Chapter 1
Couples Becoming Parents

Chapter Highlights

- Many couples struggle to adapt to parenthood and experience declines in relationship satisfaction.
- We can identify, to some extent, the couples who are at risk for struggling to adapt to parenthood.
- Brief couple education focused on adapting to parenthood can help.

Elaine slowly rocks her 6-week-old baby Jake. It is 3 am, and she has been up for more than an hour, feeding, changing, and trying to soothe him. It is the third night in a row that Jake has been difficult to settle after a nighttime feed. Elaine's husband Rob walks over sleepily and asks, "Can't you settle him? Have you tried feeding him?"

Elaine is irritated. "Of course I have, and changed him, and walked him around for an hour. Here Rob, you do something for once."

Rob: (Sighs) "What? I can't. After last night I have to get some sleep. I have to be at work early."
Elaine: "And like I don't get tired? Come on Rob, I'm exhausted."

As Rob and Elaine speak their voices rise in volume, and baby Jake escalates his crying. Elaine starts to cry and Rob retreats back to bed.

The vast majority of new born children live with their biological parents.[1] Parenthood brings an avalanche of change—some positive, some negative—to a

[1] Most of our work has been with heterosexual parent couples, but we believe almost all of the guidance in this book is potentially useful to Gay and Lesbian couples raising infants. A small but important proportion of new parents are not in a relationship with a partner. They also could benefit from assistance to adjust to parenthood. However, because single parents' needs are somewhat different from couples, we focus this book on the most common arrangement of a couple adjusting to parenthood.

W.K. Halford et al., *Clinical Guide to Helping New Parents*,
Springer Series on Couples and Health, DOI 10.1007/978-1-4939-1613-9_1

couple's life together. Parents watching their baby coo as he or she falls asleep, seeing their partner gently cuddle the baby they created together, walking together as a threesome—all can be wonderful experiences. At the same time, spouses struggling to wake in the middle of the night to yet more incessant crying, arguments with their partner triggered by exhaustion, and wondering if they will ever again have time together as a couple, can stress both partners. The stress can erode the quality of the couple's relationship. Infant care is often highly demanding and, like Elaine and Rob, many couples struggle to adapt to parenthood.

This book is a practical guide on how to educate and support couples to assist them adapt to parenthood. It is intended for psychologists, midwives, nurses, doctors, and other health professionals who work with couples becoming parents. The program presented is Couple CARE for Parents (CCP), which is a relatively brief (about 12 h of work for the couple across 4–5 months) structured program. CCP aims to help new parents develop shared and realistic expectations about parenthood, enhance their communication and mutual support skills, and promote sensitive and responsive parenting. CCP is built on adult learning principles so that each participant reflects on how they are managing the challenges and opportunities of becoming a parent, helps them develop self-change goals to enhance their adaptation to parenthood, and provides support to implement selected self-change goals.

This chapter provides a brief overview of the key changes in the couple relationship that result from the transition to parenthood. We also analyze the key risk and protective factors influencing couple and individual adjustment to parenthood, with a particular focus on the implications of this evidence for how best to support new parents. There is a brief review of the empirical evidence on the effectiveness of programs for assisting couples becoming parents. Finally we discuss the structure of CCP, and consider some practical issues in selecting how to offer CCP in different settings. The remaining seven chapters of the book focus on how to deliver each of the units that make up CCP.

Patterns of Relationship Formation and Dissolution

More than 85 % of adults marry at least once in their lifetime across most Western countries (Weston, Qu, & Hayes, 2012). A small, but increasing, proportion of the population choose not to get married, but most of them become involved in a committed couple relationship at least once in their lifetime (Australian Bureau of Statistics, 2012; Copen, Daniels, Vespa, & Mosher, 2012). These figures highlight the centrality of a committed couple relationship to almost all people's lives.

Cohabitation has some similarities with, but also some distinctions from, legal marriage. While almost all married couples report strong commitment to the relationship at the start of marriage (Weston et al., 2012), cohabiting couples differ widely in their reported level of relationship commitment (Rhoades, Stanley, & Markman, 2012). Some people cohabit after agreeing with their partner on a specific plan to marry. Other couples plan a future together that does not include marriage.

Yet other cohabitating couples have not discussed their relationship future with their partner (Hewitt & De Vaus, 2012). Even among cohabitating couples having a child together, there are couples who are unsure about whether they wish to be committed in the long term (Hewitt & De Vaus, 2012; Rhoades et al., 2012).

In most Western countries, such as Australia, New Zealand, United States (US), United Kingdom (UK), and Western European countries, there has been a modest decline in the rate of marriage across the last one to two decades, an increase in the proportion of couple households who are cohabiting rather than married, and elevated rates of divorce relative to 20 or 30 years ago (Weston et al., 2012). There also has been an increasing rate of cohabitating couples having children together, with 30 % of first-time parents cohabiting, rather than being married, in Australia and US (Australian Bureau of Statistics, 2012; Copen et al., 2012).

At the time of marriage or beginning cohabitation, people are typically optimistic about sustaining a satisfying relationship (Weston et al., 2012). However, the majority of couples experience some decline in their relationship satisfaction across time (Glenn, 1998; Halford, Lizzio, Wilson, & Occhipinti, 2007). About 40 % of Australian married couples (Australian Bureau of Statistics, 2012) and 50 % of US couples divorce (Copen et al., 2012). Rates of separation of cohabiting couples is not as well researched as rates of divorce, but estimates suggest rates of break-up of cohabiting couple is substantially higher than for married couples (e.g., Weston et al., 2012).

Clinical Connection
In what ways are cohabitation and marriage similar and different? How might you adjust the timing or content of relationship education for cohabiting couples as distinct from married couples?

