The Polomeno Family Intervention Framework for Perinatal Education: Preparing Couples for the Transition to Parenthood

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Abstract

Couples face many challenges as they transform themselves from dyad to triad. For some couples, these challenges are life-enriching experiences, while for others, chaos ensues, potentially leading to separation and divorce. The transition to first-time parenthood, even for well-functioning couples, is fraught with potential disorganization. At the same time, it provides opportunities for simultaneous self-growth and conjugal enrichment. What role can perinatal educators play in preparing couples to deal with the changes associated with this transition? To answer this vital question, the author presents her conceptualization of perinatal education as a primary family intervention framework during the perinatal period.

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Background Information

The challenge in perinatal programs is not only to prepare couples for childbirth but also *to sensitize them to the transition to parenthood and all that it entails*. Preparation for the transition to the couple partnership* within the parent role requires the educator to devote time to the couple's relationship and help them to reconnect as needed. This includes teaching the couple how to be more in tune with each other, increase their sense of intimacy, improve conjugal support and communication, and enhance their sexual relationship. The author believes that perinatal education is entering a new era as perinatal educators become well educated, expand

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*In this article, the author will refer to the couple's partnership, which includes both marital and nonmarital pairs. Other terms to be used synonymously are the *conjugal relationship* or the *conjugal dyad*.

their knowledge base, conduct research, and experiment and evaluate different approaches. She proposes that the expanded practice of perinatal education include a primary family intervention framework for couples experiencing the transition to parenthood. This article will present an approach that has evolved from the author's development and experimentation with various programs for perinatal education. What information would assist perinatal educators to prepare couples for the transition to parenthood? This can be done in separate classes, or it is possible to include this information in traditional childbirth education classes without compromising preparation for the birth experience (Polomeno, 1997e). How can this be done, if at all? When is it best done? Should perinatal education be expanded so couples can be better prepared for the transition to parenthood?

What Is the Current Situation That Is Provoking the Perinatal Educator's Need for This Framework?

Today, perinatal education is becoming a recognized specialty with a firmly established scientific basis. It has grown from a one-to-one approach in the early years to a comprehensive program, and it has developed from the practice of childbirth education (Nichols & Zwelling, 1997). Perinatal education has been defined as "health education for the family unit during pregnancy, childbirth, and the early parenting period . . . [It] is composed of a variety of different types of classes that address the needs of all family members as the family moves from one developmental life cycle stage to another during the childbearing years" (Nichols & Zwelling, 1997, p. 590). It has become family oriented by focusing on this transition period of the family (Peterson & Peterson, 1993). Malnory (1996) stipulates that, as a developmental stage, pregnancy is not only critical for the well-being of the person, the infant, and the family but also for the well-being of the couple. The perinatal educator has a supportive role of providing information about the normal processes and changes that are common during this time of transition (Lothian, 1993). Starn (1993) indicates that perinatal education may be "looked upon as an opportunity to strengthen family systems through anticipatory guidance and skill building that family members may use throughout the life cycle" (p. 35).

Zwelling (1996) indicates that "childbirth education, for the most part, has been accepted by the health care community and most childbirth classes have moved into the health care system" (p. 428). She specifies that a favorable outcome of this movement is twofold: more parents can be reached and childbirth educators can have a positive influence on the health care system. Ernst (1994) explains, "Science supports the expansion of education of parents and family-centered childbirth, mainstreaming midwifery, and developing alternatives to the acute care hospital for childbirth. These three major efforts . . . promote the fundamental need for consumers to take more responsibility for their health and for the way they use the medical care system. This basic shift of responsibility is essential to effective, long-term reform" (pp. 134-135).

Thus, if parents are to be part of effective, long-term health care reform with increased responsibility, it follows that educating parents only for childbirth is no longer sufficient but should be expanded to include the whole transition to parenthood. Sheila Kitzinger, author and long-time birth advocate, challenges perinatal educators to re-examine the content and the structure of prenatal classes. She and others recommend that educators help prepare families for fulfilling births and making smooth transitions to parenthood (Elliott, 1995). In a recent critique of the author's perinatal education program for the health promotion of expectant fathers (Polomeno, 1998a, 1998b), Budin (1998) quotes a perinatal educator who was part of the analysis: ". . . [W]e as childbirth educators have always put so much emphasis on an event that occurs in a few hours (labor and birth) and we have not focused on issues that affect these couples for a lifetime" (p. 38).

Issues that influence the preparation of couples for the transition to parenthood lie partly with trends that occur in both society and the health-care system. In this new century, these trends will influence adults, their relationships, family making, and childrearing. Perinatal education must broaden its base to prepare couples not only for childbirth and early parenting but also for the entire transition to parenthood. Broadening the base of perinatal education involves modifying current programs to include knowledge about the transition to parenthood, relational skills such as communication and emotional support, family health promotion, and enrichment of marital intimacy and sexuality.

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Predicted Family and Partnership Trends for the 21st Century

Several changes occurring in society will influence men and women, their relationships with each other, and how they will birth and parent their children. Perinatal educators have the opportunity to respond to these trends in order to meet the future needs of childbearing and childrearing couples.

In his book *Psychotrends*, Frazier (1994) highlights some of these predicted major changes:

- The family will become the psychological unit, as opposed to the primarily economic unit. The result will be towards healthier relationships and less concern over holding a marriage together. This may result in dissociating childbearing and childrearing from marriage, yet simultaneously increasing men's interest in home and parenting.
- There will be major emphasis on the protection and proper care of children. Frazier states, "We should strengthen those social contracts that ensure the health, well-being, and freedom of individuals, including parents, and particularly those individuals who nurture children. Families in all their diverse new forms need help especially when the family, whatever its makeup, includes children" (p. 117).
- A genuine gender détente characterized by enhanced cross-gender communication will prevail. "Those who master cross-gender literacy are likely to enjoy the most satisfying relationships humans can achieve" (p. 57).
- Today, the sexes are finally making an honest effort to understand one another, so that "the sexual revo-

lution made possible a serious inquiry into the ways in which men and women are alike and the ways in which each is unique" (p.67).

