Couple and Family Psychology: Research and Practice

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Online First Publication, April 7, 2025. https://dx.doi.org/10.1037/cfp0000281

AMERICAN PSYCHOLOGICAL ASSOCIATION
DIV. 43 SOCIETY FOR COUPLE & FAMILY PSYCHOLOGY
Couple and Family Psychology: Research and Practice

ISSN: 2160-4096
https://doi.org/10.1037/cfp0000281

Diversifying Research on the Transition to Parenthood: Recruitment of a Sample of Ethnic Minority, Low-Income Prenatal Couples

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The transition to parenthood (TTP) is a major life event in which romantic partners undergo significant changes in their relationship. For this reason, understanding the ways that couples change and adapt when welcoming a child into their home has been of long-standing interest to couple and family psychologists. The major body of research on TTP has successfully built a strong understanding of relationship development during this important period, but these insights have been overwhelmingly focused on the experience of affluent married couples, with little focus on changes in the relationships of unmarried couples or those from economically and racially minoritized backgrounds. To increase our knowledge about TTP among couples who have historically been excluded from couple and family psychology research, the current research describes a study designed to yield a sample of one particular group of couples who have been underrepresented in TTP literature, namely, low-income, unmarried, Spanish-speaking couples living in the United States. We present a narrative description of our processes as well as descriptive statistics for (a) recruitment strategies, (b) scheduling and administering data collection sessions, and (c) characteristics of couples who ultimately participated in the study. Results of this study will help inform other researchers who wish to expand our understanding of the TTP period by moving beyond samples of married, affluent, White, English-speaking couples.

Public Significance Statement
This study provides information for other researchers about how to successfully recruit diverse couples who are expecting a child into a study of the transition to parenthood. Improving recruitment practices is necessary to ensure that our understanding of the way relationships change when welcoming a new child into the home is representative of the experience of all couples.

Keywords: couples, diversity, recruitment, sampling, transition to parenthood

Supplemental materials: https://doi.org/10.1037/cfp0000281.supp

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Po-Heng Chen, Daniela Esquivel Cantu, Neyra Garcia, Eva Lopez, Diana Moreno, and Betul Urganci contributed equally and are listed alphabetically. The authors have no known conflicts of interest to disclose. This study was supported by Grant P2CHD042849 Population Research Center, awarded to the Population Research Center at the University of Texas at Austin by the Eunice Kennedy Shriver National Institute of Child Health and Human Development. The content is solely the responsibility of the authors and does not necessarily

continued

The transition to parenthood (TTP) is a major life event in which individuals undergo significant changes in their lives, including in their roles as romantic partners. For this reason, understanding the ways that couples change and adapt when welcoming a child into their home has been of long-standing interest to couple and family psychologists. The major body of research on TTP has revealed that many couples experience decreases in relationship and sexual satisfaction and increases in conflict after the birth of a child, but there are also many factors that can promote resilience during this time, including strong dyadic coping and social support between partners, as well as social support from friends and family, and having realistic expectations about parenthood (Alves et al., 2019; Doss et al., 2009; Hughes et al., 2020; Huss & Pollmann-Schult, 2020; Leonhardt et al., 2022; Mitnick et al., 2022; Rholes et al., 2021).

However, these insights from the TTP literature are primarily focused on the experience of affluent married couples, with little focus on changes in the relationships of unmarried couples or those from economically and racially minoritized backgrounds. Recent metascience research has documented major shortcomings in the extent to which studies of couple relationships are inclusive of couples who are not married, White, and affluent (Williamson et al., 2022). Unfortunately, these demographic gaps are also true of the TTP literature, with the majority of recently published articles about the TTP focusing on married, White, affluent, English-speaking couples (see the Supplemental Materials for results of a systematic literature review encompassing 77 studies published in the last 5 years).

To increase our knowledge about the TTP among couples who have historically been excluded from couple and family psychology research, such as those who speak a language other than English, who belong to a marginalized racial or ethnic group, or who have lower socioeconomic status, researchers must know how to recruit samples from these populations. The recruitment process, staffing needs, language barriers, and communication techniques required to be successful may be different than those to which researchers are accustomed.