The Couple Relationship and Parenthood

Most couples report that the birth of their first child is associated with feelings of joy and pleasure (Gottman & Notarius, 2000). Parenthood brings many rewards, including: (a) fulfillment of strong needs to reproduce; (b) fulfillment of social expectations; (c) a sense of achievement; (d) fun, affection, and companionship; and (e) is often seen as a symbol of love and stability in the couple relationship (Feeney, Hohaus, Noller, & Alexander, 2001). At the same time average relationship adjustment declines markedly across the first 1–2 years after the birth of a couple's first child. In a meta-analysis[2] of a large number of studies of couples becoming parents

[2] A meta-analysis is a way of combining statistically the results of multiple studies and it provides an estimate of the average effect across studies. Effect sizes are often classified as small, moderate, or large. (The statistical definition of effect sizes are: small is $d = 0.3$ *SD*, moderate is 0.6 *SD*, and large is 0.8 *SD*.)

average relationship satisfaction was found to decline markedly in couples after having their first baby (Mitnick, Richard, & Smith Slep, 2009). Overall average relationship adjustment is substantially lower among parents of young infants than couples at other life stages (Twenge, Campbell, & Foster, 2003). While the average relationship satisfaction shows a decline, there is substantial variability around this average. About 40–50 % of couples show little or no decline, 30–40 % show a marked decline, and 10–20 % decline to the extent that they meet criteria for clinical levels of relationship distress (Petch, Halford, Creedy, & Gamble, 2012).

Infant Care

Many parents are surprised by the reality of caring for a newborn who is totally dependent upon them for food, warmth, and love (Vanzetti & Duck, 1996). Sleep disturbance, crying, and feeding problems are among the most commonly reported sources of stress for new parents. Newborn infants typically sleep for between 12 and 18 h, with the average hours of sleep declining gradually across the first few years of life (Galland, Taylor, Elder, & Herbison, 2012). Soon after birth, infants' sleep patterns are haphazard, with sleep occurring in relatively short bursts (up to 3–4 h) across the day and night (Teng, Bartle, Sadeh, & Mindell, 2012). When awakened, infants usually require feeding or parental soothing (Sadeh, 1996), and hence new parents frequently are caring for their infant through the day and night. Fatigue is almost universal among parents of infants (Sinai & Tikotzky, 2012), and extreme for approximately 30 % of parents who report sleep disturbances in their infants (Teng et al., 2012).

The clearest way infants can communicate their needs is through crying, and crying is most often used to communicate distress (Evanoo, 2007). The crying usually evokes a strong response in the parent(s), which serves to have the parent attend to his or her infant's needs, but if crying persists it can become very distressing to parents. Newborn infants most often cry when they are awakened, hungry, unsettled, too hot or cold, feel unwell, need a change in the environment (a reduction or an increase in stimulation), or need sleep (Barnard, 2010). Crying occurs on average 2 h a day (or more in the case of the 20 % of infants who are diagnosed with colic) up until the age of 3 months, after which time crying usually slowly reduces in duration (Barnard, 2010).

Breastfeeding is recommended for infants until at least 6 months of age, as it strengthens the immune system and enhances neuro-cognitive development (American Academy of Pediatrics, 2012). The parent–child interaction involved with breastfeeding also enhances infant attachment, especially when the mother enjoys the process of breastfeeding (Tharner et al., 2012). While more than 85 % of women can successfully breastfeed; the demands of breastfeeding for the mother are quite high. During the first 6 weeks of life, infants typically feed for up to 3 h per day with a recommended eight feeds spread throughout the 24-h day (Gettler & McKenna, 2011). Sustaining this frequency in breastfeeding can prove very

challenging, especially for women returning to paid employment soon after the birth. Perhaps as a consequence only 60–70 % of women breastfeed at birth and only about 30 % breastfeed until 6 months (Blyth et al., 2002). Transient feeding problems are common and chronic feeding problems affect 25–35 % of infants (Manikam & Perman, 2000).

Impact of Parenthood on Parents

The experience of having a child is somewhat different for fathers and mothers. Partly this is due to the physical demands placed on women's bodies through the pregnancy, birth, and subsequent breastfeeding. The physiological changes associated with pregnancy, childbirth, and breastfeeding include hormonal variations, which can have a significant impact on the mother's psychological well-being (Clark, Skouteris, Wertheim, Paxton, & Milgrom, 2009). Often, the mother's experience during pregnancy (e.g., feeling the baby kick), makes the reality of becoming a parent more salient to her than the father. Similarly, experiencing the birth of the child for the mother often prompts a re-evaluation of her life situation (Clark et al., 2009). Many mothers experience mild depression (the blues) after the birth of their infant, and for some, these sad feelings persist and increase over time to a clinical level of postnatal depression (PND). Significant predictors of PND include prenatal depressed mood, high neuroticism, low social support, couple relationship distress, high rates of daily hassles or stressors, a history of sexual abuse, having an unplanned pregnancy, obstetric complications, perinatal stress, and a family history of psychological disorder (Klemetti, Kurinczuk, & Redshaw, 2011).

Postnatal anxiety disorders are also common in mothers, with an average of 3 % of mothers experiencing post-traumatic stress disorder (PTSD) after the birth of their child (Klemetti et al., 2011). Typically, women experience PTSD after having experienced complications during delivery such as severe injury, forceps delivery, difficult labor, or poor pain relief. Those mothers who experience pre-pregnancy psychological disorder (most commonly depression or anxiety) are at greater risk of experiencing depression or anxiety symptoms after the birth of their child (Teixeira, Figueredo, Conde, Pacheco, & Costa, 2009).

