Worrying too much about different things</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Not at All</td>
<td>o</td>
</tr>
<tr>
<td>Several Days</td>
<td>o</td>
</tr>
<tr>
<td>More Than Half the Days</td>
<td>o</td>
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<tr>
<td>Nearly Every Day</td>
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</table>

<table>
<thead>
<tr>
<th>Trouble relaxing</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Not at All</td>
<td>o</td>
</tr>
<tr>
<td>Several Days</td>
<td>o</td>
</tr>
<tr>
<td>More Than Half the Days</td>
<td>o</td>
</tr>
<tr>
<td>Nearly Every Day</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Being so restless that it's hard to sit still</th>
<th></th>
</tr>
</thead>
</table>
Not at All

Several Days

More Than Half the Days

Nearly Every Day

Becoming easily annoyed or irritable

Not at All

Several Days

More Than Half the Days

Nearly Every Day

Feeling afraid as if something awful might happen

Not at All

Several Days

More Than Half the Days

Nearly Every Day

If you marked any of the previous problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult at All

Somewhat Difficult

Very Difficult

Extremely Difficult
As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

In the past 7 days:

I have been able to laugh and see the funny side of things

- As much as I always could
- Not quite so much now
- Definitely not so much now
- Not at all

I have looked forward with enjoyment to things

- As much as I ever did
- Rather less than I used to
- Definitely less than I used to
- Hardly at all

I have blamed myself unnecessarily when things went wrong

- Yes, most of the time
- Yes, some of the time
- Not very often
- No, never

I have been anxious or worried for no good reason

- No, not at all
- Hardly ever
- Yes, sometimes
I have felt scared or panicky for no very good reason

- Yes, quite a lot
- Yes, sometimes
- No, not much
- No, not at all

Things have been getting on top of me

- Yes, most of the time I haven’t been able to cope at all
- Yes, sometimes I haven’t been coping as well as usual
- No, most of the time I have coped quite well
- No, I have been coping as well as ever

I have been so unhappy that I have had difficulty sleeping

- Yes, most of the time
- Yes, sometimes
- Not very often
- No, not at all

I have felt sad or miserable

- Yes, most of the time
- Yes, quite often
- Not very often
- No, not at all

I have been so unhappy that I have been crying
The thought of harming myself has occurred to me

- Yes, quite often
- Sometimes
- Hardly ever
- Never
For the following questions rate your satisfaction with your present relationship on the associated scales.

<table>
<thead>
<tr>
<th>Extreme Unhappy</th>
<th>Fairly Unhappy</th>
<th>A Little Unhappy</th>
<th>Happy</th>
<th>Very Happy</th>
<th>Extremely Happy</th>
<th>Perfect</th>
</tr>
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</table>

Please indicate the degree of happiness, all things considered, of your relationship.

<table>
<thead>
<tr>
<th>All the time</th>
<th>Most of the time</th>
<th>More often than not</th>
<th>Occasionally</th>
<th>Rarely</th>
<th>Never</th>
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</table>

In general, how often do you think that things between you and your partner are going well?

<table>
<thead>
<tr>
<th>Not at all TRUE</th>
<th>A little TRUE</th>
<th>Somewhat True</th>
<th>Mostly True</th>
<th>Almost Completely TRUE</th>
<th>Completely TRUE</th>
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Our Relationship is Strong

<p>| | | | | | |</p>
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</thead>
</table>
My relationship with my partner makes me happy
I have a warm and comfortable relationship with my partner
I really feel like part of a team with my partner

<table>
<thead>
<tr>
<th>How rewarding is your relationship with your partner?</th>
</tr>
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<tbody>
<tr>
<td>Not at all</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How well does your partner meet your needs?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>To what extent has your relationship met your original expectations?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
</tr>
</tbody>
</table>
In general, how satisfied are you with your relationship?
Rate how you feel about your relationship between each descriptive pair of words. Base your responses on your first impressions and immediate feelings about the item.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
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<tbody>
<tr>
<td>Interesting</td>
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<tr>
<td>Bad</td>
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<td>Full</td>
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<td>Sturdy</td>
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<td>Discouraging</td>
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<tr>
<td>Enjoyable</td>
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Boring
Good
Empty
Fragile
Hopeful
Miserable

*This question serves as a screener for “bots” it is hidden from actual participants. Any option that is selected thanks them for their participation and ends the survey.*

The transition to parenthood is hard...

- ○ True
- ○ False
The following statements concern how you feel in romantic relationships. Please respond to each statement by indicating how much you agree or disagree.

It helps to turn to my romantic partner in times of need.

- Strongly Disagree
- Disagree
- Slightly Disagree
- Neutral
- Slightly Agree
- Agree
- Strongly Agree

I need a lot of reassurance that I am loved by my partner.

- Strongly Disagree
- Disagree
- Slightly Disagree
- Neutral
- Slightly Agree
- Agree
- Strongly Agree

I want to get close to my partner, but I keep pulling back.