Researchers who study couples have long known how difficult it is to collect dyadic data (e.g., McLanahan et al., 2003), a difficulty that is further compounded when trying to reach couples who have historically been underrepresented in research. Although there is a very small existing literature that discusses strategies for recruiting underrepresented couples, it is comprised exclusively of insights from intervention studies (Baucom et al., 2018; Carlson et al., 2014; Roberts et al., 2019; Williamson et al., 2023). The prospect of convincing couples to enroll in a basic research study is even more difficult because basic science offers no direct benefit to the participants, unlike treatment studies that have the potential to provide benefit through the clinical services being provided. In addition, studies that aim to enroll couples during the TTP period have a limited window in which couples are eligible, and this also falls during a particularly busy and potentially stressful period in their lives. Thus, diversifying samples used in TTP research is an especially difficult challenge for researchers.

The current article aims to contribute information that will help couple and family psychology researchers improve their sampling and move toward a more representative TTP literature. We describe a study designed to yield a sample of one particular group of couples who have been underrepresented in TTP literature, namely, low-income Hispanic/Spanish-speaking couples. We present a narrative description of our processes as well as descriptive statistics for (a) recruitment strategies, (b) scheduling and administering data collection sessions, and (c)

represent the official views of the National Institutes of Health.

Hannah C. Williamson played a lead role in conceptualization, funding acquisition, methodology, supervision, writing–original draft, and writing–review and editing and an equal role in formal analysis. Po-Heng Chen played a lead role in data curation and a supporting role in writing–original draft. Daniela Esquivel Cantu played an equal role in investigation, project administration, and writing–original draft. Neyra Garcia played an equal role in investigation, project administration, and writing–original draft. Eva Lopez played an equal role in investigation, project administration, and writing–original draft. Diana Moreno played an equal role in investigation, project administration, and writing–original draft. Betul Urganci played an equal role in formal analysis and a supporting role in writing–original draft.

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characteristics of couples who ultimately participated in the study. Results of this study will help inform other researchers who wish to expand our understanding of the TTP period by moving beyond samples of married, affluent, White, English-speaking couples.

Method

Procedure

Data examined in the present study are drawn from a longitudinal study of low-income couples during TTP. This study was approved by the Institutional Review Board of the University of Texas at Austin. To be eligible for the study, couples had to be 18 years or older, in their third trimester of pregnancy, speak English or Spanish, not planning to put their baby up for adoption, and not participating in a teen parenting intervention run by the Women's Health clinic. Although we hoped to have a strong representation of Hispanic couples, we chose to open the study to all interested couples regardless of race/ethnicity. The study consisted of two primary components: a baseline data collection session conducted during the third trimester of pregnancy and 12 monthly follow-ups conducted during the first year of the child's life.

The baseline data collection session typically took 2 hr to complete and consisted of three different activities: self-report data collection via interview (completed separately by each partner), five cognitive tasks completed through the Inquisit platform on a laptop computer (completed separately by each partner), and a 7-min observational discussion task (completed by the partners together). Participants were compensated up to $100 per person for the baseline session ($40 for the interview, $40 for the computer tasks, and $20 for the video).

At the baseline session, participants provided their baby's due date. Approximately 2 weeks after the due date passed, we reached out to them to ask whether the baby had been born and, if so, their birth date. When participants provided their child's birth date, we sent a text message with an attached "ecard" congratulating them on the birth and a reminder that their first monthly follow-up survey would arrive on their child's 1-month birthday. Follow-ups continued to be sent each month on the date of the child's birth until the child reached 12 months of age. The monthly follow-ups consisted of self-report questions and took 10–20 min to complete, depending on skip patterns. The survey links were delivered to participants via SMS (72%) or email (28%), depending on the participants' preference. We also offered alternative methods such as calling the participant to complete the survey over the phone, but no participants elected to use those options. Participants were paid $10 per survey for completing Follow-Ups 1–6 and $15 per survey for completing Follow-Ups 7–12.

The recruitment processes described below occurred from November 2021 to May 2024. However, the clinic had fairly strict COVID-19-related policies during the first few months of the study that resulted in most patients spending very little time in the waiting room. Accordingly, only a handful of participants were recruited during this time. Thus, we believe that a more accurate estimate for the time taken to recruit this sample is approximately 2 years, from spring 2022 to spring 2024.

