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Debbie Wang

Wilfrid Laurier University, wang2930@mylaurier.ca

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**THE HOLD ME TIGHT<sup>®</sup> PROGRAM FOR COUPLES BECOMING PARENTS:  
A MIXED METHODS STUDY**

by

Debbie Wang,

Master of Social Work, Wilfrid Laurier University, 2000

Bachelor of Social Work, McMaster University, 1992

Bachelor of Arts (Psychology), the University of Tennessee, 1986

DISSERTATION

Submitted to the Faculty of Social Work

Wilfrid Laurier University

in partial fulfilment of the requirements for the degree of

Doctor of Philosophy in Social Work

Waterloo, Ontario, Canada

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## ABSTRACT

Attachment theory has made substantial contributions to the understanding of close relationships. The purpose of this study was to inquire whether an attachment-informed psychoeducational program is a feasible and effective intervention for couples expecting their first child. The overarching question was: Is an attachment-informed relationship enhancement program, such as *Hold Me Tight*<sup>®</sup> (HMT), helpful to couples in strengthening their relationship and increasing their confidence in becoming first-time parents? The research question was addressed using a mixed-methods approach.

In the first phase, the *Hold Me Tight*<sup>®</sup> program developed by Dr. Sue Johnson was modified for use with couples becoming parents for the first time. The second phase involved implementation of the modified program and the assessment of its helpfulness. Twelve couples (N=24) participated in the *Hold Me Tight*<sup>®</sup> program for Couples Becoming Parents study with zero attrition. The program, intended to help couples better understand their relationship with each other and create the best possible emotional foundation for their child, was well received.

Findings indicate the participants gained a better understanding of their own attachment behaviour towards their partners as well as their partners' behaviour towards them in times of need; such increased awareness is expected to strengthen their emotional connection. Many of the couples requested a "booster workshop" after the birth of the baby. While the changes over time on scores derived from the quantitative measures were not statistically significant, the qualitative data suggested that the HMT program may have had more effect on the men than the women. Many of the men said the program helped them feel more connected with their partners, and following the program, it was observed that many men were more able to share their vulnerable feelings (e.g. fear and inadequacy) about parenting in the presence of their partners. These behaviours suggested that the men experienced an increase in feelings of security in the

relationship with their partners. This finding was supported by marginally significant improvement ( $p = .052$ ) between pre- and post-program assessment in the males' scores on The Brief Accessibility, Responsiveness, and Engagement (BARE) Scale, which assessed their perception of their partners' attachment behaviours. Contrary to what was expected, proportionally more men than women scored above the thresholds for concern on the scale designed to screen for depression and anxiety (Edinburgh Postnatal Depression Scale, EPDS).

Evaluations and feedback provided by both facilitators and participants will facilitate future program improvement. The in-class conversation exercises were found by most participants to be the most valuable of all the activities; this reaffirmed that the greatest strength of the HMT program is the emotionally-focused conversations.

The results of this study inform practice by recognizing the need for more attention to the parental relationship and the mental health of both parents, the wisdom of utilizing attachment core concepts to support healthy relationships, and the need for early interventions that may strengthen the couple relationship and foster psychological wellbeing for the entire family. The insights from this pilot study will inform a future study of the effectiveness of this intervention using larger samples and more diverse participants.

## ACKNOWLEDGEMENTS

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My sincere gratitude goes to Dr. Sue Johnson for allowing me to modify her Hold Me Tight® program for this pilot study. I am indebted to Greg and Gillian, the program facilitators, as well as the twelve expectant couples who took part in this research. Without their

participation and generosity of their time, it would not have been possible to conduct this study. I am thankful to Waterloo Lutheran Seminary at Laurier and Langs Community Health Centre in Cambridge for offering their facilities to conduct the workshops. The two volunteer couples, Sharon and Dave as well as Trina and Steve were most helpful behind the scenes for set-up, takedown, and providing nutritious meals and refreshments for the group participants.

Attachment theory to me has been more than a theory but a real life experience. I am blessed to have close family and friends who got me through difficult times when I lost physical and emotional stamina. Their love and friendship sustained and helped me not merely to survive but thrive. The idea of having an attachment-informed relationship program for couples becoming parents was motivated by the hope that our two sons, Adam and Andrew, would benefit from this one day. It is also my way to pay it forward for the love I have received that made me who I am today. Finally, with heartfelt gratitude, I dedicate this dissertation to those who have served as my secure attachment figures along life's journey:

My Heavenly Father

My late grandparents, Mr. & Mrs. Wu

My beloved parents, Teng-Po Wang & Guei-Yun Wu

Eddie and Marsha Hooper

The late Maria deFaria

Grace R. Uloth

And my loving husband, John Pham, PhD

## TABLE OF CONTENTS

|   | Page     |
|---|----------|
| Abstract .....  | i        |
| Acknowledgements .....  | iii      |
| Table of Contents .....   | v        |
| List of Tables .....  | xii      |
| List of Figures .....   | xiii     |
| <br>  |          |
| <b>INTRODUCTION .....</b>   | <b>1</b> |
| Problem Statement .....   | 2        |
| Situating the Self .....  | 4        |
| Research Purpose and Approach .....                               | 6        |
| Organization of the Dissertation .....                            | 8        |
| <br>  |          |
| <b>LITERATURE REVIEW .....</b>                                    | <b>9</b> |
| Attachment Theory and Key Construct .....                         | 9        |
| Overview of Historical Development .....                          | 10       |
| Attachment Relationship through Affectional Bonds .....           | 12       |
| Attachment as a Behavioural System .....                          | 13       |
| Internal Working Models of Relationships .....                    | 14       |
| Individual Differences in Attachment .....                        | 15       |
| Mentalization: Reflective Functioning and Affect Regulation ..... | 19       |
| Healthy Dependence for Optimal Functioning .....                  | 21       |
| Attachment with the Brain in Mind .....                           | 22       |

|  |    |
|--|----|
| Couple Relationships Across the Transition to Parenthood .....           | 24 |
| Reorganization of the Couple Relationship .....                          | 24 |
| The Gendered Experience of the Transition and Couple Relationships ..... | 27 |
| The Importance of Fathers .....  | 28 |
| Couple Interactions and Adaptive Processes .....                         | 29 |
| Same Sex Couples and Adoptive Parents .....                              | 31 |
| Transition to Parenthood and Mental Health .....                         | 32 |
| When Does Infant Mental Health Begin? .....                              | 34 |
| Mental Health is a Family Affair .....                                   | 35 |
| Treatments and Interventions for Parental Mental Health .....            | 36 |
| Adult Attachment During the Transition to Parenthood .....               | 37 |
| Attachment and Depression .....  | 38 |
| Parental Representation and Parenting .....                              | 38 |
| Attachment Research on Couple Interactions .....                         | 40 |
| Conflict .....   | 40 |
| Sexual intimacy .....  | 41 |
| Interdependence and partner buffering .....                              | 42 |
| Couple–Focused Perinatal Interventions .....                             | 44 |
| HMT Program and its Relevance .....                                      | 47 |
| EFT and HMT: Theoretical Assumptions and Research .....                  | 47 |
| The HMT Program: Content and Process .....                               | 49 |
| Reflective Summary .....   | 51 |



|   |           |
|---|-----------|
| <b>METHODS .....</b>                                  | <b>53</b> |
| Research Questions .....                              | 53        |
| Methodology .....                                     | 55        |
| Research Design .....                                 | 56        |
| Phase One: Program Modification .....                 | 57        |
| Purpose of the program .....                          | 58        |
| Goals of the program .....                            | 58        |
| Modification of program process .....                 | 59        |
| Modification of program content .....                 | 63        |
| Phase Two - Evaluating the Modified HMT Program ..... | 67        |
| Recruitment and training of facilitators .....        | 67        |
| Recruitment of participants .....                     | 69        |
| Data Collection .....                                 | 72        |
| Facilitators' Experiences .....                       | 72        |
| Group Participants' Experiences .....                 | 73        |
| Individual Couples' Experiences .....                 | 73        |
| Data Analyses .....                                   | 79        |
| Quantitative Measures .....                           | 79        |
| Qualitative Data .....                                | 80        |
| Ethical Considerations .....                          | 81        |

|  |           |
|--|-----------|
| <b>RESULTS .....</b>   | <b>83</b> |
| Description of the Sample .....  | 84        |
| Age .....  | 84        |
| Years of Cohabitation .....  | 85        |
| Ethnicity .....  | 85        |
| Birthplace and Immigration .....   | 85        |
| Education .....  | 85        |
| Pregnancy .....  | 86        |
| Prior Experience of Individual or Couples Therapy .....  | 86        |
| Relationship Information .....   | 87        |
| Quantitative Results .....   | 88        |
| Attachment Orientation: Experiences in Close Relationship Scale-<br>Short Form (ECR-S) .....       | 89        |
| Attachment Behaviour: The Brief Accessibility, Responsiveness,<br>and Engagement (BARE) Scale..... | 90        |
| Depression and Anxiety: Edinburgh Postnatal Depression Scale (EPDS) .....                          | 91        |
| Qualitative Findings and Integration .....   | 92        |
| Do the Participating Couples Change in their Understanding of Themselves? .....                    | 92        |
| Awareness of relationship styles before the program .....  | 92        |
| Increased awareness of patterns in managing conflicts .....  | 93        |
| Increased recognition of personal vulnerabilities and emotions .....                               | 94        |
| Increased insight regarding the impact of one’s personal upbringing .....                          | 95        |
| Do the Participating Couples Change in their Understanding of their Relationship                   |           |

|   |     |
|---|-----|
| following Participation in the Modified HMT Program? .....  | 96  |
| Increased recognition and understanding of relationship patterns .....  | 96  |
| Increased recognition of partner's needs and sharing of their own needs ....  | 98  |
| Positive change in the emotional connection .....   | 100 |
| The program experience reinforced and affirmed what's working well .....  | 101 |
| Do the Participating Couples Increase their Confidence and their Ability to Work<br>Together to Create a Healthy Emotional Foundation for their Baby? ..... | 103 |
| Worries, concerns, and feelings prior to the program .....  | 104 |
| Recognizing the connection between partnering and parenting .....   | 106 |
| Intergenerational implications .....  | 107 |
| Gaining confidence in parenting .....   | 109 |
| Benefits for the child .....  | 115 |
| Feelings after the program .....  | 117 |
| Additional Observations .....   | 118 |
| More about participants with higher depression and anxiety scores .....   | 118 |
| Changing gender-role behaviours? .....  | 124 |
| Men becoming fathers .....  | 126 |
| Is the Program Content and Delivery Useful and Helpful to the Target Population<br>and What Could be Improved? .....  | 129 |
| Feedback from facilitators .....  | 129 |
| Feedback from participants .....  | 134 |
| Summary .....   | 146 |

|   |            |
|---|------------|
| <b>DISCUSSION.....</b>  | <b>148</b> |
| Summary of Findings and discussion of the Researcher’s Interpretations .....                                    | 148        |
| HMT and its Effect on View of Self/Attachment Orientation (ECR-S) .....   | 149        |
| HMT and its Effect on Couple Relationship/Attachment Behaviour (BARE) .....                                     | 150        |
| HMT and its Effect on Parental Mental Health/Depression and Anxiety (EPDS) ...                                  | 151        |
| HMT and its Effect on Confidence in Parenting .....   | 152        |
| HMT and its Effect on Men .....   | 153        |
| Improvement on HMT Content for Target Population .....  | 156        |
| Implications for Practice .....   | 157        |
| The Need for More Attention to the Parental Relationship and Mental Health .....                                | 157        |
| The Need to Utilize Attachment Core Concept to Create Healthy Relationships .....                               | 159        |
| The Need for Early Interventions that can Strengthen Relationships and Foster<br>Psychological Well-being ..... | 160        |
| Strengths and Limitations of the Study .....  | 161        |
| Implications for Future Research .....  | 163        |
| Conducting a Follow-Up Study .....  | 163        |
| Conducting Studies with Larger Samples .....  | 164        |
| Including Other Types of Expectant Couples .....  | 165        |
| Exploring Different Formats for the Program .....   | 166        |
| Understanding Men’s Depression and Anxiety .....  | 167        |
| Concluding Summary .....  | 167        |

|  |            |
|--|------------|
| <b>APPENDICES .....</b>  | <b>169</b> |
| Appendix A: Session Outline of Modified Content .....                        | 169        |
| Appendix B: Facilitator Information Letter and Consent Form .....            | 183        |
| Appendix C: Facilitator Consent Form .....                                   | 187        |
| Appendix D: Info-Graphic Flyer for Participants Recruitment .....            | 188        |
| Appendix E: Online Screening Questions .....                                 | 189        |
| Appendix F: Exclusion Screening Questions .....                              | 190        |
| Appendix G: Summary of Participants Interview Questions .....                | 193        |
| Appendix H: Program Evaluation Form for Facilitators .....                   | 195        |
| Appendix I: Program Evaluation Form for Participants .....                   | 196        |
| Appendix J: Experiences in Close Relationship Scale-Short Form (ECR-S) ..... | 198        |
| Appendix K: The A.R.E. Questionnaire .....                                   | 200        |
| Appendix L: BARE Scale .....   | 201        |
| Appendix M: Edinburgh Postnatal Depression Scale (EPDS) .....                | 203        |
| Appendix N: Relationship Information Sheet .....                             | 205        |
| Appendix O: Research Participant Consent Form .....                          | 207        |
| Appendix P: Consent to be Contacted Form .....                               | 211        |
|  | <b>212</b> |
| <b>REFERENCES .....</b>  |            |

## LIST OF TABLES

|   | Page |
|---|------|
| Table 2.1: Corresponding Child and Adult Attachment Categories .....                                  | 16   |
| Table 2.2: Summary of Partner Buffering .....   | 43   |
| Table 2.3: Characteristics of Reviewed Coupled Intervention Program .....                             | 46   |
| Table 3.1: Summary of the Quantitative Measures .....   | 74   |
| Table 3.2: Example of thematic coding process .....   | 80   |
| Table 4.1: Summary of Relationship Information .....  | 87   |
| Table 4.2: Means and Standard Deviations at Three Time Points for the Three Measures ...              | 88   |
| Table 4.3: Worries and Concerns Shared by Couples Prior to the Program .....                          | 105  |
| Table 4.4: Participants' Written Reflections on How Their Learning<br>Would Benefit Their Child ..... | 116  |
| Table 4.5: Number of Participants with EPDS Total Scores $\geq 10$ at Each Time Point .....           | 119  |
| Table 4.6A: Female Participants Whose EPDS Scores Were $\geq 10$ at Any Time Point .....              | 120  |
| Table 4.6B: Male Participants Whose EPDS Scores Were $\geq 10$ at Any Time Point .....                | 121  |
| Table 4.7: Facilitators' Feedback Rating .....  | 130  |
| Table 4.8: Group One's Rating of the Program .....  | 135  |
| Table 4.9: Group Two's Rating of the Program .....  | 135  |
| Table 4.10: Rating of the Program by all Participants (two groups combined) .....                     | 136  |
| Table 4.11: Summary of Program Contents Most Often Discussed .....                                    | 139  |
| Table 4.12: Summary of Program Enhancement Suggestions .....  | 144  |

## LIST OF FIGURES

|  | Page |
|--|------|
| Figure 2.1: Attachment Theory: Historical Development .....  | 11   |
| Figure 2.2: Summary of Key Evidence Messages on Transition to Parenthood .....                           | 26   |
| Figure 2.3: Summary of Parental Mental Health Challenges in the Perinatal Period .....                   | 33   |
| Figure 3.1: Pictorial of the Relationship Workouts Paired with each Conversation .....                   | 60   |
| Figure 4.1: Age Distribution of the Sample .....   | 84   |
| Figure 4.2: Mean Scores on Attachment Anxiety and Attachment Avoidance<br>at the Three Time Points ..... | 89   |
| Figure 4.3: Mean Scores of View of Self A.R.E. and View of Partner A.R.E by Gender...                    | 90   |
| Figure 4.4 Means on EPDS and its Anxiety Subscale over Time by Gender.....                               | 91   |
| Figure 4.5: Feeling Words Used by Women (left) and Men (right) Before Program .....                      | 106  |
| Figure 4.6: Feeling Words Used by Women (left) and Men (right) After Program .....                       | 117  |

## Chapter One

### INTRODUCTION

*If a society values its children, it must cherish their parents.* - John Bowlby

Transition to parenthood is a normal family process and one of the more stressful life events over the life course. Research indicates that the quality of the couple relationship is a key contributor to the adjustment to parenthood, especially for first-time parents (Cowan & Cowan, 2000; Parfitt & Ayers, 2014). The bond between a couple as romantic partners needs to expand and make room to include the child. Becoming parents involves major adjustment, which can bring up attachment fears and insecurities, when partners have greater needs for connection and reassurance.

Attachment theory has made substantial contributions to the understanding of close relationships. In recent years, a dramatic increase in the scientific study of the impact of attachment on wellbeing and mental health is evident. Although theoretical models differ in how they define optimal wellbeing, they all agree that deep and meaningful close relationships play a vital role in human flourishing (Feeney, 2007; Feeney, Van Vleet, & Jakubiak, 2015). Attachment theory is an important lens through which to examine the relational context of family life. Research on attachment relationships in families emphasizes that the quality of affectional ties, whether secure or insecure, within the family is a more important mediator of developmental wellbeing than the particular structure of the family context (Cowan & Cowan, 2012, Feeney; Hohaus, Noller, & Alexander, 2003). Infants who are allowed to be reliably dependent on their caregivers in their early development are observed to grow up to function more confidently and independently in the world. So too, the dependence on a partner that



develops in a secure couple relationship actually fosters autonomy and self-confidence, leading to interdependence between the partners (Mikulincer & Shaver, 2007; Overall & Lemay, 2015, Simpson & Overall, 2014). When navigated smoothly, couples can experience the transition as providing opportunities to lean on each other and deepen their relationship (Cowan & Cowan, 2000; Gottman, Gottman, & Shapiro, 2010). Cultivating and maintaining relationship fulfillment and co-parenting effectiveness are not only important for a couples' wellbeing, they are also crucial conditions for enhancing a child's developmental success (Halford, Petch, & Creedy, 2015; Holmes, Cowan, Cowan, & Hawkins, 2013).

### **Problem Statement**

Life with a new baby is not always what parents expect. While many parents adapt well to the demands of parenthood, the transition can negatively impact the couple relationship, resulting in a decline in relationship satisfaction (Lawrence, Rothman, Cobb, Rothman, & Bradbury, 2008; Reynolds, Houlston, & Coleman, 2014; Shapiro & Gottman, 2005). While the baby is the focus of attention and mutual concern of the parents, it is a vulnerable time for most couples. Life with a new baby is also associated with adverse effects on parental mental health such as depression and anxiety (Dennis & Towswell, 2013; Parfitt & Ayers, 2014). Depression during pregnancy and following childbirth was historically regarded as a phenomenon affecting only women. Yet, men's emotional health is often overlooked during their partner's pregnancy and throughout the first postpartum year. Less relationship satisfaction and perception of lack of support from the partner have been identified as two of the main contributing risk factors to the development of postpartum depression (Reynolds, Houlston, & Coleman, 2014; Twenge, Campbell, & Foster, 2003). If untreated, it is associated with undesirable parent health behaviours and fewer positive parent-infant interactions (Dennis, 2015; Paulson, Dauber, &

Leiferman, 2006). Yet, in the context of pregnancy, parenting, and early child development, the emphasis of interventions has historically been focused on the role of the woman and mother, with fathers and the couple relationship having lower profiles (Reynolds et al., 2014; Twenge et al., 2003). Although interest in the role of the father has increased in recent times, he still remains largely absent from researchers' and service providers' thoughts and discussions about parenting. Furthermore, while the fundamental impact that the quality of the couple relationship has on the individuals' health and wellbeing has been acknowledged in the literature (Feeney, 2007), it has not been a priority in the public health care setting (Meier et al. 2013). A gap exists in program planning and service delivery in terms of keeping the parents in mind to safeguard their relationship and mental health across the transition to parenthood. Prevention and early intervention are critical to addressing relationship problems.

The provision of effective psychoeducation has the potential to greatly enhance couples' experience of becoming a parent. In my comprehensive paper (Wang, 2015), I reviewed literature regarding relationship education programs that are empirically supported for this population. These couple-focused perinatal psycho-education programs, such as, *Becoming a Family Project* (Cowan & Cowan, 2000), *Bringing Baby Home* (Gottman, Gottman, & Shapiro, 2010), and *Couple CARE for Parents* (Halford, Petch, & Creedy, 2010), have demonstrated some success in preventing deterioration in relationship satisfaction across the transition for expecting couples and new parents. However, while attachment messages are embedded in most of their curriculums, the concept of the couple relationship as an "attachment relationship" has not been explicitly discussed. A gap exists in helping expectant parents become aware and make the connection between the concurrent attachment relationships that they are experiencing and future success as parents. While the infant-parent relationship differs from the parent couple

relationship, they are both attachment relationships involving deep emotional bonds that connect one person to another (Bowlby, 1969; Ainsworth, 1989). Couples are emotionally attached to and dependent on each other in much the same way that a child is on a parent for nurturing, support, and protection (Mikulincer & Shaver, 2007). Naming the couple relationship as an “attachment relationship” and/or describing it using the normative concepts of feeling safe and secure when the partner is “accessible, responsive, and emotionally engaged” (Johnson, 2008) may help expectant parents make sense of their relationship in a way that effectively influences the attachment relationship they hope to create for their child.

Couple-focused interventions have been shown to impact positively on relationship quality, satisfaction, and stability over a considerable period. The transition to parenthood can be an important point for interventions aiming to strengthen couple relationships due to the changing life patterns of couples and potential motivation of new parents to make positive changes that will benefit their child. An attachment-informed relationship enhancement program to help couples better understand their relationship with each other, effectively turn to each other for support during this stressful time of change and create the best possible emotional foundation for their expected child is needed.

### **Situating the Self**

I value relationships and believe in their power to change lives and transform society. As a clinical social worker for 25 years, both in the public sector and private practice, I recognize the value of a healthy and loving relationship as the foundation of a family and a protective feature in the development of resiliency and overall well-being. Conversely, a distressed relationship contributes to poor mental, emotional, and physical health for the parents and children.

Attachment theory has had a profound impact on me personally and professionally in understanding human relationships. I learned about parent-child attachment in 2004 during the training we received at the Region of Waterloo Public Health (ROWPH) for the provincially funded *Healthy Babies, Healthy Children* program. It provided a paradigm shift for my colleagues (mostly public health nurses) and me in viewing the relational dynamics between a mother and a child and its potential life-long impact on a child. Upon personal reflection, attachment theory also provided great insight into my own relationships: with my parents from my childhood to the present day, with my spouse for over three decades and how our relationship with each other and with our two sons created our family dynamics. The insight I gained from attachment theory and the research supporting it enhanced my self-understanding and other-acceptance as I recognized we all do our best at relating and making sense of our close relationships.

After my initial training on parent-child attachment, I went beyond the scope of my practice as a social worker at ROWPH and pursued further professional development. I am now a certified therapist and supervisor in Emotionally Focused Therapy (EFT, a psychotherapy model integrating attachment theory, experiential theory, and systemic approaches in working with couples and families), a certified Gottman educator of Bringing Baby Home program (BBH, a psychoeducational program for couples transitioning to parenthood), a parent educator of Circle of Security (COS, an attachment-based intervention program for parents) as well as a reliable Adult Attachment Interview coder (AAI, a procedural coding of interview transcripts to assess an individual's attachment orientation). In my private practice, through the lens of attachment theory, I help individuals enhance self-esteem and strengthen their ability to manage life's day-to-day challenges with more flexibility and insight. As a marriage-friendly therapist, I

work with couples to resolve conflicts, repair emotional hurts, strengthen connections, and support them in creating a clear vision of a healthy relationship, especially if they had few or no models of this growing up. Because not every individual or couple requires or has the resources for psychotherapy, I believe that relationship education could be a viable venue to help people build personal capacity for healthy relational living. My work in the area of Child and Family Health at Public Health further convinced me of the urgent need to support parents for healthy childhood development and optimal family functioning. The transition to parenthood presents an opportune time for such relationship education to strengthen the couple relationship in the interest of their future children. However, although my confidence in the tenets of attachment theory is well supported by research, I must acknowledge that my enthusiasm for this theory and the interventions based on it may have influenced this dissertation research both in implementation and in interpretation of its outcomes.

### **Research Purpose and Approach**

The purpose of this dissertation research is to inquire whether an attachment-informed relationship enhancement program is a viable, effective perinatal intervention for expectant or new parent couples. One promising development in this area is the Hold Me Tight<sup>®</sup> Program<sup>1</sup>: Conversations for Connection (HMT; Johnson, 2008), which has effectively disseminated many attachment concepts into down-to-earth, easy to understand language to help enhance couple relationships. HMT is a research-based relationship enhancement education program developed by Dr. Sue Johnson based on her book *Hold Me Tight* (Johnson, 2008). This 16-hour program is a streamlined version of Emotionally Focused Therapy for couples (EFT, Johnson, 2004). EFT is an experiential, systemic therapy based on attachment theory with strong empirical support for

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<sup>1</sup> A trademark registered by Dr. Sue Johnson

its efficacy (see Lewandowski, Ozog, & Higgins, 2015 and Snyder, Castellani, & Whisman, 2006 for reviews). Utilizing the basic interventions of EFT, the goal of HMT is to create stronger, more secure relationships in couples by encouraging them to enter into seven meaningful conversations. These conversations focus on improving couples' emotional communication rather than problem-solving strategies. HMT has been successfully adapted for working with veterans, cardiac and cancer patients, Christian couples ("*Created for Connection*" by Johnson & Sanderfer, 2016), couples from different cultures and families with teens ("*Hold Me Tight, Let Me Go*" Program). There are several recent outcome studies that have shown positive results of this program (Stavrianopoulos, 2015; Kennedy, Johnson, & Wiebe, 2016; Wong, Greenman & Beaudoin, 2017, Weissman, 2017), however, research using HMT with the expectant or new parent couple population is still lacking. This dissertation aims to integrate the practice knowledge of EFT/HMT with the field of transition to parenthood by asking the question: Is an attachment-informed relationship enhancement program, such as *Hold Me Tight*<sup>®</sup> (HMT), helpful to couples in strengthening their relationship and increasing their confidence in becoming first-time parents? Conducting a pilot study will help answer this question and determine whether a larger scale study is feasible to test HMT as a potential intervention strategy for couples becoming parents.

This dissertation research has two parts. First, I modified the current *Hold Me Tight*<sup>®</sup> Relationship Enhancement Program to "*The Hold Me Tight*<sup>®</sup> Program for Couples Becoming Parents" by making it specifically relevant to couples transitioning to parenthood. Second, I conducted a pilot study that provided a preliminary evaluation of the modified program. A mixed-methods approach was used for evaluation of this modified version of the HMT program. The objectives of this HMT pilot study are: 1) to conduct the modified HMT program and

receive feedback from the facilitators and participants regarding program enhancement; 2) to explore and seek understanding of expecting couples' experiences of the modified program; and 3) to use standardized evaluation measures to determine whether participation in the program is associated with change on these measures.

### **Organization of the Dissertation**

This dissertation is comprised of five chapters. Chapter Two is a review of the relevant literature. Attachment theory and its key concepts, the theoretical lens for this study, are described first. A critical review of the literature is also provided in the areas of couple relationships, parental mental health as well as adult attachment and its implications during the transition to parenthood. The HMT program and its relevance for this dissertation topic is also further explained. Chapter Three, "Methods," begins with the aims of the study followed by the research questions. Next, Phase One of the study is described. This involved modification of the HMT program, and describes the changes made in the content and group process from the original HMT program. Next, Phase Two is described, which includes the research design and methodology used to evaluate the modified HMT program. Data collection procedures and analysis as well as ethical considerations are also presented. In Chapter Four, "Results," the description of the research sample is followed by presentation of the quantitative results and integration of the findings from both the qualitative and quantitative data, organized by the research questions. Chapter Five, "Discussion" contains a summary of the findings and their interpretation, implications for practice, strengths and limitation of the study, and implications for further research.

## Chapter Two

### LITERATURE REVIEW

*Attachment is integral to human behavior from the cradle to the grave.* – John Bowlby

In this chapter, attachment theory and its key concepts will be discussed as the theoretical lens for this study. Following the theoretical concepts is a critical review of the literature in the area of couple relationships, parental mental health as well as adult attachment and its implications during the transition to parenthood. A review of the HMT program and its relevance for this dissertation topic will also be further explored.

#### **Attachment Theory and Key Constructs<sup>2</sup>**

While there are many theories of family functioning, attachment theory was chosen as the main theoretical framework for this dissertation research. The importance of parent-child attachment is well established as considerable evidence supports it as the foundation for infant mental health (Cohen & Slade, 2000). We now also know that adult attachment is parallel to and shares many features with parent-child attachment, a function of the same motivational behavioural system (Cassidy & Shaver, 2008). Attachment theory promotes understanding of the self and others. Its theoretical constructs have significant implications and practice applications to inform us about parenting as well as the couple relationship. With its theoretical expansion over the last 50 years and solid research backing, it is highly compatible with family

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<sup>2</sup> Some parts in this section on attachment theory are taken from the book chapter written by Wang (the author) and Stalker for *Theoretical Perspectives for Direct Social Work Practice, Third Edition*, edited by Nick Coady and Peter Lehmann. Copyright 2016, Reproduced with the permission of Springer Publishing Company, LLC ISBN: 9780826119476



systems and the life course perspectives that complement the “cradle to grave” impact that attachment has on human relationships.

### **Overview of Historical Development**

Bowlby’s attachment theory emphasizes the critical importance of relationships across the lifespan – throughout infancy, adolescence, and adulthood – and that a healthy dependence on a reliably sensitive and responsive attachment figure is important for optimal functioning and well-being “from the cradle to the grave” (Bowlby, 1979, p. 129). The idea that romantic relationships may be attachment relationships has had a profound influence on modern research on close relationships (Hazan & Shaver, 1987). A brief overview of the historical development of the theory is illustrated in Figure 2.1.

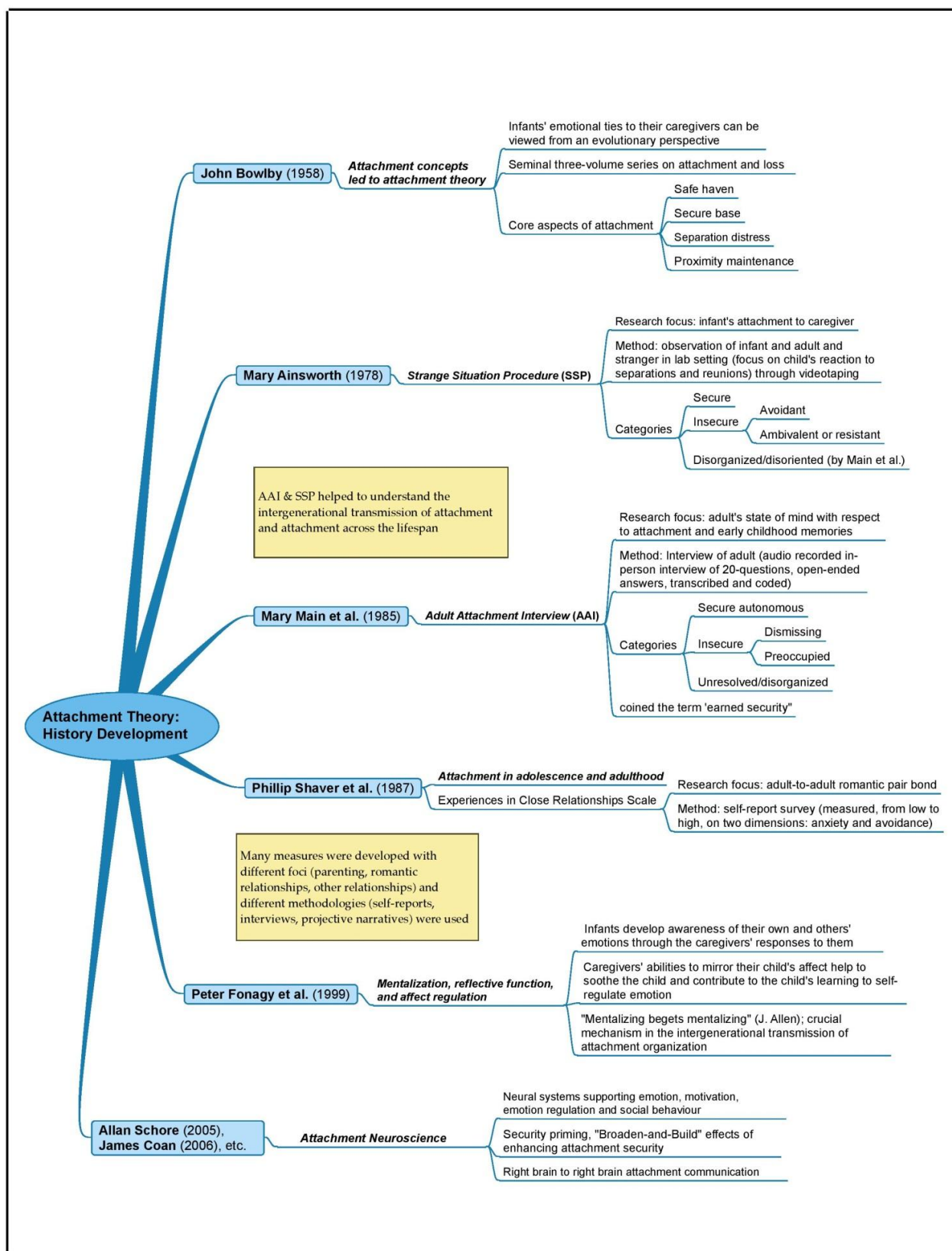


Figure 2.1: Attachment Theory: Historical Development

### **Attachment Relationship through Affectional Bonds**

According to Bowlby (1969), *all* human beings, without exception, have an innate, naturally selected need to establish and maintain close emotional bonds to significant others. Individuals come into the world predisposed to form strong emotional bonds with particular individuals who care for them (whom Bowlby termed ‘attachment figures’). Attachment is not only essential for infants and children to survive but also helps adults to thrive. In childhood, primary caregivers typically serve as the main attachment figures. Because of the social norms at the time attachment theory was initially developed, mothers were seen as the most likely primary attachment figure; more recent research (Grossmann & Grossmann, 2009) has shown the attachment figure can also be the father, that both parents can be attachment figures, and that non-biological caregivers can be a child’s attachment figures. During adolescence and adulthood, important bonds persist but are supplemented by new ones (e.g., romantic partner). In adulthood, attachment theorists refer to romantic relationships as “pair bonds” or enduring love relationships (Hazan & Shaver, 1987; Zeifman & Hazan, 2008). These relationships involve romantic love as well as sociability and affiliation, or specifically companionship and friendship. Whether in infancy or adulthood, the features that distinguish attachment bonds from other types of social ties are the same (Hazan & Shaver, 1987). Attachments are characterized by proximity seeking/maintenance (the tendency to stay in touch), safe haven (the tendency to turn to attachment figures for comfort or reassurance), separation distress (the tendency to resist and be upset by unwanted or prolonged separations), and secure base (the tendency to explore because one is confident by knowing that support is available when needed).

## **Attachment as a Behavioural System**

The central postulate of attachment theory is that primary caregivers who are available and responsive to an infant's needs allow the child to develop a sense of security. Bowlby (1969/1982) proposed that the attachment behavioural system becomes activated in times of threat or danger (e.g., when one is frightened, injured, distressed, fatigued, or ill), prompting a person to seek an attachment figure for support, comfort, or protection through proximity-seeking behaviour. Attachment behaviours in infants and young children include clinging to caregivers when frightened, protesting caregivers' departure, and following and greeting caregivers after an absence. Thus, any behaviours that increase the probability of caregivers' proximity and availability are deemed attachment behaviours. When children's attachment behaviours are adequately responded to, their attachment system becomes far less active as they move freely away from caregivers and explore the environment. The attachment behavioural system operates in balance and interdependently with the exploratory behavioural system (Bowlby, 1988; Grossmann, Grossmann, Kindler & Zimmermann, 2008).

In adulthood, the adaptive value of attachment goes far beyond physical protection to provide emotional wellbeing and developmental competence (Hazan & Shaver, 1987). A person who feels distressed – as a result of appraising the environment as threatening, or the self as in need of help – seeks physical or psychological proximity to his or her attachment figure. If the attachment figure is available and responsive, the resulting contact is expected to alleviate the distress and restore emotional and physiological balance. When adult attachment behaviour is adequately responded to, the individual's subjective experience is one of felt security: he or she experiences a sense of worth, a belief in the helpfulness of others, and is able to explore the environment with confidence.

Despite these similarities in attachment relationships, infant-caregiver relationships and adult romantic relationships differ in important ways (Zayas, Merrill, & Hazan, 2015). In particular, infant-caregiver relationships are typically complementary. That is, infants seek security and comfort from, but do not provide security or comfort to, attachment figures. In contrast, adult romantic relationships are reciprocal: Partners serve as both recipients and providers of security and comfort. In addition, adult romantic relationships are typically sexual in nature. In other words, adult attachment bonds involve the integration of three distinct behavioural systems: attachment, caregiving, and sexual mating (Zayas, Merrill, & Hazan, 2015).

### **Internal Working Models of Relationships**

Bowlby (1969/1982) emphasized that caregiver behaviour and response determines the development of predictable patterns of attachment in the child. The earliest observable patterns are behavioural, and are the first manifestations of what will become mental representations or internal working models of attachment, which will guide the individual's feelings, thoughts and expectations in later relationships (Bretherton & Munholland, 2008). These working models have two aspects, namely, models of self as worthy of care (or not) and models of others as being emotionally dependable (or not). These mental representations once solidified are relatively stable, play a role in multiple domains such as emotion regulation, close relationship functioning, and the operation of other behavioural systems (e.g., exploration and caregiving) (Mikulincer & Shaver, 2009; Sroufe, 2005).

Bowlby (1969/1982) postulated that these internal working models include both cognitive and affective aspects and are largely unconscious. Bretherton and Munholland (2008) made a crucial distinction between implicit and explicit models. We employ our implicit models

habitually and nonconsciously, that is, without awareness that they are shaping our experience. These implicit models are based on memories that guide our behaviour, and these memories become automatic procedures for interacting (e.g., “If I seek help, then I will be supported.” “If I seek help, then I will be seen as weak.”). What we may be most aware of, however, relates to emotion. We naturally resonate emotionally to each other without having to think about it (Jacobvitz, 2008). By comparison, explicit working models are conscious and therefore can be thought about and talked about. Ideally, this process of explication begins early in life when “parents perform a positive role in helping a child construct and revise working models through emotionally open dialogue” (Bretherton & Munholland, 2008, p. 107). Such clarification through narratives is essential for updating out-of-date working models of self and others, as clients experience in therapeutic contexts such as psychotherapy or individuals experience in close, dependable relationships in adulthood. Bowlby called these internalized memories of attachment “working models” because they are dynamic and capable of change. Therefore, although working models may remain stable, adult outcomes are not predetermined in childhood. With access to coherent, organized information about their own attachment, adults who have experienced rejection, neglect, or trauma are able to experience security in adulthood and facilitate secure attachment in their children.

### **Individual Differences in Attachment**

Individual differences in attachment can be referred to as attachment styles, attachment patterns, attachment orientations, or differences in the organization of the attachment system. In this section, I will provide a general overview of attachment patterns. Please refer to Figure 2.1 for specific child attachment and adult attachment categories and Table 2.1 for behavioural descriptions of each of the categories.