- There will be a shift from reproductive sexuality to psychological sexuality. The latter viewpoint will involve the fulfillment of people's needs for nurturance, security, and connectedness.
- Women will become more demanding, sexually.
- The public will continue to expand its interest in sex and increased sexual expression. A new freedom to talk openly about erotic matters will emerge.

Other authors (as cited below) predict additional societal trends will affect partnering and sexuality in the next century:

- Western society is moving from a patriarchy model to a partnership one: "The partnership model is a way to structure human relationships based on linking . . . women and men together expressing their full potential—neither superior nor inferior" (Aburdene & Naisbitt, 1992, p. xxiii).
- There is a generational movement toward wholeness. Women are developing their masculine side while men are moving toward activating their feminine side. It appears that partnership is the secret to creating a lasting and passionate relationship. However, gender differences have been described in that a woman feels partnership when she and her partner are doing things together in a cooperative manner, while a man must have his own department over which he has control (Gray, 1996).
- Men and women must become fluent in each other's language of caring and commitment so they can develop skills in a variety of ways of feeling and expressing intimacy (Wood, 1993).
- According to Monsour (1994), "Competent communication of information about oneself, as well as the competent gleanings of information about one's partner, should facilitate a sharing of meaning and understanding in a relationship" (p. 133), thus leading to intimacy. It is only through the processes of interaction and communication that intimacy is created and maintained (Keeley & Hart, 1994).

- “Being a good lover” and “keeping the excitement of sex alive” in a committed relationship will require that men and women take more direct responsibility for communicating what they want or desire, sexually (Winstead, Derlaga, & Rose, 1997).

Predicted Health Care Trends for the 21st Century

At the same time, a paradigm change is occurring in health care delivery in both the lay and professional literature. Overall, there is a rapidly emerging emphasis on establishing a prevention and wellness focus. This shift will create sweeping changes in all arenas of the health-care marketplace. Arnold and Kirby (1996) mention some of these sweeping changes: the consolidation of affiliations within communities, regions, and across continents; the improvement of the health status of communities with more integrated community efforts; the designing of accessible health care systems compatible with quality and cost containment indicators; and the expansion and dissemination of technology. The perinatal specialty is one that has profoundly and rapidly been impacted by these changes.

Jones and Maestri (1997) explain how alternative health care delivery systems such as Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Independent Practice Organizations (IPOs) are being developed in the United States: “These new delivery systems further challenged the traditional functioning of the health care system by adding services that emphasize preventive maintenance, in addition to the treatment of illness . . . [H]ospitals have responded by reducing operating costs, decreasing the average length of stay (ALOS), and implementing market strategies that target the health care needs of women. Thus, the interaction of consumer demand and economic constraints mandated that hospitals replace outmoded obstetric systems with maternity services that are high in quality, cost efficient, and consumer sensitive” (p. 38). Canada, which has a social medicine model of health care delivery, has also reorganized its health care system due to escalating health care costs.

Some predict that the relationship between the health care team and their clientele will change more towards partnership, collaboration, and consumer empowerment and participation (Cox, 1997; Jewell, 1994; Sheer, 1996;

Skelton, 1994). As a result, health care workers will need to support families by putting more emphasis on health promotion and disease prevention, increasing the significance of parenting to society, working with families to reduce fragmented care, achieving optimal outcomes, promoting a more consumer-friendly system with increased focus on primary health care/promotion education outside the walls of academic health centers, and inviting family participation in primary prevention and early treatment of illness (Cox, 1997).

The members of the health care team themselves will need to work in an interdisciplinary mode rather than a multidisciplinary one so that each member of the health care team will understand and be conversant in the cognitive maps or thought processes of the other team members. The new knowledge base, then, will be greater than the sum of the knowledge of the participants (Sheer, 1996). Quimby (1994) states, “Finally, the dialogues must take place in all health care arenas and with professionals, patients, families, policy makers, and business leaders; in short, everyone with an interest in the outcomes must participate” (p. 122). How will perinatal educators participate in these dialogues and respond to the above trends? How can perinatal education be modified? The author proposes that perinatal education be considered a primary family intervention. She has developed an intervention framework, which is presented in this next section.

A Family Intervention Framework

In this section, the *Polomeno Family Intervention Framework for Perinatal Education* will be introduced. Each component of the framework is presented below. (See Figure 1.)

Overview

Steil (1997) explains, “Relationship intimacy must be continuously affirmed through shared experiences in which partners feel understood and valued. Under these conditions, intimacy benefits both partners, enriching their relationship and promoting psychological and emotional growth. In the absence of understanding and validation, or through mere neglect, there can be stagnation and gradual deterioration, a diminution of shared experiences and a decline in appreciation and affection” (p. 76). Based on family life theory (Cowan, 1991), if a

Figure 1. The Polomeno Family Intervention Framework for Perinatal Education: Couple's Preparation for the Transition to Parenthood

couple does not successfully adapt to each stage of conjugal life, unresolved emotional issues will be brought into the next stage of conjugal life, potentially increasing the already existing strain often associated with each stage of parenthood. The accumulation of conjugal strain could eventually result in emotional withdrawal and set into motion an irreversible process leading to dissatisfaction and unhappiness with the relationship. This can potentially result in separation and divorce.