Measures

Recruitment

The Research Electronic Data Capture (REDCap) system was used to track all aspects of the project. Each time a project staff member started a recruitment conversation with a potential participant, they opened a new record in the REDCap database and recorded the outcome of that conversation. As the recruitment process continued, the outcome of each component was recorded until the recruitment process ended with the potential participant scheduling a baseline data collection session, indicating that they were not interested in participating or becoming ineligible to participate (such as one partner revoking consent, giving birth before we could schedule baseline, pregnancy loss, etc.).

Baseline Session Administration

Details about the administration of each baseline session, including the language used by each participant (Spanish or English); the date, time, and location of the session; and which aspects of the study were successfully completed, were systematically tracked within the REDCap

database. Additionally, notes about the administration of the baseline session and any unusual occurrences were recorded in an open-ended text box immediately after each session.

Participant Demographics

During the baseline interview, each participant reported on their personal demographics, including their age, race/ethnicity, household income, as well as characteristics of their relationship, including relationship status and length of the relationship.

Results

Recruitment Strategies

Venue

To successfully recruit a diverse sample of low-income couples during TTP, we partnered with a local community-serving Women's Health clinic. The clinic allowed us to approach patients in the waiting room to tell them about the study while they were waiting for their appointments. The clinic was open Monday to Friday, from 8 a.m. to 8 p.m. 3 days a week and from 8 a.m. to 5 p.m. 2 days a week, and we endeavored to have two project staff members in the clinic at all times that it was open. The clinic provided us with a table and two chairs, and we covered the table with a tablecloth and printed a large banner with logos of the research project and the university to hang on the front of the table (with text in English and Spanish). The table was situated near the entrance to the clinic, which made project staff visible to everyone walking in and out of the clinic and allowed us to immediately begin establishing rapport by greeting entering patients, assisting individuals who needed help with opening the door, directing patients to the front desk, and so forth.

Project Staff

At any given time, there were approximately six undergraduate research assistants working on the study for 10–19 hr per week. Additionally, there was one full-time postbaccalaureate-level project manager supervising and working alongside the research assistants. At times, this position was held by one person working on this project full time, and at other times, the position was fulfilled by two to three people splitting their time among multiple projects. All project staff were bilingual English/Spanish speakers and were selected based on having strong interpersonal skills.

Relationship With Clinic Staff

Maintaining a strong and positive relationship with the employees of the Women's Health clinic proved to be critical because they facilitated our day-to-day activities, including providing access to empty exam rooms and staff-only spaces to conduct data collection sessions. This was important when we encountered issues, such as needing to stay in the clinic past the operating hours when a participant appointment ran longer than expected. To maintain these relationships, we consistently engaged in small but meaningful behaviors, such as always greeting clinic staff when coming and going from the clinic, helping them with various tasks around the waiting room (such as moving furniture, carrying packages), and answering basic inquiries from patients when the clinic was particularly busy. Importantly, we made sure to follow their procedures and instructions and ensure that we never obstructed clinic operations or patient care.

Recruitment Process

To avoid any issues that might arise from attempting to identify and speak only to patients who met the eligibility criteria (i.e., were in their third trimester of pregnancy), we adopted the policy of approaching every patient in the waiting room to the extent possible. This initial conversation would typically take place in one of two ways. First, many patients paused at our table on their way in or out of the clinic, at which time project staff would engage them and ask if they would be interested in hearing a bit about the study. Second, if project staff were unable to talk to a patient at the table, they would approach them at their seat in the waiting room as they waited for their appointment.

A sequential procedure was followed for these conversations, with responses at each stage tracked. First, project staff asked if patients were interested in hearing about the study by saying something along the lines of: "Hi, my name is __ and I work with the University of Texas at Austin on a research study about couples who are

expecting a baby. Is it okay if I tell you a bit about it?" Of the 2,906 patients who were asked this question, 40% (n = 1,165) said "yes." Of note, because a new record was created every time this question was asked of a patient, this denominator is inflated for two main reasons: (a) as discussed, we approached everyone in the clinic, resulting in us talking to many people who were not eligible, and (b) there are likely patients who are included more than once because we approached them multiple times over the course of their time visiting the clinic.

If a patient agreed to hear more, then project staff gave a brief overview of the study:

> We are conducting a study about couples' experiences when they have a baby. If you decide to participate, before the baby is born you and the baby's other parent would answer some questions about yourself, do some activities on a computer, and have a videotaped conversation about what you think parenting will be like. You will also answer a few questions each month after your baby is born. You can earn up to $500 for participating in the study, $250 for each parent. Are you interested in hearing more about the study?