Table 2.1: Corresponding Child and Adult Attachment Categories (Wang &amp; Stalker, 2016).

| Child Attachment Category  | Adult Attachment Category  |
|--|--|
| <p><b>Secure:</b></p> <ul style="list-style-type: none"> <li>• Has caregiver who is consistently available, meets needs of infant and has pleasurable interaction with infant/child</li> <li>• Child trusts caregiver, turns to caregiver for comfort and safety</li> <li>• Child perceives self as lovable and has positive expectations of others</li> </ul>   | <p><b>Secure/Autonomous:</b></p> <ul style="list-style-type: none"> <li>• In AAI, describes coherent, believable narrative about childhood experiences</li> <li>• Values relationships, turns to intimate others for comfort and security</li> <li>• Is self-reflective and accepts that others have different perceptions</li> <li>• Adaptable, open, and self-regulated</li> <li>• Positive and realistic view of self</li> </ul>  |
| <p><b>Avoidant:</b></p> <ul style="list-style-type: none"> <li>• Has caregiver who is unavailable or indifferent, perhaps hostile at times</li> <li>• Learns to deny needs/feelings and avoid close relationships</li> <li>• Appears independent</li> <li>• Believes that he/she has to take care of himself/herself</li> <li>• Often compliant and displays positive affect with caregiver</li> </ul>                               | <p><b>Dismissing:</b></p> <ul style="list-style-type: none"> <li>• In AAI, describes early history of rejection or neglect, but denies importance of this on his/her development</li> <li>• Needs to be independent and self-sufficient</li> <li>• Prefers not to depend on others</li> <li>• Avoids feelings of closeness and focuses on activities</li> <li>• Suppresses feelings</li> <li>• Distances himself/herself from others who may reject him/her</li> <li>• Views self as superior</li> </ul> |
| <p><b>Ambivalent:</b></p> <ul style="list-style-type: none"> <li>• Has caregiver who is inconsistently available</li> <li>• Does not trust caregiver to be consistently available to offer comfort and security</li> <li>• Longs for closeness</li> <li>• Clingy, or impulsively angry</li> <li>• May exaggerate need to elicit caregiver's attention</li> <li>• Difficulty separating from caregiver to develop autonomy</li> </ul> | <p><b>Preoccupied:</b></p> <ul style="list-style-type: none"> <li>• In AAI, describes confusing childhood experiences, with caregivers who were unpredictably available and unavailable</li> <li>• Tends to depend heavily on others</li> <li>• Seeks approval from others and fears being devalued</li> <li>• Exhibits high levels of emotional intensity</li> <li>• Impulsive reactions</li> <li>• Views self as unworthy</li> <li>• Views others as superior</li> </ul>                               |
| <p><b>Disorganized:</b></p> <ul style="list-style-type: none"> <li>• Has caregiver who is abusive, severely neglecting or experiencing unresolved loss or trauma</li> <li>• Hypervigilant</li> <li>• Conflicted by drive to flee to caregiver for safety and flee from caregiver as source of fear</li> <li>• Responds with fight, flight, or freeze</li> <li>• Does not have organized strategy for attachment</li> </ul>           | <p><b>Unresolved/Disorganized:</b></p> <ul style="list-style-type: none"> <li>• In AAI, describes confused and incoherent family history</li> <li>• Has not resolved early trauma or loss</li> <li>• Perceives relationships as dangerous</li> <li>• Easily triggered in relationships</li> <li>• May dissociate</li> <li>• Views self as victim or becomes the aggressor to avoid this feeling</li> </ul>   |

Attachment security broadens people's perspectives and/or interpersonal skills, which in turn foster better mental health and self-actualization (Mikulincer & Shaver, 2015). However, not all interactions with attachment figures are positive and result in a sense of greater attachment security. Based on research using the Strange Situation Procedure (Ainsworth, Blehar, Waters, & Wall, 1978), and other means of assessing attachment security, significant individual differences in attachment system dynamics and functioning have been identified. Studies have established that these differences are associated with the repeated interactions people experience with their attachment figures. When attachment figures are sensitive, available, and responsive in times of need, people feel they can confidently rely on them. This, in turn, facilitates the development of a sense of connectedness and security. In contrast, when attachment figures are not reliably available and supportive, people are likely to feel a sense of attachment insecurity. Being chronically insecure, in turn, is associated with pursuing secondary attachment strategies – those that deactivate or hyperactivate the attachment system – instead of the primary strategy of proximity seeking (Ainsworth et al., 1989; Cassidy & Shaver, 2008).

Ainsworth et al. (1978) identified two types of insecurity. When caregivers tend to be cold and rejecting in times of need, people who seek proximity and support from them are likely to develop an avoidant attachment style characterized by distrust of relationship partners, strong striving for independence, and emotional distancing. People high on attachment avoidance tend to downplay the importance of emotions and relationship-related issues and to use deactivating strategies. These strategies involve dismissing of threat and attachment-related cues and suppression of attachment-related thoughts, emotions, and memories. When caregivers tend to be intrusive and to provide inconsistent and insensitive support, people are likely to develop an anxious attachment style characterized by chronic worries related to relationship partners not



being available in times of need. People high on attachment anxiety tend to perceive themselves as worthless and helpless, are hypervigilant to relationship-related cues, and use hyperactivating secondary strategies. These strategies include high sensitivity to signs of rejection, intense appeals to attachment figures, and obsessive reliance on them as a source of safety and support (Ainsworth et al., 1989; Cassidy & Shaver, 2008).

There are two independent lines of research that were initiated to explore the nature of attachment in adulthood in the 1980s. The Adult Attachment Interview (AAI) (George, Kaplan, & Main, 1996) developed by developmental and clinical psychologists, is an interview procedure to assess current state of mind with respect to attachment. While the Strange Situation focuses on attachment behaviours in children, the AAI focuses on how attachment processes are revealed through language and speech patterns. It is believed to tap into unconscious cognitive and emotional processes. The interviewer asks the adult to describe early attachment experiences, recent losses, and current relationships with one's parents and children. AAI transcripts are coded in detail and attachment categories are determined based on how organized the speaker's state of mind is regarding past attachment relationships and how coherent the speaker's narrative is when discussing this attachment history. Many studies have found that an adult's state of mind with respect to attachment on the AAI is related to his or her child's attachment classification in the Strange Situation and to parenting behaviour (See Table 2.1 for a comparison of child attachment categories and AAI categories of the caregivers).

How do we get from the parental state of mind with respect to attachment to infant attachment behaviour? According to Allen (2013), for each attachment pattern, (1) the parents' current states of mind with respect to their attachment history relate to (2) the way parents interact with their infants which, in turn, relate to (3) the patterns of security their infants display

toward them and then to (4) the adjustment in childhood, adolescence, and adulthood, which includes adult attachment patterns and caregiving behavior (p.109). Understanding this intergenerational process points the way toward intervention; the possibility of interrupting this intergenerational transmission process is one of the most inspired endeavours in attachment research.

In a second line of research, social psychologists emphasize the dimensional or continuous nature of adult attachments in terms of attachment styles that influence a person's experiences and behaviours in romantic relationships. Attachment styles, which are often conceptualized in terms of a two-dimensional space with attachment anxiety and avoidance as its axes, can be assessed with reliable and valid self-report scales such as the Experiences in Close Relationships –Revised (ECR-R) questionnaire (Fraley, Waller, & Brennan, 2000). In studies using such measures, attachment styles have been associated in predictable ways with relationship variables such as quality and length, affect regulation strategies, and many other outcomes (for review, see Cassidy & Shaver, 2008). People who score high on anxiety or avoidance tend to be anxious or avoidant in attachment relationships. People who score low on both attachment dimensions tend to be secure or have a secure attachment style. Self-report measures of adult attachment focus on views that individuals consciously hold about themselves and others in close relationships.

### **Mentalization: Reflective Functioning and Affect Regulation**

Sensitive responsiveness – to an infant, a partner, or oneself – requires attunement to mental states in self and others. Mentalization (Fonagy, Gergely, Jurist, & Target, 2002) refers to the ability to reflect upon, and to understand one's own state of mind; to have insight into what one is feeling, and why. It also involves being able to imagine and consider another's state of

mind when observing the other's behaviour. Fonagy and colleagues describe this with the phrase: "holding mind in mind". Allen (2013) refers to mentalizing as a form of emotional knowing. In the emerging field of interpersonal neurobiology, Siegel (2010) has coined the term "mindsight" to help explain mentalization and link science with practical applications to cultivate mindsight skills and well-being. Mentalization is considered a precondition of effective social skills, self-soothing, empathy, and other aspects of emotional intelligence and social-emotional maturity (Fonagy et al., 2002). This skill is thought to develop through a caregiver's empathic and insightful response to a child's distress and other emotions. This means mentalization is learned through a secure attachment to the caregiver. Insecure attachments limit the development of this important skill (Allen, 2013; Fonagy et al., 2002; Siegel, 2010).

Parental reflective functioning (Slade, 2005) is distinctive from more general mentalizing processes. It is caregivers' abilities to hold in their own minds a representation of their child's mind. When a caregiver is able to reflect on both his/her own and his/her child's mental states, whether positive or negative, and to appropriately reflect back the reality of the child's internal experience, the child develops a representation of his or her inner self, which is internalized over time. The child learns through this process of attunement or mirroring to be aware of what he or she is feeling and how to manage those affects (Allen 2013; Tronick, 2009). This is the beginning of self-organization and self-understanding, as well as an understanding that others have internal experiences (Slade, 2005).

The capacity to mentalize is also necessary for affect regulation (Fonagy et al., 2002). Regulation processes are at the core of attachment dynamics. Understanding the role of early attachment relationships in adjusting critical stress-regulating systems (Diamond, 2015), and the long-term implications of these systems for well-being, provides important new ways to

understand the fundamental functions of attachment over the life course (Overall & Lemay, 2015). Through secure attachments, children learn to self-soothe and self-regulate their emotions because their caregiver has modeled these comforting responses to them in a manner according to their experiences (Fonagy et al., 2002). In adulthood, long-term pair bonds present a number of psychological and physical benefits. Partners are capable of regulating each other's physiological systems, daily mood and affective states, and eating and sleeping patterns (also termed as dyadic regulation process, Overall & Lemay, 2015; Overall & Simpson, 2015). When individuals are threatened or challenged, the attachment system becomes activated and triggers efforts to alleviate distress and restore felt-security (Mikulincer & Shaver, 2007; Simpson & Overall, 2014). The particular ways this goal is managed depend on people's expectations regarding whether close others will be a reliable source of support.

### **Healthy Dependence for Optimal Functioning**

Acceptance of dependence by close relationship partners (and being dependent on such partners) is part of the process of becoming an optimally functioning individual (Feeney, 2007). The desire for comfort and support during hard times should not be regarded as unhealthy or childish, unlike what may be implied by the word 'dependence' (Bowlby, 1988). An important prediction of attachment theory regarding dependence is that an attachment figure's acceptance of an individual's dependence needs creates less rather than more dependence (Feeney, Van Vleet, & Jakubiak, 2015). Because dependence on close relationship partners, particularly in times of need, is an intrinsic part of human nature, relationship partners who are sensitive and responsive to this behaviour actually promote independence and self-sufficiency rather than inhibit it. Adult attachment researchers have also examined the 'broaden-and-build effects' that occur within interpersonal contexts in which actual relationship partner's responsiveness and

supportive behaviours augment one's sense of security (Mikulincer & Shaver, 2015). In other words, when a relationship partner acts as a reliable security provider, it can activate the secure-base script and gradually enhance the person's confidence in his or her social interaction with others in different contexts.

### **Attachment with the Brain in Mind**

The importance of brain development in early years is well established (National Scientific Council on the Developing Child, 2012). Modern research has demonstrated that the brain continues to create new neural pathways and alter existing ones in order to adapt to new experiences, learn new information and create new memories (Coan, 2008). The attachment relationship has its significance in brain development for both children and adults (Schoore, 2001). Collaboration between neuroscientists and attachment researchers is leading to an "attachment neuroscience" with promising potential. Researchers are examining ways to change or improve attachment-related processes such as bonding or emotion regulation. Subtle experimental manipulations can increase or decrease a person's sense of attachment security and insecurity, which in turn affects cognitions, physiology, and behaviour (Gillath, 2015). For example, researchers have found that words such as 'love', 'hug', and 'affection'; memories of social and emotional support from loving relationship partners; the names of a person's security-providing attachment figures; or drawings/photographs depicting a parent's love for a child all tend to increase people's short-term sense of security and decrease their short-term anxiety and avoidance. Although these findings focus on temporary changes in attachment, evidence exists to suggest that similar processes can have long-lasting effects with repeated security priming (Gillath, Selcuk, & Shaver, 2008). Several experimental studies have shown that a romantic partner can be a source of distress regulation and emotional equanimity. For example, Coan,

Schaefer, and Davidson (2006)'s "hand holding" experiment examined brain responses (via fMRI) of married women who underwent a laboratory stressor. Their findings suggest that holding one's spouse's hand decreases the need for vigilance and self-regulation of emotion. The stress-reducing effects of hand holding were greater for women who were more satisfied with their marriages, probably because of the stronger sense of security induced by physical contact with a responsive and supportive husband.

Neurobiological research also suggests that early stress and trauma in attachment relationships have enduring effects on stress reactivity and affect regulation (Allen, 2013; Diamond, 2015). Such traumas, including abuse and neglect, greatly compromise the capacity to regulate one's emotional state in time of stress; the neurochemical switch tends to shut down reflective thinking (mentalizing) in favour of reflexive action – fighting, fleeing, or freezing (Allen, 2013). Schore (2001) has been exploring the right brain-to-right brain communication in caregiving relationships as well as in psychotherapy and its significance in attachment outcomes. The right brain is responsible for the more intuitive, implicit, nonlinear forms of communication. According to Schore (2001), the caregiver's right brain is largely responsible for the "comforting functions" of the caregiver, while the infant's right brain is geared toward attachment. He emphasizes that the growth of the right brain continues throughout the lifespan but that its maturation is experience-dependent. Schore's research suggests attachment-based, emotion-focused therapies that have been shown to be most effective may be altering clients' brains at neurological levels as well as healing attachment traumas. For example, Diana Fosha's (2003) Accelerated Experiential Dynamic Psychotherapy (AEDP) for individuals, Sue Johnson's (2008) Emotionally Focused Therapy (EFT) for couples, and Dan Hughes' (2009) Dyadic Developmental Psychotherapy (DDP) for children and families, focus on attuning to non-verbal

right brain signals of facial expressions, body language, tone of voice, and eye contact. They emphasize the relationships (therapist and client, client-client in couples and families) right here, right now, in this room, in this moment. These therapies explore engagement - disengagement, closeness-distance, intimacy and individuation and attempt to create a new experience of relationship, leading to new internal working models, and a new experience of self in relationships. Understanding the possible connections between attachment theory and brain research will deepen the bio-psycho-social-cultural perspective of clinical social work (Schore & Schore, 2010) and equip us with more effective relational and therapeutic skills for child and family-centered practice.

### **Couple Relationships Across the Transition to Parenthood**

The transition to parenthood is recognized as a pivotal life course transition. For some, becoming a parent for the first time may be a profound stressor associated with negative long-term consequences, and for others it is an important source of wellbeing (Kluwer, 2010). There are several major changes new parents encounter with the birth of their first baby. *The Key Evidence Messages on the Transition to Parenthood* (The Relationships Alliance, 2014) provides a sound overview in understanding this developmental phase and the nature of its challenges (see Figure 2.2 for a summary). Using Figure 2.2 as background knowledge, some of the research findings that are most relevant for couples becoming parents will be discussed.

#### **Reorganization of the Couple Relationship**

In the context of the couple relationship, the transition is the long-term process of couples reorganizing their existing relationship into a new form to accommodate children (Cowan & Cowan, 2000). The transition period typically involves a decline in marital satisfaction, especially after the birth of the infant (Doss, Rhoades, Stanley, & Markman, 2009; Lawrence et

al., 2008). From the family systems perspective, this may reflect an adaptive change of focus, helping new parents to make psychological space for the infant (Cowan & Cowan, 2000). During the first pregnancy, one of the core reorganizational tasks is the transformation of the dyadic couple relationship into a mother-father-child triad (Stern, 1995). As future parents increasingly begin to view their spouse as the mother or father during pregnancy, they form representations of the spouse-as-parent (Stern, 1995).

The reorganization of representations of self and the spouse may activate both attachment and caregiving systems: the spouse as a marital partner and current attachment figure to the self as well as the self/spouse as the child's parent (Stern, 1995). This also means the creation of a new co-parenting subsystem, which is separate, but intertwined, with dyadic marital and parenting subsystems (Minuchin, 1985). The reorganizational processes can therefore be challenging due to increased demands in balancing the needs of the new baby with the needs between the parent couple.



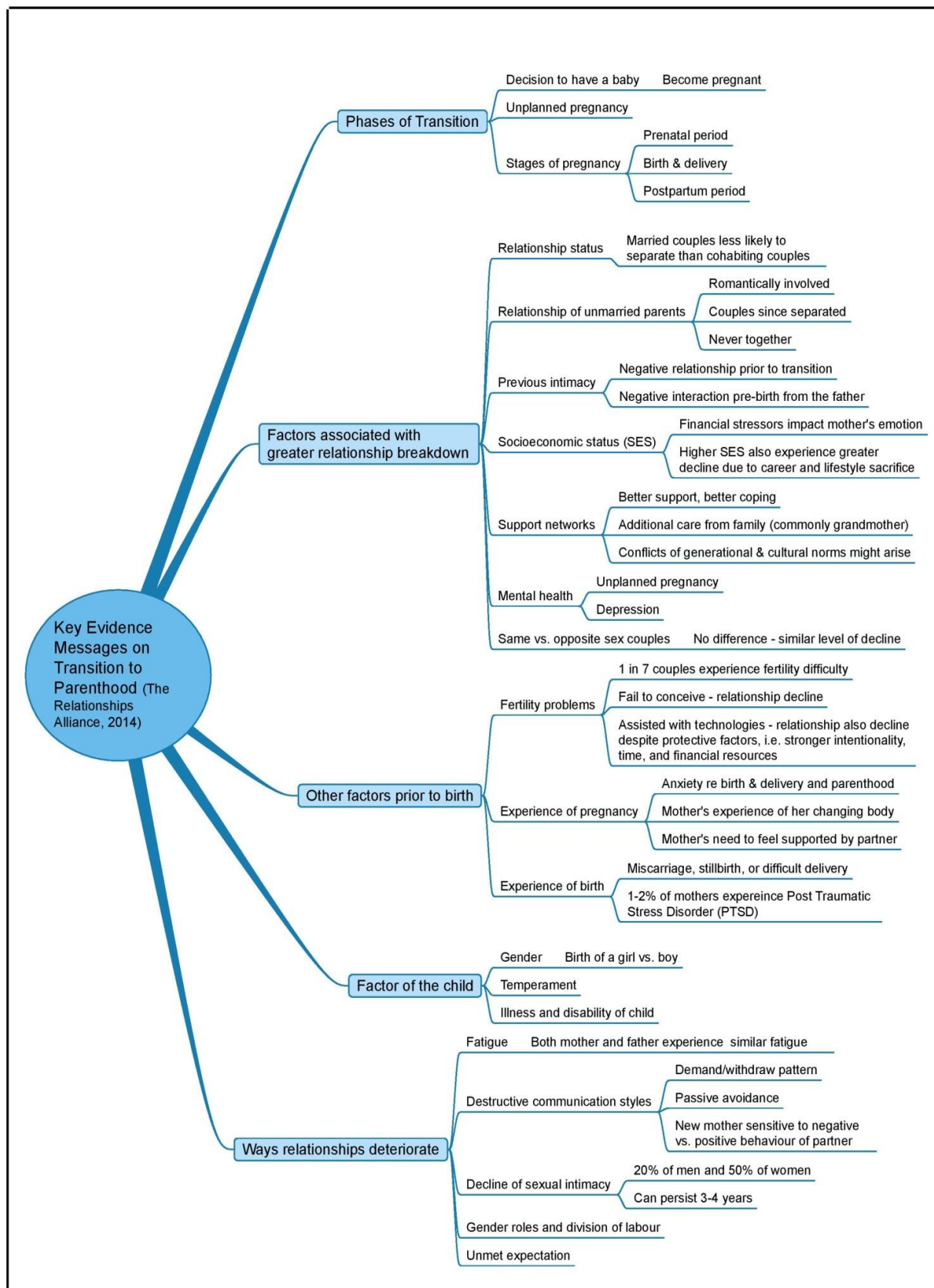


Figure 2.2: Summary of Key Evidence Messages on Transition to Parenthood

## **The Gendered Experience of the Transition and Couple Relationships**

The transition to parenthood is an almost universal experience across cultures and across eras (Feeney, Hohaus, Noller, & Alexander, 2001). Researchers in other countries have also confirmed the stressfulness of this transition (Feeney et al., 2001). The incidence and prevalence of challenges and problems might not be the same across cultures, or reduced in cultures in which the whole village is active in child raising. Research suggests the impact of parenthood is higher among women than men at least partly because pregnancy, birth, and breastfeeding place major physical demands on women's bodies (Cowan & Cowan, 2000). In addition, women are more likely than men to be the primary caregiver of their infant and often feel that the task of protecting the fetus, infant, and growing child are primarily their responsibility (Feeney, et al., 2001). Given the traditional view of women as family kin-keepers and caregivers, their life pathways tend to be embedded in, and structured by, the experiences and expectations of partners and children as well as by broadly defined societal gender-role norms (Cowan & Cowan, 2000; Feeney, et al., 2001). An important part of the strain put on the couple relationship is therefore due to changes in the content of the roles as they tend to become much more traditional and gender-based even in egalitarian relationships (Cowan & Cowan, 2000).

In addition to the major changes listed in Figure 2.2, gender is a further variable that has consistently been linked to differences in relationship satisfaction among new parents. The overall decline in relationship satisfaction is stronger for new mothers compared with new fathers (Shapiro, Gottman, & Carrere, 2000; Twenge et al., 2003). Kluwer (2010) suggests that this may be because women are usually faced with more personal and career-related changes resulting from pregnancy, childbirth and childcare. Research indicates that the division of household labour is one of the most common conflict issues for new parents (Kluwer, 2010), and

it may be influenced by new parents' own childhood experiences of gender role modelling (Gupta, 2006).

In terms of the couple relationship, a recent survey conducted in the United Kingdom (Gabb, Klett-Davies, Fink, & Thomae, 2014) offers similar findings with a modern-day slant relating to gender and parenthood. This study reports that fathers were less positive than childless men about their relationships, and mothers were more negative about their relationships than childless women. However, the mothers were significantly happier with life than the men and childless women. The report states that it could be inferred that children are the primary source of happiness for women rather than for their partners. This is further supported by the responses in the survey to the question: *Who is the most important person in your life?* Mothers were most likely to select their child/ren; fathers overwhelmingly selected their partner. This gendered response may shed some light on the tensions at play in balancing parenting and partnering when couples become parents.

### **The Importance of Fathers**

The role fathers play in affecting their partners' relationship satisfaction is crucial (Feeney, Alexander, Noller, & Hohaus, 2003; Kolvuner, Rothaupt, & Wolfgram, 2009). A body of research has identified women's marital adjustment to be more dependent on their male partner's than vice versa (Feeney et al., 2001). The key predictor of women's marital happiness postpartum is found to be her partner's level of knowledge about her 'inner world' and their relationship; and his expressions of fondness and admiration for her prenatally (Gottman et al, 2010). During pregnancy and after birth, fathers can play an important role in influencing the wellbeing of their partner, and in supporting their partners to maintain healthy behaviours that benefit their baby. Women whose partners remain involved during pregnancy are more likely to

attend antenatal care, take better care of their health and deliver healthier babies (Fletcher et al, 2014; Meedya, Fahy & Kable, 2010; Henriksen, Torsheim & Thuen, 2015). When fathers are involved in caregiving, there is a positive effect on marital satisfaction for both partners (Katz-Wise, Priess, & Hyde, 2010). Marital quality also seems to affect parenting especially strongly among fathers (Cowan & Cowan, 2000; Feeney et al., 2001). Positive marital interaction is a particularly important predictor of how both mother and father will experience parenthood and parental supportiveness later (Gordon & Feldman, 2008; Houts et al., 2008). Father's involvement and co-parenting effectiveness are not only important for a couples' wellbeing, they are also crucial conditions for enhancing a child's developmental success (Halford, Petch, & Creedy, 2015; Holmes, Cowan, Cowan, & Hawkins, 2013).

### **Couple Interactions and Adaptive Processes**

The decline in relationship quality during the transition to parenthood is common, but it is not inevitable. Estimates show that between 40% and 70% of parent couples experience a decline in relationship satisfaction in the first year of parenthood (Shapiro & Gottman, 2005). However, that leaves a sizeable remainder who navigate the transition to parenthood with no decline or even show an improvement in their relationship quality; 20% of mothers and 37% of fathers in a recent study reported an improvement in their relationship (Holmes, Sasaki, & Hazen, 2013). The quality of the couple's relationship and ability to engage with each other positively prior to the transition has been found to act as a buffer against relationship decline (Houts et al., 2008; Shapiro, Gottman & Carrere, 2000). Whether or not the pregnancy is planned has also been suggested as a possible protective factor with regards to relationship changes. Planned pregnancies offer some protection to declines in relationship satisfaction (Lawrence et

al., 2008). Good partner relationships also provide parents with a degree of protection from anxiety and depression (Misri, Kostaras, Fox, & Kostaras, 2000).

However, during the transition, most couples show a decline in positive couple communication and adaptive processes, such as relationship maintenance, emotional responsiveness and spousal support (Kluwer, 2010). Less time for couple-focused communication free from distraction, less self-disclosure, less praise, and increased negativity and conflict are reported (Cowan & Cowan, 2000; Pinquart & Teubert, 2010). Reduced frequency and quality of couple time has also been reported (Dew & Wilcox, 2011). Up to 50% of women and 20% of men report reduced sexual responsiveness for 6–12 months postpartum, and one third of couples report continuing sexual problems 3–4 years after the birth of the child (Petch & Halford, 2008; von Sydow, 1999).

In addition to other factors (see Figure 2.2), more negative interactions and less support and affection between the partners after the baby is born has been reported (Doss et al., 2009; Houts et al., 2008; Lawrence et al., 2007). Constructive problem solving is most common during the prenatal period, while the use of destructive (more harmful) problem solving is highest three months after birth; couples' problem solving styles tend to stabilize a year after birth (Houts et al., 2008) either negatively or positively. Research shows that when male partners regulate negative affect and deal with conflict openly and with negotiation, couples tend to maintain high levels of relationship satisfaction. Koivunen et al. (2009) suggest that when men are adept in attending to the relationship, it relieves their female partners of having to do an unequal amount of the emotional work.

Some researchers have focused on the need for partners to be more interdependent during the transition stage. When partners' goals and desires are at odds or partners need to change or

set aside their own personal interests (e.g., sleep or sex, who does what, when, and how), these challenges often create ‘interdependence dilemmas’ (Tran & Simpson, 2009). Individuals may feel vulnerable to exploitation, rejection, or loss, especially if their partner is not sufficiently invested in the relationship or responsive to their needs. How should couples negotiate their interdependence dilemmas to weather the difficult transition? Are there ways partners can help regulate each other’s emotional stress? Further discussion of couple interactions (e.g., conflict, support, intimacy) and dyadic regulation processes from an attachment perspective will be found later in the chapter.

### **Same Sex Couples and Adoptive Parents**

Research indicates same sex couples (Goldberg, Smith, & Kashy, 2010) and adoptive parents (Foli, 2010) in male-female relationships express similar unfulfilled and unrealistic expectations as biological parents during the adaptive processes to parenthood. On average, all new parents experience declines in their relationship quality across the first year of parenthood regardless of sexual orientation, with women experiencing steeper declines in relationship satisfaction (Goldberg et al., 2010). For adoptive parents, significant individual predictors of relationship satisfaction included: socioeconomic status (SES), partner support, enthusiasm of partner for being a parent, and feelings of rest. Findings suggest that the relationship satisfaction of adoptive mothers is not affected by infertility or factors related to the adoption process, but rather by aspects of mental health, well-being, and support that are common to the parenting experience (South, Foli, & Lim, 2013). Same-sex couples may face different challenges to those of male-female couples, such as raising children outside of mainstream norms, but this can be compensated in other areas. For example, a study of lesbian couples who became parents via

IVF treatment suggests they did not experience the same inequalities in the division of labour and relationship distress that heterosexual couples often face (Goldberg & Perry-Jenkins, 2007).

### **Transition to Parenthood and Mental Health**

The time from pregnancy to childbirth is commonly referred to as the perinatal period. Perinatal mood disorders (PMD) refers to a group of disorders that includes depression, anxiety, panic, obsessive-compulsive disorder, and posttraumatic stress disorders (PTSD) that occurs during pregnancy or the first 12-month postpartum period (Public Health Ontario, 2016). PMD are prevalent and impacts at least one in five mothers (Best Start, 2007; Dennis & Towswell, 2013), one in ten fathers (Letourneau et al., 2012; Paulson & Bazemor, 2010), one in two adolescent parents (Dinwiddie, Schillerstrom, & Schillerstrom, 2017), and one in four adoptive parents (Foli, South, & Lim, 2014). The transition to parenthood, both in pregnancy and in the early postpartum period, is associated with an increased vulnerability for mental health problems, such as depression, anxiety and other mood disorders in both parents, with higher prevalence rates among women (for a full review, see Dennis, 2015). Growing agreement is evident in the literature that the depressed feelings and moods that new parents experience are not different from depression at other times (Dennis, 2015). Based on the recent Cochrane database systematic review (Dennis & Dowswell, 2013), Figure 2.3 serves as a summary of parental mental health challenges in the perinatal period.

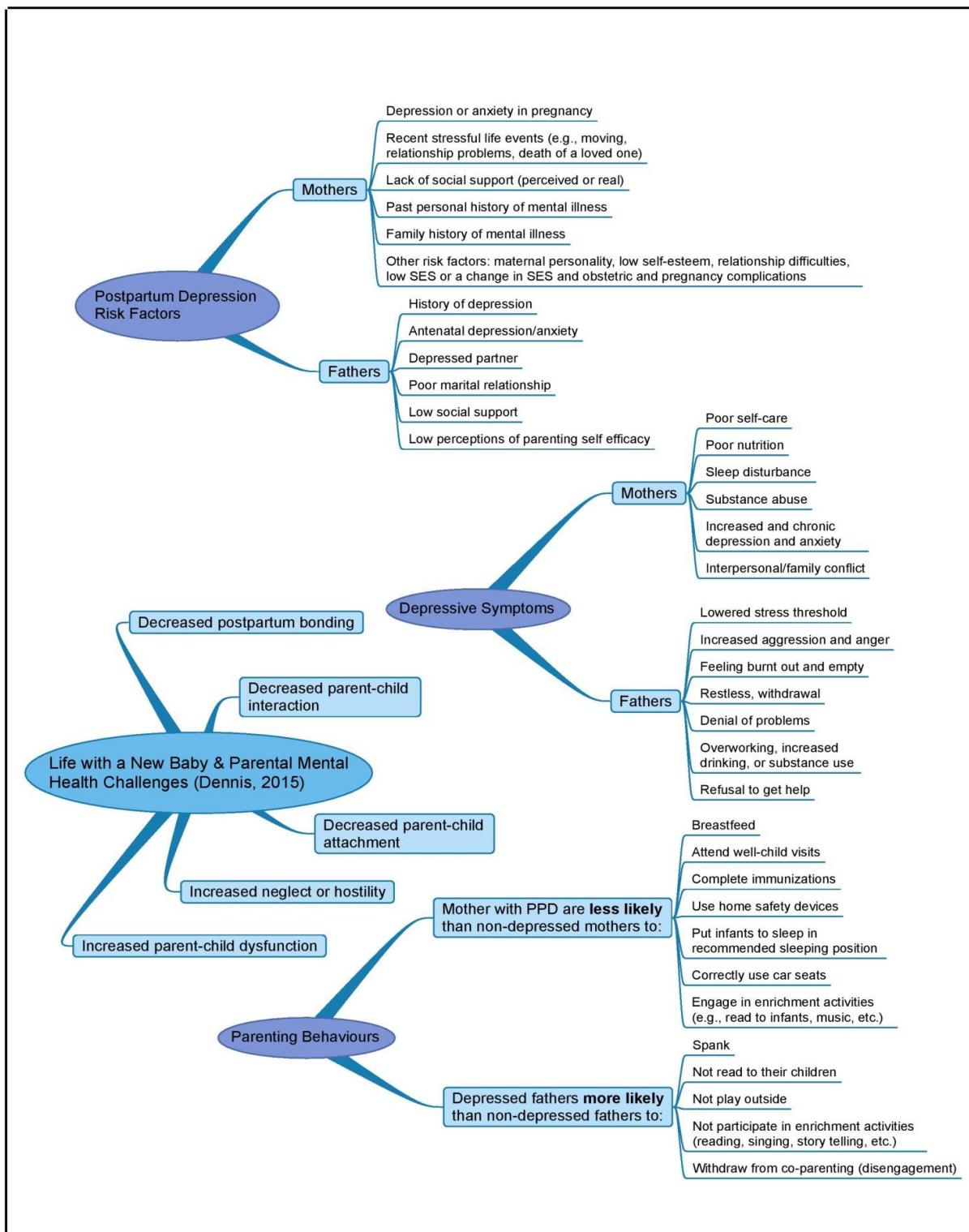


Figure 2.3: Summary of Parental Mental Health Challenges in the Perinatal Period



Perinatal mood disorders (PMD) usually go undiagnosed and untreated (Dennis, 2015). Mothers who are experiencing postpartum depression (PPD) may also experience unique barriers to reaching out for help due to the fear and stigma related to being seen as ‘unfit’ mothers (Best Start Health Nexus, 2007; Wang, 2011). Similar to mothers, fathers experience their spouse’s pregnancy as a major psychological transition, involving higher susceptibility to distress postnatally than prenatally (Dennis, 2015; Proulx, Helms, & Buehler, 2007). It is important to note that much of the PPD research either has excluded fathers or included only those where the mother was depressed. Among fathers whose partners experience postpartum depression, the incidence of paternal postpartum depression rises to 25-50% (Hildingsson & Thomas, 2014; Paulson & Bazemore, 2010). Paternal postpartum depression can be difficult to assess (Paulson & Bazemore, 2010). New fathers may seem more angry and anxious than sad (Domoney et al, 2014), yet, depression is present (See Figure 2.3 for depressive symptoms for fathers). When it is left untreated, paternal postpartum depression limits men's capacity to provide emotional support to their partners and children and can lead to withdrawal from co-parenting (disengagement) (for a meta-analysis of this research, see Wilson & Durbin, 2010). A strong association between relationship quality and depression has been reported: a poor quality relationship triggers or exacerbates depression (Proulx et al., 2007; Simpson, Rholes, Campbell, Tran, & Wilson, 2003), or alternatively, can be a consequence of mental health problems (Proulx et al., 2007). These factors can potentially have long-lasting results for infant outcomes, which have been found to extend into adolescence and beyond (Sanger et al, 2015).

### **When Does Infant Mental Health Begin?**

Infant mental health is fundamentally rooted in the attachment relationship (Slade, 2005; Meins et al, 2001). This important relationship begins in utero – the mother’s relationship with the unborn baby is a significant predictor of future relationships and is important for early

development (National Scientific Council on the Developing Child, 2012). Maternal-fetal attachment is known to increase with gestational age (Barone et al, 2014). The mother's level of prenatal attachment to the baby is associated with her making health-promoting choices, such as giving up smoking and alcohol, which will provide the unborn baby with a healthier environment (Goecke et al, 2012). Recent research shows that pregnancy also provides a potential window of opportunity for enhancing attachment in expectant fathers. Based on a longitudinal study using data from first-time fathers, paternal-fetal attachment significantly increased with the imminent birth, with potential long-term benefits for the future father-child relationship (Condon et al, 2013).

### **Mental Health is a Family Affair**

Young children develop in an environment of relationships. The genetic component of the developing fetus' temperament has been shown to be influenced by stress hormones in pregnancy (National Scientific Council on the Developing Child, 2004). How parents argued in the third trimester of pregnancy was predictive of the temperament and neurological development of the child (Gottman, Gottman, & Shapiro, 2010). In addition, postpartum depression (PPD) of one or both parents occurs at a time when the infant is maximally dependent on parental care and highly sensitive to the quality of the interaction (Dennis, 2015). While effective interventions to address maternal mental health and parent-child attachment have been one of the most important public health preventive strategies to reduce the long-term negative outcomes among children, the relationship of the parent couple and how it can potentially serve to safeguard the entire family's mental health has been significantly overlooked.

The importance of the couple's relationship in pregnancy as a predictor of the parent-baby bond is supported by research suggesting that the parent-baby relationship can be predicted

in pregnancy, by observing the interactions of the couple (Parfitt, Ayers, Pike, Jessop, & Ford, 2014). This study also supports a causal direction with the couple's relationship influencing the parent–baby relationship, rather than the other way around (Parfitt et al., 2014). An explanation of the crucial importance of the couple relationship during pregnancy may be that it is representative of the parents' fundamental underlying internal mental representations of attachment relationships in general (Iles et al., 2011), and as such, may have a greater influence on the parents' ability to bond with their baby both short term and long term. Some evidence also suggests bonding difficulties may arise in parents suffering from childbirth-related PTSD (e.g., miscarriage, stillbirth, difficult delivery, child disability, Nicholls & Ayers, 2007; Susan, Harris, Sawyer, Parfitt, & Ford, 2009). Fathers' and mothers' responses following childbirth appear to be strongly interlinked to symptoms of posttraumatic stress and postpartum depression in couples, implying that services should target both parents (Iles et al., 2011). In summary, the parent–baby bond is associated with parental mental health, the couple's relationship and infant temperament (Parfitt et al., 2014). This highlights the importance of interventions targeting the couple's relationship and helping parents to perceive their baby's temperament positively as early as possible, to prevent the formation of negative long-term interactive patterns. The significant impact of men's concurrent affective symptoms on their bond with their baby postpartum further emphasizes the importance of enhancing fathers' mental well-being in their transition to parenthood (Koivuner, Rothaupt, & Wolfgram, 2009).

### **Treatments and Interventions for Parental Mental Health**

What are some effective treatments aimed at reducing or eliminating depression among parents and do they constitute a significant preventive intervention for children? According to the Cochrane review on interventions for treating antenatal depression (Dennis & Dowswell,

2013), the recommended treatment approaches are: Pharmacological, psychological (interpersonal psychotherapy, cognitive behavioural therapy, mindfulness-based strategies), psychosocial (peer support/support groups, non-directive counselling) and alternative (relaxation/massage, exercise, yoga).

A significant gap is evident in this list of treatment approaches. The focus is mainly on intervention but not prevention, individual but not systemic. They focus on treating the individual parent, mostly the mothers, with little focus on treating the parent couple together. This literature also reveals little attention to unmet attachment needs as a way of making sense of one's mental health in a non-stigmatizing way, or how attachment-informed knowledge can help parents or parent couples gain insight and understanding of the self, each other, and how they relate to their child. Almost three decades of theory and research on adult attachment should inform public health and social work responses to the opportunities to enhance infant mental health during couples' transition to parenthood.

### **Adult Attachment During the Transition to Parenthood**

The purpose of this section is to explain how attachment theory concepts have contributed to the transition to parenthood literature and review research that has been applied to this population. Attachment theory has guided research in several areas relevant to the transition to parenthood, namely 1) research that has identified the relationship between attachment security and depression, 2) research identifying the relationships between experiences with one's own parents and one's adult attachment style and how one's attachment style in turn affects one's parenting, and 3) attachment research on couple interactions specifically around conflict, sexual intimacy, as well as interdependence and partner buffering.

## **Attachment and Depression**

The link between security of attachment and depression is particularly documented in the attachment literature. Research studies have found that parents who are high in anxious and/or avoidant attachment are significantly more vulnerable to depression and depressive symptoms (Mikulincer & Shaver, 2007). Depressive symptoms are highest among more anxious individuals, next highest among more avoidant persons, and lowest among more secure individuals (Rholes et al., 2011; Simpson et al., 2003). The results of several studies suggest that secure mothers are better able than insecure mothers to cope with pregnancy, the transition to parenthood, and parenting stresses (Feeney et al, 2001; Trillingsgaard, Elklit, Shevlin, & Maimburg, 2011). Specifically, secure mothers reported less psychological distress during pregnancy and early parenthood, felt more equipped to handle pregnancy and the transition to parenthood, reported less fear and anxiety about their own health and the health of the fetus during pregnancy, and reported more adaptive coping strategies than insecure mothers did. Following a pattern that is strikingly consistent with the larger literature on attachment styles and coping with stress (Diamond, 2015; Mikulincer & Shaver, 2007), security was associated with greater support seeking and problem-focused coping; avoidance was related to more distancing coping; and anxiety was related to greater emotion-focused coping when dealing with stressors related to pregnancy and parenthood. Research suggests interventions that target men's and women's sense of worthiness and self-esteem in their new role as parents may be beneficial to their mental health (Parfitt & Ayers, 2014).