Assumptions Underlying Promoting Partnership during Parenthood

The following five principles underlie the intervention framework:

1. Perinatal education can provide primary prevention. Keeney (1982) has defined interventions with families as the introduction into the family systems

of new pieces of information that may help families behave differently. Bloom (1984) has categorised interventions as primary, secondary, and tertiary. "Primary prevention programs are designed to prevent problems before they develop by modifying the external conditions that cause problems or by helping people cope with these conditions. In contrast, secondary prevention programs are designed to intervene with people who have developed 'early signs' of a problem, and tertiary prevention programs are meant to help people cope with existing problems and to decrease the chances of the problem developing again" (Duncan & Markman, 1988, p. 272). Perinatal education can be considered a primary family prevention because it helps couples deal with the normal transition to parenthood (Polomeno, 1999d, 1999e).

2. Family health promotion is a central component of comprehensive primary prevention programs. Preventive interventions can be in the form of preventive programs (McPheeters, 1976). Prevention programs that "view goals in terms of promoting health rather than preventing disease . . . are aimed at healthy targets during a life transition, and their goals are to promote [general] well-being" (Duncan & Markman, 1988, p. 272-273). Bomar (1996) defines family health promotion as "behaviors of the family that are undertaken to increase the family's well-being or quality of life . . . [and] activities families engage in to strengthen the family as a unit. The goal of these activities is to attain, retain, or regain the emotional and physical health of all family members" (p. 182). Perinatal education is not only a means of preparing parents for childbirth but also of helping families move toward wellness. "Pregnancy is a time in people's lives when they are particularly open to considering lifestyle changes" (Nichols & Humenick, 1988, p. 319). Thus, family health promotion is at the heart of primary intervention for families.
3. The family is the logical unit of primary care during the perinatal transition. The family becomes the logical unit for health promotion intervention during the life transition to parenthood (Pender et al., 1990). Emphasis is placed on the woman because

she is the one who is pregnant. The fetus is taken care of both directly and indirectly (Nichols & Zwelling, 1997). The father's health is also important for the family unit (Polomeno, 1998a, 1998b). Together, all three family members should be recipients of health care because the total well-being of the family unit is affected by the multiple changes occurring. Health of the family is physical and emotional; however, health of relationships also exists. Over time, an emotional and psychological distance may creep into any couple's relationship. However, the fetus can be the ideal medium through which the partners come together to enrich their conjugal relationship, especially when care is taken to nourish this opportunity (Polomeno, 1998e, 1997a).

4. Anticipatory guidance in the form of education is the primary intervention modality in family health promotion related to perinatal transition. Anticipatory guidance is an educational modality aimed at strengthening family systems in the transition to parenthood (Goldberg & Michaels, 1988). This anticipatory guidance may consist of discussion of the changes the couple is experiencing and exercises to deal with some of the issues, as well as both support and nurturing to help the couple negotiate more successfully the potential pitfalls of the transition (Starn, 1993). Thus, with the couple's gradual acquisition of new responsibilities and the implementation of new skills, education becomes a primary modality for creating optimal conditions for the transition (Schumacher & Melis, 1994). Education can also strengthen relationships, create family environments conducive to self-growth, health, and well-being for both family members and the family as a unit (Botelho & Skinner, 1995; Roth, 1989). Felner, Farber, & Primavera (1983) suggest that a life transition preventive approach focus on the entire transitional period with its adaptive needs resulting from the change being experienced. They state that "the degree to which an individual is able to recognize and to master changes in the way they view themselves and in the way they are perceived by others may significantly influence the level of success he or she has in coping with life transitions" (p. 211). Such

programs typically contain three qualities: (a) They are group-oriented; (b) they are directed to well people; and (c) they strengthen psychological health and reduce psychological maladjustment (Cowen, 1983). Indeed, comparing common experiences provides ongoing support (Lothian, 1993).

5. Partner relationship enrichment is a key strategy for preventative health care for couples. Lenz, Solken, Rankin, and Fischman (1985) write that “[c]hildbirth education classes . . . have typically limited discussion of nurturance to labor, delivery, and infant care. Increased attention could justifiably be given in these classes . . . [especially] to spouses’ nurturance of one another and to the potential benefits of sex-role attributes and behaviors for perceptions of [conjugal] quality” (p. 60). Perinatal educators can convey a message to couples that conjugality, like family life, has predictable stages of development and that conjugal strain is a normal experience, especially at critical points over the life of a marriage or conjugal relationship (Martin & Starling, 1989). Educators can also help couples tune in or increase their awareness of the changes in their relationship, especially of intimacy. The educator can prepare couples for the stresses associated with their relationship during transition to parenthood by discussing them in advance and normalizing them as they occur.

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The Concepts at the Heart of the Framework

Family Intimacy. Conjugal intimacy is foundational for intimacy within the total family. “Family intimacy is critical . . . since the family will [ideally] become the safe haven for each of its members. The sense of security the family produces will have beneficial consequences, both short-term and long-term, for their unborn’s devel-

opment and the development of other children to follow” (Polomeno, 1998e, p. 20). Schaefer’s definition of intimacy can be adapted for family intimacy: “True [family] intimacy is a process that grows with time. It is a process of knowing and being known, and it requires openness and willingness from each person involved. [Family] intimacy has no techniques . . . [and] cannot be orchestrated. It starts with the self, knowing the self and being present to the self . . . [Family] intimacy is not static. It is always moving to a new level. It is an energy flow with no barriers . . . [and] cannot be controlled. Like a feeling, it cannot be held onto or reproduced at will. We notice [family] intimacy. We do not produce it” (1989, pp. 136-137).

The Scope of Conjugal Intimacy. Street (1994) defines intimacy as interactions that relate to open self-disclosure and close personal exchanges. This includes the sharing of feelings, hopes, fears, and vulnerabilities. Conjugal intimacy includes—but is more than—sexual intimacy (Schaefer & Olson, 1981). Intimacy can exist between any two persons, but conjugal intimacy is seen as a crucial component of a healthy relationship (Kenny & Acitelli, 1994). Indeed, intimate couples report feeling the presence of their partner even though he or she is not physically present (Monsour, 1994). Knowing that the other is always in one’s thoughts is essential to the maintenance of intimacy. Adults have described it as “feeling the other in one’s blood!”—a statement that reflects the strong mind-body-spirit connection.