Although the majority of research has focused on mothers' psychological distress, a few studies have explored fathers' emotional health after the arrival of their infant. These studies have identified elevated rates of paternal depression and anxiety during the transition to parenthood, although the rates are not as high as in mothers (Schwalb, Schwald, & Lamb, 2013). The psychological distress experienced by mothers and fathers during the transition to parenthood places further stress on the couple and predicts increased risk of experiencing relationship distress (Schwalb et al., 2013).

There seems to be a reciprocal influence between individual psychological adjustment of the two partners and quality of the couple relationship. Rates of maternal reports of parenting stress, depression and worry are low when couple

relationship satisfaction is high, and when women perceive their male partner as supportive (Florsheim et al., 2003; Wicki, 1999). If maternal depression does develop, recovery is predicted by being in a satisfying and supportive couple relationship (Pope, Evans, McLean, & Michael, 1998). Conversely, maternal depression predicts deteriorating relationship adjustment (Belsky & Kelly, 1994).

Impact of Parenthood on Couple Interaction

Along with infant care demands, there are at least five other major changes that new parenthood brings, which can contribute to deteriorating couple relationship satisfaction. First, there is often inequity in the division of infant care between mothers and fathers, which can be a source of dissatisfaction to women. The care of an infant adds approximately 35+ hours of work per week to the average couple household (Craig & Bittman, 2005). Many, although not all couples, report an egalitarian approach to housework before parenthood that they plan to maintain and expect to continue while raising their child (Katz-Wise, Priess, & Hyde, 2010). However, on average women, regardless of whether they are in paid employment, do about two to three times more of the extra work generated by having a child than men (Hansson & Ahlborg, 2012). The inequitable burden of child care responsibility can be a source of significant dissatisfaction to women, particularly if they expected and desired an egalitarian division of labor (Feeney et al., 2001).

Second, after the birth there is less time for couple-focused communication free from distraction. Relative to before children, on average after becoming parents couples' communication is characterized by the use of less self-disclosure, less praise, and increased negativity and conflict (Belsky & Kelly, 1994; Gottman & Notarius, 2000). Deterioration in couple communication is not as evident in couples who show higher than average positivity before the birth (Houts, Barnett-walker, Paley, & Cox, 2008), suggesting the stresses of parenthood exacerbate pre-existing difficulties in couple communication.

Most couples report stress associated with a decline in disposable income after the birth of their first child (Thomas & Sawhill, 2005). This decline is associated with both increased costs associated with having a child, and with a decline in income if the woman reduces her hours of paid work. Men often report an increased sense of responsibility to provide financially, and tend to increase their commitment to paid employment after the birth of their child (Astone, Dariotis, Sonenstein, Pleck, & Hynes, 2010). Particularly for couples on modest incomes, the financial squeeze can substantially erode their opportunities for individual and shared leisure activities (Thomas & Sawhill, 2005).

Fourth, there is reduced frequency and quality of couple time. During the last trimester and after the arrival of the baby, parents' social and recreational activities decrease, in particular their leisure time such as weekends away and holidays away from home (Claxton & Perry-Jenkins, 2008). When couples do manage to sustain shared activities with their partners they report higher relationship satisfaction and less conflict a year after the birth of their child (Claxton & Perry-Jenkins, 2008).

Finally, many couples stop having sex in the third trimester of pregnancy and do not start again until 2–3 months after the birth of their child (Johnson, 2011). Many new mothers experience discomfort or pain during sex before and/or after the birth of their child, which reduces the sexual activity of the couple (Sagiv-Reiss, Birnbaum, & Safir, 2012). In addition, many mothers, and some fathers, report reduced sexual desire attributable to a combination of fatigue and a reduced sense of sexual attractiveness in the woman (Hipp, Kane Low, & van Anders, 2012; Johnson, 2011). For some fathers the decreased sexual interest of their partner leads to frustration, especially if these men view sexuality as a key way to experience intimacy and for validating their partner's emotional closeness to them (Perini, Ditzen, Hengartner, & Ehlert, 2012). For about 30 % of new parents, sexual problems persist for at least 3–4 years after birth (Johnson, 2011; Sagiv-Reiss et al., 2012).

Couple Interaction and Parenting

The couple relationship is well recognized as a key determinant of the quality of family life and parenting of young children (Erel & Burman, 1995). Meta-analyses of the couple dyad and parent–child dyad indicate a consistent, moderate to large effect size relationship between good couple relationship functioning and sensitive parent–child interactions (Erel & Burman, 1995; Krishnakumar & Buehler, 2000).

Consistent with research findings on the association of the couple relationship with parenting of children, chronic couple conflict predicts low sensitivity and responsiveness of parenting of infants in the first year of life (Owen & Cox, 1997). This association is particularly strong when the infant is exposed directly to couple conflict (Crockenberg, Leerkes, & Lekka, 2007). There are several pathways by which couple conflict might interfere with sensitive-responsive parenting of infants. First, the conflict distracts parents from attending to the infant, and increases parents' negative affect and physiological arousal in ways likely to interfere with higher order problem solving (Bradbury & Fincham, 1987). Difficulties with problem solving are likely to delay parents' response to the infant and reduce their sensitivity of that response. Secondly, couple conflict generates parental stress, which predicts more infant crying (Wurmser & Papousek, 2008). Infant crying is stressful to parents and predicts deteriorating relationship satisfaction (Meijer & van den Wittenboer, 2007). Thus, there is potentially an escalating cycle of negativity and upset between parents and between parents and the infant. Third, low relationship satisfaction and high conflict is associated with disagreement between partners about sharing parenting and household responsibilities (Elliston, McHale, Talbot, Parmley, & Kuersten-Hogan, 2008). Such disagreements, in turn, predict deterioration in relationship satisfaction particularly for women (Feeney et al., 2001), and is likely to be associated with further escalation of couple conflict. Overall, the findings on couple relationship satisfaction, sensitive parenting of infants and maternal adjustment suggest mutual, reciprocal influences between these factors.

