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Research Article

Relationship Satisfaction, Co-Parenting, Spiritual Disclosure, and Religious/Spiritual Coping: Exploring Links to Parents' Mental Health following a Neonatal Intensive Care Experience

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Abstract
The birth of a child is often a joyous occasion, but when a family experiences a neonatal intensive care stay, there may be mental health and relationship implications. In this quantitative study, 162 former neonatal intensive care (NICU) parents completed surveys related to their anxiety (PSWQ; Meyer et al., 1990), stress (SASRQ-for NICU; Cardena et al., 2000), depression (CESD-R; Eaton et al., 2004), relationship satisfaction (RAS; Hendrick et al., 1998), and co-parenting (Brief Measure of Co-Parenting; Feinberg et al., 2012) along with self-reports of religious/spiritual coping (Brief RCOPE; Pargament et al., 2011) and spiritual disclosure (SDS; Brelsford & Mahoney, 2008) in the couple relationship. Participants were acquired after soliciting names from a state Bureau of Health Statistics and mothers were contacted via mail with a second survey for her co-parent/partner. Respondents to this survey were married or were living together as partners. Infants were born on average at 31.65 weeks' gestation and spent an average of 33.23 days in the NICU. The average time elapsed between NICU discharge and parent survey completion was 414 days. Analyses were conducted via SPSS Version 28 and results indicated that there were significant inverse correlations between parents' mental health and their relationship functioning (spiritual disclosure, relationship satisfaction, and co-parenting). Moreover, parents' mental health challenges were significantly related to increased use of negative religious/spiritual coping. Finally, after accounting for relationship functioning, parents' use of negative religious coping had a significant link to their mental health outcomes. Thus, when parents are experiencing difficulties with their mental health after a NICU experience, they may struggle more with their marriage, co-parenting, and engage in more negative religious/spiritual coping. Therefore, additional research is needed on ways to support parents' mental health, relational functioning, and religious/spiritual lives following a NICU experience.

Keywords:
Spirituality • Religious/Spiritual Coping • Co-Parenting • Mental Health • Relationship Satisfaction

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Introduction

Along with the typical challenges that come with the birth of a child, the appearance of a fragile, sick infant and changes to the parental role can cause significant emotional distress in parents who have a child in neonatal intensive care (NICU; MacIntosh, Stern, & Ferguson, 2004). Many parents are unprepared for their infant's hospitalization and develop concerns about the potential for long-term negative outcomes for their child. Initially, not being able to hold the infant causes parental emotional distress, and later, due to the infant's potentially unstable condition, a variety of difficult emotions such as anxiety, depression, or PTSD can emerge (Seideman et al., 1997). This emotional distress can impact parents' ability to emotionally bond with their infant and respond to their needs. These difficulties coupled with prolonged mother-infant separation, frequent lack of privacy during infant care, and lack parental support in the NICU can exacerbate stress while in the NICU and have implications for parenting post-NICU discharge. Most research supports that parents' experiences in the NICU often result in elevated stress levels, anxiety, and depression (Greene et al., 2015). Parents' emotional difficulties can also cause concerns about parenting confidence and the co-parenting relationship, which includes being able to adequately meet the physical and emotional needs of the infant, post-discharge (Harris, et al., 2018).

In addition to psychological challenges, many parents may find that their religious and spiritual worldviews have relevancy in a neonatal intensive care setting (Brelsford & Doheny, 2016). Parents' religious and spiritual worldviews shape the way that families cope with stressful life situations and are often interwoven into the fabric of their psychological experiences (Mahoney, 2010). Having a child is a fundamental life turning point imbued with expectations often framed with spiritual or religious significance. Like most life changing experiences, the inculcation of religious or spiritual significance can have both positive and negative intrapersonal and interpersonal impacts when people are placed in a stressful, potentially traumatic situation. Thus, the importance of addressing spiritual and religious beliefs and coping strategies while in this stressful situation are necessary and important.