Intimacy must be recreated daily and renewed in each stage of conjugal life. The feeling that each partner is in tune with the other is also important (Keeley & Hart, 1994). If a couple feels out of synchrony, they can develop strategies to re-establish this bond and/or admit they are temporarily out of synchrony. Conjugal intimacy is a wonderful healer and a support in the hassles of everyday life. However, the changes associated with the transition to parenthood can disturb the feeling of synchrony or harmony. If so, with effort the couple can re-establish intimacy in their relationship (Clulow & Mattinson, 1989; Polomeno, 1997e), leading to a renewal of love and sexuality.

Couples should be aware that physical love is not sufficient to maintain a long-term committed relationship such as marriage (Clulow & Mattinson, 1989; Din-

If a couple feels out of synchrony, they can develop strategies to re-establish this bond and/or admit they are temporarily out of synchrony.

kmeyer & Carlson, 1989; Polomeno, 1999d, 1999e). The successful transition to parenthood necessitates emotional and psychological intimacy, the most difficult of all intimacies to experience (Carlson, Sperry, & Dinkmeyer, 1992), and include the following traits:

- an understanding of one's self and a willingness to share feelings and thoughts;
- flexibility and responsibility for one's behavior in the relationship;
- self-acceptance and acceptance of both the other and the relationship;
- commitment to the permanence of the relationship, especially if children are involved;
- trust and faith with honest, open exchanges;
- ability to live in the present and see new ways of achieving mutually compatible goals;
- ability to negotiate; and
- ability to focus, emphasize, and share positive feelings.

At least two authors, Framo (1981) and White (1998), state that the greatest gift parents can give their offspring is a viable, happy, healthy, and loving relationship. Assuming this is so, perinatal education can make a major contribution to society by helping couples tune in to the changes in the emotional and psychological intimacy of their relationship, while simultaneously promoting the emotional and physical health of the next generation.

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Thus, promoting a couple's relationship through the perinatal transition is a foundational aspect of family health promotion.

The Shared Meaning Approach to Building Intimacy

The reader is encouraged to become acquainted with Duck's (1994) *A General Model of the Serial Construction of Meaning*, which forms the basis for this section of the framework. Four stages are exhibited in the model: (a) commonality, (b) mutuality, (c) equivalence of meaning, and (d) sharing. To attain a sharing of meaning in a relationship, a couple must appraise and determine the meaning contained within their interaction. The appraisal process is activated through the use of interactive perceptions, as presented in Table 1 and repeated in Figure 1. Each person's perception (self-perception) and the other's perception (metaperception) are interwoven in a communications dance so that the couple may find meaning or the significance in a given situation, often leading to the common ground (Allen & Thompson, 1984).

When a couple feels they are sharing a situation, they will begin to feel that they are similar (Genero, et al., 1992). Similarity (Monsour, 1994) is important as one partner gains understanding about himself/herself, his/her partner, and the situation (Kelly, 1969). The couple will experience feelings of closeness and reciprocity, leading to feelings of being a team, two people in a partnership (Cutrona, 1996). This appraisal-meaning-common-ground building process is mediated by communication, social support, sexuality, intimacy, and equality (Suitor, 1991).

Primary Family Prevention: Anticipatory Guidance

The following goals form the basis of the teaching approach to promote intimacy in a couple experiencing transition to parenthood:

1. Increase the couple's awareness of how their families of origin have influenced their beliefs and values regarding parenthood;
2. sensitize the pregnant couple to the changes in their relationship during the transition to parenthood;

Table 1 Explanation of the Polomeno Family Intervention Framework for Perinatal Education

1. *A General Model of the Serial Construction of Meaning:*

Steve Duck (1994) has developed *A General Model of the Serial Construction of Meaning*, which contains four stages. In the first stage of commonality, the conjugal partners have the same attitude towards Topic X, such as the impending arrival of the new family member, but are not aware that they have this in common. In the second stage of mutuality, the partners come to realize that they share the same feelings about the topic. In the third stage of evaluation, each partner interprets the feelings about the common topic and realize to what an extent they do share the same feelings. In the last stage of shared meaning, a collective perception has developed and is integrated into the existing core of shared meaning.

2. *The Appraisal-Meaning-Common Ground Process:*

- a. Appraisal is obtained through the exchange of viewpoints, but first a person must become aware of his or her viewpoint. This is determined through perceptions. The perception that a person has of her/his situation is called a direct perception or self-perception (Allen & Thompson, 1984). Perceptions are important because they help a couple to enhance their communication about thoughts and feelings (Duck, 1994), and affect everyday interactions, feelings of intimacy, and satisfaction with the relationship (Acitelli, Douvan, & Veroff, 1993).
- b. After appraisal, a couple strives to find meaning in a situation. They ask themselves the question, what is significant about this situation? What and how does it affect me/us? Metaperceptions are critical at this stage of meaning. According to Allen and Thompson (1984), a person's perception of the other's perception is referred to as a metaperception. Dixon and Duck (1993) define meaning "... to the way a person organizes knowledge about relationships in the context of what else she or he knows about the world" (p. 180).
- c. Once a person has appraised his or her situation and has compared his or her viewpoint with the other, three comparisons are obtained: If the self-perceptions of each partner are congruent, then they are said to be similar (actual similarity); when one partner's perception of the self is congruent with that partner's perception of the other, there is perceived similarity for that partner; and when a partner's view of the other corresponds with the other partner's view of him- or herself, there is understanding (Acitelli, 1993). Once understanding has been determined, then a joint perception called the *common ground* can be obtained (Duck, 1994). Genero and colleagues (1992) explain how mutuality is critical to understanding.