Clinical Connection
What are the more effective ways couples might address the common challenges associated with becoming parents? If you are a parent, how do you think you managed the transition to parenthood?

Risk and Protective Factors for Couple Relationships

The factors that predict couple relationship outcomes across the life span fall into four broad categories (Halford, 2011), which can be integrated into an ecological model that is depicted in Fig. 1.1. (1) At the outermost level of influence are socio-cultural variables, which provide the context in which relationships occur. There also are contextual variables that operate at a local level that differentially influence couples within a given culture. For example, positive support of the couple relationship by family and friends predicts sustained high relationship satisfaction (Larson & Holman, 1994). (2) Life events include major life events (e.g., birth of a child, a change of job) and daily uplifts and hassles (e.g., being praised by the boss, getting caught in traffic, and an argument with a co-worker). Stressful life events and daily hassles each predict deteriorating relationship satisfaction (Story & Bradbury, 2004). As depicted in the diagram, some life events are shared by the couple; other life events are experienced specifically by one partner. (3) Individual characteristics are relatively stable individual differences that partners bring to the relationship, such as negative family-of-origin experiences, low partner education, psychological disorder, and certain personality variables, each of which predict deteriorating relationship satisfaction (Bradbury & Karney, 2004; Holman, 2001). (4) Finally, couple interaction includes the partners' behaviors, thoughts, and feelings during interactions. For example, positive couple communication and shared realistic relationship expectations predict a sustained and mutually satisfying relationship.

The socio-cultural context in which the couple finds themselves plays a major role in how the relationship is viewed by the couple and by those with whom they interact (Halford, 2011). The couple's expectations, values, and beliefs are built upon the cultures they are raised and live in, and play a major role in the couple's ability to enhance and sustain their relationship. For example, couples with religious backgrounds tend to view marriage as important; couples that share this belief about marriage tend to stay together (Goddard, Marshall, Olson, & Dennis, 2012). Couples who come from very different cultural backgrounds sometimes integrate their differing expectations and draw on the strengths of those diverse cultures, while other couples struggle to reconcile their different expectations (Goddard et al., 2012; Halford, 2011).

A second aspect of context is the couple's life events. The transition to parenthood is one of the most significant changes a couple experience, and this can be made more challenging if the couple is experiencing other major change at the same

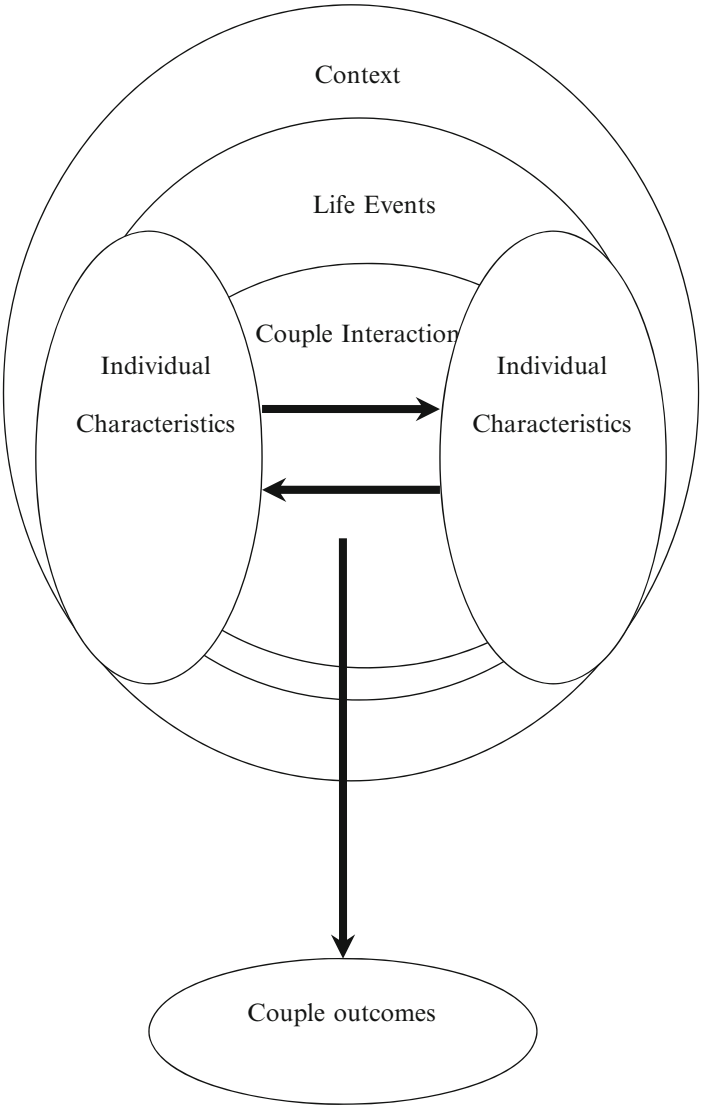

Fig. 1.1 An ecological model of influences on couple relationships

time (Neff & Karney, 2004; Story & Bradbury, 2004). Couples who transition to parenthood often need to accommodate their personal activities to those of increased household duties and care of the infant. These adjustments are associated with a decrease in quality time previously shared with their partner (Cowan & Cowan, 1992). Those couples who sustain positive communication and mutual support tend to develop a joint approach to coping with stressful events, which makes them resilient to the negative effects of life stress (Bodenmann & Cina, 2006).