## **Parental Representation and Parenting**

As discussed earlier, parental representations are described as the most important pathway through which earlier attachment experiences affect a parent's relationship with their child (Bowlby 1980; Main, et al., 1985). Parents with positive and stable childhood experiences

are more likely to form and maintain flexible, coherent attachment and caregiving representations in the transition to parenthood (Main et al., 2005). However, for parents with unresolved trauma or insecurity, this process may be more complex and painful (Cohen & Slade, 2000). Fraiberg (1975) introduced the concept of “ghosts in the nursery” (internalized attachment figures) to describe how unresolved issues related to one’s own childhood experience with parents may negatively impact and restrict one’s ability to sensitively and effectively parent one’s own infant. The “ghosts” often negatively impact feeding, sleep, toilet training, discipline, and other areas of current parenting abilities by influencing the way parents interpret their infants’ behaviour. This can lead to neglect or maltreatment. Lieberman and colleagues (2005) later proposed a counteracting influence of uncovering the “angels in the nursery” (internalized attachment figures) as growth-promoting forces in the lives of traumatized parents. They argued that early benevolent experiences with parents or other caring adults could protect against even overwhelming trauma. They also examined the re-emergence of these benevolent figures in consciousness as an instrument of therapeutic change - care-receiving experiences characterized by intense shared affect between parent and child in which the child felt nearly perfectly understood, accepted, and loved—providing the child with a core sense of security and self-worth that could be drawn upon when the child becomes a parent to interrupt the intergenerational cycle of maltreatment. Service providers can help parents learn different ways of wakening these “angels in the nursery”, to support them to become better parents.

That adult attachment style influences parenting has considerable empirical support. For example, adult self-reported attachment style predicted parental responsiveness toward distressed children during a stressful parent-child interaction (Edelstein et al., 2004), and parent-child synchrony was shown to promote secure child attachment (Selcuk et al., 2010). In the attachment

style literature, avoidance, rather than anxiety, has emerged as the dominant predictor of less observed parental sensitivity (Jones, Cassidy, & Shaver, 2015). Compared with insecure mothers, secure mothers report stronger feelings of closeness to their child, both prenatally and after childbirth (Wilson, Rholes, Simpson, & Tran, 2007). Wilson et al. (2007) found no significant links between fathers' attachment styles and feelings of closeness to children. According to Jones et al. (2015), studies including fathers are limited. The Circle of Security is a relationship-based early intervention program designed to enhance attachment security between parents and children (Powell, Cooper, Hoffman, & Marvin, 2013). It is intended to help parents increase their awareness of their children's needs and whether their own responses meet those needs. Studies have demonstrated that with increased awareness, parents can expand their moment-to-moment parenting choices where needed to break the stronghold of problematic attachment patterns that are passed from one generation to the next.

### **Attachment Research on Couple Interactions**

**Conflict.** Couple communication may vary as a function of attachment security. Secure individuals actively seek intimacy and support from their partners when they feel vulnerable and respond to conflicts in a constructive, relationship-promoting manner (Simpson & Overall, 2014; Tran & Simpson, 2009). They use more self-disclosure and more constructive approaches to conflict management, particularly when conflict is intense and central to the relationship (Feeney, et al, 2001; Simpson & Overall, 2014). Conflict has been found to be more negative in couple relationships even if only one partner has an insecure attachment style. For example, Cohn et al. (1992) found that couples with insecure husbands exhibited less positive and more conflictual behaviour during conflict discussions than couples where husbands had a secure attachment. Furthermore, when Paley and colleagues (2005) assigned pregnant couples to groups based on their attachment security (secure/insecure) and mean level

of negative emotional escalation (low/high) during a problem-solving discussion, they found that the impact of negative conflict management patterns on relationship functioning was greater for couples if the husband had an insecure attachment than if he was securely attached. Insecure husbands and the wives of insecure husbands reported greater declines in positive marital perceptions (or lower rates of positive marital perceptions compared to secure husbands and wives of secure husbands) from 3 to 24 months postpartum, but only when they were engaged in negative escalation of conflict. Salvatore and colleagues (2011) demonstrated that when adult romantic partners behave more positively during post-conflict discussions (showing they can ‘move on’ and recover from conflict), individuals who were insecure felt better about their relationship, and their relationships were more likely to be intact two years later.

**Sexual intimacy.** One important aspect of relationships that can promote bonding and convey a partner’s emotional availability is sexual activity (Little, McNulty, Russell, 2010). It is an area that expectant and new parent couples tend to overlook for reasons previously indicated (see Figure 2.2). Adults with secure attachment report more enjoyment of physical contact, and more mutually initiated sex (Birnbaum, 2015; Johnson & Zuccarini, 2010). In a study of approximately 150 couples assessed during pregnancy and again at 6 months postpartum, attachment insecurity was linked with low sexual desire and low satisfaction with sexual communication among new fathers only (but not for new mothers, or a comparison cohort of couples who did not have children; Feeney et al., 2001). New fathers with attachment insecurity may struggle with postpartum sexual intimacy because it may require discussions of when to resume sex and how to overcome obstacles to the resumption of sex (e.g., female pain, fatigue, presence of infant), when his attachment pattern tends to be associated with discomfort around self-disclosure. Peloquin and colleagues’ (2014) study suggests that individuals presenting with



attachment insecurity, whether avoidance or attachment anxiety, are particularly sensitive when it comes to their sexuality. They found that better levels of emotional safety and connection, as well as more sensitive support in the relationship could foster more positive self-image and promote assertiveness of sexual preferences and needs. Little, McNulty, and Russell's study (2010) of married couples showed that satisfying and frequent sexual activity boosts expectations of partner availability, which reduces negative associations between attachment insecurity and marital satisfaction. When anxious people have satisfying sex, they anticipate their partners will be more affectionate and dependable in the future, which improves marital satisfaction. More frequent sex also helps avoidant people maintain more positive evaluations of their marriages. Sexual intimacy is one of the most challenging areas for expectant and new parent couples to maintain. Therefore, it deserves special attention to promote pair bonding, strengthen emotional connection and enhance individual self-esteem.

**Interdependence and partner buffering.** Overall and Simpson (2015) argue that partners' responses in certain interdependence dilemmas, and the dyadic environment they create, can protect or compromise the couple relationships. For example, when one partner gets anxious and the other reacts, the anxiety can escalate. As anxiety goes up, the emotional connectedness of the couple becomes more stressful than comforting. Eventually, one or both partners feel overwhelmed, isolated, or out of control. Perceptions of the partner and relationship are crucial to understanding how well anxious and avoidant individuals cope with this difficult life transition. If anxious women perceive their partners are less supportive during the transition, they report declines in relationship satisfaction and become more anxious over time (Rholes, Simpson, Martin, Tran, & Wilson, 2012). Perceiving the partner as closer and more supportive than the partner was prior to the pregnancy protects anxious women and men

from higher depressive symptoms following childbirth (Rholes et al., 2011). Avoidant individuals also show better adjustment across the transition when they believe they can rely on their partners to help them in cooperative, non-intrusive ways (Rholes et al., 2011).

When partners meet the specific needs and concerns of avoidant and anxious individuals, they can buffer relationships from their typical destructive reactions. Simpson and Overall's (2014) most recent research publication identified some of the key partner responses that down-regulate insecure reactions in different interdependence dilemmas that avoidant and anxious individuals usually find threatening. Table 2.2 is a brief summary of their findings:

Table 2.2: Summary of Partner Buffering

|                         | <b>Triggers</b>  | <b>Partner Buffering</b>   | <b>Positive Outcomes</b>   |
|-------------------------|--|--|--|
| <b>Avoidant Partner</b> | Being the target of a partner's influence attempts<br>Perceived threats of rejection, inadequacy<br>Receiving emotional caregiving or support (e.g., encouraging discussion on emotional experiences) predicts greater distress in avoidant partners | Be more sensitive to avoidant partner's autonomy needs<br>Soften influence attempts using indirect tactics<br>Acknowledge avoidant partners' constructive efforts and positive attributes<br>Provide practical forms of support and instrumental caregiving that deemphasize the dependence and emotional vulnerability that avoidant individuals dislike  | Less anger and withdrawal<br>Avoidant partners were more calmed when their partners could support them in cooperative, non-intrusive ways<br>Evaluated self more positively and evaluated the relationship more positively |
| <b>Anxious Partner</b>  | Dilemmas center on major relationship conflicts that elicit relationship loss or abandonment concerns are significant to anxious partners – more negative emotions, less behavioural accommodation   | Partners' commitment to relationship with accommodative behaviours (e.g., resisting the urge to retaliate, calming the partner and working harder to solve the problem, accentuating how positively they feel about their partner)<br>Behavioural manifestations of commitment and responsive support convey exactly what anxious individuals want – reassurance of their partner's love and future investment | Anxious individual felt more valued and regarded and felt greater acceptance and behaved as positively as secure individuals did<br>Evaluated self more positively and evaluated the relationship more positively          |

When the dyadic environment contradicts the negative expectations of insecurely attached people, this form of dyadic regulation – in which one partner regulates the other’s responses – can yield greater security and enhance relationship well-being for the couple (Simpson & Overall, 2014). Recent researchers have demonstrated that despite the usual consistency of individual attachment style, attachment security within couple relationships can change even when previous attachment experiences were damaging (Johnson 2004; Mikulincer & Shaver, 2015). Attachment behaviours (such as accessibility, responsiveness, and engagement) have also become a focal point of marital research (Sandberg, Busby, Johnson, & Yoshida, 2012). Many positive outcomes are reported by couples that express healthy attachment behaviours as opposed to those couples that display less healthy attachment; the positive outcomes include more happiness, friendliness, support (Feeney et al., 2015), higher relationship satisfaction (Mikulincer & Shaver, 2015; Rholes, Simpson, Campbell, & Grich, 2001), higher commitment (Simpson & Overall, 2014), more intimacy (Birnbaum, 2015; Zayas, Merrill, & Hazan, 2015), and more trust (Mikulincer & Shaver, 2015). Given the number of ways that attachment is associated with marital and parenting processes and outcomes, it is apparent that the core concepts of attachment theory for couple relationships have not yet reached the practice field sufficiently to become part of the key messages for perinatal intervention.

### **Couple-Focused Perinatal Interventions**

Growing evidence demonstrates that attending group-based classes focusing on the transition to parenthood can lead to a range of positive outcomes for parents as individuals, in their relationship as a couple, and in terms of their parenting skills (Pinquart & Teubert, 2010; Schrader McMillan et al, 2009). In my comprehensive paper (Wang, 2015), I reviewed literature

regarding relationship education programs for this population that are: 1) empirically supported (see Table 2.3), 2) had positive outcomes and 3) had potential for program implementation. These couple-focused perinatal psycho-education programs have demonstrated some success in preventing deterioration in relationship satisfaction across the transition for expecting couples and new parents. As Table 2.3 illustrates, most of these programs focus on improving communication between the partners. While attachment messages are embedded in some of their curriculums, such as *Becoming a Family Project* (Cowan & Cowan, 2000), *Bringing Baby Home* (Gottman, Gottman, & Shapiro, 2010), and *Couple CARE for Parents* (Halford, Petch, & Creedy, 2010), the concept of the couple relationship as an “attachment relationship” is not explicitly discussed in these programs. A gap clearly exists in programming to help expectant parents become aware of and able to make the connection between the attachment relationships that they are experiencing and/or have experienced (with parents and partner) and their future success as parents. Naming the couple relationship as an “attachment relationship” and/or describing it using the normative concepts of feeling safe and secure when the partner is “accessible, responsive, and emotionally engaged” (Johnson, 2008) may help expectant parents make sense of their relationship in a way that effectively influences the attachment relationship they hope to create for their child. An attachment-informed relationship enhancement program to help couples better understand their relationship with each other and create the best possible emotional foundation for their expected child is needed.

Table 2.3: Characteristics of Reviewed Couples Intervention Programs

| Program  | Population Served   | Curriculum Focus  | Format  | Frequency & Duration  | Facilitator or Educator  | Assessments   |
|--|---|---|---|---|--|---|
| Becoming a Family (Cowan & Cowan, 2010)                                  | Middle-class and low-income couples having a first child  | Couple communication, individual, parent-child, generational patterns, life stress and social support | Groups of 4-6 couples; open ended discussion followed by specified agenda with exercises  | Twenty-four 2-hour sessions extending from 3 months prenatal to 3 months postpartum (total of 48 hours) | University faculty and graduate students   | Prenatal, 6 months postpartum, then 18, 36, and 66 months                   |
| Bringing Baby Home (Gottman, Gottman, & Shapiro, 2010)                   | Middle-class couples having a child   | Couple communication, individual, co-parenting, parenting   | Classes with coached practice   | Weekend workshop (16 hours)   | Licensed health and mental health professionals  | Pretest, immediate posttest, 1 year postpartum                              |
| Couple CARE for Parents (Halford & Petch, 2010)                          | Middle-class and low-income couples having first child  | Infant care, parenting, communication and conflict management, mutual support, affection and intimacy | Mixed formats: group antenatal workshop, postnatal home visits, and postnatal self-directed learning supported by telephone calls | 12 hours of work for the couple across 4-5 months   | Nurses, midwives, or psychologists   | Pretest, 5 months postpartum, 1 year postpartum                             |
| Family Foundations (Feinberg, Jones, & Kan, 2010)                        | Middle-class and low-income couples having a child  | Couple communication, co-parenting, parenting   | Groups of 6-10 couples, psycho-education  | Four 2-hour sessions prenatal, 4 sessions postpartum (total of 16 hours)                                | Childbirth educators, nurses, family workers   | Pretest, 6 months postpartum, 1 year postpartum                             |
| Mindful Transition to Parenthood (Gambrel & Piercy, 2015)                | Middle-class couples having first child   | Mindfulness practices, interpersonal activities   | A group of 13 couples   | Four-week (2 hours each) sessions   | Health educator  | Before and after program  |
| Prevention and Relationship Enhancement (PREP) (Markman & Rhoades, 2012) | Originally for middle-class premarital couples; now many new adaptations to diverse populations | Couple communication  | Psycho-education class/workshop; lecture; coached practice  | Four 2- to 3-hour meetings or weekend workshops (8-12 hours)  | Originally university faculty and graduate students; now professional and paraprofessional | Before, immediately after program, and at 1.5, 3, 4, and 5 years afterwards |

### **HMT Program and its Relevance**

The Hold Me Tight<sup>®</sup> Program: Conversations for Connection (HMT; Johnson, 2008) has great potential to be an effective program to help expectant couples be aware of the importance of their current and past experiences of attachment relationships, strengthen their emotional connection, and create more secure relationships for this target population. HMT is a research-based relationship enhancement education program developed by Dr. Sue Johnson based on her book *Hold Me Tight* (Johnson, 2008), which has been translated into 21 other languages. This 16-hour program is a streamlined version of Emotionally Focused Therapy (EFT, Johnson, 2004).

### **EFT and HMT: Theoretical Assumptions and Research**

EFT for couples, a short-term empirically validated intervention, views close relationships from the perspective of attachment theory and integrates systemic and experiential interventions ((Johnson, 2004; Johnson & Greenman, 2006). Strong empirical research supports its efficacy (see Lewandowski, Ozog, & Higgins, 2015 and Snyder, Castellani, & Whisman, 2006 for reviews). EFT is based on the principle that emotions are imperative for key attachment responses, such as requesting and offering comfort and affection (Johnson, 2004). Its interventions aim to explore underlying attachment insecurities and attachment needs that are not fulfilled, and the focus is on restructuring both attachment and caregiving interactions. Process research on EFT indicates a link between greater therapeutic success and the depth of client emotional expression in-session (Greenman & Johnson, 2013), particularly when partners can soften their stance when engaging their spouse from historically ineffective ways (e.g., criticism, blaming) and learn to approach their partner from a position of vulnerability (Dalglish et al., 2015). Studies have found that following EFT, 70% to 75% of couples move from distress to

recovery and approximately 90% show significant improvements (Johnson, 2008). EFT is being used with various types of couples in private practice and with different cultural groups throughout the world. These distressed couples include partners suffering from disorders such as depression, posttraumatic stress disorders, and chronic illness (Johnson & Wittenborn, 2012).

The key assumptions of the HMT educational program are the same as those that form the basis of EFT. Utilizing the basic interventions of EFT, the goal of the HMT program is to create stronger, more secure couple relationships. HMT has effectively disseminated many attachment concepts into down-to-earth, easy to understand language to help enhance couple relationships through emotional engagement. One example is leveraging the statement “*A.R.E. you there for me?*” (Johnson, 2008) to capture the essence of an attachment relationship (“A.R.E.” stands for “Accessible, Responsive, Engaged”). Subsequently, an A.R.E. Questionnaire was developed (Johnson, 2008) to help assess the partner relationship and facilitate an attachment security priming conversation to strengthen their connection. Several studies have shown the effectiveness of HMT groups. Stavrianopoulos (2015) found that the relationship satisfaction of 14 couples who were undergraduates at a university in New York City increased significantly upon completion of the eight-week HMT program. Research conducted with 95 couples across Canada and the US who participated in 16 HMT groups (Kennedy, Johnson, & Wiebe, 2016) showed an increase in their relationship satisfaction from pre- to post-group, with little change between the baseline assessment (8 weeks before the start of the group) and the pre-group measurement point. A recent study tested the effects of a Chinese-language version of the HMT relationship enrichment program with 23 couples in Toronto, Ontario (Wong, Greenman & Beaudoin, 2017) with results indicating statistically

significant improvements in participants' satisfaction with their attachment relationships, in their attachment security, and in their family functioning.

### **The HMT Program: Content and Process**

The HMT program consists of eight two-hour sessions and can be done in various formats (e.g., weekly, two full days, or one weekend). Facilitators for HMT programs are relationship educators with understanding of attachment theory or EFT therapists who follow a manualized facilitator's guide to conduct the program. According to the HMT manual, "a minimum of 4 and a maximum of 30 couples is recommended. If the group is larger than 6-8 couples, then it is recommended that the facilitator conduct the program with one or more colleagues, especially to support couples during the in-session exercises" (Johnson, 2010, p. xx). The essential component of the HMT program is the seven key conversations. These conversations focus on improving couples' emotional communication rather than problem-solving strategies that are the focus of other relationship enhancement programs. In the first session, couples introduce themselves and talk about what they would like to gain from the educational program. Then, the facilitator presents educational material on attachment, couple relationships, and the importance of emotional connection. This sets the stage for the sessions that involve participation in the seven "Conversations for Connection" presented in the *Hold Me Tight* book. These conversations are: 1) "Recognizing the Demon Dialogues," 2) "Finding the Raw Spots," 3) "Revisiting a Rocky Moment," 4) "Hold Me Tight," 5) "Forgiving Injuries," 6) "Bonding through Sex and Touch," and 7) "Keeping Your Love Alive" (Johnson, 2008).

Regarding the process of the HMT program, Wong, Greenman and Beaudoin (2017) provided a succinct comparison between EFT and HMT:

Group participants view recordings of actual couples engaging in the different



conversations, guided by a facilitator or therapist. As in standard EFT, couples in HMT groups first learn to identify their negative interaction patterns and the triggers of the emotional and behavioral responses that shape those patterns (conversations 1 and 2). Then, also as in EFT, couples learn to talk to each other about their vulnerabilities, insecurities, and needs for closeness once they recognize how these can be masked by secondary responses such as anger and frustration (Conversations 3 and 4). This leads into a discussion of any longstanding emotional injuries that might be present in the relationship; partners learn how to hear and respond in an empathically comforting manner to the pain that is expressed, in an effort to solidify trust in the relationship (Conversation 5). In the final two group sessions, couples learn how to improve their sex lives through emotional connection (Conversation 6) and how to maintain the gains made in the relationship enrichment group (Conversation 7) (p. 2-3).

During each conversation, the facilitators move between couples and provide guidance on how to shape the conversation to create security and trust. They focus their efforts on helping participants identify and express a wide range of emotions in order to restructure their interactions such that, when one partner expresses vulnerable feelings (e.g., fears or longings), the other partner responds with compassion and understanding (Johnson, 2004; 2010).

The HMT program helps partners become more aware of their attachment needs; they learn to ask their spouse for the support and reassurance they seek in clear, direct ways. Each partner in the couple learns how to remain emotionally accessible and responsive to the other, fostering a safe, enduring emotional bond that facilitates relationship satisfaction and effective problem solving (Dalglish et al., 2015; Johnson, 2013). The emotional connection is the key to

help strengthen a couple's relationship, so that the partner's responsiveness and supportive behaviours augment one's sense of security (Mikulincer & Shaver, 2015).

### **Reflective Summary**

From the transition to parenthood literature, it is well established that interactions between the couple and between parents and their children are interrelated. Being in a satisfying couple relationship is associated with high parenting sensitivity (Gordon & Feldman, 2008). In turn, maternal parenting sensitivity is associated with enhanced infant attachment security (Dennis, 2015), which predicts later social competence and fewer behaviour problems (Halford & Petch, 2010). Fathers tend to consider their partner the most important person in their lives (Gabb et al., 2014), but mothers tend to identify the child as the most important person for them. During pregnancy and after birth, fathers play an important role in influencing the wellbeing of their partner (Feeney et al., 2001). The parent–baby relationship can be predicted in pregnancy by the interactions of the couple (Parfitt et al., 2014). Marital quality seems to affect parenting quality very strongly among fathers (Schulz, Cowan, & Cowan, 2006), and this predicts the extent of observed co-parenting (Gordon & Feldman, 2008), which in turn predicts future female relationship satisfaction (Feeney et al., 2001). Good partner relationships also provide parents with a degree of protection from anxiety and depression (Misri et al, 2000).

Transition to parenthood is a time when attachment representations become susceptible to change within and between the parent couple. At the same time, the foundation of the expected child's attachment with parents is about to be developed. Through dedicated efforts to communicate key messages from service agencies, parenting literature, and public education, parents today are informed about the importance of infant-parent attachment. However, intellectual understanding of attachment does not necessarily translate into being able to provide

a child with a secure base. Given the number of ways that attachment is associated with marital and parenting processes and outcomes, it is apparent that the core concepts of attachment theory for couple relationship have not yet reached the practice field in a way that effectively helps couples identify the aspects of their relationships that are most vulnerable during this stressful transition. A gap also exists in helping parent couples make the connection between the attachment experiences in their couple relationship and the quality of attachment they will be able to facilitate in their child. Early interventions that focus not only on the relationships between parents and children, but also on the relationship between the parents as a couple are very much needed.

Couple-focused interventions have been shown to positively impact relationship quality, satisfaction, and stability over a considerable period (Pinquart & Teubert, 2010; Schrader McMillan et al, 2009). While any intervention may be helpful in supporting couples transitioning to parenthood, I believe that interventions that build on the core concepts of attachment theory will provide optimal preparation in terms of safeguarding the couple relationships and supporting the expectant parents to be the best parents they can be. This dissertation research, by modifying the HMT program to make it more relevant and accessible to couples expecting their first child, and evaluating its helpfulness, will be a first step in testing this belief.

## Chapter Three

### **METHODS**

*The greatest gift a parent has to give a child – and a lover has to give a lover – is emotionally attuned attention and timely responsiveness. – Sue Johnson*

There are two parts to this dissertation research. First, I modified the current *Hold Me Tight*® (HMT, a registered trademark to Dr. Sue Johnson) Relationship Education Program to make it specifically relevant to couples transitioning to parenthood. Second, I conducted a pilot study that provided a preliminary evaluation of the modified program. The aims of this HMT pilot study were: 1) To conduct the modified HMT program and receive qualitative feedback from the facilitators and participants regarding the content of the program; 2) To explore and seek understanding of expecting couples' experiences of the modified program and their assessment of its helpfulness; 3) To use three evaluation measures at three time-points (Time 1 at pre-program interview, Time 2 at start of the program, and Time 3 at post-program interview) to determine whether they would detect any quantitative changes in variables associated with the goals of the program.

### **Research Questions**

The overarching question for this research study was: Is an attachment-informed relationship enhancement program, such as *Hold Me Tight*® (HMT), helpful to couples in strengthening their relationship and increasing their confidence in becoming first-time parents?

The following sub-questions guided the research inquiry:

1. Is the program content and delivery useful and helpful to the target population? If yes, in what way? If not, how could it be improved?
  - a) From the group participants' perspectives

- b) From the program facilitators' perspectives
2. Do the participating couples change in their understanding of themselves and their relationship following participation in the modified HMT program?

In particular, how does their participation affect:

- a) Their understanding of themselves?
- How do they see themselves in relation to each other before and after the program?  
What changed?
  - Is there a qualitative and/or quantitative change in each partner's attachment anxiety and avoidance?
- b) Their understanding of their relational dynamics?
- How do they perceive or "make senses of" their relationship before and after the program? What changed?
  - Is there a qualitative and/or quantitative change in each partner's perceived relationship-specific attachment behaviours (accessibility, responsiveness, engagement)?
- c) Do the participating couples increase their confidence and their ability to work together to create a healthy emotional foundation for their baby?
- In particular how does their participation affect:
- Their views or feelings about being a parent?
  - Their level of anxiety and depression associated with the transition?
  - Following participation in the program, how do they think their baby might benefit from what they learned?

- Following participation in the program, what are they doing or ready do to create a healthy emotional environment for their family?

### **Methodology**

This study is a mixed-methods evaluation of the modified version of the HMT program. A mixed-methods inquiry offers the researcher the ability to integrate both an objective and subjective perspective using a “plurality of methodological approaches and philosophical perspectives” (Hesse-Biber & Johnson, 2013, p. 103) to bring the best of both inquiries’ methods together. The form of data used in mixed methods research can be both narrative (qualitative) and numeric (quantitative), which allows researchers to mix and match design components that offer the best opportunities for answering their specific research questions (Teddlie & Tashakkori, 2008).

In terms of epistemological stance, Johnson and Onwuegbuzie (2004) proposed that pragmatism is the philosophical partner for mixed methods research. Pragmatism offers an immediate and useful middle position philosophically and methodologically; it argues, “multiple paradigms can be used to address research problems” (Creswell & Plano Clark, 2007, p. 15). It also offers a practical and outcome-oriented method of inquiry with a more pluralistic or compatibilist approach. The most important pragmatic principle is always to consider what differences the phenomenon being studied makes for practice, and pragmatism takes an explicitly value-oriented approach to research (Johnson and Onwuegbuzie, 2004); for example, it can include the premise that educating couples to increase their knowledge on attachment relationships will be of benefit to the couples and their children. Adopting the pragmatic stance towards mixed methods research, I endeavoured to choose the combination of methods and procedures that works best for answering my research questions.

## **Research Design**

In order to identify the research design for this study the following questions were considered: What is the purpose of the quantitative method in the study? What is the purpose of the qualitative method in the study? What similarities do the two methods share and what directions do they lead to? The research design for this study corresponds to what Creswell and Plano Clark (2007) term a Triangulation Design: Convergence Model. Triangulation in social science refers to efforts to corroborate or support the understanding of an experience, a meaning, or a process by using multiple sources or types of data, multiple methods of data collection, and/or multiple analytic or interpretive approaches. A triangulation design is used when “the researcher wants to directly compare and contrast quantitative statistical results with qualitative findings or to validate or expand quantitative results with qualitative data” (Creswell & Plano Clark 2007, p. 62). Also, in triangulation designs, the two types of data are usually collected at the same time, which was the case in this study. The quantitative and qualitative approaches occurred simultaneously during the pre and post program interviews with each participating couple. The interviews and questionnaires were planned and implemented to answer related aspects of the same basic research questions. Thus, they helped to explain and interpret complementary aspects of the same phenomenon. This research design also corresponded to what Teddlie and Tashakkori (2008) called a true mixed-method design because the two types of data were integrated in the analysis and interpretation of the findings. To ensure the quality and validity of the study, the following is a brief illustration of the research design and the use of mixed methods:

1. Facilitators' Experiences (Qualitative & Quantitative)
  - a) Personal log to keep track of their experience (what worked or didn't work for each session)
  - b) Program evaluation form (Likert scales)
  - c) Post-program interview (audio recorded and transcribed)
2. Group Participants' Experiences (Qualitative & Quantitative)
  - a) Program evaluation form (Likert scales)
  - b) End-of-program focus group (audio recorded and transcribed)
3. Individual Couple's Experiences (Quantitative & Qualitative)
  - a) Self-report Relationship Information Forms, asking for demographic information, were received from each couple at the pre-program interview
  - b) Self-report standardized questionnaires for each individual partner (at Time 1, 2, and 3, collected and scored)
  - c) Semi-structured interviews with each couple
    - Pre-program interview (audio recorded and transcribed)
    - Post-program interview (audio recorded and transcribed)

### **Phase One: Program Modification**

The first phase of the dissertation research was program modification. A brief overview of the pilot study and outline of the modification was sent to Dr. Sue Johnson at the International Centre for Excellence in Emotionally Focused Therapy (ICEEFT) and a reply was received with her permission to proceed in July 2016. The researcher first modified the Facilitators' Guide for "Hold Me Tight<sup>®</sup> for Couples Becoming Parents," from the original Hold Me Tight Facilitators' Guide; secondly, the researcher created a set of PowerPoint slides to accompany the modified



Facilitators' Guide. Dr. Tat-Ying Wong, MD, an EFT trainer as well as a member of this dissertation committee oversaw the process and served as a consultant and editor for this manual.<sup>3</sup>

**Purpose of the program.** The purpose of the Hold Me Tight® couple education program is to help couples create stronger, more secure relationships by strengthening their emotional connections (Johnson, 2010). Transition to parenthood is a time that partners have greater needs for connection and reassurance around becoming parents. This modified version of the Hold Me Tight® program puts an emphasis on strengthening the concurrent attachment relationship with respect to both partnering and parenting. It aims to help expectant couples to better understand themselves and their relationships in order to increase their abilities to create a healthy emotional environment for their child and the entire family.

**Goals of the program.** The goals of the original HMT program are the following:

Participants will:

- Better understand romantic love – the pivotal moves and moments that define a relationship.
- Better understand their own and their partner's emotional responses and needs.
- Be able to describe and control negative interactions that create pain and distance.
- Be able to shape the positive moments of reaching and responding that create a secure bond.”

(Johnson, 2010, p. xvii)

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<sup>3</sup>This 80-page manual is not included in the appendix because most of the content material is based on the original Facilitators Guide, which is copyrighted to ICEEFT.

The following are goals for the modified HMT program for couples becoming first-time parents. Participants will:

- Better understand love and attachment from infancy to adulthood
- Better understand their own and their partner's emotional responses and needs
- Be able to describe the negative interactions that create emotional distance or disconnection in their relationship
- Be able to shape the positive moments of reaching and responding that create a secure bond
- Be able to utilize the attachment behaviours A.R.E. (Accessibility, Responsiveness and Engagement) to enhance emotional connection with each other and their baby

**Modification of program process.** The essential component of the HMT program is the seven key conversations. The format of the original program involves the following:

1. Session introduction
2. The facilitator presents the core concepts of the session and invites questions and discussion
3. The participants view the HMT DVD which illustrates one of the conversations, followed by discussion
4. In-class exercise accompanied with worksheet for each couple to engage in their private conversation
5. Group sharing and recap of session

The modified HMT program follows the same process as above; in addition, a brief experiential activity named 'Relationship Workout' was added as a warm-up exercise to pair

with the introduction session and each of the seven conversations (See Figure 3.1). A question inviting reflection was also added at the end of each conversation.



Figure 3.1: Pictorial of the Relationship Workouts Paired with Each Conversation

*Why the relationship workouts were added.* The Relationship Workouts are brief experiential activities that require minimal verbal communication; they are a “bottom-up approach”, encouraging experience-dependent relational skills to help support couples in their A.R.E. practice. What are the values of adding these relationship workouts to the program? Based on the attachment literature, long-term pair bonds present a number of psychological and physical benefits for adults. Partners are capable of regulating each other’s physiological systems (Overall & Lemay, 2015). With knowledge from attachment neuroscience, researchers have demonstrated ways to improve attachment-related processes such as bonding or emotion regulation for stress-reducing effects (Coan, 2006), security priming (through words, memories, images, etc., Gillath, 2015) and right-brain-to-right-brain communication (i.e., non-verbal emotional communication, Schore, 2001). This line of research indicates that our short-term sense of attachment security can be increased (or decreased), and similarly our levels of anxiety- and avoidance-related behaviour can be increased or decreased by guided verbal and non-verbal interactions with an attachment figure. Furthermore, as previously mentioned the effectiveness of EFT interventions is dependent on the level of experiencing, hence relationship workout activities that enhances the level of experiencing are expected to improve the creation of secure emotional bonds when compared with a predominately educational approach (Johnson and Greenman, 2006).

The relationship workout activities are based on this line of research and are intended to help couples experience increased emotional connection in the moment, and also to become more attentive and better attuned to each other. This skillset is considered essential in developing couples’ secure functioning as well as parental sensitivity. More importantly, the relationship workout activities facilitate the transfer of crucial attunement skills from the couple to parenting

relationship. After each relationship workout, partners process their experience and then engage in guided discussion on how each activity can also be applied to the parenting relationship. As parents, they can use these co-regulation skills to help soothe, comfort, and meet the emotional needs of their child. Children learn to self-soothe and self-regulate their emotions when their parents or primary caregiver models these comforting responses to them in a manner that corresponds to the child's experiences (Fonagy et al., 2002). The instructions for each relationship workout and their applications with supporting material (videos, articles, etc.) can be found in Appendix A - Session Outline of Modified Content.

***Why the reflective questions were added.*** During the group sharing at the end of each conversation, a reflective question was added to the program to encourage participants to talk with one another about how they would answer the question: "How will my baby benefit from what I learned?" The same question was also posted on a large paper in the classroom during the program, and participants were invited to write their reflective thoughts using coloured markers. The purpose of this question is in line with the research on reflective function. Sensitive responsiveness – to an infant, a partner, or oneself – requires attunement to the mental states of self and others. Reflective functioning, also called mentalization, is considered a precondition for effective social skills, self-soothing, empathy, and other aspects of emotional intelligence and social-emotional maturity (Fonagy et al., 2002). Parental reflective functioning is the caregivers' abilities to hold in their own minds a representation of their child's mind (Slade, 2005). When a caregiver is able to reflect on both her own and her child's mental states, whether positive or negative, and to appropriately reflect back the reality of the child's internal experience, the child develops a representation of his or her inner self, which is internalized over time (Slade, 2005). The child learns through this process of attunement or mirroring to be aware of what he or she is

feeling and how to manage those affects (Allen 2013; Tronick, 2009). By asking research participants how their child might benefit from what they learned during the program, the researcher intended to encourage participants to first reflect on what they had learned from the conversation and relationship workout, then put themselves in their unborn child's mind to envision the potential benefits their child could receive from them. It is intended to cultivate the parental reflective functioning skill for these expectant parents, even before their child is born. This again, would likely improve the effectiveness of the original HMT couple relationship education program and generalize the attunement and mentalization skills to the parenting relationship.

**Modification of program content.** Program content was modified through simplifying concepts, selecting and editing videos from the original HMT program, and adding topic areas specifically relevant to the target population. The following is a high level summary of the content modification:

- Enhanced content on the parent-child attachment and how it relates to adult attachment
- Simple and clear examples were used to illustrate the shared characteristics and distinctive needs of a child and a romantic partner in an attachment relationship
- Key messages were highlighted to increase couples' awareness of the importance of supportive relationships and mental health during the transition to parenthood and its impact on the entire family. Examples include: "Relationships are vital to health." "There is no health without mental health." "Mental health begins before the baby is born." "You are not alone. It is not your fault. There is help for you and your family."

- Examples and scenarios that aimed to facilitate the Accessibility, Responsiveness and Engagement (A.R.E) conversations were created to reflect common experiences of the prenatal population
- Perinatal sexuality was highlighted in the *Bonding through Sex and Touch* conversation
- Relevant video clips as well as other research-based or social media videos were selected to supplement the original HMT DVD teaching and concepts. Only one of the three couples interviewed by Dr. Sue Johnson from the original HMT program was used to demonstrate the key conversations; this decision was made to provide time for other supplementary materials that would be more relevant to parents expecting their first child. The couple selected is in their 30s and are parents of two young children talking about their relationship challenges. Of the three couples in the original HMT videos, this couple matches the experience of the participants better since the other two couples were older with adult children.
- Some in-class conversation worksheets were modified or replaced. Two conversation worksheets (“Secure base and safe haven: Look at your relationship through the lens of attachment security”, and “Know your relationship histories”) were added as homework activities for the couples. See in-class worksheet modifications with sources in Appendix A.

Regarding the sources of these materials, most of the added content was from Dr. Sue Johnson, the International Centre for Excellence in Emotionally Focused Therapy (ICEEFT) and research published in recent years. Other added materials were taken from field experts in the respective topic areas. They were clearly identified in the Facilitators’ Guide as added content

and the information and key messages were presented via PowerPoint slides and videos. The following is a brief summary of the sources of the added content:

***Book and research publications***

- The section entitled “Parenthood” by Dr. Sue Johnson from her book *Love Sense: The revolutionary new science of romantic relationships* (Johnson, 2013, p. 158-164), which covered the role of attachment and postpartum depression with direct relevance for the target population of this research.
- Dr. Catherine de Pierrepont’s research on perinatal sexuality (de Pierrepont, 2014)
- Research findings with statistics on couple relationships during the transition to parenthood, perinatal mental health, and infant mental health based on this author’s review of the literature in preparing to design this study.
- Some conversation worksheets were from the workbook activities included in “An Emotionally Focused Workbook for Couples” (Kallos-Lilly & Fitzgerald, 2014).

***Research-based videos***

- Video entitled, “Love Sense from Infant to Adult” (Johnson, 2016) from ICEEFT. It features two experts, Dr. Sue Johnson and Dr. Ed Tronick, who talk about key responses in love relationships.
- “The Strange Situation – Reunion” (Lifearchariot, 2015). The security of attachment in one- to two-year-olds were investigated using the '*strange situation*' procedure developed by Mary Ainsworth to observe the variety of attachment patterns exhibited between mothers and infants.



- A combination of Dr. Sue Johnson's video interviews available on YouTube that comment on the transition to parenthood and how having the first baby could be a critical time for the couple relationship; these were edited to appropriate length.
- "Dads Try the Still Face Experience", (Picture Alternatives, 2016), which illustrates a research project with fathers by Project ABC and The Children's Institute Inc., of Los Angeles that employs the now famous "Still Face experiment" developed by Dr. Ed Tronick (2009), director of UMass Boston's Infant-Parent Mental Health Program. It shows how profoundly babies read and react to their social surroundings. Prolonged lack of attention can move a baby from good socialization to bad.
- "Pregnancy and changes in a Couple's relationship" (KidCareCanada, 2013) by Dr. Caroline Steinberg, MD, of University of British Columbia. Dr. Steinberg talks about how pregnancy can cause significant changes to a couple's relationship and impact their lifestyle both inside and outside the home. She states that there is a great shift in how new parents see themselves and function in society, and that numerous issues may arise and need to be negotiated between them in order to keep their relationship strong and healthy.
- Pregnancy and the Role of Fathers (KidCareCanada, 2013) by Dr. Caroline Steinberg, MD. This video describes how the birth of a baby significantly impacts fathers, changing how they view themselves with respect to their partner, their role in the family, their career, and their financial responsibilities. It points out that a large number of today's fathers come from families that were more traditional in terms of sex roles, and so they lack a role model more suitable to the needs of the contemporary family.

The researcher also added videos from social media sites as suggested viewing to help enhance participants' learning experience or grasp key concepts from the program, for example, the concept of a secure attachment can be conveyed through Thich Nhat Hanh's 4 Mantras (OWN, 2012) These suggested videos could be used at the facilitators' discretion. They are listed in Appendix A. The completed manual and the sessional PowerPoint slides were provided to each of the facilitators in both USB stick and hard copy six weeks prior to the commencement of the first series of workshops.

