Integrating Marriage Education into Perinatal Education

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Abstract

Couples making the transition to parenthood experience challenges that can threaten the quality and stability of their relationships and the health of family members. Currently, the educational infrastructure to support the delivery of couple-relationship education during the transition to parenthood is limited. Because new-parent couples interact with the health care system at many points during this transition time, an opportunity exists for strengthening couple relationships within the system to improve the well-being of adults and children. In this article, we propose a productive collaboration between marriage/couple educators and health care systems to integrate couple-relationship education into the standard of perinatal care.

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Health care practitioners who embrace a holistic perspective of health recognize the context of human relationships as a crucial dimension of individual health (McDaniel, Hepworth, & Doherty, 1992; Rolland, 1994). While childbirth educators, nurses, and other health care professionals are sensitive to the need of addressing marital well-being as part of promoting family wholeness and health, they often lack the time, training, and resources to do more than minimal assessment and referral of distressed couples to other sources for information or counseling.

Social science has a wealth of resources to offer couples. As cited below, marriage researchers from various

disciplines have uncovered a rich body of knowledge about marriage, including the factors that contribute to marital quality and stability and significant points of risk in marital development. They have shown that one of the most critical times for marriage is during the transition to parenthood. Marriage educators have successfully translated the knowledge research provides into useful education and skills training to strengthen marriages at various times. However, they struggle to find venues to reach couples at this critical time of family transition. Seldom are they included in health care practice.

One of the most critical times for marriage is during the transition to parenthood.

Because new-parent couples interact with the health care system at many points during this time of family transition, an opportunity exists for strengthening marriages within the system to improve the physical, social, and emotional health of parents and their children. We propose in this paper a productive collaboration between marriage educators and health care practitioners to integrate marriage education into the existing standard of perinatal health care. We begin with a brief review of the documented links between marriage and health. Next, we review briefly the family-centered movement in health care that embraces a more holistic concept of health that includes an emphasis on strengthening family relationships. Then, we summarize the social science research on the transition to parenthood and how it impacts couple relationships. Finally, we outline our proposal to integrate marriage education into the health care system during the transition to parenthood and discuss practical considerations and possibilities.

Biomedical Ties of Marriage and Health

Marriage is positively related to health. Waite and Gallagher (2000) summarized a generation of health research confirming that marriage appears to contribute to a longer life, the ability to heal faster from illness, a better functioning immune system, the avoidance of health-risk behaviors, and the promotion of positive

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health practices. Moreover, the research now seems to suggest that it is not just a selection effect—healthier people choosing to marry and less healthy people not marrying or divorcing. Rather, good evidence demonstrates that marrying and staying married change behavior in ways that in turn promote and sustain health, while single life and cohabitation do not have this effect. Extensive reviews of research (Kielcolt-Glaser & Newton, 2001; Waite & Gallagher, 2000) conclude that while both men and women gain substantial health benefits from marriage, men appear to gain even more than women for most health outcomes, and women's benefits are more sensitive to the quality of the relationship.

Marriage also positively affects mental and emotional health. Married women and men are substantially more happy, less anxious and depressed, and experience less psychological distress than their single counterparts (Waite & Gallagher, 2000). Again, this health difference does not appear to be simply a selection effect. A growing body of longitudinal research documents that when people marry their mental health improves, and when people divorce it deteriorates (Waite et al., 2002). Most of these physical and mental benefits do not accrue among individuals in unhappy marriages. Moreover, if these unhappy couples stick it out through a "bad patch," 60% will later say that their marriages are once again happy (Waite et al., 2002; Waite & Gallagher, 2000). Most married men and women give their marriage the highest rating in terms of happiness, and only about 3% of presently married people across all ages rate their marriage as unhappy. However, marital quality can and does rapidly deteriorate for individuals (Waite et al., 2002); so, a happy marriage now does not immunize individuals from the risk of divorce even in the near future, and many couples do not work through the "bad patches."