Of the 1,165 patients who initially said they would like to hear about the study, 36% (n = 421) said they would like to hear more after receiving the brief overview.

Eligibility Screening

Those who were interested in hearing more about the study were then screened for eligibility to ensure that we did not waste the time of those who were ineligible. Of the 421 patients who heard the overview of the study, 62% (n = 261) were willing to be screened for eligibility, with 73% screening as eligible. Reasons for ineligibility included 11 patients who were below 18 years old, 10 patients who were unwilling to contact the baby's father or give us contact information for the baby's father to invite them to participate, and 50 patients who were pregnant but not yet in their third trimester of pregnancy. Although these patients were not yet eligible, we retained their contact information and recontacted them when they became eligible.

Reasons for Being Uninterested in the Study

For those who were not interested in hearing more about the study after the brief overview, we asked them (when possible) "Would you mind telling me why you're not interested?" Of the 483 patients who provided a reason, the top reasons for the lack of interest included 25% who reported that they were just not interested, 12% who thought they were too busy, 10% who thought that the father would not want to participate, 8% who were not in touch with the father, <1% who thought that the father would not allow them to participate, 40% who were not currently pregnant, and 4% who reported that they were ineligible for some other reason.

Even among some of the patients who were interested in being screened for the study, there were still some concerns or hesitations. For example, potential participants asked questions about how the monetary incentive for participation in the study would be distributed to them. We provided information about how they were typically distributed (through an electronic gift card system) and assured them that we would walk them through the process of receiving and redeeming the gift card at the end of the baseline session. We also informed them that we could provide incentives in other formats if they thought the gift cards would be an issue for them (e.g., cash, PayPal, Venmo, Zelle). Additionally, some potential participants expressed hesitation about participating in the videotaped portion of the study. We informed them that the interview portion of the baseline was the only required component and they could opt out of the videotaped observation or the computerized cognitive tasks. In the end, the vast majority of potential participants completed the protocol as intended (e.g., received incentives in the typical manner, participated in all aspects of data collection), but we believe that demonstrating flexibility, rather than rigidity, was an important factor in making these individuals feel comfortable participating in the study.

Engaging Fathers

In the initial months of recruitment, the clinic did not allow anyone to accompany patients to their appointments due to COVID-19 restrictions. We also found that patients often attended their prenatal appointments alone even when COVID-19 restrictions were lifted (often because fathers were unable to take time off work to attend), which meant that we were typically recruiting mothers first and then subsequently trying to engage fathers. Mothers who wanted to participate in the study were often eager to schedule their baseline session and were quite confident that fathers would be willing to participate. However,

we required that both partners be screened for eligibility, receive an overview of the study, and agree to participate in the study before a baseline session could occur (with formal informed consent occurring at the baseline session).

For fathers who were not present in the clinic at the time of recruitment, the study was typically introduced to them by the mother, consistent with the experience of other researchers who recruit underrepresented couples from community settings (Carlson et al., 2012; Preloran et al., 2001). We sent mothers home with a flyer (a paper copy or an electronic copy sent to their phone, depending on their preference) so that they had the relevant information available to them. At that time, we also scheduled a follow-up call with the mother a few days later to check in. During this check-in phone call, mothers often notified us of concerns raised by the father, most frequently that he did not think he had time to participate because of his work schedule. We worked with mothers to solve any barriers, such as letting them know that we can meet at any time and place that is convenient for them. Because of the fathers' time constraints, it was not uncommon to have back-and-forth interactions with the mother over the course of days or weeks, until the father felt that his concerns were addressed and he was ready to move forward with participation.

Written Materials

We also had a stack of flyers available on the table, which we handed out to individuals who indicated that they were interested but did not have time to talk and were also available for anyone to grab as they were walking by. The flyers were in English and Spanish and included a phone number that indicated participants could call or text, an email address, and a QR code, which directed to the study website. The website was also in English and Spanish and included a short video about the study, a written description of the study, our phone number and email address, and a form to complete if they wanted us to contact them.