Indeed, parental stress and anxiety can be impacted via the methods of coping through both secular and spiritual/religious means. In this study, we focused on religious/spiritual (R/S) coping, which can include both adaptive and maladaptive ways of dealing with a stressful situation. R/S coping is theorized to entail either a positive or a negative dimension and is often called positive or negative R/S coping (Ano & Vasconcelles, 2005; Pargament et al., 2000). Positive spiritual coping reflects a more secure relationship with God that manifests in benevolent religious reappraisals (e.g. God walks with me through this challenging time) and seeking out religious or spiritual support through prayer or with members of a spiritual community, whereas

negative spiritual coping suggests a strained or challenging relationship with God and frequently results in punitive religious reappraisals (e.g., God is angry with me and therefore punishing me through this stressful event) and spiritual/religious discontent (e.g., God is not reliable and therefore I cannot count on God to help me through this situation; Pargament et al., 2000). Thus, spiritual coping can include leaning on God for support, working with God to put plans into action, feeling abandoned by God, questioning God's love, questioning the meaning of life, and experiencing spiritual doubts, for example.

Religious and spiritual worldviews contextualize parents' life experiences in both theistic (i.e., God or gods) or non-theistic ways (i.e., general spirituality not tied to a deity; Mahoney, 2010). In our previous work, we found that NICU parents often engage in both adaptive and maladaptive forms of R/S coping (Brelsford et al., 2016). In particular, we found that increases in maladaptive forms of R/S coping co-occur with positive R/S coping. Thus, parents may report being abandoned or feeling angry with God while also leaning on God for support and love. This is a complex picture of coping, but make sense with the tenuous and unpredictable course of having an infant in the NICU. In a qualitative study, we also found that parents who endorsed higher religiousness or spirituality, reported being able to grow their spirituality and use their R/S beliefs to more effectively cope post NICU discharge (Brelsford & Doheny, 2016). We have also found that spiritual struggles with meaning are related to increases in parents' depression and anxiety (Brelsford et al., 2019). Finally, most recently, we found that higher levels of parental stress in the NICU was related to spiritual struggles, particularly with meaning making about life post-NICU discharge (Brelsford & Doheny, 2022). All these studies support the importance of continued exploration of parents' religious and spiritual beliefs and how they cope with the NICU. In summary, there is small body of research focused on the R/S coping, views, and practices in relation to familial functioning for NICU parents, but it is limited in scope.

In addition, there is a paucity of research exploring NICU parents' spiritual and religious worldviews and struggles in relation to their co-parenting and relationship functioning. Our previous work in the NICU has shown that when parents feel God has abandoned them or when they feel angry at God that they experience poorer family cohesion and increased use of denial (Brelsford et al., 2016), but this is the only study to explore these constructs to date.

The relational spirituality framework developed by Mahoney (2010) highlights how the formation, maintenance, and transformation of familial relationships is related to one's religious and spiritual beliefs, particularly their religious and spiritual behaviors, thoughts, and emotions. Specifically, "relational spirituality refers to when the search for the sacred is united, for better or worse, with the search for relationships" (Mahoney

& Boytazis, 2019, p. 522). Spiritual disclosure could be integrated into this relational spirituality framework due to the important aspects of this concept that focuses on sharing of vulnerable religious and spiritual views with a romantic partner and co-parent. This sharing can come with challenges if one partner does not agree with the other partner on these spiritual and religious views, but sharing nonetheless may signal a closer bond and be a safe haven for exploring value systems that are often informed by R/S views, beliefs, behaviors, and traditions. Thus, we wanted to explore this concept further with former NICU parents and better understand how spiritual disclosure is related to their mental health and along with co-parenting and relationship satisfaction.

Current Study

In this study we had two aims: The first aim was to explore connections between NICU parents' relationship satisfaction, co-parenting behaviors, spiritual disclosure in relation to their use of positive and negative R/S coping. The second aim was to explore connections between relational factors such as relationship satisfaction, co-parenting, spiritual disclosure, and parents' psychological well-being via their self-reports on anxiety, stress related to the NICU experience, and depression. Thus, this was an exploratory study, but we hypothesized that parents' mental health difficulties would be related to more relationship difficulties and poorer R/S coping or alternatively better relationship functioning and spiritual disclosure would be related to better mental health outcomes and increased use of positive religious and spiritual coping.