3. *Mediators of the Process:*

- a. Social Support: definition: "... responsiveness to another's needs and more specifically as acts that communicate caring; that validate the other's worth, feelings, or actions; or that facilitate adaptive coping with problems through the provision of information, assistance, or tangible resources" (Cutrona, 1996, p. 10).
- b. Communication: "Quality communication is essential to personal relationships. Nonverbal behaviors are indicative of quality communication ... people pay close attention to nonverbal behaviors as indicators of the health of their relationship" (Keeley & Hart, 1994, p. 161).
- c. Maintenance Behaviors (Winstead, Derlaga, & Rose, 1997): (a) being positive, (b) being self-disclosing, (c) demonstrating affection, (d) spending time with friends and family, (e) sharing tasks, (f) doing activities together, (g) sexual intimacy, (h) engaging in celebrations and rituals, (i) being spontaneous.
- d. Intimacy and Sexuality: Intimacy is both a process and experience of closeness resulting from the disclosure of intimate topics and the sharing of a variety of experiences ... Intimacy is seen to be a crucial component of a healthy marriage (Keeley & Hart, 1994; Kenny & Acitelli, 1994; Monsour, 1994).
- e. Equality: "Relationship equality involves equal participation in the responsibilities of the home, equal commitment to provide, equal voice in establishing priorities, and equal commitment to and investment in the work of relationships" (Steil, 1997, p. 71).

4. *Possible Consequences of Process:*

- a. "Couples who are able to provide support to another during times of duress may be able to prevent emotional withdrawal ... Sensitive and well-timed support from the spouse is an important component of maintaining emotional contact and reducing emotional isolation" (Cutrona, 1996, p. 62).
 - b. Couple develops feeling that they are a team (Cutrona, 1996).
 - c. "Mutual perception of layers of similarity is continuously modified in an attempt to establish a joint perceptual view of the relationship" (Monsour, 1994, pp. 124-5).
 - d. Intimacy is built up in the relationship (Keeley & Hart, 1994; Monsour, 1994).
 - e. Perceived agreement and understanding are more important than the actual agreement and understanding (Monsour, Betty & Kurzweil, 1993).
 - f. "The couple's comprehension or their way of understanding how they relate to each other is also important to their ability to pursue their relationship in a way that allows life's tasks to get negotiated and that provides for new opportunities for continued growth" (Bubenzer & West, 1993, p. 15).
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3. encourage the couple to share their thoughts and feelings regarding these changes during each stage of the transition to parenthood;
4. enhance communication and emotional support within the couple's relationship during the transition to parenthood;
5. assist the couple in the identification of their personal and relational strengths and resources;
6. help the couple identify and use sources of support;
7. explore each partner's realistic expectations regarding his/her role in the transition to parenthood;
8. examine similarities and differences between men's and women's responses to the transition to parenthood;
9. support conjugal and family intimacy to create feeling of a team or partnership.

Mediators and the Process of Family Intervention

The mediators include communication, social support, maintenance behaviors, intimacy and sexuality, and equality. These are addressed in Table 1.

Couples and the Transition to Partnership during Parenthood: Support from the Literature

The following theoretical content is offered as a teaching guide for the perinatal educator. Five questions are raised in this section of the article: (a) What are transitions? (b) What happens to family health during transitions? (c) What is the transition to parenthood? (d) What is the connection between the conjugal relationship and the transition to parenthood? and (e) What types of interventions are appropriate for couples coping with this transition? A perinatal educator can choose parts of this theoretical content to explain the transition to parenthood to couples attending perinatal education classes. The integration of the content will depend on the type of program being taught, the nature of the group attending classes, the time factor, the training and comfort level of the educator, and the pertinence of the theoretical background.

Transitions Defined. Transitions are pauses in the family life cycle or periods of disorganization and reorga-

nization as the family and its members advance from one stage of life to another. (See Table 2.) Cowan (1991) defines transitions as "longterm processes that result in a qualitative reorganization of both inner life and external behavior" (p. 5). Each transition has the potential to be accompanied by changes in health-promoting lifestyles (Bomar, 1996) as well as potential health disturbances at the physical, psychological, emotional, and social levels due to biological changes in hormonal function and the immune system (Dura & Kiecolt, 1991). Transitions may be developmental or situational and expected or unexpected (Murphy, 1990). Some transitions may trigger a greater response than others (Cowan, 1991). See Table 2.

Family Health During Transitions. The family unit typically undergoes four stages in its health during family transitions: (a) evaluation of the current lifestyle, (b) planning for behavior change, (c) implementation of behaviors to enhance family health, and (d) evaluation of family outcomes (Pender, 1987). It is important that members of the family unit accomplish the developmental tasks associated with each stage of the family life cycle in order to successfully move on. If crises are encountered during the family life transitions and are not resolved, then fixations, regressions, and other forms of psychological dysfunction may result (Cowan, 1991).

The Transition to Parenthood. The transition to parenthood is classically defined as the time period beginning with a pregnancy and terminating a few months after the baby's arrival (Goldberg, 1988). (See Table 2.) However, an extension has been proposed by Gottlieb and Pancer (1988) as beginning with the couple's decision to become pregnant and terminating when the child is between 2 and 3 years old (Wright & Leahey, 1994). This time span of 2 to 4 years is congruent with the time people usually need as when experiencing any of the major life transitions (Hetherington & Camara, 1984; Wallerstein & Kelly, 1980).

The author of this article has conceptualized the transition to parenthood as containing nine phases.