With respect to individuals' characteristics, normal personality variations do not account for much of the variability in couples' relationship satisfaction, although emotional stability (low neuroticism) and high agreeableness are reliably associated with higher satisfaction (Dyrenforth, Kahsy, Donnellan, & Lucas, 2010). However, low relationship satisfaction is strongly associated with the presence of psychological disorders (e.g., depression, alcohol abuse, and some anxiety disorders, especially panic disorder and generalized anxiety disorder) in one or both spouses (Whisman, 2007). There also are some individual vulnerabilities that likely increase the risk of both individual psychological disorder and couple relationship distress. For example, individuals who show deficits in interpersonal communication and negative affect regulation are at elevated risk of developing both alcohol abuse and relationship problems, which in turn might exacerbate each other (Halford, 2011).

The couple's family-of-origin experiences also predict their relationship satisfaction (Halford, Sanders, & Behrens, 2001). In particular, spouses whose parents divorced or were violent toward each other in their family-of-origin are at risk to experience inter-partner violence, declining relationship satisfaction across time, and relationship separation (Halford, Sanders, & Behrens, 2000; Perren, Von Wyl, Bürgin, Simoni, & Von Klitzing, 2005). The long-term effects of negative family-of-origin experiences seem to be mediated, at least in part, by the communication skills individuals learn while growing up. Individuals who experienced parental divorce or inter-partner violence in their family of origin show more negative communication in the early stages of their adult relationships (Halford et al., 2000; Sanders, Halford, & Behrens, 1999), which likely reflect being exposed to models of negative communication by their parents. Negative communication mediates the association of family-of-origin divorce with declining relationship satisfaction across time in newlywed couples (Story, Karney, Lawrence, & Bradbury, 2004).

Lastly, how spouses act toward each other, and how they think and feel during those interactions, plays a significant role on couple relationship satisfaction (Halford, 2011). Specifically, couples who communicate positively, support each other, and manage conflict effectively tend to have more satisfying relationships (Halford, 2011). In addition, couples who self-regulate their relationship behavior (i.e., monitor their own behavior, set self-change goals, and change their behavior to enhance the relationship) report sustained relationship satisfaction (Halford et al., 2007). In contrast, couples who do not work on their relationship tend to blame relationship difficulties on their partner and report declining relationship satisfaction (Halford et al., 2007). In the case of expectant couples, those couples who discuss and plan the pregnancy adjust better to parenthood than couples who have an unplanned pregnancy (Bouchard, Boudreau, & Hebert, 2006). Shared and realistic expectations of the relationship, and how the couple will share the tasks of parenthood, predict sustained high relationship satisfaction in the year after the birth (Feeney et al., 2001; O'Brien & Peyton, 2002).

A couple's level of commitment to each other and their relationship also predicts relationship satisfaction (Iafrate, Bertoni, Margola, Cigoli, & Acitelli, 2012; Smith, Heaven, & Ciarrochi, 2008). Couples who view their life as a shared experience are more satisfied after becoming parents (Smith et al., 2008). Using dyadic coping

(where both partners share their thoughts and feelings about stresses and seek to jointly manage the effects of stress) also predicts sustained high relationship satisfaction (Bodenmann & Cina, 2006).

Practice Tip
Research shows a complex array of factors (context, individual characteristics, life events, and couple interaction) affect couples' adjustment to parenthood. Individuals often attribute their adjustment to just one variable (e.g., "I am just not cut out to be a good parent."). Supportive education that highlights the broader influences can help people find ways to improve their adjustment (e.g., seeking additional support from others, talking differently to your spouse, and reducing stress by cutting back on paid employment).

Assessing Risk in Couples

The ecological model integrates the couple's socio-cultural context, life events, individual characteristics, and couple interaction in predicting relationship satisfaction across the transition to parenthood. In combination the ecological model allows prediction of which couples are at high risk for having difficulties adjusting to parenthood. By assessing that risk it is possible for professionals to ensure they provide high levels of support to high-risk couples. At the same time it is important to recognize that the assessment of risk is unlikely to ever predict future relationship satisfaction perfectly. Things that happen after the birth, such as having a sick or disabled child, and changing life events (e.g. loss of employment in one or both parents), are often not known before the birth and can profoundly affect couples' adjustment and need for support.

In brief, risk can be defined as those factors from the ecological model that predict declining relationship satisfaction. Specifically, as identified previously, financial stress, experience of parental divorce in the family of origin, inter-partner violence, and unplanned pregnancy are all established risk factors for poor adjustment to parenthood. In one study a count of the occurrence of these factors was used as an index of risk that could range from zero to six. High-risk scores were found to predict lower relationship satisfaction 2 years after the child was born (Petch et al., 2012). Taking a score of 3 or more as indicating high risk, it was found 45 % of high-risk couples became clinically distressed 2 years after the birth compared to only 20 % of low-risk couples.

Effectiveness of Couple Education for New Parents

There have been a large number of trials evaluating couple relationship education (RE) to assist couples becoming parents. A meta-analysis of 21 of these studies reported small effects on couple communication and relationship satisfaction

(Pinquart & Teubert, 2010). Many of the programs evaluated in these studies were very brief (one or two sessions), and these brief programs had little or no effect. Programs that were only offered after the birth of the child seemed to have, at best, small effects.[3] Moderate to large effect sizes occurred for interventions with five or more sessions held across both the antenatal and postnatal period. A limitation of much of this research was lack of long-term follow-up to evaluate whether there were sustained benefits of RE for new parents.

