INFLUENCE OF RECRUITMENT METHODS ON COUPLE INVOLVEMENT IN TRANSITION TO PARENTHOOD INTERVENTION

A Senior Scholars Thesis

by

VANESSA ALBINA COCA

Submitted to the Office of Undergraduate Research
Texas A&M University
in partial fulfillment of the requirements for the designation as

UNDERGRADUATE RESEARCH SCHOLAR

April 2008

Major: Psychology

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Approved by:

Research Advisor: Brian D. Doss
Associate Dean for Undergraduate Research: Robert C. Webb

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ABSTRACT

Influence of Recruitment Methods on Couple Involvement in Transition to Parenthood Intervention (April 2008)

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Romantic relationship satisfaction plays an important role throughout a person's life; poor relationship functioning has been linked to numerous psychological and physiological problems. Fortunately, couple interventions have been found to successfully prevent declines in relationship functioning. Despite the availability and positive impact of couple interventions, few couples actually seek couple intervention to deal with or prevent marital distress.

To attract more couples to these interventions, researchers are expanding traditional interventions to serve couples during the transition to parenthood. This is a unique opportunity for intervention because many couples are already seeking birth and parent education programs and may be more receptive to participating in a relationship intervention program than at other life stages. However, little is currently known about what types of expectant parents seek interventions or the most effective way to attract high-risk couples.

Using data from a larger study examining the differential effectiveness of couple- and parenting-focused intervention programs during the transition to parenthood, this study examines whether certain types of recruitment are especially effective in attracting diverse and high-risk couples to the intervention. The larger study utilizes four different methods of advertisement: pamphlets distributed to local OB/GYN offices, flyers posted around town, announcements at childbirth classes, and flyers posted at community agencies targeting lower income couples (e.g. WIC). To date, 384 heterosexual individuals have been recruited and screened for possible participation in the larger study. Data for the present study was obtained from these screenings.

For both men and women, results indicated that different methods of advertisement resulted in significantly different amounts of pregnancy desirability, marital status, and history of parental divorce. Results also indicated that different recruitment methods resulted in varying prevalence of men's reported violence in their family of origin and women's level of relationship satisfaction. Tests of individual group differences suggested that couples recruited through flyers posted around town and community agencies targeting lower income couples consistently had more risk factors than couples recruited through childbirth classes and OB/GYN offices.

These differences suggest ways to improve recruitment methods and will provide researchers with the information needed to reach a larger, more diverse community.

ACKNOWLEDGMENTS

I would like to thank my advisor, Dr. Brian Doss, for his guidance and support throughout my undergraduate research. As a mentor, Dr. Doss has taught me many important and valuable lessons. His guidance and insight throughout the writing process have been a vital component in the success of my work. Being a part of his lab has been an enriching and rewarding experience.

I would also like to thank Annie Hsueh for her assistance during the writing process. Her constructive comments, helpful discussions, knowledge, and support provided me with a great deal of help in writing my thesis.

I am grateful for the help provided by Kathryn Carhart, Jennifer Minarcik, and Anne Wood. Their assistance is greatly appreciated and it has been a pleasure to work with them.

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CHAPTER I

INTRODUCTION

Relationship satisfaction plays an important role throughout a person's life and its effects have been found to extend to many other areas. Previous studies have linked relationship distress to depression, anxiety, and substance use (Whisman, 1999; Whisman & Uebelacker, 2006). Additionally, relationship distress has been coupled with physiological problems such as elevated blood pressure and increased heart rate (Ewart Taylor, Kraemer, & Agras, 1991) as well as higher levels of stress hormones and lower immune system performance (Kiecolt-Glaser et al, 1993). Couples' relationship distress can also have an effect on their children's development and functioning. These effects include social and psychological functioning, as well as a large impact on behavior and performance in school (Davies & Cummings, 1994). Children with separated parents have also been found to score lower in terms of academics, social skills, and correct conduct than children with intact parents (Amato, 2001).

Due to its serious impact upon the physiological and psychological functioning of both individuals involved and the functioning of their children, maintaining a high level of satisfaction in a relationship is important. Fortunately, couple interventions have been found to successfully prevent relationship distress. Research suggests that premarital interventions have an effect on increasing positive communication, relationship

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functioning, and satisfaction (Carroll & Doherty, 2003). Premarital therapy has also been found to lower conflict and levels of aggression between partners (Markman et al., 1993). Similarly, marital therapy can reduce existing marital distress; meta-analyses have shown a large effect size ($d > .80$) on measures of relationship functioning and satisfaction after treatment (Shadish & Baldwin, 2005). In addition, marital therapy is also effective in reducing depression (Gupta et al., 2003) and increasing physical health (Osterman et al., 2003). These studies suggest that both premarital and marital interventions are useful tools to help couples achieve high levels of satisfaction and functioning.

Despite the availability and positive impact of couple interventions, few couples actually seek couple intervention to deal with or prevent relationship distress. Indeed, the majority of engaged couples do not attend premarital counseling prior to getting married (Silliman & Schumm, 2000). These low levels of participation could be explained by the fact that many couples who are not currently experiencing relationship problems do not feel the need to take actions to prevent future distress (Sullivan et al., 2004). Unfortunately, approximately 40 percent of engaged couples will ultimately get a divorce (Kreider, 2005). Moreover, only approximately 31 percent of couples actually seek any sort of relationship counseling before deciding to get a divorce (Albrecht, Bahr, & Goodman, 1983; Johnson et al., 2002). Research also suggests that many couples wait an average of six years after a relationship problem arises to seek outside help (Notarius & Buongiorno, 1992, as cited in Gottman & Gottman, 1999). When couples wait too long after the onset of relationship problems to seek therapy, the effectiveness of their participation in therapy is ultimately decreased (Snyder, 1997). Considering the positive impact that couple therapy has on a couple's relationship functioning and satisfaction,

seeking therapy after the onset of a problem is important to the success of a couple's relationship.