- Strongly Disagree
- Disagree
- Slightly Disagree
- Neutral
- Slightly Agree
I find that my partner doesn't want to get as close as I would like.

- Strongly Disagree
- Disagree
- Slightly Disagree
- Neutral
- Slightly Agree
- Agree
- Strongly Agree

I turn to my partner for many things, including comfort and reassurance.

- Strongly Disagree
- Disagree
- Slightly Disagree
- Neutral
- Slightly Agree
- Agree
- Strongly Agree

My desire to be very close sometimes scares people away.

- Strongly Disagree
- Disagree
- Slightly Disagree
- Neutral
I try to avoid getting too close to my partner.

- Strongly Disagree
- Slightly Disagree
- Disagree
- Neutral
- Slightly Agree
- Agree
- Strongly Agree

I don't worry about being abandoned.

- Strongly Disagree
- Disagree
- Slightly Disagree
- Neutral
- Slightly Agree
- Agree
- Strongly Agree

I usually discuss my problems and concerns with my partner.

- Strongly Disagree
- Disagree
- Slightly Disagree
I get frustrated if my romantic partner is not available when I need them.

- Strongly Disagree
- Disagree
- Slightly Disagree
- Neutral
- Slightly Agree
- Agree
- Strongly Agree

I am nervous when my partner gets too close to me.

- Strongly Disagree
- Disagree
- Slightly Disagree
- Neutral
- Slightly Agree
- Agree
- Strongly Agree

I worry that a romantic partner won't care about me as much as I care about them.

- Strongly Disagree
- Disagree
☐ Slightly Disagree
☐ Neutral
☐ Slightly Agree
☐ Agree
☐ Strongly Agree
We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

There is a special person who is around when I am in need.

- Very Strongly Disagree
- Strongly Disagree
- Mildly Disagree
- Neutral
- Mildly Agree
- Strongly Agree
- Very Strongly Agree

There is a special person with whom I can share joys and sorrows.

- Very Strongly Disagree
- Strongly Disagree
- Mildly Disagree
- Neutral
- Mildly Agree
- Strongly Agree
- Very Strongly Agree

My family really tries to help me.

- Very Strongly Disagree
- Strongly Disagree
- Mildly Disagree
- Neutral
- Mildly Agree
- Strongly Agree
I get the emotional help & support I need from my family.

- Very Strongly Disagree
- Strongly Disagree
- Mildly Disagree
- Neutral
- Mildly Agree
- Strongly Agree
- Very Strongly Agree

I have a special person who is a real source of comfort to me.

- Very Strongly Disagree
- Strongly Disagree
- Mildly Disagree
- Neutral
- Mildly Agree
- Strongly Agree
- Very Strongly Agree

My friends really try to help me.

- Very Strongly Disagree
- Strongly Disagree
- Mildly Disagree
- Neutral
- Mildly Agree
Strongly Agree
 Very Strongly Agree

I can count on my friends when things go wrong.

Very Strongly Disagree
 Strongly Disagree
 Mildly Disagree
 Neutral
 Mildly Agree
 Strongly Agree
 Very Strongly Agree

I can talk about my problems with my family.

Very Strongly Disagree
 Strongly Disagree
 Mildly Disagree
 Neutral
 Mildly Agree
 Strongly Agree
 Very Strongly Agree

I have friends with whom I can share my joys and sorrows.

Very Strongly Disagree
 Strongly Disagree
 Mildly Disagree
 Neutral
There is a special person in life who cares about my feelings.

- Very Strongly Disagree
- Strongly Disagree
- Mildly Disagree
- Neutral
- Mildly Agree
- Strongly Agree
- Very Strongly Agree

My family is willing to help me make decisions.

- Very Strongly Disagree
- Strongly Disagree
- Mildly Disagree
- Neutral
- Mildly Agree
- Strongly Agree
- Very Strongly Agree

I can talk about my problems with my friends.

- Very Strongly Disagree
- Strongly Disagree
- Mildly Disagree
How important is spirituality in your life?

- Very important
- Fairly important
- Not too important
- Not at all important

Do you consider yourself to be:

- Not religious/spiritual
- Slightly religious/spiritual
- Moderately religious/spiritual
- Very religious/spiritual
- Strongly religious/spiritual

*If participants select “Not religious/spiritual” for this item, the following question is skipped.*

What is your Religious Preference?