- Phase 1 – the decision to become pregnant;
- Phase 2 – physically creating the baby;
- Phase 3 – pregnancy;

Table 2 Transitions: Overview

1. *Phases*—Three phases occur within transitions. The first or early phase is characterized by conflict and uncertainty; the middle phase involves testing new alternatives; and the late phase witnesses a return to previous equilibrium or to the establishment of a new equilibrium (Cowan, 1991). Chick and Meleis (1986) indicate that the three phases of a transition include entry, passage, and exit.
 2. *Transition Conditions*—“Transition conditions include meanings, expectations, level of knowledge and skill, the environment, level of planning, and emotional and physical well-being” (Schumacher & Meleis, 1994, p. 121). Meanings are extremely important in the appraisal of a transition: “Meaning refers to the subjective appraisal of an anticipated event or experienced transition and the evaluation of its likely effect on one’s life. Meanings attached to transitions may be positive, neutral, or negative . . . Awareness of the meaning of a transition for clients is essential for understanding their experience of it as well as its health consequences” (Schumacher & Meleis, 1994, pp. 121-122). Cowan (1991) adds two other conditions: the physical and social demands faced by the individual in coping with the life change and the availability of personal resources such as social support and guidance.
 3. *Possible Consequences*—(a) Family stress (Carter & McGoldrick, 1989); (b) personal health perturbation (LaVoie, 1985); (c) sense of disconnectedness associated with disruption of the linkages on which the person’s feelings of security depend (Chick & Meleis, 1986); and (d) fixations, regressions, and other forms of psychological dysfunction may result if the inevitable crises associated with each transition are not resolved (Cowan, 1991).
 4. *Indicators of Successful Transitions*:—“[A] subjective sense of well-being, mastery of new behaviors, and the well-being of interpersonal relationships” (Schumacher & Meleis, 1994, p. 124).
 5. *Interventions*: (a) Assist clients to create conditions conducive to a healthful transition (Schumacher & Meleis, 1994); (b) maximize clients’ strengths, assets, and potentials or contribute to restoration of the client to optimal levels of health, function, comfort, and self-fulfillment (Meleis, 1991); (c) develop clients’ recognition of the problematic interpersonal change and create an environment that promotes the acquisition of skills needed for the transition (LaVoie, 1985).
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- Phase 4 – birth;
- Phase 5 – immediate postpartum, including the first 6 weeks;
- Phase 6 – 1 1/2 to 6 months;
- Phase 7 – 6 to 12 months;
- Phase 8 – 12 to 18 months; and
- Phase 9 – 18 to 24 months.

The transition to parenthood can be considered complete when the child is 2 years old. This belief is based on clinical observations from the domain of family therapy that alludes to the 2-year period demarcating a major life transition (Hetherington & Camara, 1984; Wallerstein & Kelly, 1980). Cowan and colleagues (1991) state, “We believe that it makes sense to describe the end of the transition to parenthood as occurring, on the average, when the first child is about 2 years old” (p. 88). (See Table 3.)

The Connection of Conjugal Relationship and Transition to Parenthood. A connection—both positive and negative—exists between the conjugal relationship of a couple and the transition to parenthood. (See Table 4.)

Couples usually express feelings of closeness and mutuality due to the sharing of a common project and of maturity with the increased responsibilities of childrearing (Lederman, 1984). Increased personal and conjugal fulfillment and satisfaction seem to occur (Bomar, 1989; Shereshefsky & Yarrow, 1973) with couples who have successfully adapted to the transition to parenthood. Conversely, some couples experience less conjugal satisfaction (Cowan, Cowan, Heming, & Miller, 1991) from increased personal and conjugal stress (Bomar, 1989; Cowan, et al., 1991), which may lead to an emotional distance in the relationship (Keith & Whitaker, 1988). The arrival of the first child most affects the couple’s relationship (Bradt, 1989; Broom, 1984; Clulow, 1982) and is perceived differently by men and women (Clulow, 1991).

Interventions for Couples in the Transition to Parenthood. Any interventions focusing on the couple’s relationship in the transition to parenthood should be aimed at reinforcing the relationship (Cowan, et al., 1991), which will have long-term consequences for their children’s early development and psychological well-being. Each partner’s evaluation of the transition and the com-

Table 3 The Transition to Parenthood: A Summary

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1. *Types*—Parenthood has been classified according to the following: (a) the arrival of a first child such as first parenthood (Fedele, Golding, Grossman, & Pollack, 1988); (b) the timing of parenthood such as adolescent parenthood or late parenthood (Goldberg, 1988); (c) the roles involved such as motherhood, fatherhood, or grandparenthood (Cowan, Cowan, Heming, & Miller, 1991; Goldberg, 1988; Gottlieb & Pancer, 1988; and (d) the degree of risk involved such as low-risk and high-risk (Holt, 1988).
 2. *Key Principle in the Emotional Process of the Transition to Parenthood* (Carter & McGoldrick, 1989)—The key principle in the emotional process associated with this transition is the acceptance of new members into the family system.
 3. *Developmental Tasks of the Couple during Pregnancy* (Martin & Starling, 1989)—(a) acceptance of impending parental role along with changing body image, (b) renegotiation of husband-wife roles, and (c) resolution of ambivalence.
 4. *Developmental Tasks of the Couple with Young Children* (Martin & Starling, 1989)—(a) acceptance of new family member(s), (b) development of parenting skills, and (c) renegotiation of relationships with families of origin.
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Table 4 Impact of the Conjugal Relationship on the Transition to Parenthood