In addition to these more direct benefits for adult health, links exist between marriage and children's health. A stable, two-parent family gives children both physical and mental health advantages (Amato & Booth,

1997; Waite & Gallagher, 2000). Recent meta-analytic reviews document moderate negative effects of marital conflict on children's social-psychological adjustment (Krishnakumar & Buehler, 2000), and parental conflict continues to have a negative effect on children's well-being even after divorce (Buehler et al., 1998). One of the primary mediating mechanisms between marital conflict and children's well-being is the quality of parenting in both two-parent and single-parent families (Davies & Cummings, 1994; Krishnakumar & Buehler, 2000).

Research, as cited above, supports the case for emphasizing strong marriages as an important health issue. Indeed, promoting stable, high-quality marriages may deserve a place alongside reducing smoking, drinking, and cholesterol. Marital dissolution or significant marital discord is a significant public health concern because of the costly economic consequences and the negative physical, social, and psychological impact dissolution has on many adults and children (Amato & Booth, 1997). Although divorce rates have stabilized and even declined slightly (Heaton, 2002), demographers still estimate that about 4 in 10 first marriages will end in divorce, and those in second marriages have even a greater risk (approximately 60%) of breaking up (National Marriage Project, 2001). Furthermore, a recent report of a federal study estimated that about 1 in 5 first marriages will dissolve within five years, and that 1 in 3 unions will end in 10 years (Peterson, 2001). These early years generally occur when couples also move into parenthood, which makes this transition a particularly significant time for strengthening marriage and preventing divorce. Fortunately, solid research over the past 15 years has documented what factors contribute most to marital quality and stability, and how couples can keep their relationships strong through hard times (see Gottman & Silver, 1999).

Marriage versus Cohabitation at the Transition to Parenthood

About one-third of new-parent couples in the United States are unmarried (National Marriage Project, 2001). Still, a good marriage remains an enormously popular and romantic ideal among all groups of people in our society, even among low-income men and women for whom marriage is a more challenging and complex goal (Hawkins, Nock, Wilson, Sanchez, & Wright, 2002).

Almost half of first marriages in the U.S. are preceded by cohabitation, and an increasingly common reason for cohabiting couples to marry is because of the impending birth of a child (Manning & Smock, 1995). We recognize, then, that many couples experiencing the transition to parenthood are not married, especially low-income couples. Yet, new research suggests that most of these couples are in a committed relationship and most hope to marry (Bendheim-Thoman Center for Research on Child Well-Being, 2000). Unfortunately, these are fragile families and most will not realize their hopes to stay together because of joblessness, addictions, violence, and other factors.

Throughout this paper, our use of the word *marriage* is not meant to ignore or exclude unmarried couples becoming parents who have perhaps an even greater need to work on strengthening their relationships. Unmarried couples in committed relationships have moral responsibilities to the next generation similar to married couples. In fact, we suspect that helping unmarried, new-parent couples strengthen their relationships likely increases their chances for marriage and its accompanying physical and social health benefits. Strengthening couple relationships at the transition to parenthood in health care settings, however, will require health care practitioners and systems to embrace a more holistic perspective of health. In this next section, we review elements of the holistic perspective and family-centered care that form a foundation for more support of marriage in health care systems.

The Holistic Perspective and the Family-Centered Movement

Recent developments in health care theory and practice are turning (or returning) health care system paradigms to a broader perspective of health and the care for human well-being (Engebretson, 1997; Swift, 1994). The holistic perspective growing throughout the health care system considers the whole human as irreducible and inseparable from a context that includes family and social relationships (Wendler, 1996). The fundamental purpose of health care (to promote health and well-being) is shaped by this perspective to include actions that prevent or heal breakdowns in the whole human, which involves complex, multiple dimensions of human "being" and environmental context (Engebretson, 1997; Wendler, 1996). Taking into consideration the whole

person, health care providers are recognizing more and more the need to address family life in the processes of both the prevention and healing aspects of care.

The family-centered care movement, which began in the grass-roots consumer and family-support movements of the 1960s, has influenced health care reform in the last few years (Galvin et al., 2000; Hanson & Randall, 1999; Johnson, 2000). The use of holistic and family-centered perspectives in health care have been supported in recent years by the development of theoretical frameworks and models that consider the family, rather than the individual patient, as the central unit of care (McDaniel et al., 1992). For example, Rolland's Family Systems-Illness Model provides an integrative conceptual base for describing physical health conditions in systemic terms and for defining the psychosocial impact of biological processes and diseases on family members (Rolland, 1994). In addition, this model emphasizes a multigenerational life cycle model that describes in normative terms the complex, mutual interactions among physical health, the patient, and the family.