### **Phase Two - Evaluating the Modified HMT Program**

**Recruitment and training of facilitators.** For this pilot study, a husband and wife, (male and female) team was recruited to co-facilitate the groups; having a female and male co-facilitator was desirable to respond to and validate perspectives from both genders. Each of the facilitators reviewed the Facilitator's Information Letter and Consent Form (see Appendix B) and signed the Facilitator's Consent Form (see Appendix C) to participate in the study. The two facilitators have graduate level education and both were trained in a helping profession. They were learning and practicing Emotionally Focused Therapy (EFT), familiar with the transition to parenthood life stage, and had experience with workshop facilitation. The following expectations, support and resources were made available to the co-facilitators as a form of training to prepare them to facilitate the workshops.

- Read the HMT book
- Attend an HMT workshop
- Preview the modified HMT Facilitator's Guide
- Plan and prepare the content material prior to the program and before each session
- Work with the researcher for regular check-ins, Q&A, debriefing, and support

To protect the integrity and confidentiality of the group process for both participants and the facilitators, a decision was made by the researcher and the Dissertation Committee not to audio record any part of the program sessions. To ensure that the facilitators follow the facilitator's guide in the delivery of the course, provisions were made for quality control and adherence to the actual program in the guide. The following steps were taken to ensure the fidelity of the model:

1. The facilitators were to review and provide input and feedback during the HMT content modification phase
2. Consistent outline of each session with time allotment was clearly indicated in the Facilitator's Guide to help facilitators with planning
3. The slide deck of each module with speaking notes were provided to the facilitators in advance for content practice and they were expected to follow them closely during the program
4. The facilitators were to keep track of their experiences and any perceptions that are relevant for the program (i.e., what worked or didn't work or seemed to be helpful for each session) in a personal log and submit their entries to the research after completing each day of the program
5. To complete the post-program evaluation form
6. To share their experiences of the facilitation process through a post-program interview with the following questions:
  - What worked for you as the facilitator?
  - What can be improved?
  - What impact/effect did conducting this pilot program have on you?

**Recruitment of participants.** Several strategies were employed to recruit participants for the study. 1) posters were distributed to physicians' offices in Waterloo Region, 2) a website including an attractive infographic (see Appendix D) was created; 3) a media release led to a CBC radio interview with the researcher and an article posted on the local CBC website; 4) social media (Facebook, email blast). The recruitment process was ongoing from mid-July to mid-October of 2016. The following are the inclusion and exclusion criteria employed and the rationale for each:

***Inclusion criteria***

- Couples (heterosexual or same sex) are in a committed, monogamous relationship either married or common-law. Because those who have other romantic or sexual partner(s) outside the relationship between the parents of the expected child might have challenges different from those in monogamous relationships, they were not included in this study.
- Couples have been residing with each other for at least one year. To benefit from the program, a relationship will have passed the honeymoon period (usually six months) and need time for an interactional pattern to develop after living together for a period of time.
- Couples (heterosexual or same sex) are expecting their first child (by birth, not adoption) and without children from previous relationships. The adoptive parent couple population would benefit from a research study of its own, and may have issues that are different from biological parent couples. Partners who have other child(ren) from previous relationships were not included as their experience is

different from first-time parents and their inclusion might influence the views of first-time expectant couples.

- Couples are within 34 weeks of gestation at the time of the program<sup>4</sup>. The cut-off time is to prevent physical discomfort of the pregnant partners for the two full-day workshops and/or early birth and delivery that might interfere with the post-program interview.
- Couples can commit to the 16-hour relationship research program at the designated time and dates
- Both partners are able to speak and understand English; the pilot study was conducted solely in English.

***Exclusion criteria.*** According to recommendations from those who have conducted relationship education research, couple-focused relationship programs should ensure that participants are pre-screened for relationship violence prior to the start of the program as relationship violence undermines the ability of partners to positively engage with each other (Halford, Petch, Creedy, & Gamble, 2011; Johnson, 2008). Also, the researcher chose to abide by the current exclusion criteria set by the HMT curriculum, which were:

- There is an explicit and obvious lack of commitment to the growth of the relationship by one partner.

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<sup>4</sup> The initial requirement was set at 24 weeks of gestation to prevent physical tiredness for pregnant spouses to attend the two-day program. Almost immediately feedback was received from inquirers including a medical doctor stating that it was too early a cut-off time to include people interested in participating. It was then changed to 32 weeks with permission from the Laurier Research Ethics Board (REB). We then received inquiries from women over the 32 weeks of gestation stating that they were able and willing to participate in the program. Due to the slow progress of recruitment, once again we obtained permission from the REB to change the cut-off time to 34 weeks.

- There is extensive and/or long-standing relationship distress in the relationship such that a couple would be better served by seeking out a couple therapist rather than engaging in an educational program.
- There is indication of significant physical (hitting, slapping, use of implements to hurt or intimidate) or emotional abuse in the relationship (frequent hostile name calling, derogatory comments that define the partner negatively) to the point where one person expresses fear of the other.
- There is a history of significant mental illness and/or untreated addictions in either partner that would preclude productive engagement in the group experience (treated and stable mental illness or addiction in remission for over one year will be considered) (Hold Me Tight, 2010, p. 96).

For this pilot program, 12 couples were accepted into the program. They first met the inclusion criteria as assessed by a preliminary Online Screening Questions (see Appendix E for survey questions); next, they did not meet any of the exclusion criteria (see Appendix F) as assessed via a phone interview with each individual. Finally, the researcher met with each couple in a face-to-face pre-program interview (see Appendix G for a summary of interview questions) in which their suitability for the program was again assessed.

The first group program took place on Saturday September 24<sup>th</sup> and Saturday October 1<sup>st</sup> at Waterloo Lutheran Seminary (WLS) at Wilfrid Laurier University (WLS is a teaching site for Emotionally Focused Therapy and it has its own counselling centre for the public) in Waterloo, Ontario. The second group program took place on Saturday November 19<sup>th</sup> and 26<sup>th</sup>, 2016 at Langs' Community Health Centre (a neighbourhood-based organization providing comprehensive health and social support services) in Cambridge, Ontario. Six couples

participated in each group; assignment to the groups was based on the date of enrollment with no special selection for either group. Lunch was prepared and clean up was done by one volunteer couple at each site and footrests were provided for the comfort of pregnant participants.

### **Data Collection**

Quantitative and qualitative data was collected from the two facilitators of the group programs and the 12 couples who attended the two group programs.

**Facilitators' experiences.** Since the facilitators were an integral part of the research study, data were collected from them to help evaluate the content and delivery of the program.

They were asked:

1. To provide input and feedback during the HMT content modification phase.
2. To keep track of their experiences and any perceptions that are relevant for the program in a personal log that was shared with the researcher following the workshops (i.e., what worked or didn't work or seemed to be helpful for each session).
3. To complete the post-program evaluation form for facilitators (see Appendix H).
4. To share their experiences of the facilitation process through a post-program interview using the following questions:
  - a) What worked for you as the facilitator?
  - b) What could be improved?
  - c) What impact/effect did conducting this pilot program have on you? (i.e. was it stressful? too much work? Enjoyable?)

### **Group participants' experiences**

1. Each participant of the pilot study was asked to complete a program evaluation form (see Appendix I) at the end of the two-day program.
2. The researcher also facilitated a focus group with all of the participants in each program at the end of each two-day program; duration was approximately 30 minutes using the following questions.
  - a) What do you think about the program? Was it helpful? If yes, in what way?
  - b) In your opinion, has this program increased your confidence in becoming first-time parents? How?
  - c) Has the program increased your ability to work together to create a healthy emotional foundation for your baby? How?

**Individual couples' experiences.** Standardized questionnaires were administered and scored, and in-depth interviews with each couple were conducted prior to their participation in the program and again within two weeks following completion of the program.

**Quantitative methods.** Three standardized quantitative measures were used to assess: 1) participants' self-reported attachment style (whether high in anxiety or avoidance), 2) their perceptions of the attachment behaviour (A.R.E.) of themselves to their partner and of their partner to them, and 3) the current level of anxiety and depression each participant was experiencing. Assessments of these variables were conducted at three time points (1) pre-program interview; 2) at the beginning of Day 1 of the two-day program; and 3) following the completion of the two-day program. The researcher made sure at least 30 days passed between the pre-program interview (Time 1) and the participation in the program (Time 2) so that this period could be used as a control period for comparison with the period between Time 2 and



Time 3 during which the couples received the intervention. The standardized questionnaires were employed to provide a preliminary indication as to whether these variables may be associated with the partners' experience of this preventive intervention program. Table 3.1 is a summary of the quantitative measures. This is followed by detailed description of each measure.

Table 3.1: Summary of the Quantitative Measures

| Measure/Scale   | Variables  | Description  |
|---|--|--|
| <i>Experiences in Close Relationship Scale-Short Form</i> (ECR-S, Wei, Russell, Mallinckrodt, & Vogel, 2007)  | Participants' self-reported attachment style, particularly anxiety and avoidance   | ECR-S is a 12-item self-report questionnaire that assesses attachment style in adults.<br>Results consist of two scores for the two separate factors; attachment anxiety and attachment avoidance. The minimum score for each scale is 7 and a maximum score of 42.<br>People with low scores on attachment anxiety and avoidance can be viewed as having a secure adult attachment orientation. People with higher scores are assumed to have an insecure adult attachment orientation. Higher scores are significantly and positively related to depression, anxiety, interpersonal distress, or loneliness. |
| <i>The Brief Accessibility, Responsiveness, and Engagement (BARE) Scale: A Tool for Measuring Attachment Behavior in Couple Relationships</i> (Sandberg, Busby, Johnson, & Yoshida, 2012) | Couple's perceptions of the Accessibility, Responsiveness, and Engagement (A.R.E.) of themselves to their partner and of their partner to them | BARE scale has 12 items with two items for each construct in which individuals rate both themselves and their partners.<br>Higher scores indicate more secure attachment behaviours are evident in the relationship.   |
| <i>Edinburgh Postnatal Depression Scale</i> (EPDS; Cox, Holden, & Sagovsky, 1987)   | The level of anxiety and depression each participant is currently experiencing   | The 10-question EPDS is an efficient way of identifying individuals at risk for perinatal depression and anxiety, and was designed to identify these symptoms in this population. A very high EPDS score could suggest a crisis, other mental health issues or unresolved trauma. A total score of 12 or more is considered a flag for the need for follow up of possible depressive symptoms.   |

*Experiences in Close Relationship Scale-Short Form (ECR-S, Wei, Russell, Mallinckrodt, & Vogel, 2007):*

ECR-S is a 12-item self-report questionnaire derived from the Experiences in Close Relationships – Revised (ECR-R) Adult Attachment Questionnaire, which has 36 items (Fraley, Waller, & Brennan, 2000). Based on Ainsworth’s infant attachment styles literature, this scale measures attachment style in adults who are in a romantic relationship. The ECR-S gives scores on the two factors important in adult attachment: anxiety and avoidance. The scale is designed to assess a general “trait” pattern of adult attachment as independently as possible from respondents’ current circumstances, and may be helpful in understanding how they approach close relationships.

The ECR-S has a stable factor structure and acceptable internal consistency, test-retest reliability, and construct validity. Convergent validity was established through correlation analyses with various tests (Wei et al., 2007): Excessive reassurance seeking was significantly associated with attachment anxiety but not with attachment avoidance. Depression was significantly associated with both attachment anxiety and avoidance. The ECR-S yields two scores for the two separate factors; attachment anxiety and attachment avoidance. The minimum score for each scale is 7 and a maximum score is 42.

- Attachment avoidance is defined as involving fear of dependence and interpersonal intimacy, an excessive need for self-reliance, and reluctance to self-disclose.
- Attachment anxiety is defined as involving a fear of interpersonal rejection or abandonment, an excessive need for approval from others, and distress when one’s partner is unavailable or unresponsive.

People who score high on either or both of these dimensions are assumed to have an insecure adult attachment orientation. By contrast, people with low levels of attachment anxiety and avoidance can be viewed as having a secure adult attachment orientation (Brennan, Clark, & Shaver, 1998). In addition, higher scores are significantly and positively related to depression, anxiety, interpersonal distress, or loneliness (Rholes, Simpson, Kohn, Wilson, Martin, Train, Kashy, 2011; Simpson, Rholes, Campbell, Tran, & Wilson, 2003).

The ECR-S scale was employed to determine whether there was a change in individual partner's attachment tendency (or attachment style) associated with attending the program; it also allowed consideration as to whether participants' scores supported the narratives provided during the pre and post interviews.

Permission to use this scale was given from the first author, Dr. Meifen Wei through an email correspondence. (See Appendix J for a copy of the ECR-S scale and scoring sheet.)

*The Brief Accessibility, Responsiveness, and Engagement (BARE) Scale: A Tool for Measuring Attachment Behavior in Couple Relationships (Sandberg, Busby, Johnson, & Yoshida, 2012):*

The BARE scale was developed for clinical assessment and for research purposes based on the A.R.E. Questionnaire in the HMT program (see Appendix K). It is a short, self-report measure of attachment behaviours in couple relationships. The scale has 12 items with two items for each construct in which individuals rate both themselves and their partners. The BARE demonstrates high reliability, with test-retest scores ranging from .60 to .75. The behaviours measured with the BARE include accessibility (mutual spousal availability physically and emotionally domains), responsiveness (mutual spousal attentiveness/ listening), and engagement (mutual spousal connectedness and togetherness). Higher scores indicate more secure

attachment behaviours evident in the relationship. Permission to use this scale was given from the first author, Dr. Jonathan Sandberg, through an email correspondence. (See Appendix L for a copy of the BARE scale and scoring sheet.)

In addition to assessing change in attachment behaviours associated with participation in the modified HMT program, it was expected that the BARE scores would supplement the narrative data collected from each couple, and assist in understanding whether the program had made a difference in these aspects of their relationship.

*Edinburgh Postnatal Depression Scale (EPDS; Cox, Holden, & Sagovsky, 1987):*

The 10-question EPDS is an efficient way of identifying individuals at risk for perinatal depression and anxiety (Question 3-5 as anxiety subscale). “Perinatal” is defined here as during pregnancy and postpartum within 12 months. The EPDS is easy to administer and has proven to be an effective screening tool and widely used in public health settings. It has been translated into many languages and tested in diverse population samples in a variety of countries, with women and their partners, during the perinatal period (See Appendix M for the EPDS with instructions for scoring). EPDS is in the public domain and can be accessed and printed from the internet.

To screen for probable anxiety disorders, the optimum cut-off score on the EPDS for women is 6 or more (possible range: 0-9), and for men it is 4 or more (Matthey, 2008). The anxiety subscale score often influences the total EPDS score. When the total EPDS score is greater than 12, it indicates the likelihood of depression is high; the authors indicate provision of counselling resources or referral to a mental health professional may be necessary. It was hypothesized that participation in the modified HMT program would be associated with a reduction in depression and anxiety as measured by this scale.

*Qualitative methods.* The qualitative interviews were designed to allow the participating couples to share their perceptions and experiences regarding participation in the program. The following data were collected during the research study:

1. Relationship Information Form was completed at the time of pre-program interview by each participant to enable description of the participants' relevant demographic information (See Appendix N).

2. Pre-program Interview with both members of the couple

After each partner completed the Relationship Information Form independently, an interview with both partners together took place with the following two open-ended questions:

- a) What caused you to be interested in participating in this research project?

Possible probes:

- Do you have any worries and concerns about becoming a parent?
- Do you have any worries and concerns about your relationship?

- b) How do you think being in the HMT program might be helpful to you? In what way? What are you hoping for or expecting from the program?

3. After completion of the program, the researcher interviewed each couple who participated in the program within two weeks of the day the program ended. The interview with both partners together included the following open-ended questions:

- a) What was it like participating in the HMT program as a couple?

Possible probes:

- Was it what you hoped for?
- Did the program meet your expectations?

- b) Do you think participating in the program has changed how you see or understand yourself in any way? If yes, what has changed?
- c) Do you think participating in the program has changed how you see or understand your relationship? If yes, what has changed?
- d) Has participating in this program changed your view or your feelings about being a parent? Possible probes:
- More confident or less confident? In what way?
  - How will your baby benefit from what you learned from this program?
  - Do you think the program has helped you be able to work together better to create a healthy emotional environment for your family?

All interviews were audio-recorded and transcribed.

## **Data Analyses**

### **Quantitative Measures**

The standardized measures from the three time points were scored and entered into SPSS software and a Microsoft Excel spreadsheet. Descriptive statistics were used to analyze the quantitative data. The term, descriptive statistics, refers to the analysis of data that helps describe, show or summarize data in a meaningful way such that, for example, patterns might emerge from the data (Teddlie & Tashakkori, 2009). They were utilized to describe the group participants and the relationships among the variables for the individuals, between partners, and among couples within the group.

Recognizing the small sample size of this pilot project, the findings from this analysis are not generalizable. The point of using the quantitative measures was to compare the individual

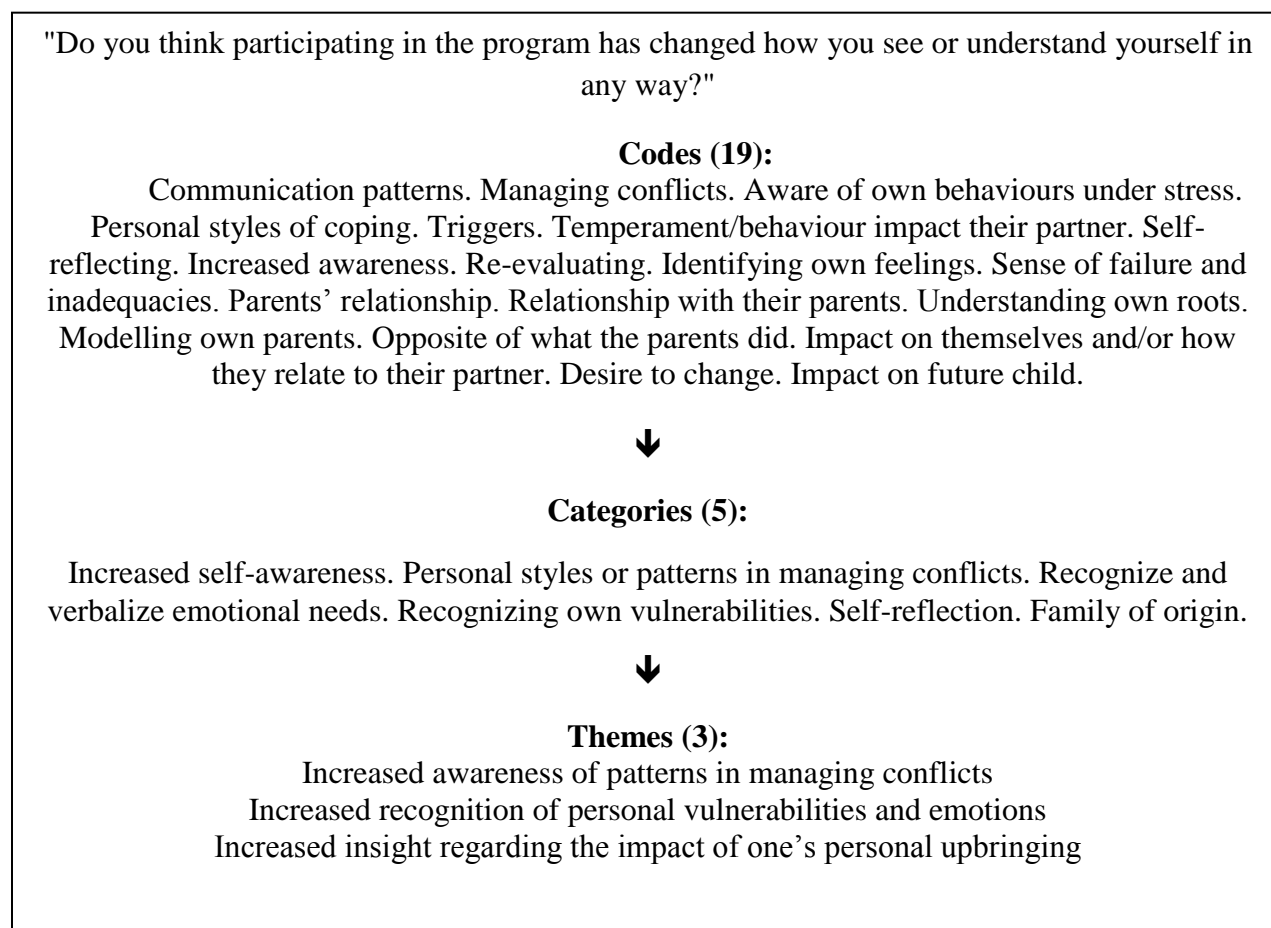
and couple participants in terms of change (or lack of change) in the scores as well as to determine whether the results would complement the qualitative findings. It was also an opportunity to see whether these measures might be useful in a study with a larger sample in the future.

### **Qualitative Data**

All audio-recorded interviews with the participants and the facilitators as well as the discussions in the focus groups were transcribed and analyzed. Thematic analysis was used to analyze the qualitative data. It is the most common form of analysis in qualitative research. Thematic analysis emphasizes pinpointing, examining, and recording patterns (or "themes") within data. Themes are patterns across data sets that are important to the description of a phenomenon and are associated with a specific research question (Braun & Clarke, 2006). The process for analyzing this qualitative data was guided by the research questions. It was done by the researcher first manually, then, with the help of NVivo software. The analysis followed the steps outlined by Braun and Clarke (2006), namely 1) familiarizing with the data; 2) generating initial codes; 3) searching for themes; 4) reviewing themes; 5) defining and naming themes; and 6) producing the report. For example, when analyzing participants' responses to the question: "Do you think participating in the program has changed how you see or understand yourself in any way?" A total of 19 initial codes were generated. To help organize the data, the coding categories were revised by collapsing and expanding as indicated by the data; in addition, the researcher kept notes of her reactions and ideas that emerged. At a later point, these codes were collapsed into three larger themes (see Table 3.2). During the thematic coding process, transcript review involved both descriptive and interpretive analysis. Inductive thematic analysis was used to allow main themes to emerge from the transcripts and salient quotes were extracted to capture

the essence of the theme. Results from both the qualitative and quantitative data were considered in the interpretation of results.

Table 3.2: Example of thematic coding process



### **Ethical Considerations**

The proposed study was reviewed and approved by the Research Ethics Board (REB) of Wilfrid Laurier University prior to engagement in any part of the research project. All participants were comprehensively informed orally and in writing about the research study, including the purpose of the study, and the methods used (i.e., the pre and post interviews, questionnaires, evaluation forms, focus group), approximate time involved in participation in the study, and assurance of confidentiality. This information was given at the beginning of the



recruitment stage. A moderately small incentive was offered in the form of a book (“Hold Me Tight,” by Dr. Sue Johnson) to each participating couple at the end of the program, and nutritious refreshments and lunch were provided during each day of the program.

A written consent form (see Appendix O) was signed by each participant to be part of the research study. At the end of the program, the research participants were asked if they were willing to be contacted for a follow-up study in the future. A “Consent to be Contacted Form” (see Appendix P) was signed at the final focus group by those who were interested. All consent forms were separated from participants' contact information and other information collected from them during the study. All contact information (names, phone numbers and email addresses) of the participants were kept apart from the data and stored in a secure place. Recordings of the conversations and transcripts were stored securely in a locked cabinet. All digital data were encrypted and password protected. All participants were told that they could withdraw from the study at any time without notice or consequences. They were assured that quotes used in reporting the findings would only be used in a non-identifying way.

During the pre- and post program interviews, when the total EPDS score of a participant was greater than 12, counselling resources and referral to a mental health professional were provided because it indicated the likelihood of depression was high. Given the nature of this study, a local information sheet for pregnancy resources and counselling were prepared and made available to all research participants.

## Chapter Four

### RESULTS

*I found the program helped me understand myself better, like emotional triggers, influences of my past, relationship needs, and having worked through the exercises and content with my wife, I feel more connected with her than I had before completing the program. – Male, Written evaluation*

This chapter begins with a description of the research sample followed by presentation of the results from the quantitative data. Next, the qualitative findings are presented, organized by the research questions in the following order: 1) Do the participating couples change in their understanding of themselves? 2) Do the participating couples change in their relationship following participation in the modified HMT program? 3) Do the participating couples increase their confidence and their ability to work together to create a healthy emotional foundation for their baby? 4) Additional observations; 5) Is the program content and delivery useful and helpful to the target population and what could be improved? For each of the research questions, I have integrated the findings from both the qualitative and quantitative data and triangulated all data sources. A summary at the end answers the overarching question for this research study, “Is an attachment-informed relationship enhancement program, such as *Hold Me Tight*® (HMT), helpful to couples in strengthening their relationship and increasing their confidence in becoming first-time parents?”

### Description of the Sample

Twelve first-time expectant couples (N=24) were recruited for the research project. They learned about the research program from various sources: Prenatal programs/midwifery/prenatal yoga studio (3), family/mother (3), friends (3), co-workers (2), and counsellor (1). Prior to participating in the program, there was a wide range of understanding regarding what the research program entailed. A few individuals said, “I have no idea what to expect;” on the other hand, two or three individuals had knowledge about EFT or HMT, and one couple had previously attended a HMT program but wanted to do it again. All 12 couples were in committed (monogamous) heterosexual relationships with 11 couples married and one in a long-term common-law relationship. All participants attended the two-Saturday programs with zero percent attrition rates.

### Age

Participants’ ages ranged from 24 to 39 years; the mean age of female participants was 29 years and for male participants it was 32.75 years. For both males and females, the mean was 32.3 years of age, mode was 31, and median was 32. Figure 4.1 illustrates the age distribution of the sample by gender.

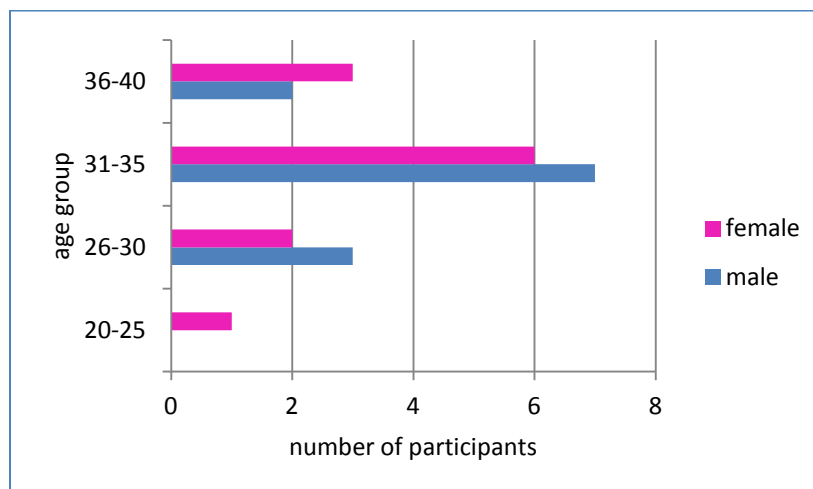


Figure 4.1: Age Distribution of the Sample

### **Years of Cohabitation**

The years of cohabitation for the sample ranged from one to nine years with an average of 4.3 years of living together. The median was three years and the mode was eight years with four couples living together two years or less and four couples living together eight years or more.

### **Ethnicity**

Fifteen out of the 24 participants (62.5%) identified themselves as Caucasian. The other nine (37.5%) identified their ethnicities as: Asian (4), Middle Eastern (2), South Slavic (1) and Caribbean (1).

### **Birthplace and Immigration**

Regarding birthplace, fifteen of the participants (62.5%) were Canadian-born with two of these identifying their ethnicity as non-Caucasian and two identifying themselves as Caucasian but having lived abroad for up to six years in their adult life. Nine participants (37.5%) were born outside of Canada: one arrived in Canada under the age of 10, five arrived during teenage years (age 11-20) and three migrated to Canada as young adults (age 21-31). The range of years of living in Canada for them was from 1.5 years to 30 years. Out of the 12 couples, the partners of six couples were born in different countries, and one was in an interracial relationship.

### **Education**

Twenty-two (91.7%) of the 24 participants had post-secondary education and all 24 were employed at the time of the pre-interview. Five participants were concerned about their job situations (e.g., potential lay off, changing jobs for better opportunity and salary, workload issues), which they said were not related to their or their partner's pregnancy.

## **Pregnancy**

Seven (58.3%) of the 12 couples stated that their pregnancy was planned. Five couples (41.7%) stated their pregnancy took them by surprise, yet they saw it as a positive event. The following was what some shared:

*“After having two miscarriages, we were in the early stages of fertility testing when we got pregnant with this pregnancy.”* Couple 2 Female (C2F)

*“Planned to have one but surprised it worked on the first try.”* (C6M)

*“Surprise [sic], but we are happy and ready to have the baby on the way.”* (C4M)

*“It was a surprise, but we weren’t preventing it.”* (C11M)

The couples were at various stages of their pregnancies during their program participation, from as early as 12 weeks up to 34 weeks of gestation. There were no pregnancy-related complications during their participation of the research program.

## **Prior Experience of Individual or Couples Therapy**

Participants were asked about any prior experience of individual and/or couple therapy to give the facilitators and the researcher a sense of their awareness of relationship issues and skill set before entering the program. Eight (33.3%) out of the 24 participants indicated that they had experienced individual counselling during their lives. No detailed information was collected as to the reasons for counselling and/or whether it was before or after the partners were living together. Three (25%) out of the 12 couples indicated they had attended couples therapy for their relationships. Among these three couples, two had longer relationship histories (8+ years) than the other couples. One of the three had experienced two breakups with one another before they decided to marry.

## Relationship Information

Within the self-report relationship information forms collected from the 12 couples prior to the program, the items 1) “Briefly describe the strengths and difficulties of your relationship” and 2) “What are your hopes for participating in this program?” were asked. A similar question “What are you hoping for or expecting from the program?” was also asked at the pre-program interview with each couple. Answers to the above questions from all 12 couples were collated and themed. Table 4.1 provides a high-level summary of the themes on couples’ relationship information forms and the pre-program interview regarding their strengths, difficulties, and what they hoped to learn from the program.

Table 4.1: Summary of Relationship Information

| <b>Strengths of Relationship</b> | <b>Difficulties of Relationship</b> | <b>Hope to Learn from Program</b> |
|----------------------------------|-------------------------------------|-----------------------------------|
| § Mutual understanding           | § Communication                     | § To improve communication        |
| § Resources and support          | § Life stress                       | § To better handle stress         |
| § Shared interests and values    | § Family upbringings                | § To have closer connection       |
| § Shared life experiences        | § Temperaments                      | § To be good parents              |

The researcher noted that most couples were readily able to identify their partner’s qualities and relationship strengths when they completed the Relationship Information Form. The difficulties in the relationship referred mostly to external stressors and interactional dynamics between the partners. The areas in which the couples hoped to learn more almost always directly corresponded to the areas of difficulties they identified in their relationships. Clearly, the couples seemed aware of their challenges and hoped that the program would give them tools to overcome these challenges. It was also interesting that they saw the program as a means to not just become better parents, but also to become stronger as a couple.

## Quantitative Results

This section reports the results from the three quantitative measures. By statistical standards, the sample size (N=24) is too small to show any statistically significant effects; the researcher was aware of this during the design phase of the study. However, quantitative data analysis was conducted to identify any trends that could be the basis for hypotheses to be tested further in a later study with a larger sample. Table 4.2 provides the means and standard deviations at the three time points for the three standardized measures. Paired t-tests were conducted for all possible pairs. Only one was close to significant at the .05 level, namely the difference between T1 and T3 for the men on their View of Partner, as assessed by the BARE.

Table 4.2: Means and Standard Deviations at Three Time Points for the Three Measures

| Self-report Measure                                   | Gender | T1    |      | T2    |      | T3     |      |
|---|--------|-------|------|-------|------|--------|------|
|   |        | Mean  | SD   | Mean  | SD   | Mean   | SD   |
| Attachment Orientation: ECR-S<br>Attachment Anxiety   | F      | 20.58 | 5.65 | 20.67 | 6.34 | 19.67  | 4.75 |
|   | M      | 18.08 | 5.32 | 16.50 | 4.74 | 17.67  | 4.48 |
|   | Total  | 19.33 | 5.51 | 18.58 | 5.87 | 18.67  | 4.63 |
| Attachment Orientation: ECR-S<br>Attachment Avoidance | F      | 12.83 | 6.69 | 12.67 | 6.05 | 12.33  | 6.64 |
|   | M      | 16.42 | 5.73 | 14.08 | 5.53 | 14.00  | 6.70 |
|   | Total  | 14.62 | 6.36 | 13.37 | 5.72 | 13.16  | 6.58 |
| Attachment Behaviours: BARE View<br>of Self           | F      | 26.25 | 2.99 | 25.33 | 2.19 | 26.50  | 2.61 |
|   | M      | 24.00 | 4.63 | 24.08 | 2.87 | 24.42  | 3.60 |
|   | Total  | 25.15 | 3.98 | 24.71 | 2.58 | 25.46  | 3.26 |
| Attachment Behaviours: BARE View<br>of Partner        | F      | 24.17 | 4.57 | 24.50 | 3.85 | 25.42  | 3.34 |
|   | M      | 23.83 | 5.24 | 25.08 | 3.12 | 25.75* | 2.86 |
|   | Total  | 24.00 | 4.81 | 24.79 | 3.44 | 25.58  | 3.05 |
| Depression & Anxiety: EPDS<br>Depression Total Score  | F      | 7.00  | 3.62 | 6.42  | 4.80 | 5.50   | 4.40 |
|   | M      | 8.17  | 3.74 | 8.42  | 4.81 | 7.08   | 3.68 |
|   | Total  | 7.58  | 3.64 | 7.42  | 4.81 | 6.29   | 4.05 |
| Depression & Anxiety: EPDS<br>Anxiety Subscale        | F      | 3.42  | 1.56 | 3.08  | 1.83 | 2.42   | 2.02 |
|   | M      | 4.58  | 2.23 | 3.92  | 2.15 | 3.25   | 2.34 |
|   | Total  | 4.00  | 1.98 | 3.50  | 2.00 | 2.83   | 2.18 |

Note: SD = standard deviation; F = female; M = male; Total = female and male combined

\*Paired sample t-tests comparing the Men's View of Partner at T1 and T3 revealed a difference close to significant  $p = .052268$  (one-tailed)

### Attachment Orientation: Experiences in Close Relationship Scale-Short Form (ECR-S)

The ECR-S is a scale designed to assess an individual's attachment style or orientation. While one would not expect a change in attachment style or orientation over a short period of time, or that this variable would change greatly in response to participation in a two-day HMT program, we were curious to compare the scores for the men's and women's attachment orientations (levels of avoidance and anxiety), as well as changes over time as measured by the ECR-S. Figure 4.2 illustrates the mean scores on Attachment Anxiety and Attachment Avoidance for both genders at the three time points.

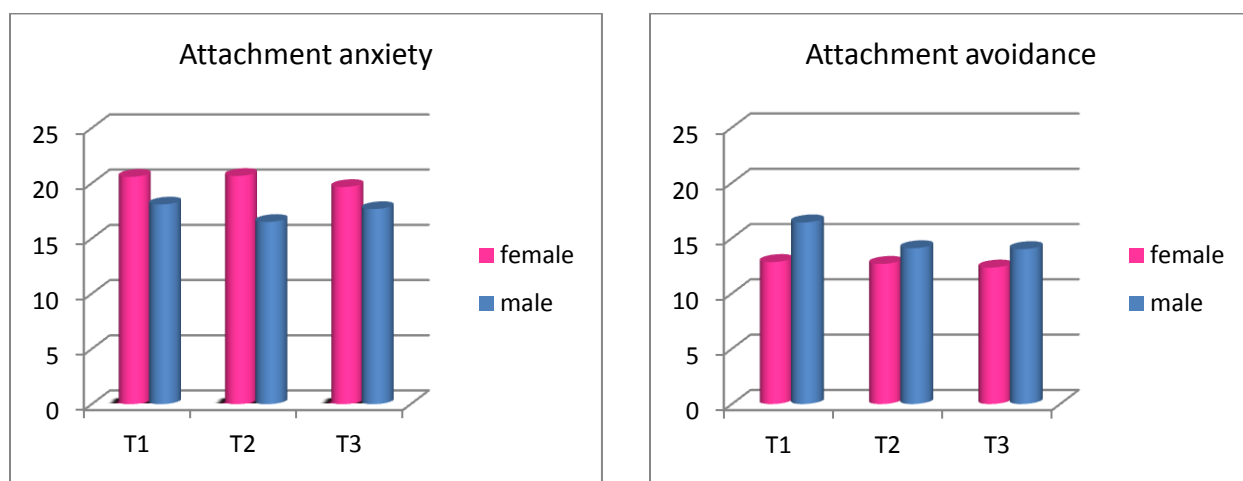


Figure 4.2: Mean Scores on Attachment Anxiety and Attachment Avoidance at the Three Time Points

The sample fell within the middle to low range of the ECR-S scores (i.e., the minimum score for each scale is 7 and a maximum score of 42; Wei, et al., 2007). Based on the literature, people who score high on either or both of these dimensions are assumed to have an insecure adult attachment orientation (Brennan, Clark, & Shave, 1998). Scores from this non-clinical sample indicate that only a few individuals had scores over 25 in Attachment Anxiety and scores



over 20 in Attachment Avoidance, suggesting that most did not have an insecure attachment orientation.

### **Attachment Behaviours: The Brief Accessibility, Responsiveness, and Engagement (BARE) Scale.**

Given the HMT program's emphasis on the partners' attachment behaviours and on the idea that emotional connection represents a basic human need, we speculated that we might see an increase in participants' rating of their own attachment behaviours with respect to their partner (View of Self A.R.E.) and a similar increase in their perception of the partner's attachment behaviours towards them (View of Partner A.R.E.). Figure 4.3 shows the sample's mean scores on View of Self and View of Partner relating to attachment behaviour at the three time points.

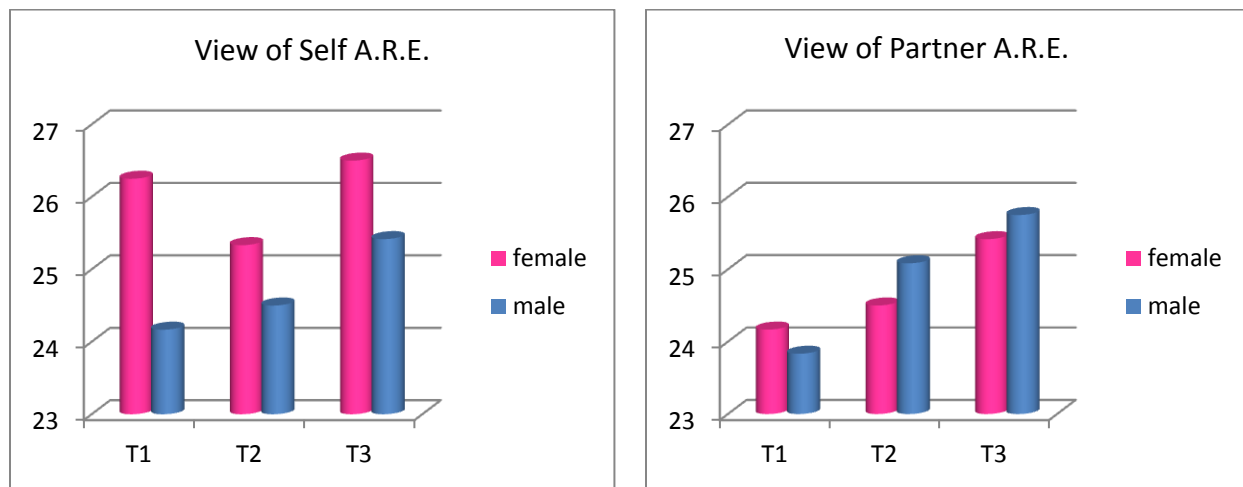


Figure 4.3: Mean Scores of View of Self A.R.E. and View of Partner A.R.E. by Gender

As stated above, the changes over time on the BARE scale are not statistically significant except for the difference in the men's View of Partner mean score between Time 1 and Time 3, which was close to significant at the .05 level. It should also be noted that in view of the number of t-tests performed, this finding may be due to chance.

### Depression and Anxiety: Edinburgh Postnatal Depression Scale (EPDS)

The EPDS scale, was used to assess levels of depression and anxiety in the participants. Figure 4.6 shows the mean depression scores on the EPDS and the mean scores on the Anxiety Subscale for the sample, including both genders at each of the three time points. Again, the differences between assessments were not statistically significant. However, as the Figure 4.4 illustrates, the mean scores tended to decrease over the three time points.