Scheduling and Administering Baseline Data Collection

Scheduling

Even after both parents had been screened as eligible and agreed to participate in the study, scheduling a time for couples to complete the baseline data collection session proved challenging. During the recruitment process, participants were asked about the best times to reach them, and call efforts were made on the days and times specified, but persistence was usually the key. Often, we exchanged many calls and/or text messages over the course of many days (or even weeks) to schedule a baseline session, an experience consistent with other researchers who recruit low-income couples (Carlson et al., 2014).

Reminders

Once a baseline visit was scheduled, we followed a sequential procedure of reminders. Seven days before the appointment (if it was scheduled more than 7 days in advance), participants received an initial reminder via phone call or text message about their appointment, with additional reminders 3/4 days before, the day before, and the day of the scheduled baseline session. Each reminder included an invitation to ask questions, as well as information specific to their visit location (e.g., directions and parking information for visits occurring at the university campus).

Cancellations and No-Shows

After scheduling baseline visits, we experienced a number of no-shows and cancellations: 49 of the 141 initially scheduled baseline sessions were not completed. The reasons for cancellation varied but typically involved an unexpected change in participants' schedules. For example, participants would inform us that they had been called into work during our scheduled appointment or that their partner was scheduled for extra hours at work during that week and no longer had extra time available. Other reasons for cancellation included not having reliable transportation to get to their appointment (e.g., car breaking down) and the pregnant parent giving birth prior to our scheduled appointment, which would make them no longer eligible to participate. When cancellations or no-shows occurred, we attempted to reschedule participants to complete their baseline session at a later time. Of those who initially did not complete their scheduled baseline session, we successfully rescheduled and completed 18 couples.

Location and Timing

We offered baseline visits in a variety of venues to make them as accessible as possible to our participants. Forty percent of participants completed their baseline in their home, which allowed them to be in a comfortable setting and not have to travel. Although a home visit would theoretically be the most convenient for the participants, we found that this was not the preferred option for many participants who reported that they had a large number of people living in their home with them, so they would not be able to have privacy, or they did not have a stable place to live where they could host us. Many participants who did not want to complete the baseline session in their home chose to come to the university campus (30% of all baseline sessions). For sessions occurring on campus, we had a parking space available right outside of the building with a staff member waiting outside to greet them, and we provided detailed instructions (with photos) about how to arrive at the location. Nonetheless, a number of participants got lost when trying to find the building and had to call for help because they had arrived at another part of campus.

Another option that many participants (25% of baseline sessions) chose due to convenience was to complete their baseline session at the Women's Health clinic, where we were permitted to use exam rooms. These sessions were typically timed to occur after the patients' prenatal appointment. Although this option was preferred by many participants so that they could travel just once, we found that participants often became tired from completing the baseline session after a medical appointment, and the furniture in the exam rooms was not comfortable for long periods of time. Finally, because the study was launched while waves of the COVID-19 pandemic were waxing and waning, we offered the option for a remote baseline session conducted via Zoom, which 4% of the couples utilized.

Across all locations, evenings and weekends proved to be the most popular times for baseline sessions, with 45% occurring on weekends, 24% occurring on weekday evenings, and only 31% occurring during normal business hours. All participants completed the self-report interview, but they could opt out of the computerized cognitive tasks and the videotaped discussion task. However, there was strong completion of these two components, with 97% completing the video and 96% completing the computer tasks.

Sample Characteristics

The procedure outlined above ultimately resulted in a sample of $N = 110$ couples enrolled into the study. Of the 421 individuals who received a full overview of the study during the recruitment process, this represents a yield of 26% (see Figure 1 for enrollment flowchart). This recruitment-to-enrollment rate is similar to a 25% yield reported by a study that recruited low-income couples into a trial of relationship education (Carlson et al., 2014) and is significantly better than the 11% yield obtained in a study that recruited low-income TTP couples into a study of relationship education (Baucom et al., 2018). Descriptive statistics of sample demographics are presented in Table 1. The majority of participants were Hispanic (79% of fathers and 84% of mothers), and nearly two thirds of participants participated in the study in Spanish. Fathers had a mean monthly income of \$3,063 (SD = \$1,658, Mdn = \$3,000), and