In practice, a more family-centered approach to health care has made inroads in the health care system. For example, in the area of childbirth, recent reforms have included redesigning newborn intensive care units and using the Newborn Individualized Developmental Care and Assessment model to revolutionize neonatal care by integrating family into the approach. Reforms that began in the 1960s included encouraging fathers and other family members to be present through the delivery (Johnson, 2000; Zwelling, 1996). However, these laudable efforts to support couples during maternity care fall short of interventions to strengthen couple relationships at this critical time. Our proposal to create a fruitful union of marriage and childbirth education during the transition to parenthood addresses this gap in practice.

Social Science, Marriage, and the Transition to Parenthood

Research on marriage supports the value of strengthening couples' relationships through education during the transition to parenthood. In examining the stability and quality of marriages as couples navigate the transition to parenthood, scholars have noted both risks and opportunities. Though the research has its limitations and findings have not been uniform, strong evidence suggests

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that marital satisfaction generally declines across the transition to parenthood. Current research emphasizes both variation in the experiences of couples through the transition and an ecological perspective of the transition. Scholars have begun to produce a clearer picture not only of the specific nature of difficult changes in family systems through the transition but also the factors that predict those changes and the associated outcomes.

The greatest risk of the transition to parenthood may be the negative effect on well-being that the decline in relationship quality can produce. As discussed earlier, substantial evidence suggests that marriage provides physical and mental health benefits; however, the evidence also demonstrates that these benefits are limited or eliminated in distressed marriages, especially for women (Waite & Gallagher, 2000). Other research has established strong links between poor marital quality and psychological and physical illness (Whisman, 2001; Wickrama, Lorenz, Conger, & Elder, 1997). It is important to note that much of the research on changes in marital quality across the transition to parenthood has under-represented couples at a higher risk for poor marital quality in the first place (Cowan & Cowan, 1995). With the exceptions of a few studies (Crohan, 1996; Levy-Shiff, 1994), nearly all of the research represents the experience of white, middle-class, married Americans. Scholars have suggested that this sampling problem may underestimate the negative effects of the transition to parenthood on couples' relationships (Belsky & Pensky, 1988; Cowan & Cowan, 1995), and it is likely that studies of couples who are less advantaged or unmarried will show greater strain and risk involved in the transition.

Perinatal Indicators

Not everyone, of course, experiences the risk and meaning of the transition to parenthood the same way. As the focus of social science research has shifted from a search

for central tendencies to an examination of individual trajectories, scholars have identified important variations in the effects that the transition to parenthood has on individuals and couples. For example, though the transition is, on average, associated with decline in marital happiness, some couples reportedly experience a “baby honeymoon” with a short-term increase in satisfaction (Worthington & Buston, 1986). In their breakthrough work in this area, Belsky and Rovine (1990) identified four specific trajectories of marital satisfaction over time: a sharp, negative change; a more modest, gradual, negative change; no change; and a modest, positive increase. They analyzed discriminating factors that influence these various trajectories and found that the factors with significant influence can be identified prior to the birth. Karney and Bradbury (1997) later determined that the initial levels of satisfaction were predicted by individual characteristics, such as personality and communication style, and the change in satisfaction over time was predicted by marital interaction factors, such as conflict and affection. They also found that the way couples interact before the birth and the changes in their interactions after the birth significantly influence the quality of their marriage over time. In more recent similar work, Kurdek (1999) discovered that couples who became parents started trajectories lower and showed steeper decline in satisfaction over time, when compared to nonparent couples. This was especially true for those transitioning to parenthood early on. Such findings provide strong support for the need to help couples establish healthy attitudes and patterns of interaction prior to the transition to parenthood and make healthy adjustments in those attitudes and interactions across the transition.