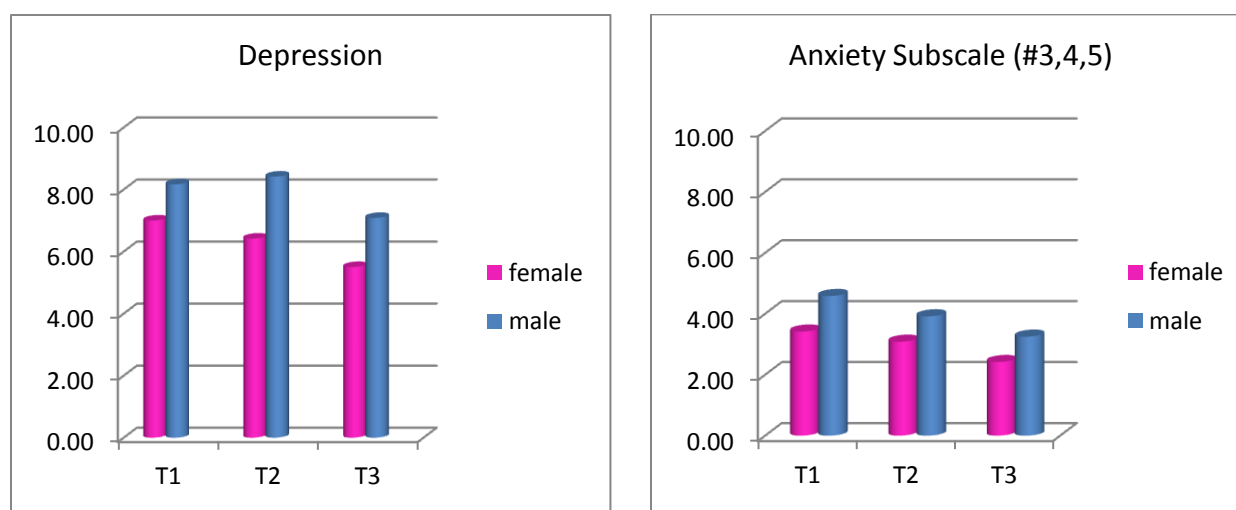


Figure 4.4: Means on EPDS and its Anxiety Subscale over Time by Gender

Based on prior research, we expected the transition to parenthood, both in pregnancy and in the early postpartum period, to be associated with an increased vulnerability for mental health problems, such as depression, anxiety and other mood disorders in both parents, but we anticipated higher prevalence rates among the women (Dennis & Dowswell, 2013, Domoney, Iles, & Ramchandani, 2014, O'Hara & Wisner, 2014). In this sample, as illustrated in Figure 4.4 the men, tended to score slightly higher than the women on anxiety as well as on depression, which was unexpected. (The differences were not statistically significant). The EPDS results will be further explored in conjunction with the qualitative findings in the next section.

## Qualitative Findings and Integration

### Do the Participating Couples Change in their Understanding of Themselves?

During the pre-program interviews, no question was explicitly asked about each partner's view of him or herself, but many participants made comments about themselves in relation to their partners. Some examples of how they described their styles of relating follow.

#### **Awareness of relationship styles before the program**

##### ***Optimistic vs. Cautious***

Male: *I feel like we have hit milestones that have been bigger challenges. We've actually performed quite well. Yeah, I'm excited; it is a lot of change.* (C7M)

Female: *But it's the before the milestone hits [that], is rough, rough waters. So that's more of my concern about as we're preparing for this baby... A little nervous, it's a big change.* (C7F)

##### ***Go-getter vs. Laid back***

Male: *I was a little too much "come on, get moving, we could do some walking, or stuff like that, don't sleep all day."* (C2M)

Female: *Because you're like a go-getter type of person and I'm not...I'm so nonchalant and you are quite the opposite.* (C2F)

##### ***Short-term vs. Long-term Planner***

Female: *Like [he] is thinking more about the short-term impact where I sometimes get really intimidated by the long-term impact.* (C4F)

Male: *And that's characteristic of us, I'm the day-to-day task based person and [she] has the long-term picture.* (C4M)

##### ***Talker vs. Silent One***

Male: *When I get stressed I tend to rant a little bit like I talk and talk and talk.* (C11M)

Female: *When we're having an argument or something like that, I tend to shut down and I don't really say much.* (C11F)

During the post-program interviews, in responding to the question “Do you think participating in the program has changed how you see or understand yourself in any way?” 18 out of the 24 individuals responded yes and were able to provide some personal insight or anecdotes. While four individuals initially replied, “not really” and two answered “no”, they all followed this short answer with comments on how the program helped them to get to know their partner more or understand their relationship better, but not themselves. For example, “*No, not really about me, but more realizing how things will be different for [her]*” (C9M). In the course of the post-program interviews, most of the participants also referred to an increased awareness when referring to the self. The themes identified by the analysis were: 1) personal style or patterns in managing conflicts; 2) recognizing own vulnerabilities and emotions; and 3) insight on personal upbringing and its impact.

**Increased awareness of patterns in managing conflicts.** Many participants talked about how the program increased their awareness of how they coped with stress and ways that they managed conflicts in their relationship. “*I think mostly it just brought awareness that... in arguments... I'm more pushy, right, with my opinions... I feel like I need to get my point across.*” (C12F) Some said that the program helped them to reflect on their ways of coping, and as a result, they were able to re-evaluate some of the ways they handle themselves in certain situations. Following the program, many participants perceived themselves as more able to identify their behavioural tendencies and their reactive emotional responses that contributed to the “downward spiral” during conflicts with their partner.

*Going through the program brings me to a... self-reflective point where I can sit back and say, 'this is upsetting me'... but I don't have to just get up and run away. (C5M)*

*When I start getting into, like, a tense situation, instead of getting angry and frustrated... now I am able to...come at it more clear-headed and open the lines of communication. (C10M)*

**Increased recognition of personal vulnerabilities and emotions.** During the post-program interviews, many partners readily talked about how some of the in-class conversations helped them recognize their vulnerabilities and the underlying emotions around issues that they had had trouble understanding on their own. The program helped them to “*dig in deeper*” and they were able to verbalize some of their vulnerabilities with their partner.

*I knew that feeling sort of like a failure is one of my big things... and with that goes these feelings of failing myself... failing everyone else around. (C3M)*

*I think my raw spot is shame... I'm sensitive to being embarrassed in public ... if I have a sense that I'm, if I feel that my behaviour, my actions or myself is an embarrassment to someone else, by just a comment or even just my own perception, it's really hard. (C9F)*

Some participants acknowledged that it was not their “second nature” to talk about feelings or emotions, but they now recognized the value of identifying their feelings and sharing their emotions with their partner to help strengthen their connection.

*...expressing myself emotionally, yeah, because I guess sometimes I'm more verbal on what I need physically but not much on emotionally. (C6F)*

*[Before]... I wasn't communicating about it the right way, so the problem seemed really overwhelming. I think it [the program] gave me more self-awareness about what my trigger points are and once we were able to connect and see ourselves on the same*

*page... it suddenly seemed to make more sense; it was like a puzzle piece had shifted into place. (C4M)*

**Increased insight regarding the impact of one's personal upbringing.** During the interviews, no specific questions were asked about personal upbringing or family of origin. Yet, many narratives emerged from both the men and the women about their parents' relationship and/or their relationship with their parents that they began to recognize had had a significant impact on themselves and/or how they relate to their partner. The following are some examples of what they shared:

*I think one of the workshops was talking about past relationships and how it affects us or influences the way you react and behave in your current relationship, and that definitely brought to light some of the reasons behind why I go about certain things in our day to day like, or how I communicate with him... Looking back on my relationship with my Dad might explain some of the ways I communicate with my husband. (C3F)*

*There have been some traumatic events in our past... because of war where I came from. I don't think I really thought about it at the time but it did leave a mark... I was wondering how those things influenced my family and my family dynamic. (C7M)*

As the quotes above demonstrate, many participants indicated that participation in the HMT program led to considerable personal reflection and increased insight regarding the intergenerational impact of important relationships on the self. The data were quite extensive and convincing. More findings on this theme will be shared in the section reporting how participants talked about increased awareness of the connection between partnering and parenting.

## **Do the Participating Couples Change in their Understanding of their Relationship following Participation in the Modified HMT Program?**

During the post-program interviews, each couple was asked to respond to the question “Do you think participating in the program has changed how you see or understand your relationship?” Most couples shared what they noticed in their relational dynamics before and after the program. The following themes reflect what the participating couples shared about their relationships and the tools and skills they put to use from the program: 1) increased recognition and understanding of relationship patterns; 2) increased recognition of partner’s needs and sharing their own needs; 3) positive change in the emotional connection; and 4) the program experience reinforced and affirmed what’s working well.

**Increased recognition and understanding of relationship patterns.** Prior to the program, couples talked about the pressures and various stressors they perceived came with having a baby. Many of them reported that during participation in the program, they began to realize that, regarding specific issues, they were not able to move forward or make progress. As a result, they often ended up in conflict and feeling stuck. During the post-program interviews, regardless of the length of time that they had been together, all of the 12 couples talked about having increased their understanding of their interactional patterns, and how helpful that increased awareness was. The following are two dialogues, one from a long-time relationship couple and the other from the couple with the shortest time together.

Female: *We’ve been together for a long time so we’ve kind of fallen into patterns.*

Male: *It helped to recognize... with our pattern and conflict and stress, where I tend to get worked up and talk, talk, talk and then [she] ...*

Female: *I become a turtle.*

Male: *So, it helped to recognize and see ...why we behave the way we do under stress.*

Female: *And ways to improve on that.*

Male: *Where we help and support each other and where things break down... what was super helpful for us was that area of it. (C10)*

Male: *We haven't been together as long as the other couples. I think, since we first met, it's only been, two years?*

Female: *Almost.*

Male: *We actually hadn't gone through like any big arguments yet, but when they talked about the pattern for arguments, I realized it's true for us as well. It pretty much always starts the same way, for small things so far. So, recognizing that helped a lot for making things smoother between us. (C6)*

Some partners talked about being more able to see the pattern of how they started getting into a conflict in the first place and why their partner reacted a certain way. With this understanding, it allowed them to approach their partner the way that their partner wanted to be approached when dealing with difficult issues.

Female: *I can get pretty defensive when he tries to talk to me about certain things when really he's just trying to talk over ideas... I can, all of a sudden, I can get panicky or defensive... that stops him from wanting to talk to me or confide in me about certain things even if it's just ideas.*

Male: *Well, we came up with kind of a plan... a code that we've implemented so that I can come to her and say this is just an idea. It doesn't mean that things are going to*



*change but I want to brainstorm with you and explain ideas. I think that's helped.*

(C3)

Being more able to identify their interactional pattern, recognize each partner's emotional triggers and behavioural tendencies, and how these affect their relationship were the significant gains from the program noted by almost all couples.

**Increased recognition of partner's needs and sharing of their own needs.** Many couples reflected on their increased understanding of the importance of recognizing their partner's needs as well as acknowledging their own needs to help offset their stress and relational conflicts. Some partners talked about recognizing that they needed to be more explicit with what they needed out of the relationship in order to help their partner understand them more.

*"I used to try and give subtle hints and things that weren't direct, and it was confusing to him. He didn't know exactly what I was asking and what I needed. I think I learned that I need to give, in terms of the relationship, I need to be clear with what that is, so that he knows and vice versa."* (C3F)

*I think that this experience has reinforced for me how much better I feel when I can actually talk to [her] about those things and feel understood... it became apparent to me that I don't always say what I'm feeling, even though I might think that I'm expressing it... it's just not being received in a way that I'm intending.* (C4M)

Through the program experience, many couples also became more aware of the stress and unspoken needs that the men, especially, might have during this transition, and how they would benefit from emotional support.

*I was so happy about learning how to rely on my husband and imagining doing that with a child in the family. But now I'm also thinking there's a lot more to consider, like his*

*stress levels and his worries and his needs as a father. I think that for me, I think that was really big because that will really help me, I mean, I want to be there for my son, but if I put undue stress on my husband or if I don't help him through some of his stuff, then that's also going to create stress for my baby. (C12F)*

The following is an interview excerpt that illustrates how one couple came to understand their different emotional needs and approaches. The man learned to respond more sensitively to his partner's emotional needs while the woman recognized that he was offering support through fixing things and solving problems.

*Male: I'm going to engrave this on a piece of wood and put it in my office. It's not the problem; it's how you feel about the problem. ... I like to fix things... It's all about the problem. Once the problem's gone, there shouldn't be any more tears, there shouldn't be any more worries, and it's not a problem anymore. But I need to be more focused on how [she] feels about the problem first. When I know that, her emotional needs are met.*

*Female: That does fix the problem.*

*Male: In the conversations we've talked about ...she felt sometimes I was a bit distant and that was a complete shock to me, because I think that I'm doing the right thing and that I'm supporting the relationship.*

*Female: But you're doing the right thing, trying to support the relationship, without me, kind of minus me, which sort of defeats the relationship.*

*Male: This is what surprised me...I thought I was doing everything right, but I realized I was missing out. So, it was using those skills to help me realize that. (C2)*

**Positive change in the emotional connection.** During the post-program interviews, without a specific question about their emotional connection, many couples shared anecdotes that illustrated the elements of A.R.E. in their relationship, and an increase in emotional connection.

Male: *I felt pretty close to you in certain exercises that we did. One of them was with eyes, looking into each other's eyes. Another was just discussing certain issues on our own.*

Female: *I thought it was fun doing activities with you and I like talking about our relationship. It gave us things to talk about that maybe we wouldn't talk about otherwise.*

(C8)

The following example illustrates the before and after effect of a couple's emotional understanding and connection. During the pre-program interview with this couple, the reason for participating, according to the male partner was *"My mom told us to come... It is free and I don't have anything else to do."* (C6M) They were not able to identify areas that they hoped to gain from this program. The one thing that they wrote on the relationship information form as a relationship challenge was 'carpooling,' without giving any context. The post-program interview helped to shed light on the stress in their relationship and how they turned it into an opportunity for emotional connection.

Male: *Often there are things that happen every single morning: I would try to get her to get up, and then she wouldn't. If she doesn't want to get up, she is delaying me getting to work. It happens every morning, so I used to get frustrated about it. After this program, we had an opportunity to talk about these sorts of things and the pattern.*

Female: *So I understand more about why he got so frustrated... I feel like I could sleep for another few minutes. Sometimes I just wanted a hug in the morning rather than he just goes and brushes his teeth. But then to him, cooking and driving is how he shows his affection really, and he doesn't know I was asking for more hugging and physical touching. After we recognized that, then 'after I hug you every morning, you have to get up'.*

Male: *Yes, so now I blackmail her with a hug every morning. Before it would just feel like she didn't care about my things.*

Female: *After the workshop we realized there are lots of layers underneath. (C6)*

The following is another example from a male partner's account of what he has since experienced from his partner who, prior to the program, tended to try to find solutions to his habit of allowing work to stress him out.

*It's made some changes, things are a little bit different especially with the way that [she] has been trying to help me out...with my work stresses; she's just being there for me, she gives me hugs, she rubs my back, I got to give her credit 100% for giving all she's got into it and trying to change the way that she approaches these situations. I'm trying very hard and it's not easy, but I'm trying very hard not to be as selfish as I've been... I wanna be there for her as much as she's been for me and now seeing it so blatantly, I don't think there's any excuse for me not to. (C1M)*

**The program experience reinforced and affirmed what's working well.** Participants reported that the program helped them to recognize areas that needed improvement in their relationship, and that the tools and skills they learned could contribute to such improvement. At the same time, many couples also talked about the strengths of their relationships and areas in

which they, as a couple, were doing well, and this awareness was very empowering for their relationships.

*“I feel like after an experience like that where we look at our relationship, I leave feeling confident or a renewed sense of confidence, like, yeah, we really do like each other and care about each other.” (C8F)*

With respect to affirming what was going well, two couples commented specifically on the helpfulness of the Forgiving Injuries conversation, and also referred to a slide in the program on ‘Key Messages in Powerful Apologies’, which listed the following pointers:

- ▶ Your hurt is valid, understandable.
- ▶ Your hurt impacts me. I care about it – it matters.
- ▶ I feel sorrow, regret, even shame – I own that I hurt you.
- ▶ I am here now.

*That apology one was interesting. One thing that we have been good about is when something goes wrong, actually stopping and apologizing for it and really meaning it. It was nice to have that reinforced by the course... something that we were doing well. (C11M)*

The following is an excerpt from the post-program interview with a couple who had experienced a significant attachment injury in their relationship but had been able to work through and repair it on their own. The program helped them recognize this as an achievement, which contributed to their pride in the strength of their relationship.

*Female: We figured out all of that on our own without any help, we didn’t go to therapy, we didn’t read any books, and we didn’t have any programs. Reading that slide ...I felt really proud of us.*

Male: *I agree. I think it was good to see that, and know that we went down the right path and it was good to see that we did it right. (C10)*

One couple reflected on the ‘Bonding through Sex and Touch’ conversation and realized that they were actually meeting each other’s needs for intimacy.

Male: *So, when the facilitator showed the three types of sex, that comes up in our conversations... I was, like, is she getting enough emotion?*

Female: *And I was worried about, is he getting enough orgasms?*

Male: *It took that conversation and it took that explanation of it and it took that realization...yeah I am fine with the amount of sex we have. And then I realized that what we both liked is the amount of affection. So, we weren’t losing any amount of affection... And we’re both happy about that. (C2)*

The above anecdotes and quotes illustrating the couples’ perceptions of positive shifts in their relational dynamics are supported by the BARE View of Partner results, where the men reported a change in a positive direction in their partner’s attachment behaviours (See Figure 4.3 and Figure 4.5).

### **Do the Participating Couples Increase their Confidence and their Ability to Work Together to Create a Healthy Emotional Foundation for their Baby?**

While the primary emphasis of the modified HMT program was on the couple relationship, we also expected that participants would increase their confidence and their ability to work together to create a healthy emotional foundation for their baby. The following questions were asked at different time points of the study to help understand participants’ views on parenting:

- At the pre-program interview, the researcher asked each couple “Do you have any worries and concerns about becoming a parent?” followed by “Do you have any worries and concerns about (the effect of having a baby on) your relationship?”
- During the program, a large piece of paper was made available on the classroom wall titled “How will my baby benefit from what I learned?” to invite participants to capture their thoughts on the wallpaper.
- During the Focus Group, the question was asked, “In your opinion, has this program increased your confidence in becoming first-time parents? How?”
- At the post-program interviews, each couple was also asked “Has participating in this program changed your view or your feelings about being a parent?”

The following themes were identified from the data collected in response to the questions listed above: 1) worries, concerns, and feelings prior to the program; 2) recognizing the connection between partnering and parenting; 3) intergenerational implications; 4) gaining confidence in parenting; 5) benefits for the child; 6) feelings after the program.

**Worries, concerns, and feelings prior to the program.** To put the changes in the participants’ confidence about working together to create a healthy foundation for their baby in context, Table 4.3 is a high-level summary of the worries and concerns shared by couples at the pre-program interview. These are consistent with the concerns identified in the transition to parenthood literature.

Table 4.3: Worries and Concerns Shared by Couples Prior to the Program

| <b>Worries and Concerns about Becoming Parents</b>                             |  |
|--|--|
| Ability to provide   | Finance, buying a house, employment, lack of support, good environment for the child   |
| Health concerns  | Pregnancy, labour and delivery, miscarriage, child's health and developmental barriers, sleep deprivation, tiredness/lack of energy, depression  |
| Time   | Shift of priorities, work life balance, household chores, parenting responsibilities   |
| Self-confidence  | Not being a good mom/dad, loss of self-identity, over-thinking or analyzing, being home with the baby, not knowing what to do with the baby, negative intergenerational impact, societal pressure/expectations on mothers, facing the unknowns, fear of change |
| <b>Worries and Concerns about the Effect of the Baby on their Relationship</b> |  |
| Time   | Relationship maintenance, time for just the two to connect, don't get breaks, finding the balance  |
| Energy   | Tired and cranky, sleep deprivation, nothing left for each other   |
| Relationship dynamics  | Change/fear of the unknowns, not being a team, loss of privacy and fun, more arguments, strain on the relationship   |

Despite the worries and concerns, most couples expressed their excitement about this transition to becoming parents. Figure 4.7 is a collation of word use frequency analyzed by Word Cloud to capture the expressions used by the participants (the size of the font indicates the frequency of the word used). The researcher saw this way of presenting the data as more concise and visually effective than the use of more direct quotes.

While the men and women expressed similar feelings about this life transition, the men expressed positive feelings (i.e., excitement, anticipation) more frequently than the women during the pre-program interviews. However, for all participants, the most frequent feeling expressed was anxiety (i.e., worried, anxious, scared) towards the upcoming changes.



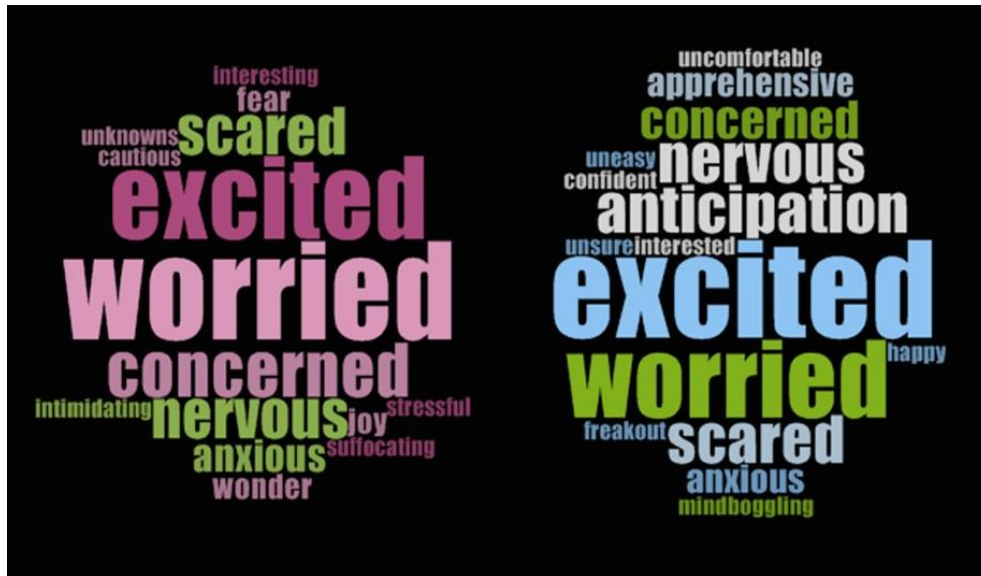


Figure 4.5: Feeling Words Used by Women (left) and Men (right) Before Program

**Recognizing the connection between partnering and parenting.** When the question “Do you think the program has helped you be able to work together better to create a healthy emotional environment for your family?” was asked, almost all couples were able to make the connection between partnering and parenting. Many shared that the tools and skills they learned had given them a better starting point for dealing with issues and anticipated stress. They said the increased understanding of attachment and emotions was especially helpful along with the skills they learned.

*“I am now aware of how I develop attachment with my child. It has also reinforced the importance of being present for my child and for my partner. Lack of emotional availability has been something that has characterized my demon dialogue with my partner, so I would not want to repeat this behaviour with my child.”* (Female, Focus group)

One of the tools employed in the program to illustrate the interactional patterns between partners was the infinity loop, which is intended to assist in identifying the negative or positive

cycles developed over time in couple relationships. One partner's behaviour, perception, and secondary emotions (e.g., frustration, worry, or excitement) could potentially evoke the other partner's primary emotions (e.g., sadness, fear or joy) and the underlying attachment needs and fears and vice versa.

*I think that infinity sign with the behaviour above and the feelings below, I think that's an interesting thing to keep in mind because I think children have an innocent way of reacting to situations and they aren't yet jaded by life experiences... so I think that will be a useful tool going forward as a parent... as the baby grows, we'll be able to apply that not only to our relationship but to our parenting with a child as well. (C1M)*

The following quote is from a woman who is referring to the modelling she hopes to provide for her child whereby she asks for her needs to be met by her partner. She recognizes that because she and her partner are not used to communicating this way, it will take practice, and they won't always do it perfectly.

*I think I'm looking forward to modelling for [the] baby having needs and looking to people for them to be met, openly. I don't think that my partner and I necessarily had that experience growing up and so we're a little more reluctant, and because of that, sometimes we don't get our needs met and we sometimes give mixed messages, and so I don't think we're going to be perfect at all. But I think that gives the potential for our kid to ask for what he want. (C7F)*

**Intergenerational implications.** During the Focus Groups, many participants appreciated the tie-ins to their own experience with their parents and families of origin and thought it was helpful to reflect on their attachment histories and acknowledge them. At the post-program interviews, couples shared many anecdotes about their family upbringing using

words such as “self-aware, self-reflect, recognize, realize, to think more, to ponder,” which demonstrated reflection and insight regarding their understanding of themselves and their attachment relationships.

Couples also commented on the helpful timing of doing this program while they were about to have a child of their own. They recognized they were motivated to make positive change for their child.

*“Both of us actually were raised in a context where conflict...could be extremely unfriendly and scary and so we don’t want that for our family and for our child. But if you’ve got that fear and it’s unresolved and both of us have a bit more knee-jerk reaction to conflict, then we’re going to repeat the patterns.” (C7F)*

One participant saw that the learning from the program could improve communication not only with his partner but also with his family of origin:

*“As a child, I was able to detect these [conflicts between his parents] through my parents’ actions. By understanding the how and why we can better ourselves, which in turn is better for our first child. The patterns in emotion can be addressed not only between couples but provide us with the tools and resources to communicate as a family as we all continue to grow.” (C5M)*

This man also shared his hope and longing that his parents could attend a workshop like HMT to help improve their understanding of the attachment dynamics between themselves and with him as their adult child. He recognized that it would also help his parents understand how he is now trying to relate to his own child as a father.

*“Because grandparents have a big role... if our parents were attending the workshop... for them to understand it, I think the bonds could be stronger as well as when the baby*

*comes on board, at least everybody's kind of on the same page... If we can get our parents involved ... the child will be able to pick up these tools organically for their future use."* (C5M)

**Gaining confidence in parenting.** In this section, I provide three couples' narratives, in brief, as case examples<sup>5</sup> to illustrate the change regarding confidence in parenting before and after the program.

### ***Case Example #1***

During the Pre-Program Interview with this couple, both openly talked about their parents' unhealthy relationships and how the environment that they grew up in might have impacted them.

#### Before the program:

Male: *... our parents lived to the extreme. You know, the arguments that we recognized, which is a shame because I could only remember the arguments, or I thought I did anyway.*

Female: *Between my parents I can only remember one time where they actually made like physical contact and it was a very awkward situation as a child ...it was rare thing to see my parents show affection... I think it influenced the way I behaved around boys or in relationships. I just try to imagine if my parents had had a loving relationship where I did get to observe the type of love they had, how would that have affected me as a child?*

Male: *... at the back of my mind I was always kind of concerned like are we going to be like our parents? Is this going to happen?*

#### After the program:

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<sup>5</sup> Each case example contains detailed relationship information. Therefore, the label to identify the specific couple is not provided to protect their privacy.

Female: *I'm excited.*

Male: *Yeah, I'm a lot more strengthened, I'm a lot more empowered, I think. I know the course helped me in building that [relationship between parent and child] bridge again.*

Female: *There [was] no unity in our parents' relationship after we maybe as children saw something that might have disturbed us... And there was no kind of correction from the parents, not as a unit anyways. My parents always came up [stairs] to talk to me about something, just one of them. I can't even remember a time when they both came to talk to me.*

Male: *It would have helped.*

Female: *I think it would have because it would have changed what I saw from their relationship and I think it would have changed their relationship because then they would have actually been unified instead of two individuals trying to explain the other person.*

When the researcher asked what had changed in their relationship, they shared the following:

Male: *We try to give lots and lots of hugs everyday, the dog comes running towards us and...*

Female: *And she squishes in and she wants to be a part.*

Male: *And we are like, yeah, this is what we want with a dog and a kid. This is what we want to share...and we do it more often, we've done it quite a bit more often, I've noticed... and I don't want to keep referring to the dog as the child but it's the best we've got so far. We'll both cuddle the dog now. So, if [she is] lying on the floor next to the dog for cuddling time, I'm gonna come down, you know. And we never used to... but I'm definitely, I want to do it more now.*

Female: *Definitely, see lots of love... And not just through hugging and that sort of thing but through the way we support one another and the way we talk to one another and the way we listen to one another. Because a lot of what I noticed in the conversation was it's not just what you're saying, it's how actively you're listening to your partner, because what they're saying isn't always what they need. Sometimes it's underneath and being able to identify the underneath, which I don't expect the child to be able to identify the underneath part but by seeing someone listen intently and support one another in that way is something that they [children] will definitely benefit from because hopefully they will then treat us that way as well and we will treat the child that way and they will treat people in their lives and future relationships [that way].*

Despite some other challenges that this couple had been through, their sense of resilience was apparent from their lively narratives. They had embraced a positive outlook on their relationship and parenting even when they could identify few positive models of this while growing up.

### ***Case Example #2***

During the Pre-Program Interview with this couple, the female partner shared briefly about her history of depression and her apprehension about the potential impact of that history on her parenting and her relationship with her partner.

#### **Before the program:**

Female: *I've had bouts of depression before and when I do have them I close up on myself. And I don't want that to impact my baby or my husband or my relationship. And I know that it impacted him before.*

After the program:

Female: *Well, we talked about, I think, the raw spots? And then we talked about attachment injuries and I noticed the commonality that you know the injury was just a very exaggerated form of the raw spots, so I noticed that this is a pattern for me and it underlies my attachment difficulties... I'm able to now recognize why I behaved certain ways, why certain things are triggers for me... I saw that pattern in my parents and I observed that, which is probably what influenced how I behave now. And, of course, that translates to, "do I want my child to see those same patterns or do I want to change those types of patterns?"*

Male: *I feel a bit more confident in dealing with issues that might come out. I mean issues in the relationship that might result with the introduction of a new family member and all the stresses. I just feel more confident that now we can take a step back and look at them and try to understand where we are rather than dive into it immediately.*

Female: *It's helped me become even more positive about it. I mean I'm aware of the risks and you know... they had a whole section on postpartum depression so I'm not oblivious about what that is, I feel like things are more normalized for me.*

Male: *I think if we as parents take that step back and try and understand the dynamic in our relationship and not let ourselves spiral into any situation when we're both stressed out or arguing or what not, it's a healthier environment in general for the baby if the parents have a healthy relationship. So, the baby will benefit from that positive mood in the house.*

The couple then talked about the commitment that they made during Conversation 7 in the program regarding “Making your love last”. This researcher asked about what their commitments were.

Female: *So, we've committed to talking about our needs...*

Male: *We've committed to, even when the baby is around, to give, at least, ourselves every week a block of time for us...just get one of our parents to come and take care of the baby for two hours to keep things positive for us and see if we can keep them positive for our baby.*

Female: *We also have our ritual of hugging in the morning and in the evening... it's really a ritual now and so we've committed to keeping our rituals.*

This couple appeared to be very connected during both the pre-program and post-program interviews. Upon review of their EPDS scores, neither of their scores was over 10 during the timeframe of this research project. They seemed to have good awareness of the potential for postpartum depression after the baby is born and were being proactive in safeguarding their relationship with adequate support and relationship-enhancing strategies in place.

### ***Case Example 3***

During the Pre-Program Interview with this couple, both partners were talking about the numerous stresses (both financial and emotional hardships) that they were experiencing, especially with the male partner's work stress. He also shared quite extensively about his worries and concerns of becoming a father with all the added responsibilities.

Before the program:



Female: *We feel that we need some more tools to get through this next rather difficult stage in our lives; we're already experiencing added stress and anxiety so we thought this would be a good opportunity for us.*

Male: *[She] encourages me not to worry about it but I can't help it, I can't...I've just been going through this ugly cycle of playing it over and over in my head.*

After the program:

Female: *We have been able to resolve many challenges throughout our history. Starting a family has introduced new stressors that have been slower to resolve. It turned out that some of our recent challenges were linked together through one overarching demon dialogue. Prior to doing this workshop, we made little progress in resolving those challenges. Now we have traction on solutions to our problems and feel empowered to confront any new challenges.*

Male: *The idea of not having a tumultuous household, not having that friction in those issues is very exciting and inspiring to me, and I wanna hit it, I wanna do it as well as I can.*

When the question was asked, "Has participating in this program changed your view or your feelings about being a parent?" The male partner responded with the following:

Male: *For me, I'm considerably less nervous than I was before and less apprehensive and scared. All that stuff's still there but I feel much more engaged. I feel like I'm a lot more excited. I'm very much looking forward to this. I mean I feed off of [her] excitement, when she shows me cool things and when she gets me to touch her belly and she's showing me what's happening with her body and as it goes further and further and I, like, sometimes I just sleep with my hand on her belly and I feel like I'm going to be*

*very good at this... it hasn't changed how much I feel, it's going to be very stressful but I think with the right attitude, which I'm slowly sort of taking on, I feel like it's not going to be that bad, it's going to be okay. And [she] keeps reassuring me that you know, no matter what we're doing, no matter what I'm doing with my work, no matter where we're living, no matter what's happening outside the baby itself, the baby's still going to be okay. The relationship is going to be better and I'm excited. I feel more engaged I think that's, I'm tuned in... with her, with us and with making sure there's a happy healthy relationship and a stronger bond with the baby... it's not just one and one or one and one, it's all three.*

During the post-program interview, the couple also talked about positive changes that they noticed in their relationship. These changes were identified even though the male partner's work situation had worsened; he was able to talk about the possibility of seeking other employment and changing his field of work.

**Benefits for the child.** During the program, participants wrote comments on a large piece of paper attached to the wall titled "What will my baby benefit from what I learned?" Facilitators encouraged the participants to write down their thoughts as an optional activity during break time throughout the two-day program. A total of twenty-four written comments reflecting participants' thoughts in response to this question were captured on the paper with coloured markers. Table 4.4 is the transcribed content organized according to the themes emerging from the analysis of the responses. These written comments and the transcripts of the focus groups and the post-program interviews were compared with respect to this question. This analysis revealed that the themes arising from the data from all three sources were similar, and these themes have been illustrated with the quotes provided throughout this chapter.

The collective written thoughts seem to this researcher, a powerful way to convey participants' takeaway learning from the HMT program especially since each comment was written with personal meaning having their child in mind. Table 4.4 serves as a compilation of participants' reflections on what would benefit their child, and reflects the comments of the majority of the participants.

Table 4.4: Participants' Written Reflections on How Their Learning Would Benefit Their Child

|   |
|---|
| <p><b>Attachment and bonding</b></p> <ul style="list-style-type: none"> <li>• Secure relationship = Healthy baby</li> <li>• Showing your child what love means every day.</li> <li>• Knowing just being there for someone is enough.</li> <li>• Learn from Thich Nhat Hanh and the mantras</li> <li>• The power of touch goes a very long way</li> <li>• Feeling more secure about our relationship will help our child feel the <u>love</u>.</li> <li>• Baby will be benefited from the closely bonded parenthood relationship!</li> </ul>   |
| <p><b>Emotions and connection</b></p> <ul style="list-style-type: none"> <li>• ∞ (infinity sign representing the couple's interactional cycle)</li> <li>• It's not the problem; it's how you feel about the problem!!! – Really hit home!</li> <li>• Sometimes when there is complaint, we are not looking for solutions, but emotional reassurance.</li> <li>• Emotions are like a tea bag, at first glance it is as per specification, but when wet, all the flavours and aromas come out.</li> <li>• Sharing fears is tricky. Structure/modeling helps. It's worth it for us &amp; our growing family.</li> <li>• If there are injuries or damages between the kid &amp; partner the other one will know or understand more on how to comfort the hurting partner and the feeling underneath, and be the moderator between the partner &amp; the kid.</li> <li>• Understand that depression &amp; anxiety might be just from hormones. Nothing too bad/broken yet.</li> </ul>  |
| <p><b>Healthy family dynamic</b></p> <ul style="list-style-type: none"> <li>• Having a low stress lifestyle ☺</li> <li>• Help us to create intention for our relationship and family life</li> <li>• Provide a loving and supportive foundation for our child.</li> <li>• We learn to build a strong couple together, baby born in a loving environment a happy baby ☺</li> <li>• Lead by example...It's not the obstacles that are the downfall. It's not helping each other over them that will cause the fall.</li> <li>• Becoming a role model for our child and learning to develop healthy relationships as they grow.</li> <li>• Teach them how to have stronger relationships in their future.</li> <li>• Our child will benefit from what we learned by having a stronger set of role models in us for what a loving relationship is, a better example than what we had. One they can live up to instead of use as a lesson of what not to do. This will lead to a stronger, closer &amp; more loving family bond that will tie us all together forever. Thank you! ♥</li> </ul> |
| <p><b>Other</b></p> <ul style="list-style-type: none"> <li>• I was deaf until I was given hearing aids</li> <li>• Maybe it's not so much what or how, but why</li> </ul>  |

**Feelings after the program.** At the post-program interviews, each couple was also asked “Has participating in this program changed your view or your feelings about being a parent?” Again, the word use frequency was analyzed to capture participants’ expressions in responding to this question. Figure 4.8 provided a general sense of participants’ feelings towards being parents after participating in the program.



Figure 4.6: Feeling Words Used by Women (left) and Men (right) After Program

Both men and women seemed to have expanded their positive expressions and lessened their worries about becoming parents after attending the program. Women expressed feeling ‘excited’ more than before (see Figure 4.7), and this was frequently accompanied with the word “prepared”, a feeling that was not named prior to participation in the program. While men continued to feel excited, they also used a new word, ‘surprised’ to describe feelings following the program. Their expression of feeling ‘scared’ increased slightly (see Figure 4.7). More findings on men’s experiences will be reported in the next section.

### **Additional Observations**

The following are some additional observations from the data analysis: 1) More about participants with depression and anxiety scores above the screening threshold; 2) Changing gender-role behaviours? and 3) Men becoming Fathers.

**More about participants with depression and anxiety scores above the screening thresholds.** In this section, I report the findings from a closer examination of all participants with EPDS scores of 10 or above ( $\geq 10$ ) at any time point during the research study (Recall that scoring  $\geq 10$  on this frequently-used screening measure is considered marginally indicative of depression, and a score of  $\geq 12$  indicates a strong probability of depression). The analysis followed the following steps: 1) The numbers of women and men who scored at 10 or above at any point were compared; 2) the relationship between high depression scores on the EPDS and attachment avoidance or attachment anxiety scores on the ECR-S was examined; 3) the qualitative data providing information regarding personality characteristics and life histories were reviewed and compared between this sub-group and those who did not score highly on the EPDS.

Each of the 24 participants answered 'no' to having any form of mental illness or being under psychiatric treatment during the screening for inclusion and exclusion criteria. One female participant disclosed having experienced depression in recent years during the pre-program interview; but her depression scores on the EPDS were below 10 and her anxiety scores were 5 or below at each of the three-time points (see Case Example 2).

To screen for probable anxiety disorders, the optimum cut-off score indicating possible concern regarding anxiety levels on the EPDS for women is 6 or more (possible range: 0-9), and for men it is 4 or more (Matthey, 2008). Among the 12 men, nine had anxiety scores ( $\geq 4$ ) at any

time point, and six of these nine scored 10 or above on depression. Among the 12 women, two had Anxiety scores ( $\geq 6$ ), and these two women plus two more had depression scores of 10 or above.

Table 4.5: Number of Participants with EPDS Total Scores  $\geq 10$  at Each Time Point

| Time period | Female participants | Male participants |
|-------------|---------------------|-------------------|
| T1          | 4                   | 6                 |
| T2          | 2                   | 4                 |
| T3          | 3                   | 3                 |

A total of 10 of the 24 participants had EPDS scores  $\geq 10$  at least once during the study; the total included four women and six men. Table 4.5 summarizes a count of participants whose EPDS scores were  $\geq 10$  at any time point. More men than women scored  $\geq 10$  at Time 1 and Time 2, but at Time 3, only three men and three women scored at or above 10.

**Women.** Table 4.6A shows the scores for the four of the 12 female participants (33%) who had EPDS depression scores  $\geq 10$  at Time 1. Of these four women, two scored 12 (12 and above indicates “strong possibility for depression”) and the other two scored at 10 and 11, which is considered marginally indicative of depression. At Time 3, the scores of two of the four women had decreased to below 12, while the scores of the other two remained above 12.