- Muslim
- Protestant
- Latter-Day Saint (Mormon)
- Jewish
- Catholic
- Other (Specify): ________________________________________________
Below is a series of statements about motherhood. Indicate how often you agree with each statement.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Always Agree</th>
<th>Agree Most of the Time</th>
<th>Agree Some of the Time</th>
<th>Disagree Some of the Time</th>
<th>Disagree Most of the Time</th>
<th>Always Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>If I make a mistake, people will think I am a bad mother.</td>
<td></td>
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<tr>
<td>If my baby is crying, people will think I cannot care for him/her properly.</td>
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<tr>
<td>People will probably think less of me if I make parenting mistakes.</td>
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<tr>
<td>Seeking help with my baby from other people makes me feel incompetent.</td>
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<tr>
<td>I am the only person who can keep my baby safe.</td>
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<tr>
<td>Good mothers always put their baby’s needs first.</td>
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<tr>
<td>I should feel more devoted to my baby.</td>
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<tr>
<td>If I love my baby, I should want to be with him/her all the time.</td>
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<tr>
<td>If I fail at motherhood, then I am a failure as a person.</td>
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<tr>
<td>It is wrong to feel disappointed by motherhood.</td>
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<tr>
<td>It is wrong to have mixed feelings about my baby.</td>
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<tr>
<td>Negative feelings towards my baby are wrong.</td>
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</tbody>
</table>
**This question is only displayed if participant identifies “Father” as their parental identify.**

Below is a series of statements about fatherhood. Indicate how often you agree with each statement.

<table>
<thead>
<tr>
<th>Always Agree</th>
<th>Agree Most of the Time</th>
<th>Agree Some of the Time</th>
<th>Disagree Some of the Time</th>
<th>Disagree Most of the Time</th>
<th>Always Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>If I make a mistake, people will think I am a bad father.</td>
<td></td>
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<tr>
<td>If my baby is crying, people will think I cannot care for him/her properly.</td>
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<tr>
<td>People will probably think less of me if I make parenting mistakes.</td>
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<td>Good fathers always put their baby’s needs first.</td>
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</tbody>
</table>
I should feel more devoted to my baby.

If I love my baby, I should want to be with him/her all the time.

If I fail at fatherhood, then I am a failure as a person.

It is wrong to feel disappointed by fatherhood.

It is wrong to have mixed feelings about my baby.

Negative feelings towards my baby are wrong.
Please read the items below and respond by selecting the number that corresponds with how you typically respond in situations of adversity or trials.

My faith helps push me to overcome difficult tasks in life.

- Strongly disagree
- Somewhat disagree
- Neither agree nor disagree
- Somewhat agree
- Strongly agree

I continue to do the right thing despite facing hardships.

- Strongly disagree
- Somewhat disagree
- Neither agree nor disagree
- Somewhat agree
- Strongly agree

Hardships give me a sense of renewed purpose.

- Strongly disagree
- Somewhat disagree
- Neither agree nor disagree
- Somewhat agree
- Strongly agree

My faith helps me stand up for what is right during challenging times.

- Strongly disagree
- Somewhat disagree
I am able to do the right thing even in the midst of hardship.

- Strongly disagree
- Somewhat disagree
- Neither agree nor disagree
- Somewhat agree
- Strongly agree

My sense of purpose is strengthened through adversity.

- Strongly disagree
- Somewhat disagree
- Neither agree nor disagree
- Somewhat agree
- Strongly agree

My faith helps me withstand difficulties.

- Strongly disagree
- Somewhat disagree
- Neither agree nor disagree
- Somewhat agree
- Strongly agree

I retain my will to live despite my hardship.

- Strongly disagree
I find meaning in my struggles.

- Strongly disagree
- Somewhat disagree
- Neither agree nor disagree
- Somewhat agree
- Strongly agree
Please take a moment to think about what makes your life and existence feel important and significant to you. Please respond to the following statements as truthfully and accurately as you can, and also please remember that these are very subjective questions and that there are no right or wrong answers.

I understand my life’s meaning.

- Absolutely Untrue
- Mostly Untrue
- Somewhat Untrue
- Can't Say True or False
- Somewhat True
- Mostly True
- Absolutely True

I am looking for something that makes my life meaningful.

- Absolutely Untrue
- Mostly Untrue
- Somewhat Untrue
- Can't Say True or False
- Somewhat True
- Mostly True
- Absolutely True

I am always looking to find life's purpose.

- Absolutely Untrue
- Mostly Untrue
- Somewhat Untrue
- Can't Say True or False
My life has a clear sense of purpose.

- Absolutely Untrue
- Mostly Untrue
- Somewhat Untrue
- Can't Say True or False
- Somewhat True
- Mostly True
- Absolutely True

I have a good sense of what makes my life meaningful.

- Absolutely Untrue
- Mostly Untrue
- Somewhat Untrue
- Can't Say True or False
- Somewhat True
- Mostly True
- Absolutely True

I have discovered a satisfying life purpose.

- Absolutely Untrue
- Mostly Untrue
- Somewhat Untrue
I am always searching for something that makes my life feel significant.

I am seeking a purpose or mission for my life.

My life has no clear purpose.
Somewhat Untrue
Can't Say True or False
Somewhat True
Mostly True
Absolutely True

I am searching for meaning in my life.