The Significant Issues

The most significant aspects of marriage affected by parenthood are labor (shared and unshared responsibility for household work and paid employment), leisure (individual leisure time and the way couples spend time together), and love (the way couples interact with each other) (Belsky, Lang, & Rovine, 1985; Belsky & Pensky, 1988; Crawford & Huston, 1993; Crohan, 1996). It appears that changes in these realms lead to increased conflict and fatigue which, in turn, lead to the decline in marital quality. Generally, research suggests that couples’ division of household labor becomes more traditional,

which, if different from what was expected, can cause conflict (Cowan & Cowan, 1995, 2000). In addition, for couples with careers, greater attachment to one’s work identity predicted more negative relationship outcomes (Levy-Shiff, 1994). Studies on the way couples spend their time together show that, while the total amount of time they spend together does not necessarily change or differ from childless couples, the pleasure and rejuvenation couples receive from their time together decreases (Belsky et al., 1985; Crawford & Huston, 1993). The more stress and fatigue couples experience because of these changes, the more likely they are to engage in conflict, and the way they handle conflict may also change. Crohan (1996) found that some couples making the transition changed toward a more passive-avoidance communication pattern and suggested this might be due to reluctance to expend the now scarce time and energy to see conflicts through. She also found that, in some couples, more passive-avoidance strategies actually predicted greater marital happiness. Other researchers have examined additional factors predicting stability in marital quality at several levels. For couples themselves, one of the greatest predictors of their successful adjustment after the transition is the way they relate to each other before the transition (Belsky & Rovine, 1990; Wallace & Gotlib, 1990), especially the amount of love they express and the amount of attention they pay to each other (Shapiro, Gottman, & Carrère, 2000).

Transition Preparation

Researchers have stressed the importance of using this information to prepare couples for the transition to parenthood (Belsky & Pensky, 1988; Cowan & Cowan, 2000; Shapiro et al., 2000; Worthington & Buston, 1986). Some scholars also suggest that, from a developmental perspective, this transition is an important point of readiness at which couples are receptive to learning and open to influences that could have important long-term effects (Duncan & Markman, 1988; Powell & Cassidy, 2001). Ideally, interventions would be based on these empirically known risk and resiliency factors. Although the research shows that attitudes and relationship skills are important to adjustment (and are the very things that can be effectively influenced through educational interventions), few such interventions exist. Several authors have specifically suggested childbirth

education as a potentially effective venue for marriage intervention (Belsky & Pensky, 1988; Duncan & Markman, 1988; Institute for American Values, 2000; Powell & Cassidy, 2001). In addition, missing from this research are studies of the effects of marriage education interventions on infant and child health despite the reasonable possibility that health outcomes could be significantly improved by less stressed couple relationships.

Connections at the Transition to Parenthood

Health care systems interact with couples and families throughout the transition to parenthood, from preconception, to prenatal care and birth preparation, to the actual birth experience, and beyond into pediatric care. Since the early part of the last century, the experience of childbirth has become almost entirely institutionalized by the health care system. Though childbirth was once very much a family affair, with more than 90% of all births taking place in the home up until 1900, it is now accepted as a public health concern with 99% of all U.S. births occurring in hospitals (Zwelling, 1996). Now, professional health care providers address not only the obstetric issues of the birth but also the before and after care of both mothers and children.

Perhaps the most significant interaction health care systems have with both men and women as couples during this time is through childbirth education. Shortly following the turn of the century, childbirth education began to take its place in antepartal preparation. Beginning with the early efforts of the American Red Cross and the Maternity Center Association, childbirth education has become a widespread practice employing specially certified childbirth educators, nurses, and midwives (Nichols & Zwelling, 1997).

Childbirth education has expanded to perinatal education and now interfaces with individuals across a broad range of time and content (Duncan & Markman, 1988; Haire, 1999; Nichols & Zwelling, 1997). Many couples are becoming involved in counseling classes even before pregnancy, based on the idea that because maternal conditions three months prior to conception greatly influence the pregnancy and outcome, pregnancy should be considered a 12-month experience. Perinatal education is offered in a variety of forms of prenatal classes. These classes are primarily informational and some are tailored to unique populations, including older first-time

parents, parents with multiple gestations or expecting cesarean births, and adopting parents. In many settings, early, middle, and late pregnancy classes are also offered in respective trimesters with content relative to the specific issues of each stage. Pregnancy fitness classes and breastfeeding classes are focused on specific aspects of the mother's physical health and preparation for infant care.