We were curious to see whether participants scoring above these screening thresholds on the EPDS would also score higher on the ECR-S, the measure of attachment style. Theoretically, those who scored higher on attachment anxiety would be expected to score higher on measures of depression and anxiety. The two women (Participant Group 1-F1 and Participant Group 1-F5) who scored above 12 at Time 3 also scored high on Attachment Anxiety at all time points based

on the ECR-S (score 25 and above); one of these two women (Participant Group1-F1) also scored high on Attachment Avoidance (score 20 and above) at Time 1 and Time 3. Mental health information and community resources were provided to these two women following the post-program interviews.

Table 4.6A: Female Participants Whose EPDS Scores were  $\geq 10$  at Any Time Point

| Female participant | Time point | EPDS: Depression & Anxiety |                  | Attachment Orientation: ECR-S |           |
|--------------------|------------|----------------------------|------------------|-------------------------------|-----------|
|                    |            | Depression Score           | Anxiety Subscale | Anxiety                       | Avoidance |
| Group 1 – F1       | T1         | 11                         | 5                | 26                            | 20        |
|                    | T2         | 18                         | 6                | 28                            | 17        |
|                    | T3         | 13                         | 5                | 27                            | 21        |
| Group 1 – F5       | T1         | 12                         | 6                | 27                            | 15        |
|                    | T2         | 13                         | 5                | 28                            | 15        |
|                    | T3         | 14                         | 7                | 25                            | 13        |
| Group 1 – F6       | T1         | 12                         | 3                | 20                            | 6         |
|                    | T2         | 7                          | 2                | 16                            | 6         |
|                    | T3         | 10                         | 3                | 14                            | 8         |
| Group 2 – F5       | T1         | 10                         | 3                | 10                            | 25        |
|                    | T2         | 6                          | 3                | 14                            | 26        |
|                    | T3         | 4                          | 1                | 11                            | 25        |

**Men.** Table 4.6B shows that 6 of the 12 male participants (50%) had EPDS depression scores  $\geq 10$  at Time 1 with their anxiety scores ranging from 4 to 8. Among the six men at 10 or above, two scored  $\geq 12$  at Time 1. At Time 3, the depression scores for three of the six men (50%) had decreased below 10.

Table 4.6B: Male Participants Whose EPDS Scores were  $\geq 10$  at Any Time Point

| Male participant | Time point | EPDS: Depression & Anxiety |                  | Attachment Orientation: ECR-S |           |
|------------------|------------|----------------------------|------------------|-------------------------------|-----------|
|                  |            | Depression Score           | Anxiety Subscale | Anxiety                       | Avoidance |
| Group 1 – M1     | T1         | 10                         | 6                | 18                            | 29        |
|                  | T2         | 17                         | 5                | 21                            | 17        |
|                  | T3         | 13                         | 6                | 19                            | 20        |
| Group 1 – M2     | T1         | 12                         | 6                | 11                            | 14        |
|                  | T2         | 14                         | 6                | 14                            | 10        |
|                  | T3         | 7                          | 1                | 16                            | 13        |
| Group 2 – M1     | T1         | 13                         | 8                | 21                            | 21        |
|                  | T2         | 10                         | 3                | 25                            | 24        |
|                  | T3         | 8                          | 2                | 22                            | 19        |
| Group 2 – M2     | T1         | 10                         | 6                | 15                            | 30        |
|                  | T2         | 9                          | 6                | 14                            | 26        |
|                  | T3         | 10                         | 7                | 14                            | 26        |
| Group 2 – M4     | T1         | 11                         | 6                | 15                            | 22        |
|                  | T2         | 15                         | 6                | 14                            | 24        |
|                  | T3         | 13                         | 6                | 15                            | 26        |
| Group 2 – M5     | T1         | 10                         | 4                | 14                            | 24        |
|                  | T2         | 7                          | 5                | 12                            | 26        |
|                  | T3         | 6                          | 5                | 11                            | 25        |

However, at Time 3 two men (Participant Group 1-M1 & Participant Group 2-M4), still had scores of 13 indicating that they were still likely experiencing depressive mood.

As would be expected, the two men who scored above 12 at Time 3 also scored high on Attachment Avoidance on the ECR-S. Mental health information and community resources were provided to these two participants following the post-program interviews.



According to these scores, in this small sample, more men than women were above the screening thresholds for depression and anxiety during the period of the study. At the end of the program, two women and two men had EPDS scores  $\geq 12$ . These four individuals also scored highly on either Attachment Anxiety or Attachment Avoidance, with one woman having scores high on both Attachment Anxiety and Attachment Avoidance. These associations are in accordance with the literature stating that depression and anxiety are often linked with insecure attachment.

*Patterns in the qualitative data.* The researcher examined the qualitative data provided by the 10 participants who scored  $\geq 10$  on the EPDS and compared it to those who did not score highly on the EPDS. The following was noted:

- Six of the 10 (60%), (4 males and 2 females) either made mention of, or it was inferred by their partner that they had a “natural tendency” to be anxious or “over-thinking”. Only two out of the 14 participants (14.3%) without high EPDS scores mentioned such characteristics.
- Three of the six males scoring  $\geq 10$  on the EPDS (50%) talked about having traumatic histories (i.e., abuse, experience of war) while none of the males with lower EPDS scores made such disclosure. Also, none of the female participants referred to these kinds of traumatic histories.
- Six out of the 10 individuals (60%), (5 males and 1 female) talked about the negative impact that they perceived from their experiences in their family of origins (i.e., unhealthy family dynamics growing up, parents’ divorce, personal decision to cut off with family of origin). This can be compared to only four out of the 14 participants

with lower EPDS scores (28.6%) that alluded to the negative impact of their family of origins.

- Among the nine participants in the total sample who were born outside of Canada, five individuals (3 females and 2 males) had EPDS scores  $\geq 10$ ; one other participant born outside Canada was the participant who self-disclosed she had a past history of depression but her EPDS score was lower than 10 at Time 1. Including this participant, six out of 9 or 67% of participants born outside Canada scored  $\geq 10$  on the EPDS. This can be compared with five out of 15 (33%) participants who were born in Canada who had EPDS  $\geq 10$ .

***Couples with both partners having higher EPDS scores.*** Among the 10 individuals with higher EPDS scores, there were two couples where both partners had high scores. At the end of the program, the EPDS scores for both partners in one of these couples decreased to under 10 (male: 10  $\rightarrow$  7  $\rightarrow$  6 and his anxiety scores were 4  $\rightarrow$  5  $\rightarrow$  5; female: 10  $\rightarrow$  6  $\rightarrow$  4 and her anxiety scores were 3  $\rightarrow$  3  $\rightarrow$  1). This couple's relationship difficulties were described in their relationship information form as "conflicting schedules in commutes and weekend planning, [he] gets stressed easily and [she] is sometimes indecisive, poor communication at times." After participating in the program, they shared how they were able to gain a better understanding of each other's emotional needs and felt less stressed and anxious. Their narratives were clear, consistent and supported by each partner's reduced EPDS scores.

However, the other couple's EPDS scores increased with both partners' scores over 12 at Times 2 and 3: (male: 10  $\rightarrow$  17  $\rightarrow$  13 and his anxiety scores were 6  $\rightarrow$  5  $\rightarrow$  6; female: 11  $\rightarrow$  18  $\rightarrow$  13 and her anxiety scores were 5  $\rightarrow$  6  $\rightarrow$  5). This is a couple described how they had experienced many stressors in their life together. As they indicated in their relationship

information form: “We have gone through financial hardships (extra cost of school etc.), and emotional hardships (miscarriages & resurfacing of past traumas from before we met). We are currently in the process of getting our finances in order and perhaps to buy a house; but at the very least, we will be moving in the next six months, which raises stress levels significantly.”

Did this couple benefit from the HMT program despite their stress level and high EPDS scores? They worsened in the control period between T1 and T2 and improved during the intervention period between T2 and T3, suggesting that HMT may reverse the trend of worsening distress. Their narrative was captured in the previously described Case Example #3 that described how they had gained confidence in their ability to parent well. It was encouraging to see that the program may also be effective in helping partners such as these who are both dealing with high levels of anxiety and depression; participating in the program appeared to strengthen their connection and give them a sense of hope for the future amongst all the stress and challenges they were facing. While the researcher advised that this couple seek support from health care providers for intervention to help safeguard their mental health, the reduced EPDS scores from Time 2 to Time 3 for each of the partners were promising. It appeared that participating in the HMT program was a step in the right direction and served as a helpful experience for this couple.

**Changing gender-role behaviours?** During the interviews, the researcher was surprised by dialogues that referred to behaviours that do not conform to traditional gender-role behaviour or common stereotypes about gender-related characteristics. At least 10 of the 24 participants made various statements that reflected such nonconformity. Seven of these ten were male and three were female. Are these role reversals an emerging trend to more neutral gender-role

behaviour among men and women in our society? The following excerpts from many individuals including both genders and different cultural backgrounds are examples.

***Problem-solving.***

*"In general it seems that mostly it's the men that like to solve the problems or offer the solutions, whereas it seems that I try to offer solutions always and it's really going to be a struggle for me and has been [to avoid doing this]..." (C1F)*

***Men's emotional needs.***

*I'm definitely a lot more emotionally sort of, I don't know if it's vulnerable or if I let it control me more than I should. (C1M)*

*How much better I feel when I can actually talk to [her] about those things and feel understood... (C4M)*

***Household chores.***

*After work I cook and we eat... usually she's just on the computer. (C6M)*

*A dirty dish is a dirty dish but we've kind of agreed that [her] doing this is 48 hours long, which I need to accept, but my "I'll do it" is 2 minutes long, which she accepts. But it just took conversation. I'm cool now, if there's a dirty dish there for 48 hours, it doesn't drive me mad if she says she'll do it. (C2M)*

***Caretaking/Nurturing.***

A woman talked about her fear that her partner might make the baby his priority ahead of her and their relationship. *"The fear that my partner is suddenly going to be focused on the baby...not our relationship... that our weak points are going to become extra fragile."* (C7F)

*Whenever she needs me I can just pause what I'm doing and go see her, see what she needs. But then if she doesn't call me, I didn't think she needed anything but apparently she always wanted attention. Knowing that I would also pay more attention to her while I'm doing my stuff. (C11M)*

***Sexual Intimacy.***

*Because we're not having sex as much as we used to... but I am fine with the amount of sex we have. I realized that what we both liked is the amount of affection. So, we weren't losing any amount of affection... And we're both happy about that. You know, we're not banging boots every 5 minutes and we don't feel like we need to because we're getting enough of each other. (C8M)*

*The biological possibilities of our bodies are far beyond what stereotypically our culture tells us should be the case. Women can be like 'microwaves,' and men can be like 'convection ovens,' it just depends on the circumstances and the person. (C10F)*

The examples above demonstrate challenges to common assumptions about differences between men and women and traditional gender roles. They also touch on topic areas that are pertinent to the transition to parenthood literature and research. It will be interesting to see how this generation of men and women make personal adjustments, negotiate their relationships, share caretaking, and divide the labour during the transition to parenthood and beyond. While these indications of changing roles in couple relationships are interesting, they are beyond the scope of this research project.

**Men becoming fathers.** During the focus groups and interviews, men talked about feeling more connected and being more confident in relating to their partner after attending the HMT program. While feeling excited, some shared that they were surprised by some information

they learned and some said that they got “*a bit more scared*” related to what they have learned about themselves.

***The relational impact of becoming a parent.*** Quite a few men said that it was the first time that they learned about how life with a baby could potentially impact their relationship satisfaction. One man talked about what it was like for him.

Male: *If anything, it maybe scared me a little bit more and maybe at the same time made me more comfortable about other things, like how to be with certain issues between us.*

Researcher: *Which part made you scared?*

Male: *Well, the whole two days all you heard about was, it's going to change and it's going to be stressful, I mean, we didn't talk much about how awesome the baby's going to be. It was all... Well, all the stats...[about how 67% of couples reported decreased relationship satisfaction associated with becoming parents] - they are pretty high, pretty strong.*

Female: *Yeah, it's probably an eye opener for us too because people don't like to say that. I have girlfriends and my girlfriends tell me about stuff like that.*

Male: *My friends don't tell me anything.*

Female: *Yeah, his friends don't talk about stuff like that. (C8)*

***The emotional part of parenting.*** While many men said they had thought about the logistical effects of becoming a parent, such as the increased need to provide and their ability to provide, many had not thought about the emotional impact they themselves would have on the child. “...it served as a catalyst to get me thinking about those sorts of challenges that will occur and [to] be aware of it.” (C9M) Recognizing that a child can pick up on parents' emotions, and be influenced by the characters of their parents, some men experienced feelings about the

incredible amount of responsibility inherent in becoming a parent, and responded with mixed emotions:

*“We’re entering this phase where we’re going to have a person where we’re teaching these things to. It can be intimidating...” (C3M)*

*“I see my parents in myself and that’s the real scary part for me.” (C5M)*

**Lack of positive role models.** In the previous sections, many comments and quotes revealed that the men had been motivated by the program to reflect on their attachment histories, yet, some seemed not yet able to move beyond this awareness. Trying to make sense of the past, yet, at the same time recognizing their lack of positive role models, created some uneasy feelings.

*I don’t know if it increased my confidence as yet. I have my days, some days are good, other days I freak out a little bit. I think my biggest worry is just trying to be a good dad, the kind that wasn’t really the best to me... me and my dad kind of have a rocky past. We don’t get along too well, don’t really talk. So, I think my biggest problem is [fear of] making some of the mistakes that he made with me. (C10M)*

**Sense of inadequacy.** In the HMT program, the facilitators and participants talked about how both men and women have common emotional triggers, and how we respond differently to threats to relationships based on our attachment orientation. These attachment behaviours are most often based in our fear of abandonment or rejection, and are frequently connected to fears that we are inadequate or not good enough. Here is one woman’s perspective of the men’s experience in the group:

*It seemed to me that a lot of the men vs. women had very similar raw spots and a lot of them [men] in the course seem to be feeling inadequate or a failure ...where I would feel*

*like I was just nagging him about certain things, but things like that brought him to think that he wasn't adequate or good enough... and then I'd explain to him, well, part of the reason I'm asking you or nagging is because I feel like [you] doing these things shows that you care or that you love me and so when you're not doing them I feel a little neglected. (C3F)*

*I knew that feeling sort of like a failure is one of my big things... and with that goes these feelings of failing myself... failing everyone else around. (C3M)*

The researcher also noticed that several men started verbalizing their fears during the post-program interviews. “*I am even more scared.*” (C5M) “*I didn't know about that.*” (C9M) “*My biggest worry is just trying to be a good dad.*” (C10M) These men seemed to become more open, ready to reach out and connect with their partner to share their vulnerabilities after participating in this research program.

### **Is the Program Content and Delivery Useful and Helpful to the Target Population and What could be Improved?**

**Feedback from facilitators.** Upon completion of the two pilot workshops, both facilitators submitted their log sheets along with their written program evaluation forms. The researcher then scheduled a face-to-face interview to obtain verbal feedback about the program content and delivery.

**Evaluation of the program.** Table 4.7 is a collation of their feedback. In the written evaluation, the facilitators rated their experience and evaluation of the program on the following aspects (1 is poor; and 5 is excellent):



Table 4.7: Facilitators' Feedback Rating

|               | <b>Facilitator's Guide</b> | <b>PowerPoint Content</b> | <b>In-Class Exercises</b> | <b>Video/DVD</b> | <b>Handouts</b> | <b>Overall Rating</b> |
|---------------|----------------------------|---------------------------|---------------------------|------------------|-----------------|-----------------------|
| Facilitator 1 | 3                          | 5                         | 5                         | 4                | 5               | 4                     |
| Facilitator 2 | 4                          | 5                         | 5                         | 4                | 5               | 5                     |

The facilitators commented that the program brings to light the stresses a newborn baby puts on a family. They believed the participants completed the program with a new understanding of their relationship and with new tools to deal with marital conflict in a positive way.

*Since the target population were about to have their first child, they were about to undergo significant relationship stress. As someone who works with couples who have been in years of conflict aggravated by parenting stress, I find it quite useful to see couples develop their relationship skills before the child is born. I find it useful that these children will be born into homes where their parents have more tools for addressing marital conflict in a positive way. (Male facilitator, written comment)*

Both facilitators said the content material was well laid out and true to EFT. They stated they felt confident in delivering the program and its content and that the allotted time was adequate to cover all content material for the program.

*"The introduction to what attachment theory is, is especially helpful and well received by the participants." (Male facilitator, written comment)*

Both facilitators commented that the repetition of a concept followed by practice, then, asking, "how do you think this will help your baby" supported the participants to make the

connection between their relationship with their partner and their relationship with their baby. They said that both groups of participants left with some new concepts and ideas about addressing conflict and creating connections.

**Areas for improvement.** The following were areas the facilitators felt needed improvement:

**Facilitators Guide.** The facilitators thought that the Facilitators Guide needed to line up more closely with the PowerPoint slides. Some recommended videos suggested in the Facilitators' Guide were not available in the PowerPoint. They would have liked to show some of the supplementary videos, but they did not have access to Wi-Fi to do so. They suggested that these videos could be embedded in the PowerPoint presentation or as hidden slides.

**HMT DVD.** The facilitators suggested that some of the video clips featuring Dr. Sue Johnson working with the couple could be shorter in length.

**Content.** The female facilitator recommended expanding the conversation on “Bonding through Sex and Touch” because participants seemed “*hungry for more information*”. “*The information presented seemed fairly clinical with all the statistics – need more anecdotes.*” (Female facilitator, written comment)

**Group Process.** Both facilitators noted that the couples were diverse in many ways even though they were all experiencing their first pregnancies. They found it challenging to deal with the broad range of couple dynamics such as:

- Disparity in how quickly they processed the material
- How much time each couple needed for exercises
- Different pacing among couples for doing the HMT conversations.

*“Some seemed to already know the concepts that needed to be introduced and talked at length about them while others were unaware.”* (Male facilitator, interview).

*“Some being moved to tears and embracing when doing couple exercises and some seemed less engaged.”* (Female facilitator, interview)

The facilitators also stated that the two groups were very different from each other. While the first group seemed engaged in the process to some degree, the second group was much more open and interested. After the first group, the facilitators felt the need to do a more comprehensive icebreaker than what was suggested in the Facilitators Guide at the beginning of the first day. They believed this would help them to get a better sense of who the couples were and what their concerns might be.

*“Upon reflection, our own experience having facilitated the groups helped with the second group.”* (Male facilitator, interview).

*“Having the icebreaker helped acclimatize the participants.”* (Female facilitator, written comment).

Because of the more comprehensive icebreaker, the facilitators felt they were able to put participants in the second group more at ease, the group was more cohesive, and couples were more uniform in their engagement.

***Impact facilitators had on the couples.*** Both facilitators commented on how the hospitality offered to the participants made an impression from the beginning for both groups. Couples were greeted at the door, helpers had refreshments ready, and footstools were available for the pregnant partners; this created an inviting atmosphere that helped put participants at ease.

*Little details that showed that they were cared about and they weren't just being used for some study, but that we actually have their best interest at heart and make them comfortable.” (Male Facilitator, Interview)*

Despite a few technology glitches and various minor limitations (e.g., limited parking, many stairs, room temperature) at each facility, they said that they were able to improvise and be flexible in handling each situation. They made sure that the set-up of the rooms in each facility was conducive to create a safe holding place for couples' private conversations, which occurred between psycho-educational teachings.

*“We modeled for participants the importance of having the conversations. We framed it in a helpful way and gave them the space to share.” (Female facilitator, Interview)*

For the second group, an unexpected pastoral emergency caused the male facilitator's absence on the 2<sup>nd</sup> day, which left the female facilitator to handle all the teaching content and to be the sole support to couples during the conversations. According to the female facilitator, it altered the group process and created considerable disappointment in the participants. It was an oversight on both the researcher and the facilitators' part for not having a contingency plan in place for unforeseen situations when one or both facilitators were not able to deliver the scheduled session(s).

***Impact on the facilitators themselves.*** Both facilitators shared the personal and professional impact they experienced from conducting this pilot program.

*“For me, I see these young couples kept giving me flashbacks of my time when our first child arrived and I was left glad for these couples to have the tools that I didn't have at that time.” (Male facilitator, interview)*

*“Well for me, it reaffirmed my passion for infant mental health... I think working with people before the baby’s even here really demonstrates that it really never is too early to have an impact on a child’s wellbeing.”* (Female Facilitator, interview)

**Experiences as co-facilitators.** Both facilitators stated that they enjoyed the entire process together from preparing for the workshops, to reviewing the slides, to facilitating the workshop.

*“We supported each other during the process. When I took the lead role in talking he would step back and watch the dynamics of the group, interjecting when some didn’t understand.”* (Female facilitator, Interview).

They stated that it was effective for them when one focused on the educational material and one focused on the group process. However, both agreed that back-up needs to be built in for the future (e.g., equipment and facilitator).

**Feedback from participants.** Feedback specifically relating to content and delivery were collected via couple participants’ written evaluations and the focus groups conducted at the end of the second day of each of the research group meetings. The two groups were initially intended to be homogenous with the same program format, content, and process. However, the group process was altered with the first group having two facilitators for both days and second group having only one facilitator on the second day of the program due to the unforeseen circumstance that resulted in the male facilitator’s absence.

**Group ratings of the program.** The following are the quantitative results of the program evaluation summary. The individual group results are presented first (Table 4.8 and Table 4.9) followed by the combined group result.

Table 4.8: Group One's Rating of the Program

|                       | <b>1</b><br>(Poor) | <b>2</b><br>(Fair) | <b>3</b><br>(Average) | <b>4</b><br>(Good) | <b>5</b><br>(Excellent) | <b>Total</b> |
|-----------------------|--------------------|--------------------|-----------------------|--------------------|-------------------------|--------------|
| Facilitators          |                    |                    |                       | 3                  | 9                       | 12           |
| Contents              |                    |                    |                       | 4                  | 8                       | 12           |
| Videos                |                    |                    | 3                     | 5                  | 4                       | 12           |
| In-class Exercises    |                    |                    |                       | 5                  | 7                       | 12           |
| Conversation handouts |                    |                    |                       | 6                  | 6                       | 12           |
| Overall rating        |                    |                    |                       | 4 (33%)            | 8 (67%)                 | 12 (100%)    |

Note: Group one's Evaluation took place on October 1<sup>st</sup>, 2016

There were distinct differences between the two groups' ratings of the program. As shown in Table 4.9, the second group rated the program lower compared to the first group with considerable disparity in the rating of the facilitators and the videos. Two participants in the second group assigned each of these categories with scores under 3, which means below average. However, both groups rated the content and in-class exercises positively (with all scores at 4 or 5 (80% and above)). The following Table 4.10 is the combined result of the program.

Table 4.9: Group Two's Rating of the Program

|                       | <b>1</b><br>(Poor) | <b>2</b><br>(Fair) | <b>3</b><br>(Average) | <b>4</b><br>(Good) | <b>5</b><br>(Excellent) | <b>Total</b> |
|-----------------------|--------------------|--------------------|-----------------------|--------------------|-------------------------|--------------|
| Facilitators          |                    | 2                  | 2                     | 4                  | 4                       | 12           |
| Contents              |                    |                    |                       | 10                 | 2                       | 12           |
| Videos                |                    | 2                  | 5                     | 3                  | 2                       | 12           |
| In-class Exercises    |                    |                    |                       | 6                  | 6                       | 12           |
| Conversation handouts |                    |                    | 2                     | 4                  | 6                       | 12           |
| Overall rating        |                    |                    | 1 (8%)                | 9(75%)             | 2 (17%)                 | 12 (100%)    |

Note: Group two's Evaluation took place on November 26<sup>th</sup>, 2016

Table 4.10: Rating of the Program by all Participants (two groups combined)

|                       | <b>1</b><br>(Poor) | <b>2</b><br>(Fair) | <b>3</b><br>(Average) | <b>4</b><br>(Good) | <b>5</b><br>(Excellent) | <b>Total</b> |
|-----------------------|--------------------|--------------------|-----------------------|--------------------|-------------------------|--------------|
| Facilitators          |                    | 2                  | 2                     | 7                  | 13                      | 24           |
| Contents              |                    |                    |                       | 14                 | 10                      | 24           |
| Videos                |                    | 2                  | 8                     | 8                  | 6                       | 24           |
| In-class Exercises    |                    |                    |                       | 11                 | 13                      | 24           |
| Conversation handouts |                    |                    | 2                     | 10                 | 12                      | 24           |
| Overall rating        |                    |                    | 1 (4%)                | 13 (54%)           | 10 (42%)                | 12 (100%)    |

Through thematic analysis, participants' comments and feedback about the program were organized into four categories: 1) program delivery; 2) program content; 3) program enhancement; 4) request for follow-up, which helped answer the question of whether the program was effective and helpful.

***Program Delivery.*** Besides the program content, many participants commented on the format and process of the program. Many made positive comments about the timing, breaks, and resources. In terms of program delivery, discussions were around the following topics: 1) Facilitators, 2) Group process, 3) In-class conversation exercise.

*Participants' Evaluation of Facilitators.* Both groups made mention of the guidance from the facilitators, which helped navigate the learning process.

*"I felt very relaxed and the facilitators enabled us to share."*

From Group 1, many said "the facilitators were excellent". However, a few mentioned that the instructions could have been explained more clearly for some of the in-class exercises. For the second group, participants shared their disappointment about not having the male facilitator on the second day as they enjoyed the dynamic of the couple that led the workshop.

*“The facilitation was a drawback for me... I guess we didn’t have the [same] experience as the other group.”*

Some shared that with only one facilitator covering the content, there was not enough time and space left for responding to prompts during group discussions on the second day. In addition, they would have liked to have had the perspective of both facilitators, which they thought would have created more balance.

Some comments in the evaluation forms indicated that the female facilitator was “apologetic” about the featured videos before showing them, which influenced their perceptions.

*“Let us come to our own conclusions.”*

At the same time, there was also feedback to highlight the positive impact the facilitator made on the participants.

*“I loved [female facilitator] and her insight. She really was able to identify and help me/us through some parts we struggled to find our way through.”*

The group participants in the focus group said they were looking forward to having both facilitators. But, they said, it didn’t need to be a male and a female, just two facilitators partnering together for future programs.

*Group Process.* Many participants said that they enjoyed the atmosphere of having other couples to share with and contribute in the discussion.

*“We both enjoyed just sitting together with other soon-to-be parents and... also the curiosity and vulnerability across the table. That was a nice experience; I’d never done anything like that before.”* (Female, Group 2).



It was reassuring for participants to know that other couples have similar struggles and concerns. They liked the mix of the group (e.g., various lengths of the relationship, different stage in pregnancy) and the size of the group.

*“It was a small enough group that everyone got to share and it didn’t take a long time to share, but it was sufficiently large that there was quite a range of experience in the group.”* (Male, Group 1).

They appreciated being able to hear what others do to cope with stress and to gain different perspectives.

*“It was comforting hearing our problems were shared by the other five couples.”* (Female, Group 1).

This experience helped validate their experiences with a shared sense of togetherness.

#### *In-Class Conversation Exercise.*

*“The conversations were very useful and [also] having the opportunity in this kind of safe environment of the workshop to address things [that] may otherwise, on our own, be initially uncomfortable in talking about with one another [was helpful].”* (Female, Group 1).

Most felt that an adequate amount of time was allotted for each conversation. However, some felt that there was not enough time to get into the things that were started in many of the conversations.

*Maybe a little more time to talk during the exercises, but that may have just been us, being slow to chomp into some of the more difficult situations/conversations.* (Written evaluation, Group 2).

**Program Content.** With respect to content, the following themes were identified: 1) Most mentioned content materials; 2) Comments on the featured videos; 3) Format and length of the program.

*Most mentioned content materials.* During the focus groups, many participants referred to specific learning from the content material. Table 4.11 is a summary of the content materials most often commented upon.

Table 4.11: Summary of Program Contents Most Often Discussed

| Core Content  | Supplementary Content   |
|---|---|
| <p><i>Conversations:</i></p> <ul style="list-style-type: none"> <li>• Identifying the Demon Dialogue</li> <li>• Finding the Raw Spots</li> <li>• Forgiving Injuries</li> <li>• Bonding through Sex &amp; Touch</li> </ul> <p><i>Conversation handouts</i></p> <p><i>Reflective Question:</i></p> <p>“How will your baby benefit from what you learned?”</p> | <p><i>YouTube Videos:</i></p> <ul style="list-style-type: none"> <li>• The movie clips and videos help illustrate different types of Demon Dialogue</li> <li>• The eye contact experiments</li> <li>• The 4 Mantras</li> <li>• The Power of Touch</li> </ul> <p><i>Relationship Workout Activities:</i></p> <ul style="list-style-type: none"> <li>• Hand holding check-in</li> <li>• Eye Gaze</li> </ul> |

Regarding the Conversations, by far the most talked about was the concept of the Demon Dialogue, which helped many couples to see how a specific pattern plays out in different ways in their relationship. According to the participants, the Raw Spots conversation was difficult, yet, at the same time, it enabled them to express their feelings about everyday matters in a deeper, more meaningful way. These conversations evoked a lot of emotions and helped them reflect on the dynamics of their family of origin, which, in turn, helped some to explore and understand their

emotional triggers and vulnerabilities. For the Forgiving Injuries conversation, many felt that it was more geared toward long-term relationship couples with chronic hurts or big ruptures. Some participants said that they hadn't had these kinds of conflicts or injuries in their relationships,

*"...the focus [of the Forgiving Injuries conversation] was more on helping couples rebuild from a point of problem instead of enhancing a relationship from where it is."*

They suggested that the Forgiving Injuries conversation should have more examples of working through the more common upsets of daily life or small repeated conflicts, so they could better relate to it at this stage of their relationship. The same was true of the Bonding through Sex and Touch conversation. Some participants said that instead of coming from a disconnected place in a relationship, the material could use more adaptation to provide a more helpful context for the pregnancy and new parents and offer ways to enhance a couple's sexual intimacy.

Two female participants commented on gender stereotypes associated with emotions and with sex in some contexts over the course. They found that they connected with the content associated with the opposite gender more.

*"They [examples of gender-related experiences] were just reversed for me and I can understand that may not be for the majority [of women] but for me. It's still normalizing because [the information] was there, even if it was presented as an issue for the other gender."* (Female, Focus Group 2)

*"For the conversation about connection through touch and sex, the biological possibilities of our bodies are far beyond what our culture tells us should be the case... it just depends on the circumstances and the person. This is an area where it is easy to fall into stereotyping."* (Female, Focus Group 1)

For the conversation handouts, some participants commented that the instructions were

not as clear as they could be, at times. Finding ways to keep the conversation questions user-friendly and easier to follow would cause less confusion and eliminate the need to seek clarifications from the facilitators during the exercise.

The reflective question after each conversation “How will your baby benefit from what you learned?” was well received by most participants as “food for thought”. However, several male participants talked about their difficulties answering such a question.

*“...After doing the exercise from Hold Me Tight and, all of a sudden, being asked to imagine how does this help with a baby, the transition is a little awkward. Well, I can’t relate because I don’t have a baby yet.”* (Male, Focus Group 1).

More bridging might be required to help participants put themselves in a child’s mind and make the connection between partnering and parenting, and how the skills learned in the program can be transferrable to their relationship with their baby.

Regarding the supplementary content, participants referred to the helpful videos from YouTube that complement the key concepts presented in the HMT program.

*“I think using videos on YouTube are very effective, as more people are consuming information that way...I think they feel more real.”* (Male, Focus Group 2)

Many male participants commented on the impact of the non-verbal exercises, such as the eye gaze and handholding activities, and found them to be more effective communication tools than simply talking things out. The “Four Mantras” video was mentioned numerous times in both groups by both male and female participants for its simple and powerful messages to help highlight the key elements of a secure attachment relationship.

*Comments on the videos.* Many participants had rather passionate discussions about the featured couple and the videos of their conversations with Dr. Sue Johnson. "The videos were trying at times." The following is a summary of participants' comments:

- Some clips take too long to get to the point
- Some would like to observe different couples to help provide a variety of relationship contexts and conflict issues, especially featuring couples during pregnancy or becoming first-time parents
- A few participants thought that following one continuum of the same couple's journey was helpful to see their dynamic and how they made progress through each conversation

*Length and format of the program.* The common themes regarding the length and format of the program were that participants benefited more from the first day than the second day; they suggested a different format could make it easier to receive the full benefits of the program. The following are some noteworthy comments based on the themes:

*Gained more from the first day than the second day of the workshop*

- Due to topics "... After the first day we largely identified the raw spots and how we get into conflict so between the two we already kind of started to have a conversation about it, what works for each other so by the time we got to the second part of the workshop, we already kind of worked out our systems." (Female, Focus Group 1)
- Feeling exhausted "I was pretty exhausted on the second day...I did find that maybe later in the day as we went on...I was kind of drained and went and did the exercise but I was just less focused, it was too much." (Male, Focused Group 2).

*Format could be different so couples receive the full benefits of the program*

- Spread out the sessions more: *“The only thing that I struggled with is that it’s just two days. So, it’s a very packed day for the second part of the day. I kind of wish, if we could do that, if there were four sessions instead of two big ones, that’s for me.”* (Male, Focus Group 1)
- More role plays instead of watching the conversation videos: *“I feel like rather than watching the same couple... over and over again that we could have kind of done some role playing together, discussed it and then broken up into pairs that would have made it more applicable for me.”* (Male, Focus Group 1)
- Condense the program: *“There’s a lot of good stuff in the course and everyone should attend... but if you could condense it, so it’s easier for people to make a commitment and benefit from it.”* (Male, Focus Group 2)

***Suggestions for Program Enhancement.*** Many creative, yet practical suggestions came from the participants to help improve this pilot program for expectant couples in the future.

Table 4.12 captures most of the suggestions:

Table 4.12: Summary of Program Enhancement Suggestions

| <b>Program Enhancement Suggestions</b> |  |
|--|--|
| <b>Content</b>                         | <ul style="list-style-type: none"> <li>• Fewer videos, more in-class exercises</li> <li>• More role playing with scripts for practice instead of watching the conversation videos</li> <li>• More examples involving different couples – pregnant couple, couple with baby or parents who have done the program to share how they have utilized the skills after the baby is born</li> <li>• Further adaptation of Conversation 6 on Bonding through Sex and Touch for pregnancy and new parents to help enhance intimacy and alleviate stress</li> <li>• Add a commitment piece for reflection, e.g., “What are both of you willing to do or change for the relationship?”</li> </ul> |
| <b>Delivery</b>                        | <ul style="list-style-type: none"> <li>• More time taken by facilitator on each slide (or less slides)</li> <li>• More explanation of research findings presented/more interactive discussion about those findings</li> <li>• Two people with a shared partnership facilitate the program</li> <li>• Acknowledge culturally defined gender norms without gender stereotyping</li> </ul>  |
| <b>Format</b>                          | <ul style="list-style-type: none"> <li>• Add a brief consultation session with each couple to provide support/referral</li> <li>• Make it a 4 half-day program, 2 sessions during pregnancy and 2 after the baby is born</li> <li>• Condense the program and make it part of an existing prenatal program</li> <li>• Invite couple’s parents to sit in on the talk on introduction to Attachment</li> </ul>  |

***Request for follow-up.*** At the end of the program, all 24 participants signed the “Agree to Contact” form. During the focus group discussions as well as at post-program interviews, most of the couples expressed their wishes to have a follow-up contact, a booster session, or a post-baby HMT program for the following reasons:

- to touch base on how the learned skills have helped or been applied
  - “*We have the tools but that’s all theoretically speaking.*” - Male
  - “*...just a check in to make sure that we are ok.*” - Female
- to continue the research study to benefit the child

*“It might be interesting for you and for your study to see [if] what you hoped for is happening to our child.” - Female*

- A booster session to refresh key concepts after the baby is born

*“We need a booster session just to be sure that we remember how to handle the challenges that the child actually puts on parents.” – Female*

- A full post-baby HMT program for returning couples to see how couples are progressing

*“It would be interesting to see how Demon Dialogues change...(“yeah” many participants agree)” – Female*

*“And how the raw spots...what they are now and what they are after the baby...when they are activating could be completely different now.” - Female*

The researcher wondered, “Is there any added value to attending the HMT program for the second time?” Since the participants included a couple who attended a regular HMT program two years ago, they were asked during the post-program interview whether they saw value in attending a second time.

*Male: Having gone through Hold Me Tight before, I thought it was a lot easier to go through this one. I kind of knew what to expect and I was little more prepared to go through those conversations with [female partner] ...this time I went through with an end game knowing more potentially what I would be able to get out of it, so I wanted to maximize that and I do feel like I got a lot more out of it this round.*

*Female: For me, this was a bit different from the last time we went through the seminars because everything was brought back to how it affects the baby. So, really got me thinking about how our relationship and our struggles with our relationship will affect*



*the baby... so I think I got more out of the conversations because they seemed more relevant...because all of a sudden, there's now something more important than just [male partner] and I involved so I felt I really had to dig deep, and I think I might have put a little bit more into this one.*

*Male: I think we both got more out of this session than we did the last session.*

### **Summary**

The overarching research question was “Is an attachment-informed relationship enhancement program, such as *Hold Me Tight*® (HMT), helpful to couples in strengthening their relationship and increasing their confidence in becoming first-time parents?” The answer is a definite yes based on all sources of data as well as the lack of attrition. Because of the small sample size, the quantitative measures could not provide evidence for the effectiveness of the modified HMT program; however, the scores over time on these measures suggested that most of the participants benefited from the program in the expected ways. The qualitative findings provided an in-depth understanding of the positive effects of the program indicating most couples found the program very helpful.

Many participants indicated that participation in the HMT program helped them to gain better understanding of themselves and make positive change in their relationships. Recognizing the stressors they would face as new parents, many couples said that having the tools learned in the program increased their ability to recognize the underlying issues, increased feelings of connection with their partner, and helped to build their confidence about being parents. Many were able to apply what they learned to their relationship, recognizing how it would benefit their child. Some couples provided anecdotal accounts of what they were already doing or planning

to do to create a healthy emotional environment for the entire family with their baby in mind. Evaluations and feedback provided by both facilitators and participants will facilitate future program improvement. In addition, a closer examination of the quantitative and qualitative data from participants with higher depression and anxiety scores was conducted; this analysis supported the expected relationships between the two types of data. An interesting observation was also made regarding what may be an emerging trend away from traditional gender-role behaviours. Whether gender-role behaviours around problem-solving, household chores, caretaking/nurturing, men's emotional needs, and sexual intimacy are changing requires further study. Another important observation was the sense of vulnerability expressed by many of the men regarding the experience of becoming fathers.

## Chapter Five

### DISCUSSION

*I think probably the biggest thing that was reaffirmed for me in the seminar was always, not always, often, there would be issues that would be insurmountable, feel like mountains, but when you have a secure connection, those mountains seem to shrink, and with the baby coming, there will be enough mountains anyway, so instead of making the mountains out of a molehill, when I feel like there is a mountain, I can have the tools to make the molehill out of the mountain.*

- Female, post-program interview

This chapter begins with a summary of the findings and discussion of the researcher's interpretations followed by practice implications in relation to the literature. The strengths and limitations of this research are identified and suggestions regarding future areas of study that could extend or clarify the findings are discussed followed by a concluding summary.

#### **Summary of Findings and Discussion of the Researcher's Interpretations**

This is the first study of a perinatal couple-focused intervention utilizing an attachment-informed relationship educational program. The Hold Me Tight® program for Couples Becoming Parents is also one of only a few EFT-derived interventions that have been conducted exclusively with the first-time expectant parent sample. The overarching research question was “Is an attachment-informed relationship enhancement program, such as *Hold Me Tight*® (HMT), helpful to couples in strengthening their relationship and increasing their confidence in becoming first-time parents?” The research question was addressed with a mixed-methods approach. Twelve couples participated in the study with zero attrition. Overall, their answers to the research question indicated that all found the program helpful in many ways.

Because of the small sample size, the quantitative measures could not provide evidence for the effectiveness of the modified HMT program; however, trends were identified and the scores over time on the three standardized measures moved in a positive direction suggesting that most of the participants benefited from the program in the expected ways. The thematic analysis of the qualitative data provided an in-depth understanding of the beneficial effects of the program.