Figure 1
Enrollment Flowchart

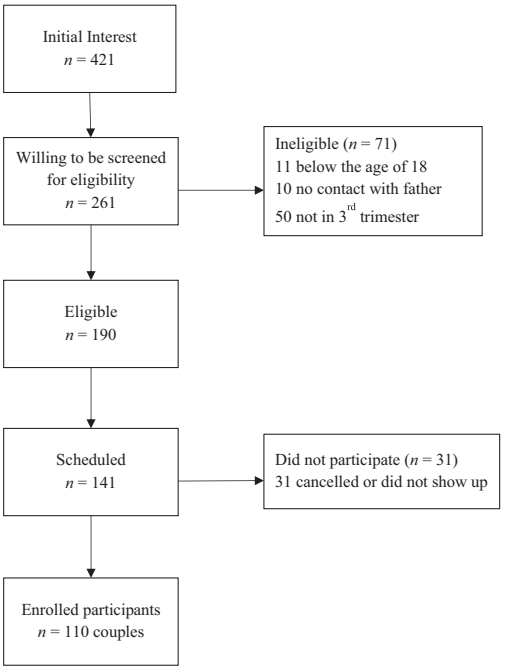

Table 1
Descriptive Statistics of the Full Sample

Demographic characteristic	Father			Mother		
	Proportion (%)	*M*	*SD*	Proportion (%)	*M*	*SD*
Age (years)		31	8		28	6
Monthly income (USD)		$3,063	$1,658		$1,697	$3,084
Education						
No high school degree	39			35		
High school degree or equivalent	45			34		
Some college or associate's degree	9			15		
College degree	7			15		
Beyond college	0			2		
Language						
Spanish	63			63		
English	37			37		
Race/ethnicity						
Hispanic	79			84		
Non-Hispanic White	10			6		
Non-Hispanic Black	9			4		
Asian or Pacific Islander	2			2		
Native American	0			1		
Other identities	0			3		
Region of origin for Hispanic						
Mexico	64			62		
Central America	21			26		
South America	10			8		
Cuba	4			3		
Puerto Rico	1			1		
Relationship status						
Married	39			43		
Common-law marriage	47			40		
Steady relationship	11			14		
On-again/off-again relationship	1			3		
Just friends/not in a romantic relationship	2			1		
Planned pregnancy						
Unplanned	31			38		
Planned	48			43		
Neither planned nor unplanned	21			19		
First-time parent	56			61		

Note. $N = 110$ couples. USD = United States dollar.

mothers had a mean monthly income of $1,697 ($SD = $3,084, $Mdn = $900). The median annual household income of $46,800 in this sample is well below the national median of $74,580 (Guzman & Kollar, 2023). Thus, we were successful in enrolling a sample of low-income, primarily Hispanic couples who are expecting a child.

Discussion

Recent metascientific research has highlighted a major lack of diversity in samples used to study couples and families (Perez-Brena et al., 2022; Tseng et al., 2021; Williamson et al., 2022). A systematic review of the recent TTP literature presented in the current article (see Supplemental Material) indicates that these studies follow the same pattern, with the majority of the literature representing White, affluent, English-speaking, married couples. Common recruitment techniques used in TTP studies include placing flyers in medical offices and making announcements at prenatal classes. These types of passive recruitment techniques, in which researchers expect participants to reach out to them and volunteer themselves, are common in couples research but often yield samples that are affluent and highly educated (Karney et al., 2004).

As seen in the present study, a much more active recruitment procedure was needed to reach couples who have been historically underrepresented,

and even explicitly excluded, from TTP studies. Past research indicates that important practices for recruiting historically underrepresented participants include hiring staff who are a cultural and linguistic match for participants, making all study materials available in multiple languages, being extremely flexible in how the study will be administered, and actively reaching out to participants and maintaining open lines of communication with them, all of which were employed in the present study (Areán & Gallagher-Thompson, 1996; Leonard et al., 2003; Yancey et al., 2006). These practices ultimately resulted in a sample of low-socioeconomic status, linguistic and ethnic minority couples, but the amount of time and effort needed to engage in these practices and achieve this sample were significant.

One major challenge to recruiting this sample of couples was securing the participation of male partners. As reported in the Results section, a large number of mothers who were potentially interested in participating in the study did not continue through the recruitment process because they thought the father would not participate. We found that reluctance from fathers was also a barrier even for mothers who did not anticipate this, with a number of eligible and interested mothers reporting that they could not schedule a baseline session because the father was not interested. Engaging male partners is a perennial issue for researchers who collect dyadic data (Barton, Hatch, & Doss, 2020; Barton, Lavner, et al., 2020; Preloran et al., 2001), and TTP may be an especially stressful time to ask these men to commit to participating in a research study, particularly a basic science study with no benefit to the couple or the child.