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1. *Impact of the Transition on the Family Unit and Its Members—Positive consequences:*
 - a. “Couple relationship quality implicated in the child’s early social, emotional, and cognitive development” (Cowan et al., 1991, p. 99).
 - b. “The feeling of increased closeness usually resulted from sharing the pregnancy and from the maturity that came from the process of merging into their new roles together and discovering new aspects of one another” (Lederman, 1984, p. 102).
 - c. “Well-adapted marital relationships were characterized by such factors as an intense degree of affection, empathy, satisfying sexual adjustment, mutuality of goals, and flexibility in decision-making” (Shereshefsky & Yarrow, 1973, p. 51).
 - d. “Beginning with the sharing of the birth experience, which may be viewed by some couples as the high point of their lives, parenthood can be a source of mutual sharing and sense of pride for what they have created” (Bomar, 1989, p. 323).
 - e. Fulfillment of personal needs as individuals and the possibility that satisfaction in the parental role may energize performance in other areas (Bomar, 1996).
 - f. One of the major changes in the couples’ relationships during the transition to parenthood is an enhanced feeling that they are working as a team (Belsky, Spanier, & Rovine, 1983).
 - g. Equalization of power imbalances and reinforcement of commitment to one another (Whitbourne, 1986).
 2. *Impact of the Transition on the Family Unit and Its Members—Negative consequences:*
 - a. Decline in marital satisfaction (Cowan, Cowan, Heming, & Miller, 1991).
 - b. Postpartum distress for mothers and fathers potentially leading to the “blues,” depression, and psychosis (Cowan et al., 1991).
 - c. “Prebaby state of the parents and their marriage contributes much more than the baby does to their postbirth adaptation levels” (Cowan et al., 1991, p. 80).
 - d. “The transition to parenthood seems to increase the stress in parents’ lives, amplify the differences between the spouses, and thereby increase their level of marital dissatisfaction” (Cowan et al., 1991, p. 80).
 - e. Deterioration in the quantity of partners’ time together (Cowan et al., 1991).
 - f. “Even when the parents stay together, their dissatisfaction with their relationship as a couple tends to color the quality of their relationships with their preschool age children” (Cowan et al., 1991, p. 104).
 - g. Stress of everyday living, including fatigue, noise, and confusion in the home; additional household work; added financial burdens; lack of control over routines; disagreements over childrearing practices; concerns about parental competence and child’s welfare (Bomar, 1989).
 - h. Intimacy in the couple’s relationship is the dimension that is the most affected in the transition to parenthood (Polomeno, 1997e). This has been associated with the birthing event (Polomeno, 1998c, 1998d) and with the couple’s relationship with their fetus (Polomeno, 1998e; 1997a).
 - i. “. . . divorces can begin around births. The legal divorce may not take place until later, but the marriage develops a hairline fracture then” (Keith & Whitaker, 1988, p. 438).
 3. *First Parenthood:*
 - a. Major change from dyad to triad and accompanying role changes (Belsky, Lang, & Rovine, 1985; Broom, 1984; Clulow, 1982; Gottlieb & Pancer, 1988; Saunders & Robins, 1987; Wallace & Gotlib, 1990).
 - b. Disengagement from selected roles and relationships as well as the definition, creation, and integration of new roles and relationships (Antonucci & Mikus, 1988).
 - c. Enormous amounts of physical time, energy, and effort to enacting the parental role (Antonucci & Mikus, 1988).

(continued next page)

Table 4 Continued

- d. Significant moment of generational change (parenthood and grandparenthood) with reorganization of relationships both inside and outside the family (Clulow, 1982; Cowan et al., 1991).
 - e. Major stressors include the accession of infant member, plurality pattern change to triad, activation of parental roles of mother and father, temporary or permanent withdrawal of wife from workforce, residential and location changes, and activation of kinship networks (Bomar, 1989).
 - f. Factors that make first parenthood difficult: (a) paucity of preparation, (b) limited learning during pregnancy with parenthood adjustment being more difficult than marital adjustment, (c) abruptness of transition with the new mother starting out immediately on 24-hour duty, and (d) lack of guidelines for successful parenthood (Rossi, 1989).
4. *Gender Differences:*
- a. “. . . the transition to parenthood tests the capacity of a couple to manage the boundaries of closeness and distance, sameness and difference, in a flexible way that allows the balance between being together and being apart to change over time” (Clulow, 1991, p. 259).
 - c. For the mother (Clulow, 1991): (a) physical changes, (b) during pregnancy becomes introspective, (c) women’s evaluations of the marital relationship decline after the birth till 6 months, (d) women see themselves more as mothers and less as partners, (e) the new mother is more affiliative in the early months of the postpartum as she is engrossed with her infant but becomes more autonomous during the latter part of the first year as her child begins to be more independent (Fedele, Golding, Grossman, & Pollack, 1988).
 - d. For the father (Clulow, 1991): (a) becomes aware of changes in his partner but later, (b) may unconsciously identify with her, becoming like her in order to manage feelings of envy and exclusion, (c) subject to contradictory pulls as they become fathers: strong pull to identify with women and become a parent, while economic realities impede his active involvement as parent, (d) evaluation of marital relationship plunges at 18 months with little shift in perceptions of partner and parent, (e) “It seems as if the very affiliative first-time father tends to reduce the intensity of his wife’s exclusive, intimate ties with the infant by maintaining a close relationship with his wife and by meeting some of the infant’s needs for closeness and nurturance” (Fedele, Golding, Grossman & Pollack, 1988, p. 105).
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bination of their evaluations could affect their satisfaction with the relationship (Cowan & Cowan, 1988). After an appraisal process, the couple’s strengths and resources can be utilized in order to reduce any negativity that could be attributed to relationship failure rather than the stress associated with the transition itself. A group setting such as that provided by perinatal education classes can be the ideal safe haven or time-out for couples to explore issues, concerns, thoughts, and feelings (Clulow, 1982; Cowan et al., 1991). The role of the perinatal educator is to facilitate this awareness, create a safe environment for exploring issues, support the couples in their exploration through effective communication, reinforce existing strengths and resources, and assist the couples as they develop their feelings of partnership leading to the couple’s common ground.

Applications of the Polomeno Family Intervention Framework

Several perinatal education concepts or programs are summarized below and represent various aspects of the intimacy intervention useful with transitioning couples. These may be integrated into a traditional childbirth

education course or added as separate courses to a comprehensive perinatal program.

Health Promotion from the Couple’s Perspective. A couple is encouraged to understand and establish health promotion for themselves and lay the foundation for the next generation (Polomeno, 1999d, 1999e). Health and all its dimensions, including their love for each other, are stressed as important for the couple’s relationship and for short-term and long-term conjugal satisfaction and intimacy.