There have been seven randomized trials of RE for new parent couples that have assessed the effects of education for 12 months or more. Of these trials four found clear and substantial benefit of couple education, one had unclear findings, and two found no benefits of education. The first of the studies that found no clear benefit of RE was conducted with 290 couples who were recruited through a public maternity ward located in the Netherlands (Trillingsgaard, Baucom, Heyman, & Elklit, 2012). Couples were allocated to one of three conditions: the Positive Relationship Education Program (PREP), an information-based control group (INFO), or care as usual. Across 2 years, all three groups declined in relationship satisfaction, and no significant differences were found between the conditions.

The Building Strong Families (BSF) project is a very large ($n = 6{,}212$ couples) eight-site evaluation of several different RE programs for unmarried couples expecting a child together. Within a randomized controlled trial design at each site, at 15-month follow-up there was no overall effect of RE across sites on relationship satisfaction (Wood, McConnell, Moore, Clarkwest, & Hsueh, 2012). Attrition and low attendance was a substantial problem across most sites, but supplementary analyses showed that the outcome averaged across all sites for even the couples attending RE was not reliably better than for matched control couples. At one site (Baltimore) there was evidence that couples receiving RE were worse off than the control couples. A notable exception to the otherwise null results was observed at the Oklahoma City site, where an adaptation of PREP for new parents achieved high rates of attendance and enhanced couple relationship satisfaction in participants. Interestingly, the total duration of the RE at this site was substantially shorter than at the other sites, yet this was the only program with evidence of positive effects. In a recently released 3-year follow-up of the BSF, the benefits of RE in Oklahoma city on relationship satisfaction had attenuated. But the program continued to have an effect in reducing separations from 59 % of couples in the control condition to 51 % of couples who received RE (Wood, Moore, Clarkwest, Killewald, & Monahan, 2012).

Shapiro and Gottman (2005) did a small-scale trial of RE with 38 couples expecting their first child. The RE consisted of a couple-focused workshop, plus five home visits that provided information and skills training, which was compared to a waitlist

[3] In addition to providing an estimate of the average effect across multiple studies, meta-analysis also can be used to estimate statistically what characteristics of a program influence how much effect that program has.

control. The pattern of findings on relationship satisfaction was complex with some initial deterioration and then improvement in the relationship satisfaction of couples receiving RE. Given the modest sample size in that study, the replicability of the unpredicted[4] curvilinear relationship adjustment trajectory of the intervention is open to question.

Schulz, Cowan, and Cowan (2006) evaluated a RE program that consisted of 24 weekly 2-h group sessions that ran from the last months of pregnancy through to well after the birth. They found RE enhanced relationship satisfaction through to a 5-year follow-up, which is impressive. However, the program involved a lot of RE and hence would be expensive to deliver, and require a substantial commitment for participants.

Cowan, Cowan, Pruett, Pruett, and Wong (2009) recruited 289 couples who were expecting their first child, or who had a young child. The couples were predominantly low-income couples of Mexican or European ancestry. RE consisted of 16 weekly 2-h group sessions focused on parenting, couple communication, individual stress management, and social support, with a focus on promoting father's involvement with parenting. The couple RE was compared with a father-only group covering similar content; or a single information session (control). Both the couple and father-only conditions showed higher relationship satisfaction than the control, with the couple condition producing stronger effects than the father-only condition 18 months after RE.

Halford, Petch, and Creedy (2010) recruited 71 couples ($n=71$) expecting their first child who were randomly assigned to either: (a) Becoming a Parent (BAP), a maternal parenting education program; or (b) Couple CARE for Parents (CCP), a couple relationship and parenting education program. Relative to BAP, CCP reduced negative couple communication from pre- to post-intervention, and enhanced relationship satisfaction in women but not men to 1 year follow-up.

In summary, four of the six trials of RE just reviewed produced positive effects but two studies did not. There are several possible explanations for the mixed findings. One plausible explanation is the characteristics of the couples in the studies. Given that only 40–50 % of expectant couples report a substantial decline in relationship satisfaction across the transition to parenthood (Doss, Rhoades, Stanley, & Markman, 2009), the small average effect of RE (Pinquart & Teubert, 2010) might reflect that many couples adjust well to parenthood without RE. One study found that in marrying couples only those at high risk of future relationship problems benefited from RE (Halford et al., 2001). Perhaps the benefit of RE for expectant couples is also moderated by risk.

[4] The changes in satisfaction across time can be described statistically as a trajectory, and a curvilinear trajectory is when change begins in one direction and the rate or direction of change alters across time. (For example, if couples' satisfaction declines from pre-relationship education to post-relationship education but then starts to increase later.) Complex curvilinear change requires a lot of data points to estimate accurately, and hence this study with a small sample of couples and a complex pattern of findings needs to be interpreted cautiously.

Petch et al. (2012) evaluated the effectiveness of RE in 250 couples expecting their first child. The couples were assessed on risk and randomly assigned to Couple CARE for Parents (CCP), a couple relationship and co-parenting focused education program ($n = 125$) or the Becoming a Parent Program (BAP), a mother-focused parenting program ($n = 125$). Risk was associated with greater relationship and parenting adjustment problems. Relative to BAP, CCP women decreased their negative communication and showed a trend to report less parenting stress irrespective of risk level. High-risk women receiving CCP reported higher relationship satisfaction, and were less hostile and intrusive in their parenting, than high-risk women receiving BAP. There were no effects of CCP for men on relationship satisfaction. However, high-risk couples were much less likely to be distressed in their relationship if they received CCP.