Methods of Childbirth Preparation

Prepared childbirth classes currently come in a variety of methods, originally stemming mostly from three major influences: the psychoprophylactic method (Lamaze), the Dick-Read perspective, and the Bradley husband-coached labor approach. These types of classes move beyond merely informing expectant parents of the childbirth process by addressing cognitive, affective, and psychomotor domains of managing labor through information, support strategies, and specific coping skills. And, finally, they incorporate and are supplemented by postpartum classes that cover some parenting and infant care topics and exercise and fitness programs (Nichols & Zwelling, 1997). In general, childbirth education has been based on a family-centered approach, involving more family members and now increasingly including more parenting content (Duncan & Markman, 1988). Polomeno (2000) has called for perinatal educators and the health care community to incorporate couple relationship content into its work with expectant and new parents.

Although legitimate criticism challenges the continued development of childbirth education (Haire, 1999; Zwelling, 1996), it is generally considered an effective and important part of the health care system. Maternal and child outcomes have been improved significantly by this education, though many outcomes remain in need of documentation (Nichols & Zwelling, 1997). Bryan's (2000) study of a supplemental prenatal class designed to help couples increase their abilities to care effectively and sensitively for their newborns showed that prenatal education can help both mothers and fathers become more effective infant caregivers. Education as a primary prevention in general has become a well-accepted aspect of public health (Turnock, 1997) and a continued focus for perinatal care. Consumers and providers attach great importance to learning at this time (Nichols & Zwelling, 1997).

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Parent Relationship Opportunity in Childbirth Education

The acceptance of childbirth education makes it a particularly fertile place to introduce marriage and relationship education. Couples who are becoming parents tend to focus so intently on the physical birth experience they do not see the bigger picture of family change on the horizon. However, their openness to learning at this time and their participation in childbirth education provide a unique opportunity to strengthen their relationships. As health care practitioners continue to adjust the content of childbirth education to meet the needs of consumers (Moore & Billings, 1993), they will do well not only to prepare couples for the experience of giving birth and becoming caregivers to dependent infants but also to attend to the relationship changes that couples face at this time in their lives. After all, couples usually come to the childbirth experience with a deep sense of connection to each other and great anticipation for the journey of parenthood. We know, however, that this journey often challenges a couple's relationship in ways that can threaten the viability of the family they are creating. With this knowledge comes an opportunity—perhaps even a responsibility—to provide education to strengthen couple relationships. Midmer, Wilson, and Cummings (1995) have documented that the second trimester of pregnancy is an opportune time for such education.

An Educational Infrastructure for Marriage Education in the Health Care System

Currently, a limited educational infrastructure exists to support the delivery of marriage education to couples during the transition to parenthood. This is in contrast to a growing infrastructure to help couples prepare for marriage during the time of their engagement. Recently, many religious institutions have become more active in

encouraging and promoting better marriage preparation and support for married couples (Institute for American Values, 2000), and even state governments are implementing policies to encourage better marriage preparation (Hawkins et al., 2002). Changes to marriage during the transition to parenthood, however, have not been a specific focus of religious-based or government-sponsored educational services. Land-grant universities have extensive educational outreach structures through the cooperative extension service and have increasingly addressed family problems (Rasmussen, 1989). However, family extension agents generally do not reach large audiences, and they have generally given priority to parenting and other family life issues over marriage, although marriage is now getting increased attention. Activists in the marriage movement and marriage education professionals in other settings have been building marriage-strengthening programs nationwide, but again, few have specifically targeted and reached couples at the critical transition to parenthood. Because the health care system already has access to couples during this transition with an educational infrastructure in place, we propose a collaboration between marriage education and the health care system.

A Team Approach

We do not argue for a specific program, although some strong curricula appear to be available (Jordan, Stanley, & Markman, 1999; Polomeno, 2000). (Also, see the "Parenting Together" program [<http://parenting.che.umn.edu>] and the "Marriage Moments" program [<http://marriagemoments.byu.edu>].) Instead, we call for teams of marriage educators and health care providers, especially perinatal educators, to work together to find different and creative ways to realize the goal of integrating marriage education into health care systems within their unique contexts and circumstances. We believe experimenting with different levels and timing of intervention will be valuable, from encouraging transitioning couples to use self-guided workbooks to strengthen marriage, to incorporating educational modules on relationship issues into existing childbirth education curricula, to more intense, multisession seminars focused directly on marriage during the transition to parenthood. Different levels of intervention will fit the various resources and constraints of health care systems and couples.