Another challenge was the bilingual nature of our project, as well as language barriers resulting from working with low-socioeconomic status participants with lower levels of formal education, which often required adaptation. Project staff reported that potential participants were typically much more open to speaking with them when they were approached in their preferred language, which led project staff to develop the habit of paying attention to the language that patients used when speaking to the clinic front desk staff to help them determine the correct language to use when approaching that patient. When they were unsure of the correct language to use, they approached with a bilingual greeting (e.g., *Hi, buenos días!*). Additionally, potential participants responded more positively and appeared more willing to engage in conversation when research staff not only spoke in their preferred language but also utilized idioms or informal phrases commonly used in the patients' culture (e.g., *¡Que padre!*). This helped our team connect with participants and develop a positive relationship early in our interactions.

Once we transitioned from informal recruitment conversations to data collection, the language and structure of many psychological measures posed difficulties. For many of our participants, the advanced vocabulary, formal sentence structure, and rating scales utilized in the baseline questionnaire were difficult to understand, which sometimes lead to frustration and diminished engagement. Ameliorating this issue required additional preparation from our research staff, as we had to ensure that everyone in our team understood every interview item in great depth and was prepared to provide synonyms and definitions for complicated terms, expand on difficult questions, and/or paraphrase language using simpler vocabulary when needed, in both English and Spanish. We also showed a large, printed version of the response options for each question to help participants visualize and select a response. A similar issue arose with the many dialects of Spanish spoken by our participants, who hailed from many different Spanish-speaking countries. For example, depending on the country of origin, the words *secundaria*, *preparatoria*, or *bachillerato* may be the appropriate translation for "high school." This highlights the importance of having native speakers from diverse linguistic backgrounds when conducting research in multiple languages. Staff must be capable of adapting study materials to a level consistent with participants' language skills but also knowledgeable of geographic and cultural differences and prepared to bridge any potential language barriers.

Other challenges stemmed from mounting a complex research study in the community. Recruiting at the community clinic allowed us to reach our target population but also exposed project staff to some difficult situations. Because our recruitment table was located near the front doors of the clinic, project staff were the first to encounter any unusual incidents that occurred, such as agitated and threatening patients and individuals experiencing homelessness mistakenly seeking urgent medical care at the clinic. Less

severe difficulties included young children taking flyers and pulling the banner off the table or wanting to talk or play with project staff while their parents were busy with the receptionists/doctors. Overall, spending a great deal of time in the waiting room of a community-serving clinic required project staff to be professional, flexible, and quick on their feet.

Completing a multimodal data collection procedure in a variety of locations also led to a number of challenges. For example, many participants lived with other people, including their own children, other adult and child family members, and roommates (including roommates with children). This sometimes made it difficult to find a private and less distractive space to conduct the baseline session. Often, spaces such as bedrooms, backyards, and front porches needed to be used. A number of couples had recently moved into their home so they had very little furniture. Additionally, when participants agreed to the arrangement, we would provide a third staff member at the baseline session to help entertain and keep an eye on children who would be present, though participants often insisted that the children would be able to entertain themselves and did not need a babysitter. Our recommendation would be to always provide a babysitter if any children will be present.

Even for participants with no one else in the home, some did not have multiple different rooms that they were willing/able to use for data collection, which resulted in both partners' interviews taking place in the same main room of the home. Project staff tried to put as much distance between the partners as possible, situate them so they were not looking toward each other, and used a white noise machine in the middle of the room to mask sound. Although not an ideal setup, staff reported that participants were focused on providing their own responses to the interview and appeared to be unable to hear each other.

When visiting participants' homes, we always planned to be fully self-sufficient by bringing fully charged laptops and video camera, extra batteries, and Wi-Fi hotspots so that we did not need to plug in our equipment or access participants' home Wi-Fi, in case these options were not available to us. The challenges we would face were not necessarily known prior to arriving at the home, which required project staff to be flexible and problem solve on the spot. Our guiding principle was always to treat participants with the utmost respect for inviting us into their homes and to work with the situation at hand (e.g., sit on the floor if needed) without giving any impression that we were inconvenienced or that the situation was suboptimal in any way.