In summary, the balance of evidence supports the effectiveness of RE in assisting new parent couples to adjust to parenthood. Couple CARE for Parents is the only program that has been replicated in two trials to enhance couple relationship satisfaction, although several other programs also have found positive effects. Benefits are likely to be greatest for high-risk couples.

The Structure of Couple CARE for Parents

Couple CARE for Parents (CCP) consists of six units, which are designed to address the needs of most couples who are becoming parents. In CCP it is emphasized that there is no one right way to have a great relationship, and each couple is assisted to define how they want to relate. This approach involves the couple being provided information, and undertaking experiential exercises, to clarify their beliefs about what constitutes a good relationship, and to develop shared and realistic expectations for their relationship and the sharing of parenthood. Couples also are assisted to develop their couple relationship and parenting skills, to self-evaluate their current behavior in the relationship, and to self-select personal changes intended to realize their shared view of their relationship. This self-change focus encourages each partner in the relationship to take active responsibility for sustaining and enhancing the relationship. CCP covers those areas identified in the research reviewed in this chapter as predicting future relationship satisfaction, and the components of effective relationship education.

Table 1.1 summarizes the content covered in the CCP. As is evident from the structure, the program extends from the last trimester of pregnancy through to 4–5 months after the birth of the child. As described above, the evidence suggests starting programs before the birth are more likely to produce benefits for couples. However, sometimes it might be difficult to recruit couples during the antenatal period. In these instances, program content needs to be modified to be appropriate for couples after the birth.

Table 1.1 Structure and Content of Couple Care for Parents program

	Weeks from birth	Unit content
1.	–6, group workshop	Expectations of parenting, couple communication (Chaps. 2 and 3)
2.	–4, home visit	Conflict management (Chap. 4)
3.	+3, home visit	Taking baby home: infant care, stress management (Chap. 5)
4.	+6, self-directed	Sharing infant care: mutual partner support, social support, shared positive couple activities (Chap. 6)
5.	+9, self-directed	Couple caring and sexuality (Chap. 7)
6.	+12, self-directed	Looking ahead: managing change, preventing problems, sustaining a relationship focus (Chap. 8)

Practical Issues in Offering Couple CARE for Parents

Modes of Delivering Couple CARE for Parents

In order to enhance accessibility of support for new parents, it is useful to consider what modes of delivery are attractive to couples. We encourage providers to offer CCP in a range of delivery modes, recognizing that different delivery modes are likely to appeal to different couples.

CCP can make use of different combinations of delivery modes to enhance accessibility and cost-effectiveness. As we typically deliver CCP, the six units are offered in a mix of face-to-face groups, home visits to a single couple and flexible delivery. A full-day face-to-face workshop is provided to groups of couples when the expectant mother is about 6–7 months pregnant. Many couples are keen to access relationship education at that time, and willing and able to set aside time to attend a full-day session. The group session allows couples to learn from other couples about the diversity of expectations and approaches couples take to sharing parenthood.

In our most common form of CCP delivery, couples complete the final pre-birth and all four post-birth units at home, avoiding the inconvenience of travel when in advanced pregnancy or when caring for a young infant. There are two home visits by a relationship educator, one in the last month before the birth and the second about a month after the birth of the child. The visits give the educator opportunity to observe the home environment, which provides information on how the couple is managing. For example, if the home is very untidy with few safe places for the infant to explore, then education and assistance can be provided to develop a safe and stimulating environment for the child. The last three units of CCP are done in flexible delivery mode and involve the couple completing structured exercises together, and having a telephone call with an educator. The flexible delivery is cheaper and easier to implement than the home visits, as it does not involve travel for the educator, and allows couples to complete the program in their own home and at times that suit them.

Regular (about monthly) completion of units provides most couples with reasonable time to complete the various tasks, while limiting the duration of time they are committing to working on the program. It also encourages the couple to establish a routine for completing units, such as setting aside a particular evening in 1 week per month. Finally, it allows the CCP educator to address issues with couples as they become most salient. For example, expectations about how parenting will be managed are discussed before the birth, and reviewed soon after the birth. Parental concerns about common infant care challenges, like feeding, crying and sleeping, are addressed soon after the baby is born. Concerns about sexuality are addressed a couple of months after the birth when many couples are seeking to recommence sexual activity.

When running CCP with groups of couples the ideas are introduced and couples do exercises in the sessions, and this process allows use of the group processes to enhance learning. The content of each unit can be covered in a 2-h group session. However, having couples with a newborn attend regular sessions can be challenging. Therefore this book focuses predominantly on delivery to one couple at a time, at least after the birth. We also suggest ways that procedures can be adapted for other modes of delivery.

CCP also can be delivered in face-to-face mode in monthly sessions with one couple. In this mode the couple completes one unit per month over about 6 months from the last trimester of pregnancy through to about 4 months after birth, which seems to work well. In working face-to-face with an individual couple it is possible to work through the same ideas and tasks as with the group delivery format.

When CCP is provided in flexible delivery mode, couples complete the program at home, and need access to the CCP materials. In this modality, the typical time commitment for couples for each unit is 60 min to do the individual and couple exercises, and 45 min for the telephone call with the educator. The flexible delivery mode allows the couple to negotiate whether they want to complete the program more quickly, or space out units over a more extended period. However, we find the approximately monthly occurrence of sessions seems to work well for most couples.

Clinical Connection
What form and timing of sessions might work best for the couples you are likely to work with? What structure might be easiest to deliver in your system?

Learning Processes in Couple CARE for Parents

A distinctive characteristic of CCP is that it offers an active, skill-focused approach to relationship education. This means the sessions focus on having couples try out new ways of relating, and having spouses talk to each other about their relationship. There is some didactic input from the educator, but face-to-face sessions are

structured primarily around couple-based activities. These activities always lead toward partners defining changes they wish to implement in their relationship between sessions.