Absolutely Untrue
Mostly Untrue
Somewhat Untrue
Can't Say True or False
Somewhat True
Mostly True
Absolutely True
Please answer the following items based on how you feel, that is, at the present moment using the scale below. Try to answer each item as accurately as possible based on your response to that item alone, without regard to your answers to previous items.

---

I am feeling optimistic about life's challenges.

- [ ] Strongly disagree
- [ ] Somewhat disagree
- [ ] Neither agree nor disagree
- [ ] Somewhat agree
- [ ] Strongly agree

---

Right now, I expect things to work out for the best.

- [ ] Strongly disagree
- [ ] Somewhat disagree
- [ ] Neither agree nor disagree
- [ ] Somewhat agree
- [ ] Strongly agree

---

I am feeling optimistic about my future.

- [ ] Strongly disagree
- [ ] Somewhat disagree
- [ ] Neither agree nor disagree
- [ ] Somewhat agree
- [ ] Strongly agree

---

I feel that something good will happen today (in the next 24 hours).

- [ ] Strongly disagree
- [ ] Somewhat disagree
The future is looking bright to me.

At the moment, I expect more to go right than wrong when it comes to my future.

I am expecting things to turn out well.
What has your experience been like as you have started and progressed through your transition to parenthood?

________________________________________________________________

What biological changes have occurred during this experience that you were prepared for and also that you were not expecting?

________________________________________________________________

What expectations did you have when you first began this transition? Were those expectations met?

________________________________________________________________

What type of support have you been provided during this transition? How has that level of support impacted your overall experience? How has this transition impacted your relationship with your significant other?

________________________________________________________________

How has your transition to parenthood impacted any preexisting mental health concerns or contributed in the development of any mental health concerns?

________________________________________________________________

How has COVID-19 impacted your transition to parenthood?

________________________________________________________________
Upon completion of the last question, the following message is presented.

END OF SURVEY MESSAGE

Your response has been recorded. We thank you for your time spent taking this survey.

Please share the survey link and your unique ID with your partner so they can take the survey as well.

The link to the survey is: https://usu.co1.qualtrics.com/jfe/form/SV_6R280hs3a7qvHH1E

If you wish to be entered into the drawing, please click the link below to enter.

Enter Drawing Here

The following survey is the entry form for the drawing.

Before you proceed to the survey, please complete the captcha below.

Thank you for your participation in our Transition to Parenthood study. Please enter your name, your partner’s name, and a good email address that we could send the prize to if chosen. In order to qualify for the drawing both you and your partner will need to complete the survey and submit an entry form.

Full name

______________________________

Partner's full name

______________________________

Email Address

______________________________
Appendix B: IRB Certificate of Exemption
From: Melanie Domenech Rodriguez, IRB Chair
       Nicole Vouvalis, IRB Director

To:   W David Robinson

Date: May 20, 2021

Protocol #: 11547

Title: Biopsychosocial-Spiritual Changes During the Transition to Parenthood

The Institutional Review Board has determined that the above-referenced study is exempt from review under federal guidelines 45 CFR Part 46.104(d) category #2:

Research that only includes interactions involving educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met: (i) The information obtained is recorded in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subject; (ii) Any disclosure of the responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation, or (iii) the information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and the IRB conducts a limited IRB review to make required determinations.

This study is subject to ongoing COVID-19 related restrictions. As of March 15, 2020, the IRB has temporarily paused all in person research activities, including but not limited to recruitment, informed consent, data collection and data analysis that involves personal interaction (such as member checking and meaning-making). If research cannot be paused, please file an amendment to your protocol modifying procedures that are conducted in person. The IRB will notify you when in person research activities are once again permitted.

This exemption is valid for five years from the date of this correspondence, after which the study will be closed. If the research will extend beyond five years, it is your responsibility as the Principal Investigator to notify the IRB before the study’s expiration date and submit a new application to continue the research. Research activities that continue beyond the expiration date without new certification of exempt status will be in violation of those federal guidelines which permit the exempt status.

If this project involves Non-USU personnel, they may not begin work on it (regardless of the approval status at USU) until a Reliance Agreement, External Research Agreement, or separate protocol review has been completed with the appropriate external entity. Many schools will not engage in a Reliance Agreement for Exempt protocols, so the research team must determine what the appropriate approval mechanism is for their Non-USU colleagues. As part of the IRB’s quality assurance procedures, this research may be randomly selected for audit during the five-year period of exemption. If so, you will receive a request for completion of an Audit Report form during the month of the anniversary date of this certification.

In all cases, it is your responsibility to notify the IRB prior to making any changes to the study by submitting an Amendment request. This will document whether or not the study still meets the requirements for exempt status under federal regulations.

Upon receipt of this memo, you may begin your research. If you have questions, please call the IRB office at (435) 797-1821 or email to irb@usu.edu.

The IRB wishes you success with your research.
Appendix C: Study Letter of Information
The Biopsychosocial-Spiritual Transition to Parenthood

You are invited to participate in a research study by David Jenks, a Doctoral Student in Human Development and Family Studies Department at Utah State University.