### **HMT and its Effect on View of Self/Attachment Orientation (ECR-S)**

Regarding view of self, many participants indicated that participation in the HMT program led to increased awareness of their personal style or pattern of managing conflicts and increased recognition of their own vulnerabilities and emotions. In addition, many narratives emerged from both the men and the women about their family of origins, which they began to recognize, had had a significant impact on themselves and/or how they relate to their partner. They indicated that participation in the HMT program led participants to considerable personal reflection and increased insight regarding the intergenerational impact of attachment relationships on the self.

Since attachment style or orientation is postulated to develop early in life, one would not expect a large change in attachment style to be associated with a two-day HMT program. The tendency for women in the sample to score higher on attachment anxiety than the men, and the men were higher on attachment avoidance, which is in accordance with previous attachment research (Mikulincer & Shaver, 2007). This trend also supports research on gender-role socialization indicating that women in general find it more important in a relationship to be able to share their feelings with their partner and men in general find it less important than women to feel emotionally close to their partner (Levy & Kelly, 2010). The qualitative findings indicated

that many of the men became more open about their feelings and experiences (and therefore less avoidant) with their partner during the HMT conversations. But what caused the change? Certainly, in this sample, the men demonstrated willingness to identify and openly share family of origin issues and acknowledge their concerns around financial challenges. The felt sense of safety in the program and group may have empowered these men to face some of the emotional realities associated with parenthood instead of withdrawing or avoiding these issues.

### **HMT and its Effect on Couple Relationship/Attachment Behaviour (BARE)**

Strengthening the emotional connection through increased accessibility, increased responsiveness and greater emotional engagement is the ultimate goal of the HMT program. Most couples shared anecdotes that illustrated the elements of A.R.E. in their relationship, and an increase in emotional connection. Participants reported that the program helped them to recognize areas that needed improvement in their relationship as well as the strengths of their relationships and areas in which they, as a couple, were doing well. This increased awareness of their strengths was experienced as very empowering for their relationships.

Anecdotes and quotes illustrating the couples' perceptions of positive shifts in their relational dynamics are supported by the BARE View of Partner results. The men's View of Partner between T1 and T3 revealed a difference close to statistical significance  $p = .052268$  (one-tailed) based on a paired t-test. This finding suggests that the men in this sample were receptive and responsive to this experiential, attachment-informed HMT program with positive effect in increasing their connection with their partners. We can speculate that when one partner experienced the other partner's positive attachment behaviours, they tended to reciprocate and vice versa (Johnson, 2004); such reciprocity likely helps to create or strengthen a healthy dyadic emotional system and potentially enhance both partners' relationship satisfaction. Evident in

their narratives, many couples conveyed a sense of hope and confidence in building or maintaining a solid relationship for themselves and their ability to cope with the stresses involved in parenting.

### **HMT and its Effect on Parental Mental Health/ Depression and Anxiety (EPDS)**

Based on prior research, we expected the transition to parenthood, both in pregnancy and in the postpartum period, to be associated with an increased vulnerability for mental health problems, such as depression, anxiety and other mood disorders in both parents with higher prevalence rates among women (Dennis & Dowswell, 2013, Domoney, Iles, & Ramchandani, 2014, O'Hara & Wisner, 2014). It was surprising, therefore to find that the men (as a group) in this sample tended to score higher than the women on both depression and anxiety. However, the mean differences were not statistically significant.

The closer look at the individuals and couples with depression scores above the threshold indicating risk revealed that 10 of the 24 participants had scores considered marginally indicative of depression at least once during the period of the study; the total included four women (33% of all women) and six men (50% of all men). An examination of the qualitative data provided by these 10 participants revealed somewhat greater indication of anxious or avoidant personal traits, past traumatic histories, negative perception of their families of origin, and immigration experiences compared to the participants scoring lower on depression. These findings are consistent with prior research indicating that individuals with such traits or experiences are at greater risk to experience mental health challenges such as depression and anxiety (Dennis, Merry, Stewart & Gagnon, 2016; Karsten et al., 2012; Ross & Dennis, 2009).

Both partners in two couples had high scores on depression; the scores of one of these couples' were reduced below the threshold for concern at T3. The other couple's depression and

anxiety scores decreased from Time 2 to Time 3, but the final scores remained above the threshold for concern. However, the narratives of the two individuals in the latter couple regarding their experience in the program indicated they perceived themselves as having gained confidence in their ability to parent well. It appeared that participating in the HMT program may be not only preventive in terms of reducing distress for both male and female expectant parents, but also therapeutic for couples who are dealing with higher levels of anxiety and depression. Again, research with larger samples is needed to confirm this hypothesis.

### **HMT and its Effect on Confidence in Parenting**

Almost all couples could make the connection between partnering and parenting, stating that the increased understanding of attachment and emotions was especially helpful. Many participants appreciated the tie-ins to their own experience with their parents and families of origin and thought it was helpful to reflect on their attachment histories and acknowledge them. Couples also commented on the helpful timing of doing this program while they were about to have a child of their own. Evidence for the intergenerational transmission of attachment has been well established in the attachment literature (Fraiberg, 1975; Lieberman et al., 2005) and in the transition to parenthood (Allen, 2013; Main et al., 2005). It is also the focus of parent-child attachment-based interventions (Circle of Security; Powell, 2013). In this study, the participants' reflective functioning skills appeared to be enhanced as they processed their own attachment experiences in the context of the couple relationship with their child in mind. They recognized they were motivated to make positive change in building healthy relationships with their partner and with their child.

Three case examples illustrated the change regarding confidence in parenting before and after the program. The opening quote at the beginning of this chapter summarizes the positive

effects most of the participants experienced from the program. Several participants resonated with and referred to one female group member's analogy that having a secure connection using the tools they had could "*make a molehill out of the mountain*" (C1F) of becoming a parent.

### **HMT and its Effect on Men**

The qualitative data suggests promising outcomes for both men and women who participate in the modified HMT program, and that the HMT program may have had more impact on the men than the women. These are encouraging findings in view of previous research indicating that when male partners are able to regulate negative affect (which usually indicates secure attachment) and deal with conflict openly and with negotiation (again an indication of secure attachment), couples tend to maintain high levels of relationship satisfaction. The men in this study talked about feeling more connected and being more confident in relating to their partner after attending the HMT program. Koivunen et al. (2009) suggest that when men are adept in attending to the relationship, it relieves their female partners of having to do an unequal amount of the emotional work, again contributing to relationship satisfaction and reducing distress.

Although not statistically significant, the tendency for the men to score higher on the anxiety and depression scales and above the thresholds for concern was unexpected. The men with higher EPDS scores had more anxious or over-thinking traits than those with lower EPDS scores, and their negative experiences with their families of origin or possible history of psychological trauma might have impacted their wellbeing. At the end of the program, two women and two men had EPDS scores  $\geq 12$ , which causes us to wonder if the likelihood of male partners experiencing increased vulnerability to depression and anxiety may be equally as high as for their female partners. The proportion of men scoring highly on this measure (2 in 12) or 1



in 6 in this small sample exceeds the statistics in the literature that indicates one in 10 fathers (Letourneau et al., 2012; Paulson & Bazemor, 2010) and 1 in 5 mothers (Best Start, 2012; Dennis & Towswell, 2013) may experience perinatal mental health challenges. The qualitative findings support this possibility; most of the men in this sample shared that, while feeling excited about becoming fathers, they worried about financial issues and the uncertainties about the future. Furthermore, they were surprised by some information they learned and some said that they got “*a bit more scared*” related to what they had learned about themselves and about parenting. (One of the things that surprised some male participants was the statistics regarding decrease in relationship satisfaction associated with becoming parents). Many of these men expressed a sense of vulnerability as they increasingly recognized the relational impact of becoming a parent, the emotional aspects of parenting, their lack of ideal role models, and their own feelings of inadequacy. This researcher considered these men’s sharing of their more vulnerable feelings about parenting in the presence of their partners as a positive sign, demonstrating a greater feeling of security in the relationship with their partner. As previously mentioned, this high level of experiencing and emotional engagement has been shown to be a positive prognostic sign in EFT (Johnson and Greenman, 2006). It also confirmed the value of this aspect of the modified HMT in that it brings important research findings on the transition to parenting to the forefront while couples are focusing on their relationships and learning to provide more support to each other. The improved quality of their relationships may have served as a buffer to allow the men to be more able to experience, openly share and cope with the anxiety that is understandably related to increased awareness of the responsibilities inherent in becoming a parent.

Another possibility is that men who are experiencing more depression and anxiety than the norm, or men who are more willing to talk about their negative feelings are more likely to volunteer to participate in a relationship-enhancing program like HMT. It must be acknowledged that the men who participated in this study may not be representative of all men preparing to become a parent for the first time. Men who are not experiencing depression or anxiety, or at least men who are not able or willing to acknowledge these feelings may be less likely to participate in relationship enhancing programs that encourage verbal expression of emotions. Future studies comparing couples who choose to participate in HMT programs for expectant couples with those who choose not to could clarify the answer to this question.

The dialogues within the groups that referred to participants' behaviours that do not conform to traditional gender-role behaviour or common stereotypes about gender-related characteristics were not expected. These behaviours were related to approaches to problem-solving, household chores, caretaking, men's emotional needs, and sexual intimacy. However, the presence of these dialogues and the sensitivity to gender stereotypes expressed by some of the participants supports the findings of other studies indicating that millennial men and women have the least traditional notions about gender roles of any generation or time period (Carlson, Hanson, & Fitzroy, 2016; Pedulla & Thébaud, 2015).

In summary, during this preventive intervention program, more of the men participants reported experiencing stress and anxiety than did the women. Are men becoming more open about their emotional vulnerability? Is this a new trend for the expectant couple population or is this finding specific to this sample? Perhaps the sense of safety in the group made them more willing to take risks and take advantage of the opportunity for support, which is frequently absent for men. Only a study with a larger and more representative sample can answer this question.

However, these findings support the need to provide support to men during the transition to parenthood, and change the common practices that focus only on the expectant mothers.

### **Improvement on HMT Content for Target Population**

Valuable feedback was received from both facilitators and participants about the content and delivery of this pilot program. The facilitators affirmed that the introduction to attachment theory seemed especially helpful and well received by the participants, and the participants confirmed the learning about attachment and emotions was useful. The couple participants in both groups confirmed that the guidance from the facilitators was essential in navigating the learning process and that two facilitators who are in a marital or co-parenting partnership was ideal. The feedback also supported the group format as many participants said talking and listening to other participants contributed to their learning. The in-class conversation exercises were found by most participants to be the most valuable of all the activities; this reaffirmed that the greatest strength of the HMT program is the emotionally-focused conversations. The add-on Relationship Workouts were also well received; they were shorter, simpler, less time consuming experiential exercises designed specifically for the expectant parents who may tire more quickly than other couples. Many male participants commented on the impact of the non-verbal exercises, such as the eye gaze and handholding activities, and found them to be more effective communication tools than the verbal exercises for them. Therefore, these exercises should be retained and refined. The ideas of using videos with expectant couples, doing live demonstrations and replacing some of the conversation videos with more role-plays are options that can be added to the Facilitator's Guide. In view of the comments regarding gender stereotypes associated with emotions and with sexual behaviour, the content should be revised to minimize such stereotyping.

Regarding the length and format of the program, a few of the male participants stated that they were feeling exhausted after the two full-day program and the amount of emotional sharing; it is interesting to note that none of the female participants at various stages of pregnancy expressed the same sense of exhaustion. Does this once again imply that talking about feelings and relational dynamics is more challenging for many men because of the traditional socialization of men compared to women who are generally socialized to be more invested in relationship work despite its emotional labour (Levy & Kelly, 2010)?

Some suggested that the program would be improved if the sessions were more spread out over time, or in a different format (e.g., make it a four half-day program, two sessions during pregnancy and two after the baby is born; condense the program and make it part of an existing prenatal program). They suggested such changes could make it easier to receive the full benefits of the program. At the end of the program, many couples said they would like a booster session. This is further evidence that the participants found the program helpful and were aware that changing long-standing attachment patterns is not easy.

### **Implications for Practice**

Several implications for practice have emerged from this study: 1) the need for more attention to the parental relationship and the mental health of both expectant parents; 2) the wisdom of utilizing attachment core concepts to support healthy relationships with this population; 3) the need for early interventions for expectant couples that can strengthen relationships and foster psychological well-being.

### **The Need for More Attention to the Parental Relationship and Mental Health**

The findings from this study support the idea that the perinatal period is a ‘teachable moment’ for first-time parent couples; many of these couples review their own health behaviours

at this time and are actively interested in engaging with professionals and learning about pregnancy, birth, parenting, and likely changes in their relationship (Cowan & Cowan, 2000). This is only possible if service providers address couples rather than mothers alone. A gap exists in program planning and service delivery in terms of keeping both parents in mind to safeguard their relationship and mental health across the transition to parenthood. Significant changes to the environment that new parents experience during their transition to parenthood are urgently needed. These changes include:

- Services, particularly, GPs, obstetricians, midwives, public health nurses and family visitors should use the various entry points at which they engage with families to engage positively with fathers as well as with mothers. And they need to be trained to do this, for example, they need to be trained in the use of validated screening instruments, and how to identify expectant parents who are at higher risk, i.e., pre-existing mood disturbance, trauma, immigration/ dislocation, lack of supports.
- The content of prenatal and postpartum engagement needs to be expanded to cover relationships, father involvement, and parental mental health; interventions need to address these issues in ways that ‘make sense’ to both genders.
- Expectant fathers should be given much more information about perinatal mood disorders and helped to recognize depression and/or anxiety symptoms in themselves and their partners, since both fathers’ and mothers’ depression in the perinatal period erodes relationship satisfaction and can have long-standing negative impact on children.
- Health care providers and public health nurses should be trained to recognize mental health challenges in men and should be required to interview fathers as well as mothers in the prenatal and postpartum periods.

### **The Need to Utilize Attachment Core Concepts to Create Healthy Relationships**

As this study has demonstrated, some of the core attachment concepts from the HMT program can be readily utilized as part of the key messages for perinatal intervention in the practice field. The findings from this study suggest that teaching couples about attachment theory can increase awareness and understanding of the concurrent attachment relationships that expectant couples are experiencing and make them aware of the relationship between their couple relationship and their ability to provide a healthy foundation for their child's development. Education and training for prenatal educators, therapists/counsellors, health care providers and peer helpers on attachment-informed key messages is highly recommended. These attachment core concepts should be disseminated using plain, simple language similar to the educational materials developed for parent-child attachment programs in order to reach adults from all walks of life, including individuals of low socioeconomic status, which were not represented in this research sample. One such example is leveraging the statement "*A.R.E. you there for me?*" to help illustrate the essence of a secure attachment relationship. Subsequently, the A.R.E. Questionnaire with 15 attachment behaviour statements (Johnson, 2008; see Appendix K) can be effective in helping partners quite accurately assess the quality of their attachment relationship. Engagement with the A.R.E. Questionnaire could, for many couples, facilitate a relationship-enhancing conversation on their own, or help them to identify that support in the form of professional help may be needed. The attachment related information does not always have to be delivered in face-to-face interactions. In today's technology savvy society, it could be delivered using brief messaging or light touch information (e.g., via Twitter, Facebook page, electronic message screen at clinics, smart phone apps); key attachment messages could also be incorporated into existing prenatal programs (e.g., Preparing for

Parenthood, Child Birth & Parenting classes). With a ‘drip, drip effect’, these key messages could help expectant parents make sense of their relationship in a way that connects to the attachment relationship that they hope to create for their child.

### **The Need for Early Interventions that can Strengthen Relationships and Foster Psychological Well-being**

Prevention and early intervention are critical to addressing relationship problems. New parenthood is a time when working models of attachment may be particularly malleable, and the findings of this study support the view that this transition period is a crucial time in the life course of couple relationships. Early intervention can help individuals address basic insecurities and develop a stronger relationship and increase attachment security before embarking on parenthood. In addition, this study suggests that efforts to reach out to expectant and new fathers are important. As Gottman et al (2010) put it: ‘The emotional state of caregivers is the real cradle in which the new baby is held.’ (p. 168). Men clearly play a key role in supporting their partners both before and after the birth. Prenatal educators and practitioners can help new parents through the transition via programs that focus on the couple relationship alongside the challenges of parenting a new baby. Currently, there is no couple-focused relationship program for this target population available in the Region of Waterloo or elsewhere. Social workers and others need to advocate specifically for an attachment-informed HMT workshop, and not just workshops focused on communication, problem solving, or the cognitive-behavioural approach. Acquiring A.R.E. skills is experience-dependent, similar to the skills taught in parent-child attachment-focused programs (e.g., Circle of Security). The HMT program is designed to help facilitate this process in building secure attachment. Furthermore, based on the findings of this study, the modified HMT may have an especially positive effect on men and their emotional connection

with their partners. A HMT program such as the one employed in this study will help engage men, enhance their emotional experience, and strengthen their relationships with their partners during this crucial period when they may need the most support. We can expect that when a couple's relationship is strengthened, it helps to reduce parental anxiety and depression. When a relationship is experienced as safe and secure, we can expect to see that parents become more accessible, responsive, and emotionally engaged with their baby; this will directly enhance infant mental health and affect generations to come as adverse childhood experiences are prevented. This is an economically sound early intervention for the entire family; as a society, can we afford not to provide attachment-informed programs or services for this important population that bear the seeds shaping our future? This timely investment is guaranteed to bring exponential returns.

### **Strengths and Limitations of the Study**

As in all research studies, this study has both strengths and weaknesses. The adaptation of the HMT program for couples expecting their first child is a significant contribution to the effort to identify empirically supported interventions that support future parents and the mental health of the next generation. The completion of this study will increase the likelihood that a larger study of the effectiveness of this intervention will be conducted. The mixed methodological design is a definite strength. Although the quantitative portion of the project falls short of positivist standards for generalizability due to the small sample size and non-significant results, it was useful to pilot the three measures in that we have some indication that they could be useful measures of relevant change in a future study with a larger sample. The qualitative portion of the study offers a rich exploration and description of participants' experiences.

In addition to the strengths noted above, this study has several limitations. The use of three time points is a lesson learned with respect to the design of the study. The original intent



was to create a wait list control period between Time 1 and Time 2 to help assess the intervention effect between Time 2 and Time 3. However, it is likely that the scores on the quantitative measures were influenced by the Time 1 pre-program interview in which participants learned more about the HMT program and its resources, and were encouraged to talk about their relationship. It was, therefore, not a genuine control period. Furthermore, the period of time between the pre-program interview and the participation in the first day of the program varied because of recruitment and logistical issues.

This study was a pilot investigation of a modified program, designed to test the program's feasibility and applicability. Therefore, the sample in some ways was homogeneous (e.g., heterosexual, monogamous, first-time pregnancy by birth) with inclusion criteria intended to limit participant variables that would complicate the data analysis. As a result, many people who wished to participate in this pilot program were turned down (e.g., a couple in an open relationship, male partners with child(ren) from previous relationships, couples waiting for adoption, male gay couples) based on the stringent exclusion criteria. While there was a good blend of race and ethnicity, almost all participants were high functioning, well educated, and motivated to participate in the program. Consequently, the sample was limited in its representativeness especially in terms of education and socioeconomic status. Ideally, this program should be adapted for single parents who can bring a support person (grandparent, friend, caregiver, etc.) as a parenting partner, especially since these expectant parents and their children are at greater risk for less desirable outcomes.

The two workshops were intended to be the same in terms of the number of facilitators present for each day. However, because of an unforeseen conflict, one group had only one facilitator on the second day of the program, which may have impacted that group's evaluations

of the program. Also, due to scheduling demands, the post-program interviews were staggered over the two weeks following completion of the program. The impact of this relatively small variation on the overall qualitative findings is not clear.

Another important limitation is the lack of an adequate control or comparison group, which some would argue makes it difficult to attribute the observed changes in both qualitative findings and quantitative results to the intervention alone. It would indeed be informative if future research were to include a control or comparison condition (e.g., one group of participants would receive the HMT for couple intervention and the other a parenting workshop), in order to isolate the effects of the intervention. The generalizability is also a concern due to the small sample size of this study. For these reasons, although the findings of the present study are promising, it will be necessary to replicate them before making stronger claims about the program's applicability and effectiveness.

### **Implications for Future Research**

This mixed-methods pilot study points to several potential future studies: 1) conducting a follow-up study with the participants of this study; 2) conducting studies with larger samples; 3) including different types of expectant parents; 4) exploring different formats for the program; and 5) increasing understanding of men's depression and anxiety.

#### **Conducting a Follow-Up Study**

The next logical step is to conduct a mixed-method follow-up study with this sample to explore whether this modified HMT program has an ongoing sustainable impact on these 12 couples. For the quantitative measures, this researcher would use the same standardized measures used in this study and add one more measure, such as the 25-item Postpartum Bonding Questionnaire (Brockington, Fraser & Wilson, 2006) to assess the parent-infant relationship. For

the qualitative inquiry, the goals would be to explore 1) How do the couples believe participating in the modified HMT program affected their relationships after the baby was born? 2) How do they think participating in the modified HMT program impacted their confidence in parenting? 3) How do the couples describe how they buffer the natural challenges associated with parenting? 4) What would the couples hope to receive in a HMT booster session? This proposed study could be done when their babies are between the ages of six months and one-year old, the period when postpartum anxiety and depression continue to be prevalent among new parents, and the couples' adjustment to parenting is still in process. Depending on the participants' availability and interest, further follow-ups or case studies could be considered to help inform the long-term effect of this attachment-informed HMT intervention on the couple relationship, parenting, and family functioning.

### **Conducting Studies with Larger Samples**

A larger scale study is necessary to further evaluate the effectiveness of the modified HMT program. The length of the HMT program and the human resources required to deliver the program can be quite costly to replicate without grants or funding to support such endeavours. Given the importance of improving children's mental health, it is likely that funding for additional research to assess the effects of the program could be obtained. Also, the HMT for Couples Becoming Parents program could be conducted with more couples at one time (e.g., 12 – 20 couples) if additional helpers and lay peer facilitators are recruited to support couples during each of the seven conversations of the program. To generate a larger sample, participants could be recruited in different cities and the research program could be conducted in various sites. Once the modified Facilitator's Guide, the PowerPoint slides and couple videos are further refined, more workshop facilitators and helpers can be trained to help conduct the

program. A multi-site study could be strategically located in cities with established EFT Communities or Centres (e.g., Ottawa, Toronto) or graduate schools with EFT courses as part of the curriculum (e.g., Tyndale Seminary, Waterloo Lutheran Seminary); these centres would facilitate recruitment of those who are keen to learn and practice EFT to be trained as facilitators or volunteer helpers for the research program.

To provide increased rigour, having a randomized control or comparison condition would help isolate the effects of the intervention. Based on the experiences learned from this present study, this researcher would not recommend using a wait list as a control group. Because of the very brief prenatal time period for recruitment, a waiting list control seems to be unrealistic. In addition, the HMT is quite well-known (e.g., the best-selling *Hold Me Tight* book) with its website having a good amount of information on the attachment concepts and detailed information on the Seven Conversations, which the control group participants could access during the waiting period. An alternative would be to have couples who attend an attachment-based parenting workshop or an educational material-only information session serve as a control group. The couple-focused HMT intervention could be compared with the alternative intervention to test its effects on the couple relationship, parenting, and family functioning.

### **Including Other Types of Expectant Couples**

Recruitment of expectant couples can be challenging based on this researcher's experience using the criteria for this study. Future studies should assess the program's helpfulness with other types of expectant couples, such as, couples having a second or third child, couples where at least one partner has some previous experience with parenting, couples who are planning to have children through pregnancy but are not yet pregnant, or couples who are in the process of adopting a child, teen couples, older couples, single parents, and couples

with children conceived through reproductive technology. Having more inclusive criteria would likely make recruitment easier.

It is also recommended that attempts be made to recruit samples that include couples with less education and lower socioeconomic status than was the case in the current study.

### **Exploring Different Formats for the Program**

Future studies could also test different formats for the modified HMT intervention, such as, four half days, two hours weekly, online delivery, different physical settings, integration with prenatal classes, hospitals, obstetrical clinics, community centres, faith communities or public health services. Research participants of this study suggested dividing the program into several sessions and spreading them across the perinatal period (e.g., two half-day sessions during prenatal and two half-day sessions postpartum) for the target population. Testing different formats of delivery to see whether having part of the program offered during the postpartum period affects the outcomes would be of value. Will couples have similar or different experiences of the program when baby is in the picture? In addition, if booster sessions were offered to couples during the first two years of their child's life, would interest and attendance be sufficient or would the natural challenges of being parents take precedence? What would be the format of these booster sessions that would best support these couples' attachment relationships? Examples might include a half day scheduled refresher of the HMT in a group format with an opportunity to engage in some of the seven conversations; an HMT style café in the community (e.g., Ontario Early Years Centre with childcare) on a scheduled weekday evening; or bi-weekly or monthly drop-ins for couples to work on their HMT conversations with support available. Another question arises: would these booster sessions increase couples' help-seeking behaviour when their relationships are in trouble?

## **Understanding Men's Depression and Anxiety**

Larger samples would allow us to see whether the observation that more men than women scored above thresholds of concern on the depression and anxiety screening scale extends to larger groups. Does the intervention increase anxiety and depression for some men as they become more aware of the responsibility of parenting? Or, are the men who agree to participate in such a program more likely to experience anxiety and depression than men who are not experiencing distress? Would men who are not experiencing distress be more difficult to engage or reluctant to attend a relationship program? The sample in the current study is not representative of all men expecting a child for the first time. More ways need to be explored to promote HMT programs and to make them more inviting and accessible to all types of men. When more expectant fathers are attending HMT with their partners, we will gain more understanding about men's anxiety and depression and find ways to more effectively support fathers during the transition to parenthood.

## **Concluding Summary**

This is the first study of a perinatal couple-focused intervention utilizing an attachment-informed relationship educational program. The Hold Me Tight® program for Couples Becoming Parents is well-received by expectant couples, and shows promise in terms of reducing the stress on these couples and supporting their efforts to strengthen their relationship and be good parents. The program helped participants gain a better understanding of their own attachment behaviour towards their partners as well as their partners' behaviour towards them in times of need; such increased awareness is expected to strengthen their emotional connection.

It appears that the HMT program in this study may have had more impact on the men than the women. A study with a larger and more representative sample is needed to learn

whether male participants experience greater benefit than female participants from such a program,

In spite of some limitations, the results of this study help to inform practice knowledge in recognizing the need for more attention to the parental relationship and the mental health of both parents, the wisdom of utilizing attachment core concepts to support healthy relationships, and the need for early interventions that can strengthen relationships and promote psychological well-being. The adaptation of the HMT program for couples expecting their first child is a significant contribution to the effort to identify empirically supported interventions that support future parents and the mental health of the next generation of infants and children. The completion of this pilot study will increase the likelihood that a larger study of the effectiveness of this intervention will be conducted.

## Appendix A: Session Outline of Modified Content

### DAY ONE MORNING

#### UNDERSTANDING LOVE AND ATTACHMENT

Couples are introduced to the key concepts of attachment theory, which offers a revolutionary new way to see, and shape love relationships

Relationship Workout: Hand Holding Check-Ins

1. Face your partner and hold each other's hands during this Check-in Q & A exercise
2. I will ask you questions and you will answer silently
3. The only person who will know your answer is your partner
4. How? When your answer is "yes" to the question – gently squeeze your partner's hand
5. When your answer is "no" to the question – remain holding your partner's hand

Processing experience:

What did you learn from this non-verbal, handholding communication exercise? Did anything surprise you?

Discussion of application:

- Research has found that when a couple is faced with an anxious situation, if a husband will hold his wife's hand, it leads to the release of oxytocin in the brain of both the husband and the wife. Oxytocin is the connection hormone. So physical touch, such as holding hands, can be a big part of an emotional connection.
- Hand holding during labour and delivery can help ease the intense physical discomfort and soothe the threatened brains of both partners, especially the mother's.
- Optional video for viewing: Soothing the Threatened Brain by Dr. Sue Johnson (2013) (Length 3'49)

Suggested DVD viewing for introduction:

1. Hold Me Tight DVD – First Impressions from A. & B. (Length 1'16)
2. Dr. Sue Johnson on Attachment Theory (Length 9'10) – Excerpt from *Creating Relationships that Last: A Conversation* DVD
3. Love Sense: from Infant to Adult (11'28) by Dr. Sue Johnson & Dr. Ed Tronick
4. The Strange Situation – Reunion (5'00)

In-class exercise for introduction session

The A.R.E. Questionnaire: Each partner completes the A.R.E. questionnaire and shares their answers with their partner.



## DAY ONE MORNING

### CONVERSATION 1: RECOGNIZING THE DEMON DIALOGUES

Couples identify the negative and destructive remarks they make to each other during conflict or argument to get to the root of the problem and figure out what each other is really trying to say.

#### Relationship Workout: Two Working as One

##### Objectives:

- 1 Work together to complete an assigned task as quickly as possible (i.e., build a symbol of love with Lego pieces, fold a paper airplane)
- 2 Notice your experience during the activity
- 3 Process and share your experience with your partner

##### Procedure:

- 1 Each use one hand to hold your partner's hand without letting go throughout the activity
- 2 Use your free hand along with your partner's other hand to accomplish the assigned task
- 3 Once you are done - raise your hands and say, "done!"

##### Processing experience

- 1 What is it like to be working together
- 2 What is it like to depend on your partner
- 3 How does this experience relate to your usual couple interactional pattern

##### Suggested DVD Viewing for Conversation 1:

1. HMT DVD with A. & B. (Disc One 6:55-24:02) – Length 17:55
2. Dr. Sue Johnson's YouTube talks (combined the following into one, (10'00)
  - What is a healthy marriage? (3'52)
  - How can I tell if my relationship will last? (0:00-1:19)
  - How can I tell if my marriage is in trouble? (5'46)
3. Movie Clips to illustrate the Demon Dialogue
  - Movie Clip: The Breakup – “I am Done!” Scene (2'58)
  - Video Clip: It's Not about the Nail (1'41)
  - Movie Clip: Star Trek Into Darkness (1'56)
  - 6-Year-Old Girl's Advice (2'54)

##### In-Class Exercise: Practice HMT® Conversation 1

Using the original HMT worksheet

## DAY ONE AFTERNOON

### CONVERSATION 2: FINDING THE RAW SPOTS

Couples identify their emotional triggers, also referred to as “raw spots.” These are vulnerable feelings that exist underneath anger, blame, and numbing. Couples become aware of these underlying feelings and begin to share them with their partner.

Relationship Workout: Eye Gaze – The Power of Eye Contact

Video Viewing: World’s Biggest Eye Contact Experiment (2015) 2:20

Suggested Discussion:

- What moved you when watching this video?
- Did you ever experience the “Kind Eyes” when you were growing up where a special someone who was delighted in you and accepted you just the way you were?

Instructions:

1. Turn and face your partner
2. Remain silent
3. Be present with each other through eye contact for 1 minute

Processing Experience:

- Share with your partner: How did you feel during this exercise - was it easy, hard, comfortable, or weird?
- Share with your partner: What you noticed in your partner

Discussion of Application:

- By utilizing mirror neurons through face to face, eyes to eyes contact, we can calm our nervous system when we are stressed, tired, or in need of connection

Suggested DVD Viewing for Session Two:

1. HMT DVD with A. & B. (Disc One 54:01-1:11:20) – Length 17’20
2. YouTube – What is Attachment? (3:27)

Role Play with Underlying Emotions

What’s Really Behind a Heated Discussion? A Script Demonstrating Cycle Positions and Underlying Emotions (adapted from script created by Kimberly Akamine & Rebecca Jorgensen)

In-Class Exercise: Practice HMT® Conversation 2

Using the original HMT worksheet

## DAY ONE AFTERNOON

## CONVERSATION 3: REVISITING A ROCKY MOMENT

Couples talk about their new understanding of the relationship pattern, how each impacts the other, and how fear drives them to react. This conversation provides a platform for de-escalating conflict, repairing rifts, and building emotional safety.

Relationship Workout: Voice, Volume and Facial Expressions

Objectives:

Using voice tone and facial expressions to support verbal message

Procedure:

1. Partners take turn to recall a moment of connection - Share their experience of the connecting moment and elaborate on what that meant to them (2 minutes each)
2. While listening, the receiving partner take notice of their internal response to the sending partner's message, tone of voice and facial expression

Processing experience:

Process and share their experience with their partner

1. What is it like to hear the message from your partner?
2. What do you notice about your partner's voice and facial expressions?
3. Share your experience with your partner

Supporting Material for Viewing:

1. Video: Baby recognizes dad's voice (0'41) - Baby Penny is 3-minute old. She stopped crying to see her dad for the first time. He has been talking to his baby just about every day in the womb.
2. YouTube: Motherese (2'34) – Faces are rich information sources for babies throughout life. Babies also love to hear the music of voices.
3. Research findings on how sleeping babies are affected when their parents argue.

### Discussion of Application:

- The importance of talking to your baby while still in the womb and the impact of the tone of your voice, which reflects your emotional state.
- Our voice and body language are powerful tools for connection or disconnection. It is important to attune to the underlying emotions reflected in the tone of voice and body language when the non-verbal message is incongruent with the verbal message.
- When there is incongruence between the verbal and non-verbal messages, in these situations, our feelings and attitudes are affected by the following (by Mehrabian, see comments)
  1. Body Language 55%
  2. Tone of voice 38%
  3. Content 7%

No DVD viewing

Transcript Reading & Discussion: A. & B. work through a Rocky Moment

Each couple then examines a time in the past or a more current event when they became stuck in their Demon Dialogue. They are encouraged to use the same steps as A. and B. did to write a story about how they could have contained the momentum of their negative cycle and created a base of safety instead.

If time permits, each couple will envision a potential future conflict once their baby is born. They will come up with responses that they can make to slow down the demon dialogue and allow them to ally together to stop the spiral.

In-Class Exercise: Practice HMT® Conversation 3

Using the original HMT worksheet

Added one more question (the following) to the Conversation worksheet:

Now envision a potential conflict in the coming months once your baby is born. What might this conflict be and why? Can you each come up with at least two responses that you can make so you can slow down this dialogue and allow yourself to take control of it? Ask your partner if your responses will help him or her.

## HOMEWORK ACTIVITIES DURING THE WEEK

### HOMEWORK ACTIVITIES

#### Instructions:

- ▶ Read the worksheets.
- ▶ Take time to reflect on your experiences.
- ▶ Write down your answers.
- ▶ Talk it over with your partner.

#### Homework Activity #1

Safe Haven & Secure Base: Look at Your Relationship through the “Lens” of Attachment Security

Kallos-Lilly, V. & Fitzgerald, J. (2015). *An Emotionally Focused Workbook for Couples*, p. 19-20

#### Homework Activity #2

Know Your Relationship Histories - Talk about your histories, together.

Kallos-Lilly, V. & Fitzgerald, J. (2015). *An Emotionally Focused Workbook for Couples*, p. 19-20

DAY TWO MORNING  
CONVERSATION 4: HOLD ME TIGHT

This conversation allows partners to become more accessible, emotionally responsive, and deeply engaged with each other.

Video: Eye Gaze Experiment - How to Connect with Anyone (2015) 5'19

Relationship Workout: Presence. Presence. Presence.

Video Viewing: Empathy by Brene Brown (2013) 2:53

- Empathy requires your full presence and attunement, perspective taking, staying out of judgment, recognizing and communicating emotion in other people. Empathy is seeing you, hearing what you have to say, and feeling with you.
- This workout consolidates the previous skills: Face to face, voice to voice, and “You are special to me” eye gaze

Instructions:

1. Partner A – Share feelings or concerns relating to this pregnancy or parenting
2. Partner B – Try to listen with attunement and without verbally saying anything. Notice anything that comes up that may block attunement with the sharing partner.
3. Switch every 2 minutes for 2-3 rounds

Processing experience:

- Which role do you like better? Which role was easier? Harder? Why?
- Do you feel more connected with your partner? What helped you to connect? What hindered you from connecting?

Supporting Material for Viewing:

YouTube: Empathy by Brene Brown (2013) 2:53

Youtube: Beautiful Commercial from Thailand Disconnect to Connect (2010) 1:36

Discussion of Application:

- Attunement and misattunement in couple relationship
- Attunement and misattunement in parenting

## Content

PARENTHOOD by Dr. Sue Johnson: An excerpt from Dr. Sue Johnson's book *Love Sense: The Revolutionary New Science of Romantic Relationships* (p. 158-164)

Suggested DVD Viewing for Conversation 4:

1. HMT DVD with A. & B. (Disc Two, 00:00 – 02:05-20:30) – Length 19'50
2. Still Face Experiment with Dads (4:28)
3. Pregnancy & Changes in Couple's Relationship by Dr. Caroline Steinberg, MD – 2:28
4. Pregnancy & the Role of Fathers - by Dr. Caroline Steinberg, MD – (0:00-1:20, 2:21-4:09)

In-Class Exercise: Practice HMT® Conversation 4

Using the original HMT worksheet

DAY TWO MORNING  
CONVERSATION 5: FORGIVING INJURIES

Emotional injuries may be forgiven, but they never disappear. Knowing how to find and offer forgiveness empowers couples to strengthen their bond. In this conversation, each partner takes turns in sharing a significant hurt while the other helps heal the partner's hurt.

Relationship Workout: Mindfulness: Breathing Together

Connecting with others enriches our lives. Researchers find that when we feel close to friends and loved ones we experience greater energy and vitality, increased clarity, and an enhanced sense of value and dignity.

Instructions:

Allow 10 -12 minutes for this exercise.

1. Begin by sitting facing one another, spines relatively erect.
2. Close your eyes and bring your attention to the sensations of your breath in your belly. Notice how your belly rises with each inhalation and falls with each exhalation. Whenever you find your attention wandering, gently return it to the sensations of the breath. You may notice some feelings of uneasiness or anxiety doing this while facing your partner. Just allow those feelings to come and go, returning your attention to the breath.
3. Once you've developed a little bit of concentration, gently open your eyes. Allow your gazes to rest on one another's bellies. Watch the breath of your partner as you also continue to notice the rising and falling sensations in your own body. Perhaps your breathing will start to synchronize; perhaps it won't. Either way, just try to remain aware of your own breathing and that of your partner for the next 1 or 2 minutes.
4. The following phase can feel rather intense, so feel free to adjust your gaze as you see fit. Try raising your gaze to silently look into the eyes of your partner. Don't try to communicate anything in particular—just take in the experience of being with your partner. Allow yourself to notice your breath in the background while you focus most of your attention on looking into your partner's eyes. If this starts to feel too uncomfortable, feel free to lower your gaze to your partner's belly again. You can shift back and forth between the belly and the eyes to adjust the intensity of this experience. (1 to 2 minutes).
5. Now, begin to imagine what he or she was like as a young child. Imagine your partner



growing up in his or her family. Imagine how he or she went through the same stages you did—going off to school, becoming a teenager, leaving home, and eventually becoming the adult he or she is right now. Be aware that your partner has had thousands of moments of joy and sorrow, fear and anger, longing and fulfillment—just like you. (Allow a long pause).

6. Now begin to imagine – the baby is here, a little living being solely dependent on you and your partner’s nurturing to survive. How is your partner doing? (Pause). Be aware that, just like you, your partner is dealing with this transition in life. He or she will probably have to make quite a few adjustments. Imagine how this will be for him or her—both the pleasant and unpleasant aspects. Can you feel what your partner might be feeling? (Allow a long pause).
7. Once you’ve imagined your partner’s life after the baby is born, bring your attention back to how he or she is now in the present. Then drop your gaze down to your partner’s belly and breathe together again (1-2 minutes).
8. Finally, finish the exercise with another minute of meditation with your eyes closed. Notice the different feelings that accompany each phase of the exercise.

Processing experience:

- 1 What would you like to share about your experience with your partner?
- 2 Do you feel more connected with your partner? What helped you to connect? What hindered you from connecting?

Supporting Material:

- The above “Mindfulness: Breathing Together” instructions are a modification based on *Mindfulness in Relationships: Breathing Together* by Dr. Ronald D. Siegel, PsyD
- Video: Roots of Empathy Project

Discussion of Application:

- The benefits of mindfulness practice on stress reduction, health & well-being, and to enhance compassion and empathy
- The mindfulness practice for transition to parenthood (Gambrel & Piercy, 2015) – based on neurobiology and mindfulness practice to help couples develop skills of internal and interpersonal attunement. Its outcomes suggest that it may be especially helpful for men because of differences in social support needs and relational processes in the prenatal

period. Male participants felt that they became more identified as fathers after attending the program.