Method

This quantitative study included 110 mothers, 51 fathers, and one non-binary parent, resulting in a total sample size of 162 individuals. Out of these participants, 110 were biological mothers, 50 were biological fathers, and two were a non-biological second caregiver. These participants were recruited from a US state Bureau of Health Statistics and Studyfinder at a Mid-Atlantic Children's Hospital. Inclusion criteria required that parents had premature babies who experienced a NICU stay, but did not experience infant death at the time of data collection. Further, to be included in this study, parents must be fluent in English and be 18 years of age or older. Mothers and fathers were contacted separately via regular mail, following university Institutional Review Board (IRB) approval, and were invited to complete a survey. Families who returned the surveys were compensated with a gift card as a token of appreciation for their participation. For the full study, out of the 1,013 surveys mailed to mothers, a total of 123 surveys were returned, resulting in a response rate of 12.1%. Additionally, nine mothers were recruited through Studyfinder, the university hospital's study locator website. Therefore, a total of 185 valid responses from parents/caregivers were obtained from the full study. However, for this study, we explored the responses

of 162 parents/caregivers because of our focus on caregivers in a romantic/co-parenting relationship. Thus, of these 162 responses, 143 were from parents who are married (88.3%) and 19 respondents reported living with their partner but were not married (11.7%).

Table 1
Means, Standard Deviation, Minimum and Maximum scores, and Internal Consistency of Primary Study Variables and Scales

Constructs	*M*	*SD*	*Min*	*Max*	*a*
Stress	32.26	27.94	0	114	.95
Worry	48.97	15.90	19	80	.95
Depression	30.65	14.66	20	100	.91
Positive religious coping	14.14	7.52	7	28	.97
Negative religious coping	9.24	3.78	7	23	.88
Co-parenting	69.13	13.65	13	84	.89
Relationship satisfaction	28.26	4.82	12	33	.86
Spiritual disclosure	43.95	17.99	19	76	.96

M = Mean, SD = Standard Deviation, Min = Minimum, Max = Maximum

Regarding the characteristics of the infants, the average gestational age was 31.65 weeks, with a range of 24 to 39 weeks. Infants spent an average of 33.23 days in the Neonatal Intensive Care Unit (NICU), with a range of 5 to 112 days and 91.7% of parents had no previous experience with the NICU. Infants' average birth weight was 3.60 pounds. Also, the mean time elapsed between NICU discharge and parent survey completion was 414 days (ranging from 62 to 968 days), so on average parents completed these surveys over a year after NICU discharge.

For this study, participants provided information about their age, biological sex, race and ethnicity, marital status, educational qualifications, employment status, and income. Additionally, parents' religious and spiritual lives were assessed through questions such as self-perceived religiousness and spirituality, attendance at religious services, engagement in prayer, and religious affiliation.

To assess religious and spiritual (R/S) coping, participants completed the Brief RCOPE (Pargament et al., 2011). This scale was comprised of 14 items, with 7 items each for positive and negative religious and spiritual coping subscales. Participants rated the frequency of their use of each coping strategy on a Likert scale ranging from 1 (not at all) to 4 (a great deal). In this study, the positive R/S coping subscale demonstrated good internal consistency (Cronbach's alpha = .97), as did the negative R/S coping subscale (Cronbach's alpha = .88). Historically, the Brief RCOPE has been shown to possess good concurrent validity, predictive validity, and incremental validity in predicting well-being, even when controlling for factors such as race, age, sex, mood, and social support (Pargament et al., 2011).

Anxiety levels were assessed using the Penn State Worry Questionnaire (PSWQ) developed by Meyer et al. (1990). This scale consisted of 16 self-report items that

measured an individual's tendency, frequency, and disposition to worry. Participants rated each item on a Likert scale ranging from 1 (not at all typical of me) to 5 (very typical of me). Higher scores on the PSWQ indicate higher levels of worry. In this study, the PSWQ exhibited good internal consistency (Cronbach's alpha = .95) and has demonstrated high convergent and discriminant validity in both clinical and non-clinical samples (Meyer et al., 1990).