The purpose of this research is to explore how the transition to parenthood impacts the biological, psychological, social, and spiritual aspects of life for parents so that helping professionals, such as counselors, therapists, and medical professionals, can more fully help the family as they make this important transition.

Your participation in this study is voluntary and you may withdraw your participation at any time for any reason.

If you take part in this study, you will be asked to complete a survey that will take approximately 25 minutes to complete. This survey goes through various biological, psychological, social, and spiritual measures that will be used to explore these aspects in your life as you navigate the transition to parenthood. You will not be able to stop and return to the survey so you are asked to devote at least 25 minutes to make sure that you have time to complete the whole survey. As part of that survey, you will be asked to create a unique identifier per the instructions in the survey, that identifier will consist of the last 3 letters of your last name and the last 3 numbers of your phone number. This identifier will be used to link your responses to your partner’s responses. You will need to know your partner’s, and they will need to know yours.

The possible risks of participating in this study include loss of confidentiality, and additional risks, including emotional discomfort that may result from answer survey questions. Your responses will help caring professionals such as medical and mental health professionals better understand the impact that the transition to parenthood has on the couple relationship and various aspects of life. We cannot guarantee that you will directly benefit from this study but it has been designed to learn more about the transition to parenthood and potential needs that may arise during this time.

We will make every effort to ensure that the information you provide remains confidential. We will not reveal your identity in any publications, presentations, or reports resulting from this research study.

We will use an online survey platform to collect your responses that will only be accessible by the research team. Online activities always carry a risk of a data breach, but we will use systems and processes that minimize breach opportunities. Survey responses will be securely stored in a restricted-access folder on Box.com, an encrypted, cloud-based storage system.

For your participation in this research study, the first 100 COUPLES to complete the survey will be given a $10 amazon gift card, everyone will also receive the opportunity to enter a drawing to win one of three $50 amazon gift cards. At the end of the survey after you have completed your portion you will be prompted to follow a link to enter in your name and email address for drawing purposes. This information will be kept in the secure box.com folder until the drawing and will then be destroyed.

You can decline to participate in any part of this study for any reason and can end your participation at any time by exiting out of the survey.

If you have any questions about this study, you can contact David Jenks at david.jenks@usu.edu. Thank you again for your time and consideration. If you have any concerns about this study, please contact Utah State University’s Human Research Protection Office at (435) 797-0567 or irb@usu.edu.
The nature of this survey is to explore the biological, psychological, social, and spiritual dimensions of the transition to parenthood. Part of the survey will ask about things such as depression, anxiety, thoughts of self-harm, and suicide. If you or someone you know is experiencing difficulties with mental health or any of the topics explored in this survey, please get help.

The following are some resources that may be of assistance.

Find a therapist near you: https://www.psychologytoday.com

National Perinatal Association: http://www.nationalperinatal.org/mental_health

Substances Abuse and Mental Health Services Administration: https://www.samhsa.gov/

National Suicide Prevention Lifeline: https://suicidepreventionlifeline.org/

National Suicide Prevention Hotline Number: 1-800-273-8255

By continuing to the survey, you agree that wish to participate, you are 18 years of age or older, you or your partner are currently pregnant, you or your partner have given birth within the past year, you and your partner are making the transition to parenthood in some way, you have a partner who is also willing to complete the survey, and you both have time to complete the survey in its entirety. You agree that you understand the risks and benefits of participation, and that you know what you are being asked to do. You also agree that if you have any questions about your participation, you know how to contacted the research team.
Appendix D: Recruitment Flyer
The Transition to Parenthood

Have you given birth within the past year, are you or your partner currently pregnant, or are you planning to make the transition to parenthood in some way?

During the transition to parenthood, there are a lot of changes that take place and these changes can be very challenging to manage. You and your partner are invited to participate in a study (IRB: #11547) by completing a 25-minute survey examining the transition to parenthood and how various aspects of life are impacted by this transition within the couple relationship.

In order to participate in this study, you must currently be pregnant, have given birth within the past year, be making the transition to parenthood in some way, be 18 years or older, have a partner who is also willing to complete the survey, and have time to complete the survey in its entirety.

The first 100 COUPLES to complete the survey and submit their information at the end of the survey will be given a $10 amazon gift card, you will also be given the option to enter in your name and email address to be entered into a drawing for one of three $50 amazon gift cards. In order to qualify for the drawing both you and your partner will need to complete the survey and submit the entry form at the end.

Questions may be directed to a member of our research team at: david.jenks@usu.edu

**No information is collected by scanning either of these QR codes**

To message yourself a link to the survey scan this QR code with your phone. It will open your messaging app where you will put in your OWN phone number to receive the message.