The learning processes in CCP incorporate key principles of adult learning, principles that facilitate self-directed learning. First, CCP is designed to reflect Kolb's (1984) Experiential Learning Cycle. Kolb's cycle has wide currency in adult education, and there is significant empirical support indicating that it does describe how people learn from experience (Lizzio & Wilson, 2004). Kolb describes the learning process as an iterative four-stage cycle: (1) a concrete experience followed by (2) observation and reflection, leading to (3) the formation of abstract concepts and generalizations, leading to (4) hypotheses to be tested and applied in future action, which in turn leads to new experiences. In essence, this means people often learn from experiences and reflections on those experiences. It is necessary to provide didactic input (e.g., lectures, demonstrations) to introduce abstract ideas (e.g., a model of good communication). However, experiences that prompt people to be reflective around issues related to the idea (e.g., seeing an example of poor communication and being asked to reflect on what makes it poor communication), often enhances receptiveness and understanding of the abstract idea. Furthermore, once the idea is introduced adults are unlikely to apply it without experiences that prompt them to apply and then reflect on the idea (e.g., communicate with their partner and then use the model to self-evaluate their own communication).

Clinical Connection
What is the best learning experience you had in the last few years? How was that learning experience structured?

The experiences in each CCP unit reflect Kolb's (1984) experiential learning cycle. Each unit in CCP begins with an experience to prompt reflection, followed by an input of ideas, and modeling of key relationship skills. The presentation is structured to prompt further reflection on the personal relevance of the ideas and skills. For example, in the group format the CCP unit on communication begins by eliciting comments from different couples about what constitutes good communication, and the importance of communication in a couple's relationship. Each couple is invited to reflect on the different ideas offered by other couples. This is followed by modeling of good communication, and description of a model of effective communication. Partners then talk together reflecting on the strengths and weaknesses of their communication. In face-to-face delivery (groups or individual couples) the educator can model the key relationship skills via a demonstration.

There are exercises in each unit of CCP through which couples can relate the ideas and skills introduced in the program to their relationship. The exercises are a mixture of partners working independently and together, with each person self-appraising their own behavior in relation to a particular relationship topic (e.g., communication, caring, and support); setting their own goals for a desired self-change

with the aim of improving their relationship; developing realistic strategies for implementing and monitoring the change; and seeking feedback on the progress and effectiveness of their change efforts. The learning for each unit is completed with a written self-change plan that helps each partner to consolidate and apply their learning. The program provides a structure that combines individual reflection with opportunities for couples to progressively share, discuss, and negotiate ideas and behaviors as they work through the tasks in each unit. Thus, consistent with Kolb's learning cycle, the program is structured to give couples experiences, prompt reflection on those experiences, and promote self-directed change.

In group face-to-face delivery the exercises completed by the couple are complemented with group discussion. For example, in the first unit that is delivered when the woman is pregnant, couples are asked to reflect upon the time taken to care for a new born infant. Group discussion often focuses upon just how demanding the care schedule is, and different ways partners can support each other with this considerable work load. We often have each couple identify and discuss a couple they know who has adapted well to parenthood. (Some expectant parents do not know any other parents with young children, and just identifying that they have no examples to draw upon is useful in itself.) We ask the couples about what behaviors they notice in the parents that lead them to believe that couple are adapting well to parenthood. We then ask each couple to tell the group a key relationship behavior they have identified as characteristic of good adaptation to parenthood, and we write the behaviors each couple identified up on the board. When couples discuss what they think are the most important behaviors to manage the transition to parenthood well, this often highlights that there are some behaviors important to most couples, and some behaviors that are important to particular couples.

After couples have completed the exercises, the educator's role is to prompt and support couples through the program. In particular, the educator reviews the concepts introduced by the lectures or discussion in face-to-face mode, and the exercises completed by the couple. The educator focuses on promoting self-directed learning by shaping and modeling self-change skills. For example, in the second unit on communication the educator listens to a sample of the couple's communication and then asks each partner to self-appraise their own communication. These self-appraisals are shaped by the educator to ensure that each partner has developed realistic and concrete ideas about specific strengths and weaknesses, which can be used to generate self-change goals. It is important to note that self-directed learning does not mean there is no input from the educator, but rather that the educator helps the partners to clarify and define their learning goals.

Research in adult education shows that interaction with an educator is often vital to learning (Rourke & Anderson, 2002). Specifically, learners often report the need for such contact to sustain engagement with the programs of learning, and feel they need to receive meaningful feedback quickly in order to guide future performance. Even though CCP can be completed in large part by couples at home if they have access to the program materials, the program was not designed to be a self-help program for couples. It has not been evaluated for its efficacy without an educator, and for that reason the program materials are only made available to educators rather than couples.

Conclusion

In summary, there are as number of key implications of the research evidence for practice of couple education for new parents. First, the substantial demands of infant care often surprise couples, and can erode couple relationship satisfaction and individual mental health. Second, the ecological model is a useful way to summarize the diverse range of factors that influence couple adjustment to parenthood, and can help identify couples who might be at particular risk for poor adjustment to parenthood. Third, couple education that addresses the challenges of parenthood, and promotes mutual partner support can assist couples, and is likely to be of particular benefit to high-risk couples. Fourth, education that is of 10–12 h duration, which begins in the antenatal period and extends into the postnatal period, is easy for couples to access even when busy caring for a young infant, and encourages self-directed experiential learning, is most likely to be helpful. The remaining chapters of this book provide specific guidance on how to deliver the Couple CARE for Parents program, which incorporates these research-based principles.