Depressive symptoms were measured using the Center for Epidemiologic Studies Depression Scale—Revised (CESD-R) developed by Eaton et al. (2004). This 20-item scale assessed participants' experiences and symptoms of depression over a two-week period, with responses ranging from 0 (not at all or less than one day) to 4 (nearly every day). A total CESD-R score was computed by summing the ratings across all 20 items. Higher scores indicate a greater presence of depressive symptoms. The CESD-R demonstrated good internal consistency in this study (Cronbach's alpha = .91) and has shown strong convergent and discriminant validity in previous research (VanDam & Earleywine, 2011).

Parents' experiences of stress following NICU discharge were assessed using the Stanford Acute Stress Reaction Questionnaire (SASRQ) developed by Cardeña et al. (2000). This 30-item questionnaire measures the frequency of stress-related experiences on a scale ranging from 0 (not experienced) to 5 (very often experienced). Participants were also asked to indicate the number of days they experienced each symptom, with response options ranging from 0 days to 5 or more days. The SASRQ demonstrated good psychometric properties in this study, with a Cronbach's alpha coefficient of .95 in this study. The measure has been found to possess good content validity, as well as convergent and discriminant validity (Cardena et al., 2000).

The Relationship Assessment Scale (RAS; Hendrick et al., 1998) was used to measure relationship satisfaction among participants and their partners. The RAS is a 7-item measure that uses a 5-point scale. Responses range from 1 (low satisfaction) to 5 (high satisfaction). Participants are asked questions such as "How well does your partner meet your needs?" and "How often do you wish you hadn't gotten into this relationship?" Scoring on this scale reflects receiving a high/low score, therefore, the lower the score the less satisfied you are with your partner and vice versa for a high score. Previous studies have shown that the RAS produces high internal consistency (Graham et al., 2011). The internal consistency for this present study was .86.

The Spiritual Disclosure Scale (Brelsford & Mahoney 2008) was used to measure spiritual and religious openness. It is a 20-item measure that asks questions about religious and spiritual conversations with their partners on a scale of 1 (never) to 4 (often). Participants are asked questions such as "I share information about my spiritual journey with my partner." The Spiritual Disclosure Scale demonstrated high

internal consistencies in prior research (Brelsford & Mahoney, 2008; Luquis et al., 2012). The internal consistency of this measure was .96 for this study.

The Brief Measure of Co-Parenting (Feinberg et al., 2012) is a 14-item scale used to assess the co-parenting relationship. This measure is a brief measure of the full-scale Co-Parenting Relationship Scale. The brief measure of co-parenting assessed coparenting agreement; division of labor related to coparenting. exposure to conflict. coparenting support, undermining coparenting, endorsement of partner's parenting, and coparenting closeness with seven items being reverse coded to provide a total score with higher scores indicating a more effective co-parenting relationship. Each item is rated on a 7-point scale ranging from 0 (not true of us) to 6 (very true of us). The full scale of the Co-Parenting Relationship Scale has good reliability and stability (Feinberg et al., 2012). Internal consistency for the brief scale in the current sample was $\alpha = .89$.

Results

Participant Demographics

Participants in this study were on average 31.6 years old with a range of 19-63 years, with mothers being slightly younger than fathers on average (30 vs. 33 years of age). A majority of participants (88.3%) identified as White, 2.5% as African American/ Black, 3.0% as LatinX, 1.8% as Asian/Pacific Islander, .6% as American Indian/ Alaskan Native, and 3.8% as Other/Biracial/ Multiracial. Most mothers in this sample reported having some college experience to a graduate degree (84.9%) and most were employed full-time (55.6%), while 28.7% reported being stay at home parent. Similarly, 79.6% of fathers, reported attending some college to receiving a graduate degree and most reported working full time (87.4%). Mothers' most common response on income was under $25,000 (40.5%) with the second most indicated response of $50,000-$74,999 (22.9%); whereas most fathers reported an income of $50,000-$74,999 (32.3%) and the second most common response was $35,000-$49,999 (19.4%).