Health Promotion for the Expectant Father. The promotion of family health should be expanded to include the expectant father (Polomeno, 1998a, 1998b), especially since he is traditionally left out while the pregnant partner and fetus are being cared for by the health-care team.

Fetal Touch. A couple can rediscover each other through a third person, namely, the fetus (Polomeno, 1998e, 1997a). Conjugal partners can enter into the world of the unborn, learn about their child’s development, touch and massage the fruit of their love, and

become intimate with their child before his or her birth. As the expectant parents caress the pregnant abdomen, their touch can become loving, sensual, sexual, and even erotic (Polomeno, 1997a). The baby shares in the expectant parents' intimate exchanges and closeness.

Intimacy During Pregnancy. Many couples become more separate during the physical and psychological changes associated with pregnancy. Each partner may withdraw temporarily from the relationship to ponder these changes and integrate them into their psyche. If so, this temporary rift can lead to the withdrawal of physical intimacy, which may set a negative precedent for the future of the relationship. To prevent negative outcomes, intimacy should then be evaluated by the couple during pregnancy, and the couple can be encouraged to focus on the sexual changes occurring at that time and learn to understand each other's experience (Polomeno, 1997e).

Sexuality of the Birth Event. Intimacy continues as the couple gives birth to their offspring (Polomeno, 1998d, 1998e). "The sexual overtones associated with the birth event [when] discussed by perinatal educators [can assist couples to] continue the psychological work involved in transforming the intimacy dimension of their relationship . . . The transformation of the couple's intimacy which begins with pregnancy and continues during labor and birth can become important in laying the foundation for the couple's future family intimacy" (Polomeno, 1998c, p. 18). When each stage of the transition to parenthood is fully lived and integrated into the couple's core of shared meaning, they are supported in becoming successful parents and having a happy and intimate relationship. Broome and Koehler (1986) support the notion that ". . . unmet expectations [about the birth event] could lead to a generalized feeling of dissatisfaction with both the event and the spouse that could affect perceptions of parenting and marital satisfaction later" (p. 40).

Sex and Breastfeeding. In the postpartum, as mothers choose to breastfeed their babies, this experience also has sexual overtones and can affect and be affected by a couple's relationship and their intimacy (Polomeno, 1999a). Consequences of breastfeeding include a mother's needs for affection being met in part by her baby,

the normal sensual feelings associated with the experience, and the precarious nature of the woman's libido. For her, the breasts are no longer considered as a primary erogenous zone, and this may require the male partner to modify his sexual repertoire during this period. Milk-filled breasts sexually excite some men. Couples with sexual openness have used their imagination to enrich their experience when milk ejects from the woman's breasts following her orgasm during the sexual encounter.

Postpartum Sexuality. The couple's sexual relationship often requires some adjustment in the postpartum (Polomeno, 1996). The woman's libido may not automatically return after the birth of her baby, but it can be reawakened and nurtured by her partner. A four-stage process for the reawakening of a woman's libido has been prepared. This information has been greatly appreciated by both men and women. The use of perineal massage can be encouraged, especially as a means of desensitizing the vagina and preparing it for the resumption of sexual intercourse in the postpartum.

Social Support. A couple often needs external social support to successfully adjust to the transition to parenthood. At times and for various reasons, a woman may find herself alone in this adjustment (Polomeno, 1997b). Couples can be taught to strengthen their support system. This information is applicable for heterosexual couples, but much of its content can also be pertinent for gay and lesbian couples. Building strong support systems can be helpful for all life situations. One goal will be to promote, both directly and indirectly, the child's physical, emotional, and social development.

Grandparents. Intergenerational support is also important for the couple's successful transition to parenthood. Grandparents can be helpful in enhancing both conjugal intimacy and family intimacy (Polomeno, 1999b, 1999c). The grandparents can be buffers for any stress that may occur in each stage of the transition to parenthood. Harmonizing the relationships between the conjugal partners and between themselves and their offspring is very helpful. The grandparents themselves are experiencing their own transition, which could have an impact on their children and grandchildren. Thus, providing support for the grandparents' transition may as-

What couples may not have learned from their childhood role models related to partnering and parenting can be addressed in programs of perinatal education.

sist them to offer more optimal support for the new parents.

High-Risk Pregnancy. A couple's intimacy may be disturbed by high-risk pregnancy, especially if antenatal hospitalization is required (Polomeno, 1997c, 1997d). Even couples experiencing normal pregnancy gain preparedness by obtaining a basic understanding of high-risk pregnancy, the organization of at-risk perinatal health services, and coping strategies to deal with the emotional upheavals associated with the situation.

Conclusion

To what extent are perinatal educators and/or comprehensive perinatal programs preparing couples for the transition to parenthood? Many are beginning to do so, but some educators may need more knowledge and training in order to better prepare couples for this important life transition. Martin and Starling (1989) believe that clinician educators must especially increase their familiarity with conjugal issues and recent changes in health services. Many couples can benefit from supportive anticipatory guidance and counseling that acknowledges the predictable changes in their relationships (Goldberg & Michaels, 1988). The normalization associated with anticipatory guidance can reduce anxiety and frustration that often surround conjugal conflict and set the stage for adaptation and resolution. One aspect of the perinatal educator's role becomes that of validating the couple's feelings. Additionally, sharing feelings in discussion within a group setting of expectant parents can reopen channels of communication for a participating couple. Cutrona (1996) says, "In the same way that people are not born with the knowledge of how to be good parents, we are not born knowing how to be supportive marital partners" (p. 101). What couples may not

have learned from their childhood role models related to partnering and parenting can be addressed in programs of perinatal education. Healthy families is the desired outcome for perinatal education practice, the greater society, and ultimately, the health-care system.

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