- **Roots of Empathy Project** - Roots of Empathy is an evidence-based classroom program. At the heart of the program are a neighbourhood infant and parent who visit the classroom every three weeks over the school year. A trained Roots of Empathy Instructor coaches students to observe the baby's development and to label the baby's feelings. In this experiential learning, the baby is the "Teacher," which the instructor uses to help children identify and reflect on their own feelings and the feelings of others. This "emotional literacy" taught in the program lays the foundation for safer and more caring classrooms, where children are the "Changers".

Suggested DVD Viewing for Conversation 5:

1. HMT DVD with A. & B. Disc 2, 52:58 – 01:08:44, Length 15'46
2. YouTube: The Four Mantras of True Presence by Thich Nhat Hanh (3'05)

In-Class Exercise: Practice HMT® Conversation 5

Each partner takes turns to share a significant hurt and also to help heal their partner's hurt. The goal is to learn how to repair a rift in their bond.

Questions are compiled from Kallos-Lilly, V. & Fitzgerald, J. (2015). *An Emotionally Focused Workbook for Couples*, p. 107, 113, 115

## DAY TWO AFTERNOON

### CONVERSATION 6: BONDING THROUGH SEX AND TOUCH

Couples find how emotional connection creates great sex, and good sex creates a deeper emotional connection.

Relationship Workout: Contact Comfort – The Power of Touch

Video Viewing: Fight off Loneliness with Touch by Helena Backlund Wasling (2014) - with edited version (0:00-2:30, 4:13- 4:51, 5:41 – 7:51) Length 3'50

Brief Discussion:

- The importance of touch - to form a long lasting attachment and bond to the infant
- The touch we need early on to be able to handle stress later in life, function socially, develop normally, and survive
- Harry Harlow's monkey experiment – Contact comfort

Instructions:

1. Receiving Partner: Recall an experience of receiving comfort and soothing from touch and write down on a piece of paper, the kind of contact comfort that you would like to receive from your partner for 10 seconds for this relationship workout (e.g., hand holding, hug, kiss).
2. Giving Partner: Recall an experiencing of giving comfort and soothing through touch and stay with how it felt to be able to do that.
3. Once the receiving partner is done writing his or her “contact comfort” request, participants will stand up and turn to each other.
4. The receiving partner shows the giving partner what's written and the giving partner will respond by offering exactly what the receiving partner requested.
5. Then switch roles with the receiving partner becoming the giving partner and the giving partner becoming the receiving partner. Both are encouraged to be fully present and pay close attention to bodily experiences of giving and receiving the “contact comfort” requested.
6. Facilitator indicates when participants can switch roles (counts the time: 1001, 1002, 1003, till 1010).

Processing experience:

- Share your experience in giving and receiving contact comfort.
- What it is like to be physically and emotionally present, engaged and responsive to each other?

Supporting Material for Viewing:

Videos:

1. Fight off Loneliness with Touch by Helena Backlund Wasling (2014) 0:00-2:30 and partial segments from 4:13 - 4:51, 5:41 – 7:51. Total length: 3’50.
2. Welcome Home Exercise for Couples by Stan Tatkin (2009) 4’05 (only for reference)

Discussion of Application:

Contact comfort is an important part of our lives and the interactions we have with others. A simple reassuring physical response can remedy attachment insecurities in an instant. Research shows that emotional connection manifested in physical ways (i.e., hugs, handholding) provides benefits to the heart and reduces stress. When two groups of couples were told to discuss an “angry event,” the group that held hands and hugged before the confrontation evidenced a lower heart rate and blood pressure.

Setting the Stage

The following is from Catherine de Pierrepont, PhD, University of Ottawa – Perinatal Sexuality

See Catherine de Pierrepont’s conference presentation slides

Interview with Catherine de Pierrepont Article from Toronto Star on February 25, 2016

In-Class Exercise: Practice HMT® Conversation 6

Questions are adapted from Kallos-Lilly, V. & Fitzgerald, J. (2015). An Emotionally Focused Workbook for Couples, p. 136-137

DAY TWO AFTERNOON  
CONVERSATION 7: KEEPING YOUR LOVE ALIVE

The last conversation focuses on love being a continual process of losing and finding emotional connection. Couples learn to be deliberate and mindful about maintaining connection

Relationship Workout: The Story of Us

Instructions

1. This Relationship Workout will be combined with HMT Conversation 7.
2. Together, the couple will discuss and answer the questions from HMT Conversation 7.
3. Capture your answers in images, words, songs or whatever you can come up with to create a story with significant attachment meaning.
4. Write or draw your story to illustrate your love and connection on the piece of paper provided to you.
5. Decide on how you will share your story with the group at program closing.

Suggested DVD Viewing for Conversation 7:

1. HMT DVD with A. & B. (Disc Two 1:34:08 – 1:41:44) – Length 7'36
2. YouTube: Love Lesson | Life's Big Questions Unscripted by Jubilee Project, length 4'18

In-Class Exercise: Practice HMT® Conversation 7

Questions are modified from the original HMT

This Conversation will be combined with the Relationship Workout #8. Use images, words, songs or whatever you can come up with to create a story of your relationship.

## **Appendix B: Facilitator Information Letter and Consent Form**

WILFRID LAURIER UNIVERSITY

Facilitator Information Letter

Hold Me Tight®: For Couples Becoming First-Time Parents

Pilot Study of An Attachment-Informed Relationship Program for Couples Becoming Parents

Researcher: Debbie Wang, MSW, PhD Candidate, Faculty of Social Work

Advisors: Dr. Carol Stalker & Dr. Marshall Fine

You are invited to participate in a research study as a facilitator for an attachment-informed relationship program for couples becoming first-time parents. This study is conducted by a doctoral student in the Faculty of Social Work PhD program at Wilfrid Laurier University.

### **PURPOSE**

The purpose of this study is to increase knowledge about the helpfulness of an attachment-informed relationship program designed to help couples better understand their relationship with each other and create the best possible emotional foundation for their expected child.

### **RECRUITMENT AND TRAINING**

For this pilot program, a male and a female are preferred to co-facilitate in order to respond to and validate perspectives from both genders. The facilitators should have graduate level education in one of the helping professions (preferably with basic Emotionally Focused Therapy training), be familiar with the transition to parenthood life stage, and have experience with workshop facilitation. The following expectations, support and resources will be made available to the co-facilitators as a form of training to prepare them for the pilot study.

- Read the HMT book
- Attend a HMT workshop and become familiar with the current program content
- Preview the adapted HMT Facilitator's Guide to provide input and/or feedback
- Plan and prepare the content material prior to the program and before each session
- The researcher will be available for regular check-ins, Q&A, debriefing, and support to the facilitators

## INFORMATION

You will be asked to facilitate the *Hold Me Tight for Couples Becoming Parents* program upon completion of the above training and preparation. Facilitation of the program involves the following:

1. Conduct two 16-hour HMT program on four Saturdays (2 Saturdays for each group from 9:00 a.m. to 5:00 p.m., 5-6 couples for each group) in September and/or October 2016 in Waterloo, Ontario.
2. Before each group begins the program, you will receive the couples' Relationship Information Forms from the researcher so that you can review the background information of each participating couple.
3. During the program, you will follow the Facilitator's Guide closely when leading the workshop and guiding the couples through the seven conversation exercises (most of which are demonstrated to the group through DVD). Each couple then proceeds with their dialogue while you will be asked to move between couples and provide guidance on how to shape the conversation to create and increase a sense of security and trust. You will be responsible for facilitating a group debriefing after each conversation.
4. After each day-long session of the program, you will record in The Facilitator's Log to keep track of your experiences and any perceptions that are relevant for the program (i.e., what worked well, what could be improved, any challenges encountered, overall experience of facilitating the sessions). The Facilitators' logs are intended to help you remember your experiences when the researcher meets with you for a follow-up interview (see below). You will be asked to submit your logs to the researcher following the final interview.
5. Upon completion of the two group programs, you will be asked to complete a brief evaluation questionnaire regarding your experience facilitating the program. This will take no more than 10 minutes.
6. Both facilitators will participate in a follow-up interview together with the researcher, which will take approximately 45 minutes to one hour. The interview will be audio-taped and transcribed. The interview will be scheduled at a time that suits your schedule and at a location that is convenient for you.

## RISKS

You may experience some performance anxiety when delivering the program. There may be a possibility of emotional discomfort or frustration to you when listening to group participants describing challenges during your facilitation of the program. There is also the possibility that you may experience a loss of self-confidence if you are not able to answer some of the questions. During the post-program interview, at your request, questions can be repeated or deleted to meet your comfort level.

## BENEFITS

By committing to participate in this research study, you will be able to receive training, support, and content material to deliver the modified HMT relationship enhancement program at no cost to you. The researcher hopes and expects that having an opportunity to facilitate this relationship program will be a positive experience for you and will expand your skillset in delivering the HMT program.

By taking part in the program evaluation and post-program interview you will have an opportunity to contribute to the findings of the research and thereby directly contribute to the information about this program that will be shared with other scholars and the general public.

## CONFIDENTIALITY

All information you provide will be kept strictly confidential and all efforts will be made to maintain your anonymity. After the audio recording of your interview, the digital file of the interview will be labelled with an assigned number in place of your name. The transcription of the interview will be seen by the researcher and the members of the researcher's doctoral committee but will only be identified by the assigned number. The digital audio file and transcription will be kept secure in a locked cabinet in the researcher's home and destroyed no later than December 2021.

In the consent form, you will be asked if the researcher may quote your words as long as there is nothing in the quotation that would identify you. You may also indicate if you would like to review any quotation before it is used in the dissertation, a publication or a presentation.

## PARTICIPATION

Your participation in this study is voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at any time without penalty and without loss of benefits to which you are otherwise entitled. If you withdraw from the study, your data will be removed from the study and destroyed. You have the right to omit any



questions(s)/procedure(s) you choose. You can end the conversation at any time. There is no financial compensation for your participation.

#### FEEDBACK AND PUBLICATION

A copy of the dissertation will be shared with you as well as any publications from the dissertation. Results of this research will be communicated through academic, professional and community channels. Papers and workshops will also be presented at professional conferences and if you are interested, you may be invited to present the findings with the researcher.

#### CONTACT

If you have questions at any time about the study or the procedures, (or you experience adverse effects as a result of participating in this study) you may contact the researcher Debbie Wang, at the Lyle S. Hallman Faculty of Social Work, Wilfrid Laurier University, 200 Duke Street, Kitchener, Ontario, 519-884-1970 extension 5295, or by e-mail at [dwang@wlu.ca](mailto:dwang@wlu.ca).

This project has been reviewed and approved by the University Research Ethics Board. If you feel you have not been treated according to the description in this form, or your rights as a participant in research have been violated during the course of this project, you may contact Dr. Robert Basso, Chair, University Research Ethics Board, Wilfrid Laurier University, 519-884-0710, ext. 4994 or [rbasso@wlu.ca](mailto:rbasso@wlu.ca)

Thank you for your consideration.

Debbie Wang, MSW, RSW, PhD Candidate

Principal Researcher

## Appendix C: Facilitator Consent Form

WILFRID LAURIER UNIVERSITY

Facilitator Consent Form

Hold Me Tight®: For Couples Becoming First-Time Parents

Pilot Study of an Attachment-Informed Relationship Program for Couples Becoming Parents

### CONSENT

I have read and understand the above information concerning the research project being conducted by Debbie Wang, a PhD student at Wilfrid Laurier University regarding the *Hold Me Tight for Couples Becoming Parents* program. I have had the opportunity to ask any questions and receive additional details I want about the study. I understand that all personal or identifying information gathered in this pilot study will be used for research purposes and will be considered confidential. Findings from the research will be in summary form only in any reports or publications. I understand that if there are any comments or information that I do not want the researcher to share or quote in a report or publication, I can identify this to the researcher at any time. I understand that I may withdraw my consent to participate at any time without penalty, and that my data will be destroyed if I do.

Check all boxes that apply:

I agree to participate in this study as one of the facilitators

I agree to keep a personal log during the two group programs

I agree to complete the program evaluation form after both programs are finished.

I agree to have my post-program interview audio-taped.

I give my permission for quotes from my interview to be used as part of the final written material.

I would like to review any quotes from my interview before I give permission for them to be included in publications or presentations.

Research Participant's Name: \_\_\_\_\_


Research Participant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Researcher's Signature: \_\_\_\_\_ Date: \_\_\_\_\_


## Appendix D: Info-Graphic Flyer for Participants Recruitment

# Hold Me Tight

## for Couples Becoming Parents




16-Hour Program over 4 Saturdays  
During May & June 2016




Interview

Follow-up


### Requirements for Couples Participation




You are in a committed relationship and are living with each other




You are expecting your first child (by birth not adoption)



You and your partner have no other child(ren) from previous relationships





You will be within 24 weeks of pregnancy at the first week of May 2016





You and your partner can both commit to attend the 4 four-hour sessions and 2 interviews

### Contact


 Researcher: Debbie Wang, PhD Social Work Candidate, Wilfrid Laurier University

 [dwang@wlu.ca](mailto:dwang@wlu.ca)

 xxx-xxx-xxxx

 [www.debbiewang.com](http://www.debbiewang.com)

- FREE relationship enhancement program
- Nutritious refreshments are provided during the program
- A copy of the Hold Me Tight book by Dr. Sue Johnson



## Appendix E: Online Screening Questions

Inclusion Screening Survey Link: <http://goo.gl/forms/Jp3O6CM1s1>

Please click the following statement if it is true for you:

Question 1: I am in a committed relationship.

Yes       No

Question 2: My partner and I have been living together for over a year.

Yes       No

Question 3: My partner and I are expecting our first child through pregnancy.

Yes       No

Question 4: My partner and I do not have other children from previous relationships.

Yes       No

Question 5: My partner and I will be within 34 weeks of pregnancy at the first week of September 2016

Yes       No

Question 6: My partner and I are willing to commit to a 16-hour relationship program for a research study during September and October on 2 Saturday mornings in Waterloo, Ontario.

Yes       No

Question 7: My partner and I can speak and understand English.

Yes       No

## Appendix F: Exclusion Screening Questions

Exclusion Criteria: The following are questions to help determine whether the program is suitable for you and your partner:

1. \*Has there been long-standing relationship distress in your relationship? (No)

\*If yes, what caused the distress? On a scale of 1 (low) to 10 (high), how much has the relationship distress impacted your overall sense of well-being at present

If it is greater than 7, the individual/couple is not suitable for the program

2. Are you committed to your partner and the growth of your relationship? (Yes)
3. Are you experiencing any form of abuse (e.g., physical, emotional, financial, sexual) in your relationship with your partner at present? (No)
4. Are you afraid of your partner? (No)
5. \*Have you experienced any form of abuse in your relationship with your partner or other in the past? (No).

\*If yes, did you get some help at the time? On a scale of 1 (low) to 10 (high), how much has the past abuse had a negative impact on your overall sense of well-being at present?

If it is greater than 7, the individual/couple is not suitable for the program

6. Have you had a serious mental illness or addiction problem? (No)
7. Has your partner had a serious mental illness or addiction problem? (No)

\*If yes, proceed with the following inquiries:

- “Has the mental illness or addiction been treated?” (Yes)
- “Has it been in remission for over 1 year?” (Yes)

If the answer is “No” to the above questions, the individual/couple is not suitable for the program

8. If none of the above are endorsed, I will administer the 10 questions of the EPDS to screen for depression, anxiety and suicidal thoughts.

\* The EPDS includes one question (Item 10) about suicidal thoughts and should always be checked. If this item is answered “yes”, further inquiry about the nature of any thoughts of self-harm is required in order for the level of risk to be determined (e.g., appropriate referrals need to be made) or call 911.

When the total EPDS score of the participant is greater than 12, it indicates the likelihood of depression is high, which will also make the couple not suitable for the program. Counselling resources will be provided or referral to a mental health professional may be necessary.

Individuals who did not respond with the researcher’s anticipated answer for any of the question or the researcher felt the individual’s needs are greater than this program could provide, the phone interview will end here. If the potential participant seems distressed, the researcher will refer the individual partner or couple for assessment or treatment by a registered health

professional. For those who responded the above questions according to the preferred answers, the 10-item EPDS (see Appendix F) will be used to continue the screening.

If both partners are cleared from the exclusion criteria and still interested in the program, they will be invited to participate in the research study. The letter of information and consent form will be mailed or emailed to them after the phone screening. After the couple has had the chance to discuss, a follow-up phone call will be made to set up the pre-program interview meeting.

## Appendix G: Summary of Participants Interview Questions

### Pre-Program Interview Questions

The researcher will be interviewing both partners (together) after each partner has completed the relationship information form. The following are the two open-ended questions that they will be asked and the interview will be audio recorded:

- a) What caused you to be interested in participating in this research project?

Possible probes:

- Do you have any worries and concerns about becoming a parent?
- Do you have any worries and concerns about your relationship?

- b) How do you think being in the HMT program might be helpful to you? In what way?

- What are you hoping for or expecting from the program?

### Focus Group Questions

The researcher will facilitate a focus group at the end of the last session of the program with all of the couples that have participated in the study. The focus group is expected to take approximately 30 minutes. The following are the questions:

- a) What do you think about the program? Is it helpful? If yes, in what way?
- b) In your opinion, has this program increased your confidence in becoming first-time parents? How?
- c) Has the program increased your ability to work together to create a healthy emotional foundation for your baby? How?



## Post-Program Interview Questions

The researcher will interview both partners (together). The following are the semi-structured questions that will be asked in this audio-recorded interview:

- a) What was it like participating in the HMT program as a couple?

Possible probes:

- Was it what you hoped for?
- Did the program meet your expectations?

- b) Do you think participating in the program has changed how you see or understand yourself in any way? If yes, how did you see yourself before and how do you see yourself now? What has changed?

- c) Do you think participating in the program has changed how you see or understand your relationship? If yes, how did you see your relationship before and how do you see it now? What has changed?

- d) Has participating in this program changed your view or your feelings about being a parent? Possible probes:

- More confident or less confident? In what way?
- How will your baby benefit from what you learned from this program?
- Do you think the program has helped you be able to work together better to create a healthy emotional environment for your family?

## Appendix H: Program Evaluation Form for Facilitators

### Program Evaluation Form for Facilitators Hold Me Tight for Couples Becoming Parents - Program Evaluation

Facilitator: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for your role as the facilitator in this evaluation process. This questionnaire asks you to give some feedback on the *Hold Me Tight: For Couples Becoming Parents* program. Your feedback is valuable, as it will help us assess this program and make improvements to it. Please answer each question and make any comments you think would be useful.

1. Please rate the program on the following dimensions, where 1 is poor and 5 is excellent:

|                     |   |   |   |   |   |
|---------------------|---|---|---|---|---|
| Facilitator's Guide | 1 | 2 | 3 | 4 | 5 |
| Powerpoint Content  | 1 | 2 | 3 | 4 | 5 |
| Exercises           | 1 | 2 | 3 | 4 | 5 |
| Video/DVD           | 1 | 2 | 3 | 4 | 5 |
| Handouts            | 1 | 2 | 3 | 4 | 5 |
| Overall Rating      | 1 | 2 | 3 | 4 | 5 |

2. What did you find most useful about this program for the target population?

3. Have you encountered any challenges with the content material that is used for the program?

4. Is the allotted time enough to cover all content material for the program? Please explain.

Yes                       No                       Depends on the Day

5. Overall, please indicate how confident you feel delivering the program and its content. Please explain.

Very confident                       Confident enough                       Not confident

6. Overall, do you think the participants got what they were looking for from this program?

## Appendix I: Program Evaluation Form for Participants

### Hold Me Tight for Couples Becoming Parents - Program Evaluation

Group: \_\_\_\_\_ Date: \_\_\_\_\_

This questionnaire asks you to give some feedback on the *Hold Me Tight: For Couples Becoming Parents* program. Your feedback is valuable, as it will help us assess this program and make improvements to it. Please answer each question and make any comments you think would be useful.

1. Please rate the session on the following dimensions, where 1 is poor and 5 is excellent:

|                |   |   |   |   |   |
|----------------|---|---|---|---|---|
| Facilitators   | 1 | 2 | 3 | 4 | 5 |
| Content        | 1 | 2 | 3 | 4 | 5 |
| Exercises      | 1 | 2 | 3 | 4 | 5 |
| Video/DVD      | 1 | 2 | 3 | 4 | 5 |
| Handouts       | 1 | 2 | 3 | 4 | 5 |
| Overall Rating | 1 | 2 | 3 | 4 | 5 |

2. What did you find most useful about this program? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. What do you wish could have been added or done differently in this program? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. Overall, did you get the outcomes you were looking for? \_\_\_\_\_

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5. Would you recommend this program to other couples who are expecting their first child? \_\_\_\_\_

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6. Any other comments/suggestions? \_\_\_\_\_

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The program evaluation form is adapted from HMT's online downloadable program evaluation form

[www.iceeft.com/ProgramEvaluationForm.pdf](http://www.iceeft.com/ProgramEvaluationForm.pdf)

## Appendix J: Experiences in Close Relationship Scale-Short Form (ECR-S)

Instruction: The following statements concern how you feel in romantic relationships. We are interested in how you generally experience relationships, not just in what is happening in a current relationship. Respond to each statement by indicating how much you agree or disagree with it. Mark your answer using the following rating scale:

| 1                    | 2        | 3                    | 4       | 5                 | 6     | 7                 |
|----------------------|----------|----------------------|---------|-------------------|-------|-------------------|
| Strongly<br>Disagree | Disagree | Slightly<br>Disagree | Neutral | Slightly<br>Agree | Agree | Strongly<br>Agree |

- \_\_\_\_\_ 1. It helps to turn to my romantic partner in times of need.
- \_\_\_\_\_ 2. I need a lot of reassurance that I am loved by my partner.
- \_\_\_\_\_ 3. I want to get close to my partner, but I keep pulling back.
- \_\_\_\_\_ 4. I find that my partner doesn't want to get as close as I would like.
- \_\_\_\_\_ 5. I turn to my partner for many things, including comfort and reassurance.
- \_\_\_\_\_ 6. My desire to be very close sometimes scares people away.
- \_\_\_\_\_ 7. I try to avoid getting too close to my partner.
- \_\_\_\_\_ 8. I do not often worry about being abandoned.
- \_\_\_\_\_ 9. I usually discuss my problems and concerns with my partner.
- \_\_\_\_\_ 10. I get frustrated if romantic partners are not available when I need them.
- \_\_\_\_\_ 11. I am nervous when partners get too close to me.
- \_\_\_\_\_ 12. I worry that romantic partners won't care about me as much as I care about them.

### Scoring Information:

Anxiety = 2,4,6,8 (reverse), 10, 12

Avoidance = 1 (reverse), 3, 5 (reverse), 7, 9 (reverse), 11

Results consist of two scores for the two separate factors; attachment anxiety and attachment avoidance. The minimum score for each scale is 7 and a maximum score of 42.

- Attachment avoidance is defined as involving fear of dependence and interpersonal intimacy, an excessive need for self-reliance, and reluctance to self-disclose.
- Attachment anxiety is defined as involving a fear of interpersonal rejection or abandonment, an excessive need for approval from others, and distress when one's partner is unavailable or unresponsive.

People who score high on either or both of these dimensions are assumed to have an insecure adult attachment orientation. By contrast, people with low levels of attachment anxiety and avoidance can be viewed as having a secure adult attachment orientation (Brennan, Clark, & Shave, 1998). In addition, higher scores are significantly and positively related to depression, anxiety, interpersonal distress, or loneliness.

Wei, M., Russell, D.W., Mallinckrodt, B., & Vogel, D. L. (2007). The experiences in Close Relationship Scale (ECR)-Short Form: Reliability, validity, and factor structure. *Journal of Personality Assessment*, 88, 187-204.

## Appendix K: The A.R.E. Questionnaire

### Accessibility, Responsiveness, Emotional Engagement

From your viewpoint, is your partner accessible to you?

- |   |       |
|---|-------|
| 1. I can get my partner's attention easily.                             | T   F |
| 2. My partner is easy to connect with emotionally.                      | T   F |
| 3. My partner shows me that I come first with him/her.                  | T   F |
| 4. I am not feeling lonely or shut out in this relationship.            | T   F |
| 5. I can share my deepest feelings with my partner. He/she will listen. | T   F |

From your viewpoint, is your partner responsive to you?

- |  |       |
|--|-------|
| 1. If I need connection and comfort, he/she will be there for me.  | T   F |
| 2. My partner responds to signals that I need him/her to come close.   | T   F |
| 3. I find I can lean on my partner when I am anxious or unsure.  | T   F |
| 4. Even when we fight or disagree, I know that I am important to my partner and we will find a way to come together. | T   F |
| 5. If I need reassurance about how important I am to my partner, I can get it.                                       | T   F |

Are you positively emotionally engaged with each other?

- |   |       |
|---|-------|
| 1. I feel very comfortable being close to, trusting my partner.                   | T   F |
| 2. I can confide in my partner about almost anything.                             | T   F |
| 3. I feel confident, even when we are apart, that we are connected to each other. | T   F |
| 4. I know that my partner cares about my joys, hurts, and fears.                  | T   F |
| 5. I feel safe enough to take emotional risks with my partner.                    | T   F |

Johnson, S. (2010). Hold Me Tight

## Appendix L: BARE Scale

### The BARE items listed by subscale

Please circle the number that best represents your experiences in your current relationship with your partner.

---

#### Accessibility

- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| 1. I am rarely available to my partner.           | 1 | 2 | 3 | 4 | 5 |
| 2. It is hard for my partner to get my attention. | 1 | 2 | 3 | 4 | 5 |

#### Responsiveness

- |  |   |   |   |   |   |
|--|---|---|---|---|---|
| 3. I listen when my partner shares her/his deepest feelings. | 1 | 2 | 3 | 4 | 5 |
| 4. I am confident I reach out to my partner                  | 1 | 2 | 3 | 4 | 5 |

#### Engagement

- |  |   |   |   |   |   |
|--|---|---|---|---|---|
| 5. It is hard for me to confide in my partner.               | 1 | 2 | 3 | 4 | 5 |
| 6. I struggle to feel close and engaged in our relationship. | 1 | 2 | 3 | 4 | 5 |

#### Partner's Accessibility

- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| 7. My partner is rarely available to me.            | 1 | 2 | 3 | 4 | 5 |
| 8. It is hard for me to get my partner's attention. | 1 | 2 | 3 | 4 | 5 |

#### Partner's Responsiveness

- |   |   |   |   |   |   |
|---|---|---|---|---|---|
| 9. My partner listens when I share my deepest feelings. | 1 | 2 | 3 | 4 | 5 |
| 10. I am confident my partner reaches out to me.        | 1 | 2 | 3 | 4 | 5 |

#### Partner's Engagement

- |  |   |   |   |   |   |
|--|---|---|---|---|---|
| 11. It is hard for my partner to confide in me.                            | 1 | 2 | 3 | 4 | 5 |
| 12. My partner struggles to feel close and engaged in<br>our relationship. | 1 | 2 | 3 | 4 | 5 |

---

1 = Never True; 2 = Rarely True; 3 = Sometimes True; 4 = Usually True; 5 = Always True.



## Instructions for Clinicians: Scoring the BARE

1. Reverse score all items in the Accessibility and Engagement sections (#s 1,2,5,6, 7,8,11,12)
2. Sum the items in each sub-scale, or for the total scale add all sub-scales together, higher scores means more attachment behaviours reported, higher scores are better
3. Remember there are both self and partner scores (where you rate your partner)
4. Interpretation of numbers

The guidelines reported below come from a sub-sample that approximates a nationally representative group in terms key demographics (religion, race, etc.) We have broken down the scores into red, yellow and green: red means needs some work, yellow means some concern, green means doing well. Specifically, the low, medium, high breakdown represents BARE scores and their association with marital quality scores (problems areas, satisfaction, stability); red means low marital quality, yellow means medium, green means high. Although a few sub-scales were statistically different for men and women, in no case were the differences clinically significant or meaningful.

|        | BARE total Self | BARE total Partner | Accessibility Self | Accessibility Partner | Responsiveness Self | Responsiveness Partner | Engagement Self | Engagement Partner |
|--------|-----------------|--------------------|--------------------|-----------------------|---------------------|------------------------|-----------------|--------------------|
| Red    | 20              | 17                 | 8                  | 7                     | 5                   | 4                      | 6               | 6                  |
| Yellow | 23              | 22                 | 8.5                | 8                     | 6                   | 6                      | 8               | 8                  |
| Green  | 26              | 26                 | 9                  | 9                     | 8                   | 8                      | 9               | 9                  |

5. We recommend using the total scores, as the range in individual sub-scales may not provide enough spread to help the clinician or client.

## Appendix M: Edinburgh Postnatal Depression Scale (EPDS)

**Edinburgh Postnatal Depression Scale (EPDS)**

The EPDS is a 10-item questionnaire. Women are asked to answer each question in terms of the past seven days. A score is calculated by adding the individual items as indicated below for each question (note some items have reversed scoring).

UNIVERSAL SCREENING is a quick and easy way to determine women at risk as well as helping to reduce stigma of mental health problems. The Edinburgh Postnatal Depression Scale – EPDS – can be done in-person or over the phone. The EPDS is also valid for use with partners.

**EPDS Screen**

|   |  |   |  |   |
|---|--|---|--|---|
| <b>Anxiety Subscale</b>                                   | 1. I have been able to laugh and see the funny side of things: |   | 6. Things have been getting on top of me:                      |   |
|   | As much as I always could                                      | 0   | Yes, most of the time I haven't been able to cope at all       | 3 |
|   | Not quite so much now  | 1   | Yes, sometimes I haven't been coping as well as usual          | 2 |
|   | Definitely not so much now                                     | 2   | No, most of the time I have coped quite well                   | 1 |
|   | Not at all   | 3   | No, I have been coping as well as ever                         | 0 |
|   | 2. I have looked forward with enjoyment to things:             |   | 7. I have been so unhappy that I have had difficulty sleeping: |   |
|   | As much as I ever did  | 0   | Yes, most of the time  | 3 |
|   | Rather less than I used to                                     | 1   | Yes, sometimes   | 2 |
|   | Definitely less than I used to                                 | 2   | Not very often   | 1 |
|   | Hardly at all  | 3   | No, not at all   | 0 |
|   | 3. I have blamed myself unnecessarily when things went wrong:  |   | 8. I have felt sad or miserable:                               |   |
|   | Yes, most of the time  | 3   | Yes, most of the time  | 3 |
|   | Yes, some of the time  | 2   | Yes, quite often   | 2 |
|   | Not very often   | 1   | Not very often   | 1 |
|   | No, never  | 0   | No, not at all   | 0 |
|   | 4. I have been anxious or worried for no good reason:          |   | 9. I have been so unhappy that I have been crying:             |   |
|   | No, not at all   | 0   | Yes, most of the time  | 3 |
|   | Hardly ever  | 1   | Yes, quite often   | 2 |
|   | Yes, sometimes   | 2   | Only occasionally  | 1 |
|   | Yes, very often  | 3   | No, never  | 0 |
| 5. I have felt scared or panicky for no very good reason: |  | 10. The thought of harming myself has occurred to me: |  |   |
| Yes, quite a lot  | 3  | Yes, quite often                                      | 3  |   |
| Yes, sometimes  | 2  | Sometimes   | 2  |   |
| No, not much  | 1  | Hardly ever   | 1  |   |
| No, not at all  | 0  | Never   | 0  |   |
|   |  |   |  |   |
|   |  |   | TOTAL SCORE: _____   |   |

### Interpreting EPDS scores

Clinical judgment is integral to interpreting EPDS scores, as in some cases the score may not accurately represent a woman's mental health. For example, a woman may have a low score, even though there is good reason to believe that she is experiencing depressive symptoms. A very high EPDS score could suggest a crisis, other mental health issues or unresolved trauma.

Scores may be influenced by several factors, including the patients understanding of the language used, their fear of the consequences if depression is identified, and differences in emotional reserve and perceived degree of stigma that is associated with depression.

### When follow-up care is required

A total score of 12 or more is considered a flag for the need for follow up of possible depressive symptoms. In the antenatal period repeat the EPDS in 2-4 weeks if a women's score is 12 or more in line with clinical judgment. If the second EPDS score is 12 or more, refer to an appropriate health professional, ideally the women's usual GP. In the postnatal period arrange referral or ongoing care if a women's score is 12 or more in line with clinical judgment.

Follow-up may also be needed if scores on Questions 3, 4 and 5 suggest possible symptoms of anxiety.

For scores of 1, 2 or 3 on Question 10, the safety of the woman and children in her care should be assessed and, according to clinical judgment, advice sought and/or mental health assessment arranged.

Cox, Holden, & Sagovsky (1987).

## Appendix N: Relationship Information Sheet

Couple # \_\_\_\_\_ Partner # \_\_\_\_\_

### Personal Information

Name:

Age:

Gender: Male or Female

Ethnicity:

Where were you born?

How long have you been living in Canada?

What's your highest education?

What kind of work do you do?

Contact number to best reach you:

Email:

Current relationship status (please check all that apply to you):

Single

Living together

Committed relationship

Re-married

Engaged

Separated

Married

Divorced

Have you ever been involved with therapy?  Yes  No

Are you currently, or have you previously been, in couple's therapy?  Yes  No

Briefly describe your present relationship:

Your partner's name:

Length of time living together with your partner:

Important or relevant history/events:

Strengths and difficulties of your relationship:

What are your hopes for participating in this couples' program?

## Appendix O: Research Participant Consent Form

WILFRID LAURIER UNIVERSITY

INFORMED CONSENT STATEMENT

Hold Me Tight: For Couples Becoming First-Time Parents

Pilot Study of An Attachment-Informed Relationship Program for Couples Becoming Parents

Researcher: Debbie Wang, MSW, PhD Candidate, Faculty of Social Work

Advisors: Dr. Carol Stalker & Dr. Marshall Fine

You are invited to participate in a research study. The purpose of this study is to increase knowledge about the helpfulness of a relationship program designed to help couples better understand their relationship with each other and create the best possible emotional foundation for their expected child. The researcher is a doctoral student in the Faculty of Social Work PhD program at Wilfrid Laurier University.

### INFORMATION

Participants of this study will be asked to take part in the *Hold Me Tight for Couples Becoming Parents* program:

1. You and your partner will be asked to attend and participate in the program on 2 Saturdays in Waterloo during 2016. Total time over the two Saturdays is 16 hours for the program. In each of the two sessions, there will be conversation exercises for you and your partner followed by group discussion.
2. Together as a couple, you will be asked to first meet with the researcher for a brief interview (approximately 30 minutes) before the program begins. This interview will be scheduled at a time and place that is convenient for you.
3. During the 2-day program, you will be asked to first answer the questions in a brief questionnaire package before the workshop starts. At the end of the second day workshop, you will be asked to fill out a program evaluation form and answer questions in a second brief questionnaire package. You will also be asked to participate in a focus group on the last day of the program with other couples from the group. The focus group will take approximately 30 to 45 minutes. A total of 10-12 participants (5-6 couples) will be taking part in the program and the focus group. The interviews and the focus group will be audio recorded and transcribed for analysis.

4. Following the program you will be asked to participate as a couple in a follow-up interview, which will take approximately one hour. The interviews will be scheduled at times that suit your schedule and at a location that is convenient for you.

## RISKS

It is possible that while recounting stories about your relationship and expectations about parenting, participants may find themselves experiencing emotional upset. Participants may ask the researcher or the program facilitators to stop the line of questioning that is upsetting; if they wish, participants may stop their participation in the program and the research study at any time.

In the event that a participant feels it would be beneficial to follow up with a counsellor, the researcher will provide contact information about counsellors in the participants' geographical area who may be able to assist in dealing with issues that arise during the group program, the pre and post program interviews or the focus group.

## BENEFITS

By committing to participate in this research study, you will be able to attend a relationship enhancement program at no cost to you. You will also receive a copy of the *Hold Me Tight* book by Dr. Sue Johnson and nutritious refreshments will be provided during each session of the program.

I hope and expect that having an opportunity to take part in this relationship program will be a positive experience for you and your partner, and will give you a picture of the many ways to strengthen your relationship with each other and with your baby.

By taking part in the focus group and individual interviews you will have an opportunity to contribute to the findings of the research and thereby directly contribute to the information about this program that will be shared with other scholars and the general public

## CONFIDENTIALITY

All information you provide will be kept strictly confidential and all efforts will be made to maintain your anonymity. After the audio recording of your interviews, the digital file of the interviews will be labelled with an assigned number in place of your name. The transcription of the interviews will be seen by the researcher and the members of the researcher's doctoral committee but will only be identified by the assigned number. The digital audio file and transcription will be kept secure in a locked cabinet in the researcher's home and destroyed no later than December 2021.

At the end of this letter, you will be asked if the researcher may quote your words as long as there is nothing in the quotation that would identify you. You may also indicate if you would like to review any quotation before it is used in the dissertation, a publication or a presentation.

## CONTACT

If you have questions at any time about the study or the procedures, (or you experience adverse effects as a result of participating in this study) you may contact the researcher Debbie Wang, at the Lyle S. Hallman Faculty of Social Work, Wilfrid Laurier University, 200 Duke Street, Kitchener, Ontario, 519-884-xxxx, or by e-mail at [dwang@wlu.ca](mailto:dwang@wlu.ca).

This project has been reviewed and approved by the University Research Ethics Board. If you feel you have not been treated according to the description in this form, or your rights as a participant in research have been violated during the course of this project, you may contact Dr. Robert Basso, Chair, University Research Ethics Board, Wilfrid Laurier University, 519-884-0710, ext. 5225 or [rbasso@wlu.ca](mailto:rbasso@wlu.ca)

## PARTICIPATION

Your participation in this study is voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at any time without penalty and without loss of benefits to which you are otherwise entitled. If you withdraw from the study before data collection is completed your data will be destroyed. You have the right to omit any question(s)/procedure(s) you choose.

## FEEDBACK AND PUBLICATION

Results of this study may be submitted for publication in books, journal articles, or presented at academic/professional conferences. At your request, the researcher will send you a summary of the results once the dissertation has been successfully defended.

## CONSENT

I have read and understand the above information. I have received a copy of this form. I agree to participate in this study by taking part of the pre-program and post program interviews, by attending the 16-hour program, and the focus group at the end of the program.

Participant's signature \_\_\_\_\_ Date \_\_\_\_\_

Participant's e-mail /contact number \_\_\_\_\_

Participant's signature \_\_\_\_\_ Date \_\_\_\_\_

Participants e-mail/contact number \_\_\_\_\_



Researcher's signature \_\_\_\_\_ Date \_\_\_\_\_

### Agreement regarding quotations

I agree that the researchers may quote my words as long as there is nothing in the quotation that will identify me.

Yes \_\_\_\_\_

No \_\_\_\_\_

Yes \_\_\_\_\_

No \_\_\_\_\_

I wish to review any quotation before it is included in a report or other publication.

Yes \_\_\_\_\_

No \_\_\_\_\_

Yes \_\_\_\_\_

No \_\_\_\_\_

I would like to receive a copy of the summary of the research results.

Yes \_\_\_\_\_

No \_\_\_\_\_

Yes \_\_\_\_\_

No \_\_\_\_\_

The email or mailing address to which research results should be sent to is:

---

---

---

## Appendix P: Consent to be Contacted Form

### Consent to be Contacted Form

Future Follow-Up Study on Hold Me Tight for Couples Becoming Parents

Researcher: Debbie Wang, MSW, PhD Candidate, Faculty of Social Work

I agree that the researcher may contact me in the future if a follow-up study is conducted that inquires into our experiences after our baby is born. Such a study would help evaluate the long-term outcomes for parents who have participated in the Hold Me Tight for Couples Becoming Parents program. I understand that I have the right to choose to participate or decline at the time of contact.

Participant's signature \_\_\_\_\_ Date \_\_\_\_\_

Participant's e-mail /contact number \_\_\_\_\_

Participant's signature \_\_\_\_\_ Date \_\_\_\_\_

Participants e-mail/contact number \_\_\_\_\_

Researcher's signature \_\_\_\_\_ Date \_\_\_\_\_

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