Most parents identified as Catholic (20.8%), 2.6% Presbyterian, 2.6% Muslim, 2.6% Congregational, 3.9% Baptist, 5.8% Lutheran, 0.6% Hindu, 9.7% atheist, 7.1% agnostic, 13.6% no religious affiliation, and 25.3% as other religious affiliation. In this study, 34% of parents reported being not religious at all, 27.7 % slightly religious, 21.4% moderately religious, and 17% considered themselves very religious. With respect to spirituality, 21.6% parents considered themselves to be very spiritual, 25.9% moderately spiritual, 27.2% slightly spiritual, and 25.3% not spiritual at all. Most parents also stated that they do not go to religious services (34.6%) or pray (31.7%). Yet, about 23.6% stated that they pray more than once a day and 19.8% of parents stated

that they attend religious services every week or more. Overall, a higher percentage of mothers reported engaging in prayer, attending religious services, seeing themselves as religious or spiritual, and having a religious affiliation than fathers.

Analyses

We conducted basic descriptive analyses (mean, *SD*, range, alphas) for all major study variables (positive and negative R/S coping, depression, anxiety, stress, co-parenting, spiritual disclosure, and relationship satisfaction) using SPSS Version 28. Next, we performed Pearson product-moment bivariate correlations between all major study variables to explore the statistical associations between variables. Finally, we completed three hierarchical regression models where parents' relationship satisfaction and co-parenting were in the first step, followed by positive and negative R/S coping and spiritual disclosure in the second step. Each model was used to determine the significant predictors for each outcome variable (depression, anxiety, and stress), to understand the unique contribution that R/S coping and spiritual disclosure has toward each of these outcome variables.

Correlations

Pearson product-moment correlations were conducted between all major study variables. Regarding the three main outcomes variables relating to parents' mental health, parents' anxiety was significantly positively correlated with negative religious coping (r = .24, p < .05). and significantly inversely correlated with relationship satisfaction, co-parenting, and spiritual disclosure (r = -.28, -.33, and -.20, p < .01) with (r =-.28 and -.33, p < .01, respectively; r = -.20, p < .05). For parents' depression, there was a significant positive correlation with their use of negative religious coping (r = .31, p < .01). and significant inverse correlations with relationship satisfaction and co-parenting (r = -.37, and -.52, p < .01, respectively). Finally, for parental stress, there was a similar result with a significant positive correlation with use of negative religious coping (r = .36, p < .01) and significant inverse correlations with relationship satisfaction and co-parenting (r = -.30 and -.35, p < .01, respectively).

When exploring parents' relational functioning, there was a significant positive correlation between their use of spiritual disclosure and their relationship satisfaction (r = .26, p < .01). and co-parenting. (r = .28, p < .01). There was also a significant positive correlation between relationship satisfaction and use of positive religious coping (r = .21, p < .05; see Table 2 for all intercorrelations).

Table 2
Correlations among Primary Study Variables

	1	2	3	4	5	6	7	8
1. Anxiety	--							
2. Stress	.50**	--						
3. Dep.	.46**	.56**	--					
4. Spir. Dis.	-.20*	-.14	-.10	--				
5. Rel. Sat.	-.28**	-.30**	-.37**	.26**	--			
6. Co-Par.	-.33**	-.35**	-.52**	.28**	.75**	--		
7. Pos. RC	-.15	-.04	-.01	.77**	.21*	.15	--	
8. Neg. RC	.24*	.36**	.31**	.17	-.06	-.12	.30**	--

Note: N = 116. Dep = Depression. Spir. Dis. = Spiritual Disclosure. Rel. Sat. = Relationship Satisfaction. Co-Par.= Co-Parenting. Pos. RC = Positive Religious Coping. Neg. RC= Negative Religious Coping.

Hierarchical Multiple Regressions

Hierarchical multiple regression analyses were conducted to explore how R/S coping and spiritual disclosure related to parents' stress, anxiety, and depression, respectively, after accounting for co-parenting and relationship satisfaction. This incremental validity model was utilized to determine if after accounting for relational functioning, that R/S coping and spiritual disclosure was related to parents' mental health outcomes. Thus, relationship functioning variables (relationship satisfaction and co-parenting) were entered into the first step of the regression equation followed by negative and positive religious coping and spiritual disclosure in the second step predicting to each of the mental health outcomes (parental stress, depression, and anxiety).