The Timing and Settings

In addition, we believe it will be fruitful to experiment with offering these educational opportunities at different times. When new modules are incorporated into existing childbirth education classes, the timing of marriage education is prenatal. However, it is possible that this kind of educational offering will be even more effective when offered 3–6 months after the birth of the baby when the realities of relationship changes begin to set in. That is, it will be valuable to continue to expand the concept of perinatal education to include curriculum best delivered after the birth of the child. However, the logistics and stresses of postnatal timing (e.g., child-care arrangements, new daily stresses) are daunting and participation likely will be lower than when the timing occurs before the birth. Some health care institutions offer perinatal parenting classes that cover the early years of child development and child guidance. Modules on strengthening marriages in the context of parenting demands would fit well into such classes.

Furthermore, we encourage exploring other professional settings for offering marriage education, in addition to childbirth programs. These would include public health clinics that serve lower-income populations. Similarly, most states now have significant home-visiting programs to reach higher-risk parents during pregnancy and/or the first year of life. Community health nurses in these settings have focused on mother and child health and infant care; however, with the right materials presented in appropriate ways, they could add relationship strengthening information and exercises to their programs. Olds and colleagues (1997) report that community health nurse visits with at-risk mothers before and after the birth produced significantly better child and maternal outcomes even 15 years later, compared to mothers who did not receive home visits. And Koger (2002) reports that a Michigan State University home-visiting program produces long-term, positive results in parenting behavior. Hence, we are optimistic at the possibilities for strengthening couple relationships as well through this kind of personalized education. Midwives, doulas, and pediatricians also could find ways to integrate marriage education into their professional services. Each setting may have particular advantages for reaching certain couples during the transition to parenthood.

A related issue is identifying who will deliver the educa-

tion. Self-guided instructional materials are an option and are the easiest to integrate into existing health care practice. Some research confirms that self-guided psychological interventions can be successful (Scogin, Bynum, Stephens, & Calhoun, 1990). Still, this approach may not be as effective for less motivated couples as more intensive, instructor-guided programs. Other options include employing specialized marriage educators from the community or providing additional training to existing health educators and other practitioners. (For information and training in various marriage and relationship enhancement programs, see www.smartmarriages.com).

Conclusion

We believe the time is now ripe for integrating the goal of strengthening marriages into the health care system. We are not advocating the wholesale replacement of current childbirth and parenting curriculum with education geared solely to guide couples across the challenging relationship terrain of early parenthood. Childbirth and parenting education have an important role to play in helping to promote more satisfying birth experiences for parents and optimal health for infants and children. But the focus of education can be enlarged and supplemented to include helping parents create stronger, more stable relationships that will improve the physical and psychological health of children and adults throughout their lives.

The movement in health care systems to be involved in strengthening marriage and family life is already underway. The need has been defined. We have suggested possible directions and resources. It is simply now time for greater action.

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Lamaze Certification Program Receives NCCA Accreditation

The National Commission for Certifying Agencies (NCCA), the accrediting body of the National Organization for Competency Assurance (NOCA), has accredited the Lamaze International Certification Program. The Lamaze Certification Program is the only childbirth educator certification program that is accredited by NCCA.

NOCA's mission is to promote excellence in competency assurance for practitioners in all occupations and professions. NCCA establishes accreditation standards, evaluates compliance with these standards, and recognizes programs that meet these standards with accreditation. The Certification Council, under the leadership of Judy Lothian, has worked diligently for almost 10 years to insure that all the criteria for excellence would be met. The peer review process by NCCA was rigorous. Lamaze Certification now joins both ACNM and IBLCE in being recognized for excellence in competency assurance.

The Lamaze Certified Childbirth Educator can now confidently advertise to her employer and clients that she is certified by the only certification program for childbirth educators that meets the accreditation standards of the NCCA. And congratulations to the members of our Certification Council for all of their hard work in achieving this recognition.