To go directly to the survey scan this QR code with your phone.
David Bradley Jenks Jr, MA, LMFT
Doctoral Candidate
2185 North 500 East
North Logan, UT 84341
Email: jenks.davidb@gmail.com
Phone: (801) 721-5894

EDUCATION

Doctor of Philosophy, Human Development and Family Studies
Utah State University, Marriage and Family Therapy Emphasis
September 2018- Current

Working towards completion of Ph.D. in Human Development and Family Studies with an emphasis in Marriage and Family Therapy, *anticipated completion Fall 2021*. Gaining experience conducting high quality research, continuing development of clinical skills related to Marriage and Family Therapy, preparing and submitting documentation for COAMFT accreditation, receiving experience as a Clinical Supervisor (under supervision) to receive AAMFT approved supervisor designation, and developing skills related to the teaching of Human Development and Family Studies and Marriage and Family Therapy. Dissertation focused on the systemic experience of couples during the transition to parenthood.

Master of Arts, Marriage and Family Therapy
Pacific Lutheran University
September 2014- December 2016

Received training to become systemically-oriented, contextually sensitive MFT professional who address the diverse needs and clinical concerns of individuals, couples, families, and communities. Obtained the ability to work in a wide range of human service professions, especially those servicing children and families. Additional experience gained assisting MFT program with preparation for accreditation and submitting final accreditation document.

Bachelor of Science, Marriage and Family Studies
Brigham Young University—Idaho
January 2010- December 2013

Completed classes in Psychology, Sociology, Human Development (Child, Adolescent, and Adult), Family Development, and Parenting. Gained an understanding of the dynamics of healthy and strong families.

CLINICAL EXPERIENCE

5/21 – present    Licensed Associate Marriage and Family Therapist, Utah State University, Logan, UT. Provide individual, marriage, family, and couple’s therapy to clients in and around Cache Valley Utah. Working with clients experiencing a variety of issues related to emotional and relational difficulties such as communication problems, infidelity, roles and boundaries, and intimacy issues.

9/18 – present    Marriage and Family Therapy Doctoral Intern, Utah State University, Logan, UT.
Provide Family and Couple's therapy to clients in the student run clinic at Utah State University. Working with clients experiencing a variety of issues related to emotional and relational difficulties such as communication problems, infidelity, roles and boundaries, and intimacy issues.

4/17 – 7/18  **Mental Health Professional, MultiCare Behavioral Health, Puyallup, WA.** Provided individual, couples and family therapy, and fulfilled case management needs for adults between the ages of 18 and 59 diagnosed with a variety of disorders such as Schizophrenia, Bipolar Disorder, Depression, Anxiety and PTSD. Conducted intakes for walk in clinic and completed diagnostic formulation and intake documents as required.

12/16 – 4/17  **Child and Family Therapist, Nexus Youth and Families, Auburn, WA.** Provided individual and family therapy to youth and adolescents diagnosed with presenting problems such as Depression, Generalized Anxiety Disorder, Adjustment Disorder, and ADHD. Gained experience diagnosing through conducting intakes with clients.

1/16 – 12/16  **MFT Intern, Nexus Youth and Families, Auburn, WA.** Provided individual and family therapy to youth and adolescents diagnosed with presenting problems such as Depression, Generalized Anxiety Disorder, Adjustment Disorder, and ADHD. Gained experience diagnosing through conducting intakes with clients.

**TEACHING EXPERIENCE**

**Fall 2020**  **Graduate Student Instructor- HDFS 6390: Practicum in Marriage and Family Therapy (In Person), Utah State University, Logan, UT.** Teacher of Record for Masters level practicum course in Marriage and Family Therapy program. Provide supervision and instruction to current Marriage and Family Therapy students surrounding topics such as clinical practices, theories in MFT, and ethics.

**Spring 2020**  **Graduate Student Instructor- HDFS 2400: Marriage and Family Relationships (In Person/Online), Utah State University, Logan, UT.** Teacher of Record for an undergraduate general education course examining important aspects of marriage and family relationships such as cultural diversity, intimacy, parenting, communication, finances, abuse, conflict, marriage development through the years, and various theories related to marriage and family dynamics. Course taught in person on campus at Utah State University with approximately 75 students. Smoothly transitioned course to online teaching during COVID Pandemic.

**Fall 2019**  **Graduate Student Instructor- HDFS 2400: Marriage and Family Relationships (Broadcast), Utah State University, Logan, UT.** Teacher of Record for an undergraduate general education course examining important aspects of marriage and family relationships such as cultural diversity, intimacy, parenting, communication, finances, abuse, conflict, marriage development through the years, and various theories related to marriage and family dynamics. Course taught in broadcast format to distance education sites across Utah.
Fall 2019  
**Guest Lecturer - Anxiety Disorders: Assessment and Diagnosis, Utah State University, Logan, UT.** Presented lecture discussing the assessment and diagnosis of anxiety disorders to master’s students in the Marriage and Family Therapy Program at Utah State University.