For the first regression, with the outcome variable of parental anxiety, the first step of the model contributed 10% of the variance with co-parenting having a significant $\beta = -.27$ ($p < .05$) and the second step accounted for 7% of the variance with negative R/S coping having a significant $\beta = .21$ ($p < .05$; see Table 3).

Table 3
Hierarchical Regression of Parents' Relationship Functioning and Spirituality on their Levels of Anxiety

	Variable	Model 1		Model 2		
	B	SE(B)	β	B	SE(B)	β
Co-Parenting	-.33*	.15*	-.27*	-.26	.15	-.21
Relationship Satisfaction	-.21	.40	-.06			
Negative Religious Coping				.96*	.39*	.21*
Positive Religious Coping				-.12	.29	-.05
Spiritual Disclosure				-.14	.12	-.16
R^2	.10**			.17*		
F for change in R^2	7.51*			3.28**		

Note. * $p < .05$. ** $p < .01$.

For the second regression, with the outcome variable of parents' depression, the first step of the model contributed 22% of the variance with co-parenting having a significant $\beta = -.27$ ($p < .05$) and the second step accounted for 7% of the variance with negative R/S coping having a significant $\beta = .21$ ($p < .05$, see Table 4).

Table 4
Hierarchical Regression of Parents' Relationship Functioning and Spirituality on their Levels of Depression

	Variable	Model 1		Model 2		
	B	SE(B)	β	B	SE(B)	β
Co-Parenting	-.33*	.15*	-.27*	-.26	.15	-.21
Relationship Satisfaction	-.21	.40	-.06	-.16	.40	-.05
Negative Religious Coping				.96*	.39*	.21*
Positive Religious Coping				-.12	.29	-.05
Spiritual Disclosure				-.14	.12	-.16
R^2	.22**			.29*		
F for change in R^2	18.76**			4.20*		

Note. * $p < .05$. ** $p < .01$.

Finally, for the third regression, with the outcome variable of parental stress, the first step of the model contributed 11% of the variance with co-parenting having a significant $\beta = -.30$ ($p < .05$) and the second step accounted for 12% of the variance with negative R/S coping having a significant $\beta = .36$ ($p < .05$; see Table 5).

Table 5
Hierarchical Regression of Parents' Relationship Functioning and Spirituality on their Levels of Stress

	Variable	Model 1		Model 2		
	B	SE(B)	β	B	SE(B)	β
Co-Parenting	-.65**	.26*	-.30*	-.56*	.25*	-.26*
Relationship Satisfaction	-.19	.69	-.03	-.11	.66	-.02
Negative Religious Coping				2.71**	.63**	.36**
Positive Religious Coping				-.46	.29	-.12
Spiritual Disclosure				.04	.19	.02
R^2	.11**			.23**		
F for change in R^2	7.83**			6.21**		

Note. * $p < .05$. ** $p < .01$.

Discussion

This was the first study to explore former NICU parents use of spiritual disclosure and R/S coping in relation to their relationship functioning. A main finding was that parents who talk about religious or spiritual issues tend to have better relationship satisfaction and co-parenting and engaged in more positive R/S coping, which can include praying to God or looking to benevolent aspects of their spirituality to cope with challenges. Further, those parents who used more negative forms of R/S coping tended to have poorer psychological well-being (including anxiety, depression, and stress), which has been found in other studies of NICU parents (Brelsford & Doheny, 2016). Further, those parents who reported experiencing more psychological distress also reported lower levels of relationship satisfaction, challenges with caregiving, and less open R/S discussions. All of these relational factors could contribute to feeling higher levels of anxiety, stress, and depression after experiencing a challenging situation with a newborn. Since the experience of birth and parenting has been

disrupted, parents may feel guilt or other challenging emotions, which could in turn exacerbate pre-existing difficulties with mental health or could be the impetus for increased anxiety, depression, and stress.