Finally, we also encountered difficult situations that are to be expected when dealing with a perinatal population. Multiple patients whom we first spoke with early in their pregnancy informed us that they had experienced pregnancy loss when we recontacted them once our records indicated that they had entered their third trimester. Project staff were trained to expect this common occurrence (American College of Obstetricians and Gynecologists, 2022) so they could respond with condolences rather than shock or surprise. We also prepared resource handouts specifically for this occurrence to share with these participants.

In sum, by describing the many challenges we encountered and the large amount of work required to recruit this sample, we do not wish to discourage other researchers from attempting to engage underrepresented and marginalized couples in their research. Instead, we wish to equip researchers with a better understanding of what the active recruitment process entails, so that they can adequately prepare their budgets and staffing plans to increase their likelihood of success. To improve representation of diverse couples in TTP studies, recruitment procedures must be planned with the same amount of care and intentionality as the rest of the research protocol, and timelines and expected sample sizes may need to be adjusted (Roberts et al., 2019). We hope that the insights we gained from this recruitment effort will help other researchers begin to work toward bridging the diversity gap that has recently been highlighted in couple and family psychology.

Limitations

There are also some limitations inherent to this study that must be considered. First, traditional "TTP" studies would enroll only couples in which both partners were first-time parents. More restrictive inclusion criteria, such as requiring couples to be in a first marriage in studies of newlyweds, result in a less diverse sample of couples (Rogge et al., 2006), and the same is likely to be true of TTP studies as well. Given that multipartner fertility and blended families are common in lower income populations (Monte, 2019), we chose not to require couples to be

primiparous to be more inclusive and fully representative of the experiences of low-income couples expecting a child.

Another important limitation is the demographic makeup of the recruitment staff. Because we wanted to include Spanish-speaking couples, recruitment staff needed to be bilingual to converse with patients in English or Spanish in the waiting room. This resulted in all recruitment staff being of Hispanic origin, which was helpful in connecting with Hispanic patients, but meant that they were not a cultural match for non-Hispanic patients. The patient population at the clinic is 84% Hispanic, 6.1% White, and 5.4% Black; thus, our final sample was a close match for the population from which we were recruiting, and it does not appear that any groups were systematically turned off by the makeup of the recruitment staff. However, researchers recruiting from a more ethnically/racially diverse setting will need to grapple with how to staff their team to ensure that all potential participants feel comfortable with the staff. Overall, because this study was conducted in a single community clinic, the strategies that worked best for this project may not generalize to other settings. Additionally, the reputation of the university within the community, and specifically within marginalized groups within the community, likely plays a strong role in the success (or not) of the recruitment process.

Clinical Implications

Although there are no direct clinical implications of this research, this work is relevant to the ultimate goal of improving the effectiveness of couple and family psychological practice in historically marginalized groups. Over the past two decades, low-income couples have been the target of intervention efforts funded by the U.S. federal government through the Healthy Marriage and Relationship Education Initiative. Healthy Marriage and Relationship Education funded programs enroll a large number of Black and Hispanic couples, often during the TTP period, and there is growing recognition that these couples are not always well-served by these programs (Hawkins et al., 2022). Attenuated treatment effects among low-income racial/ethnic minority couples indicate that our intervention models may not generalize well to couples who are not White and affluent, and there are likely factors that are important to the couples being targeted by these interventions that are not being addressed (Bradbury & Lavner, 2012).

Pouring more money into further dissemination of these intervention models to underrepresented couples, without a parallel investment in basic research on the experiences that influence outcomes in these couples, is unlikely to yield large gains in treatment effectiveness. Indeed, researchers have called for more basic research on relationship functioning in the couples being targeted by these interventions, including Hispanic and Spanish-speaking couples (Johnson, 2012; Karney, 2021; Orengo-Aguayo, 2015). If the calls for more basic research focused on historically underrepresented couples are to be heeded, researchers must improve their toolkits to be able to successfully recruit these couples into their studies. The present study provides a roadmap for greater inclusion of low-income Hispanic couples during TTP.

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Received August 28, 2024
Revision received January 27, 2025
Accepted January 28, 2025 ■