Spring 2018  
**Online Guest Lecturer - Parenting and Divorce: A Therapist’s Perspective, Utah State University, Logan, UT.** Presented lecture exploring issues related to parenting when couples go through divorce. Provided insight into therapeutic aspects of divorce and how to help parents cooperatively parent through separation.

Fall 2018  
**Guest Lecturer - Strengthening Marriage and Families, Utah State University, Logan, UT.** Presented lecture on the importance of marriage and how to strengthen marriage and families to 90 undergraduate students in the Human Development and Family Studies Department at Utah State University.

Fall 2018  
**Guest Lecturer - Ethics and Boundaries in Therapy, Utah State University, Logan, UT.** Presented lecture discussing the importance of creating and maintaining ethical boundaries in therapy and how to navigate the formation of those boundaries to master’s students in the Marriage and Family Therapy Program at Utah State University.

Fall 2018  
**Guest Lecturer - Mental Health and Suicide, Utah State University, Logan, UT.** Presented lecture on mental health, suicide, and the importance of being aware of warning signs of suicide to undergraduate students in the Human Development and Family Studies Department at Utah State University.

Fall 2018  
**Guest Lecturer - Suicide Prevention and Assessment, Utah State University, Logan, UT.** Presented lecture discussing suicide assessment and prevention in therapy to master’s students in the Marriage and Family Therapy Program at Utah State University.

**ADDITIONAL TEACHING EXPERIENCE**

Summer 2021  
**Teaching Assistant - HDFS 2400: Marriage and Family Relationships, Utah State University, Logan, UT.** Assisted instructor with teaching or teaching-related duties, such as teaching classes, developing teaching materials, preparing examinations, and grading examinations or papers.

Spring 2021  
**Teaching Assistant - HDFS 3110: Human Sexuality, Utah State University, Logan, UT.** Assisted instructor with teaching or teaching-related duties, such as teaching classes, developing teaching materials, preparing examinations, and grading examinations or papers.

Spring 2021  
**Teaching Assistant - HDFS 1010: Balancing Work and Family, Utah State University, Logan, UT.** Assisted instructor with teaching or teaching-related duties, such as teaching classes, developing teaching materials, preparing examinations, and grading examinations or papers.
Fall 2020  Teaching Assistant- IIDFS 1010: Balancing Work and Family, Utah State University, Logan, UT. Assisted instructor with teaching or teaching-related duties, such as teaching classes, developing teaching materials, preparing examinations, and grading examinations or papers.

Summer 2020  Teaching Assistant- IIDFS 1500: Human Development Across the Life Span, Utah State University, Logan, UT. Assisted instructor with teaching or teaching-related duties, such as teaching classes, developing teaching materials, preparing examinations, and grading examinations or papers.

Summer 2019  Teaching Assistant- IIDFS 4220: Family Crisis and Intervention, Utah State University, Logan, UT. Assisted instructor with teaching or teaching-related duties, such as teaching classes, developing teaching materials, preparing examinations, and grading examinations or papers.

Spring 2019  Teaching Assistant- IIDFS 3130: Research Methods, Utah State University, Logan, UT. Assisted instructor with teaching or teaching-related duties, such as teaching classes, developing teaching materials, preparing examinations, and grading examinations or papers.

Spring 2019  Teaching Assistant- IIDFS 3210: Families and Diversity, Utah State University, Logan, UT. Assisted instructor with teaching or teaching-related duties, such as teaching classes, developing teaching materials, preparing examinations, and grading examinations or papers.

Spring 2019  Teaching Assistant- IIDFS 2660: Parenting and Child Guidance, Utah State University, Logan, UT. Assisted instructor with teaching or teaching-related duties, such as teaching classes, developing teaching materials, preparing examinations, and grading examinations or papers.

Fall 2018  Teaching Assistant- IIDFS 2400: Marriage and Family Relationships, Utah State University, Logan, UT. Assisted instructor with teaching or teaching-related duties, such as teaching classes, developing teaching materials, preparing examinations, and grading examinations or papers.

Fall 2018  Teaching Assistant- IIDFS 3130: Research Methods, Utah State University, Logan, UT. Assisted instructor with teaching or teaching-related duties, such as teaching classes, developing teaching materials, preparing examinations, and grading examinations or papers.

Fall 2018  Teaching Assistant- IIDFS 3210: Families and Diversity, Utah State University, Logan, UT. Assisted instructor with teaching or teaching-related duties, such as teaching classes, developing teaching materials, preparing examinations, and grading examinations or papers.
RESEARCH

Interests

Ongoing research interests include the impact of illness on the family system, the transition to parenthood, and the impact of attachment on therapy outcomes. Other interests consist of sex/intimacy education and therapy within Conservative Christian families, therapeutic processes and interventions in relational therapy, impact of attachment style in couple interactions and therapy, and improving education of MFT professionals.