Relationally, the finding that spiritual disclosure, which entails open discussions with a spouse or partner, is related to lower levels of anxiety and use of positive religious coping has implications for therapists and counselors who work with these former NICU parents. Additionally, parents' use of spiritual disclosure was also related to better relationship satisfaction and co-parenting, which is important when navigating a stressful life situation such as the NICU. Some children will continue to have medical impacts even a year after discharge, and therefore having a supportive partner can be an important factor in better mental health, which is also an important finding in relation to therapeutic work with these families. This finding harkens back to the relational spirituality framework (Mahoney, 2010), which focuses on the formation, maintenance, and transformation of relationships through the lens of spiritual connections. This spiritual connection may be even more important in the NICU setting and post discharge when emotions can be high and people may find that they lean on faith to navigate the unknown of having a child with health conditions so early in life. Alternatively, this could be a time that parents stop communicating with each other about their views, beliefs, and aspirations, which could degrade the co-parenting/romantic relationship resulting in dissolution of some marriages. Thus, finding a way to engage and share with each other about the more vulnerable aspects of life, including questioning faith, leaning into God's will, or even being angry with God can be safer in a healthy partner relationship.

This study is important in that NICU parents can have more fragile family units due to the stress of parenting a sick child or experiencing different emotions following a NICU experience. Thus, when parents have relationship challenges, trickledown effects on children can occur. In general, there are few psychological supports in NICUs and even fewer psychological supports include a spiritual component. Family-integrated NICU care places an emphasis on the family unit as a method of increasing the quality of care for the neonate (He et al., 2018), but few short-term interventions exist to address parental distress and R/S aspects of their lives. Interventions stemming from a psychospiritual framework may be especially appropriate for NICU parents given the increased risk for death and/or life-long health problems necessitating their infant's NICU placement. The psychospiritual perspective, which includes both psychological and spiritual aspects of health and wellness, can positively impact parents' ability to cope with stressors while in the NICU and bolster positive perceptions of their ability to parent a fragile newborn. Thus, this study provides additional supports for this family centered care lens that focuses both on parents' relational functioning and their religious and spiritual lives as factors in their mental health.

Limitations

The limitations of this study include the cross-sectional nature of the data, which inhibits the ability to infer causation. Further, although the focus of this study was exploring outcomes related to parental mental health in relation to their R/S coping and spiritual disclosure and other relational factors, it could also be said that mental health impacts one's relationship satisfaction and co-parenting. Further, our sample was rather homogenous in that we had little racial and religious diversity as most participants were white, Christian, and reported having some college education. Thus, the generalizability of these findings to non-Christian parents from more ethnically and economically diverse backgrounds may be limited. However, it does appear that we had a robust sample of non-affiliated parents and those who reported atheist or agnostic views. In addition, we combined mothers' and fathers' reports for this study. Due to the small number of fathers in this study, we opted for this approach.

Another limitation to note, is that we did not explore parents' mental health prior to entering the NICU, which could impact results from this study. We only have one time point for this study, which was post NICU discharge and the average response was a year following that intensive care experience. Thus, parents likely have settled into life with their newborn and may have found ways and means to cope more effectively with the NICU experience a year later. Other individuals may continue to struggle with feeling guilty or responsible for their infant's NICU experience, which is more common with mothers.

Conclusion and Implications

When thinking about how to support families in the NICU and post discharge from this intensive care setting, practitioners should consider family-based interventions, which involve supporting and educating parents while also integrating them into care of their newborn. Family-integrated care, places parents at the center of the NICU experience in that they are fully integrated into the care of their infant via presence at the bedside, engagement in feeding and infant care, and participating in medical rounds (Franck & O'Brien, 2019). This approach also includes mandatory parent education and peer support that are central to improved short and long-term parenting outcomes such as stress and anxiety. Since family-centered care involves parents as partners and stems from core values of respect and dignity for the family, involving them in caregiving while maintaining transparency in the provider-family relationship would yield the best outcomes upon discharge. Including their R/S views, values, ways of coping, and spiritual conversations would be an important addition to family care. Thus, the presence of psychological supports inculcated with R/S aspects might best serve our families who are navigating a neonatal intensive care experience. Providing a safe space to talk about psychological concerns, spiritual questions and doubts, relationship concerns, and other intrapersonal challenges could mean that not only do

parents experience a more positive NICU experience, but also when they transition to caring for their infant on their own, they may feel more confident with the supports they have acquired and strategies they have gained while in the intensive care setting.

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