Referred Journal Articles


Publications in Preparation


Guest Editor


National Presentations

ADDITIONAL EXPERIENCE

Spring 2021  Founding Research Lab Member- Perinatal Mental Health Lab, Utah State University, Logan, UT. Working on various research projects focused on Perinatal Mental Health with research team consisting of faculty advisor and additional graduate students at Utah State University.

Spring 2020  Research Assistant- Graduate Student Researcher: Relationship Checkup, Utah State University, Logan, UT. Conducted sessions, recruited participants and assisted researchers with research project exploring the effectiveness of a 2-session relationship checkup to improve couple dynamics.

Fall 2019  Research Assistant- Graduate Student Researcher: Relationship Checkup, Utah State University, Logan, UT. Conducted sessions, recruited participants and assisted researchers with research project exploring the effectiveness of a 2-session relationship checkup to improve couple dynamics.

Summer 2019  Research Assistant- Graduate Student Researcher: Relationship Checkup, Utah State University, Logan, UT. Conducted sessions, recruited participants and assisted researchers with research project exploring the effectiveness of a 2-session relationship checkup to improve couple dynamics.

Summer 2019  Program Assistant- Accreditation, Utah State University, Logan, UT. Assisted Marriage and Family Therapy Program with preparing and submitting documents for COAMFTE accreditation. Duties consisted of compiling, writing, and preparing standards for accreditation document.

PROFESSIONAL LICENSES, DESIGNATIONS, AND MEMBERSHIPS

Exp. 9/30/22  LMFT, Licensed Marriage and Family Therapist, Utah. License # 10968035-3902

11/18 - present  AAMFT Approved Supervisor (Under Supervision), currently gaining supervision and supervision of supervision hours for full designation.

11/18 – present  UAMFT, Member of the Utah Association of Marriage and Family Therapy

9/14 – present  AAMFT, Professional Member of the American Association of Marriage and Family Therapy

AWARDS AND HONORS

2021-2022  Utah State University Emma Eccles Jones College of Education and Human Services Human Development and Family Studies Ila Smith Taggart Scholarship - Graduate
<table>
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<tr>
<th>Year</th>
<th>Event/presentation</th>
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<tr>
<td>2020-2021</td>
<td>Utah State University Emma Eccles Jones College of Education and Human Services Human Development and Family Studies Phyllis R. Snow Memorial Endowment - Graduate</td>
</tr>
<tr>
<td>2020</td>
<td>3rd Place in the American Association of Marriage and Family Therapy (AAMFT) 2020 Student Ethics Competition</td>
</tr>
<tr>
<td>2019-2020</td>
<td>Utah State University Emma Eccles Jones College of Education and Human Services Brent C. and Kevon Miller Graduate Scholarship</td>
</tr>
<tr>
<td>2019-2020</td>
<td>Utah State University Emma Eccles Jones College of Education and Human Services Human Development and Family Studies Phyllis R. Snow Memorial Endowment - Graduate</td>
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**TRAININGS AND CERTIFICATIONS**

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<tr>
<th>Date</th>
<th>Description</th>
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<tbody>
<tr>
<td>8/21</td>
<td>Professional Development Resources- Suicide Prevention: Evidence-Based Strategies. Completed 3-hour suicide prevention training.</td>
</tr>
<tr>
<td>1/20</td>
<td>Gottman Couples Therapy Level 1 Training: Bridging the Couple Chasm. Completed Gottman level 1 workshop focused on research-based strategies and tools to help couples successfully manage conflict using the Gottman method.</td>
</tr>
<tr>
<td>1/19</td>
<td>Intro and Intermediate R for Social Researchers. Completed 14-week continuing education workshop in utilizing R to analyze data in the Social Sciences</td>
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<tr>
<td>11/18</td>
<td>Fundamentals of Supervision Course. Completed 30-Hour AAMFT Approved Supervisor Course.</td>
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<tr>
<td>8/18</td>
<td>Social and Behavioral Responsible Conduct of Research Course. Completed CITI certification course for the responsible conduct of research. Credential ID 28263426</td>
</tr>
<tr>
<td>8/18</td>
<td>Group 1: Social, Behavioral, and Education Researchers. Completed CITI certification course for social, behavioral, and education researchers. Credential ID 28263425</td>
</tr>
<tr>
<td>4/17</td>
<td>Behavioral Health Issues in Older Adults. Completed 2 hour online training discussing issues in older adults oriented for paraprofessionals.</td>
</tr>
<tr>
<td>3/16</td>
<td>Parent Child Interaction Therapy Training. Completed 11 hours of training in Parent and Child Interaction Therapy, which is a program for children and their parents where they are taught techniques for discipline and how to reinforce positive behaviors.</td>
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</table>
5/15  **Trauma Focused CBT Online Training.** Completed a 10 hour online training course on Trauma Focused Cognitive Behavioral Therapy for children and adolescents impacted by trauma.

1/15  **Prepare/Enrich Certification.** Completed an all-day training to become certified as a Prepare/Enrich facilitator working with pre-marital and marital couples to strengthen their relationship.