Help-seeking behavior

Given the low rates of couples that seek interventions to prevent or lower relationship distress, it is important to determine why couples do and do not seek these interventions. There are many theories concerning help-seeking behaviors for individual psychological and physical health. The health belief model theorizes that people are most likely to take part in preventative actions for four main reasons: (1) they believe that they could be affected by a potential problem, (2) they believe that this problem could lead to severe consequences, (3) they believe that the preventative behavior is not too difficult or time consuming, and (4) they believe that the preventative measure is effective (c.f. Strecher, Champion, & Rosenstock, 1997). This model has been used to describe a multitude of help-seeking behaviors, including help-seeking behaviors for social, psychological, physiological, and other health-related issues (c.f., Sullivan et al., 2004). Other models (e.g., Ajzen & Fishbein, 1980) theorize that the influence of important others and one's demographics also have a tremendous impact on an individual's help-seeking behavior (Ajzen & Fishbein, 1980). For example, in seeking help for individual psychological functioning, studies have shown that men are less likely than women to seek help for emotional problems (e.g., Kessler et al., 1981); the authors suggested that this gender difference resulted from women's greater ability to recognize a feeling and define it as a problem (Kessler et al., 1981).

Despite the well-developed theories concerning help-seeking behaviors for individuals' physical and psychological functioning, much less is known about couples' help-seeking behavior. Premarital education is often sought for external reasons, such as the need to fulfill premarital counseling requirements imposed by their religious establishments. Studies have shown that more than 75% of premarital counseling that couples attend each year is accounted for by religious organizations (Stanley, Amato, Johnson, & Markman, 2006; Sullivan & Bradbury, 1997). Specifically for men, other factors that have been found to predict rates of seeking premarital education include age, religion, cost, and recommendation from someone that they respect (Sullivan et al., 2004). For women, factors that have been found to increase the likelihood of women seeking premarital education include perception of risk for divorce, perception of the consequence of divorce, perception of obstacles involved in counseling, and recommendation from someone that they respect (Sullivan et al., 2004).

Similarly, studies have examined the reasons and predictors of seeking marital therapy. Gender is an important defining factor of couples' help-seeking process. Couples' help-seeking behavior is often motivated by the woman, who is often the one to identify a relationship problem and decide to receive help from an outside source (Doss, Atkins, & Christensen, 2003). Other predictors of couples' help-seeking behavior include relationship satisfaction, perceived communication problems, and elevated levels of depression (Doss et al., 2007). In contrast, when couples who did not seek marital therapy before getting divorced were asked why, 33 percent blamed a reluctant and unwilling spouse, 17 percent didn't think that there was a problem, and 9 percent

believed that their problem was a private matter (Wolcott, 1986). However, the most frequent answer was that it was "too late" to seek assistance from a mental health professional (Wolcott, 1986), highlighting the importance of intervening with distressed couples earlier.

Considering the magnitude of the impact that romantic relationships have upon the individual functioning of all that are involved, there is a clear need for couples interventions. Unfortunately, the largest barrier to the effectiveness of couples interventions is that many at risk couples know that premarital education and marital therapy are available, but do not believe that it will help them. Therefore, it is important for pre-marital counselors and therapists to better serve their community by attracting couples to their interventions in ways that align with what is currently known about the help-seeking behavior of couples. One way to increase couples' participation is to analyze what types of advertisement are most effective in attracting high-risk couples to current interventions. Once it is known what forms of advertisement work best to reach their community, pre-marital counselors and therapists can work to enhance these methods and attract more couples to their interventions.

Transition to parenthood – a unique opportunity

One of the most stressful times in a couple's life is the transition to parenthood. Although having a child can be a very happy event in the life of a couple, studies have shown that couples experience declines in marital functioning and satisfaction as well as a rise in individual stress levels (Shulz, Cowan, & Cowan, 2006). Longitudinal studies

have shown that these effects have an impact on both the health of the parents and the psychosocial development of their child (Cowan & Cowan, 1995).

The transition to parenthood is a unique opportunity to intervene with couples. During this transition, many couples already seek birth and parenthood education programs and are more easily attracted to a relationship intervention program. Also, the transition to parenthood is one of only a few times when couples jointly complete education classes, which provides a unique opportunity to work with both partners (Doss, Carhart, Hsueh, & Rahbar, in press). Therefore, many couples that would not typically seek outside help for their relationship may be more easily attracted to relationship intervention programs during this important stage in life, making the transition to parenthood an important time to successfully reach couples who may otherwise be unlikely to seek relationship help.

Research has shown that the effects of couple interventions delivered during the transition to parenthood are promising. Post-treatment measures of the effects of one transition to parenthood intervention found strong effects at one and a half years after the intervention, and even stronger effects three years after the intervention (Markman, Floyd, Stanley, & Storaasli, 1988).

What are the best ways to attract these couples?

Although couples having their first baby may be more receptive to participating in couples interventions than they would during other stages of life, little is known about what types of expectant parents seek these interventions or the most effective ways to

attract couples – especially high-risk couples – to these interventions. Advertising methods can have a large impact upon how many and what types of couples seek psychological interventions. Indeed, advertisement for studies of pre-marital education through newspaper advertisements has been shown to attract couples at higher risk for marital distress than recruitment through marriage licenses (Karney et al., 1995). Additionally, couples recruited for studies of premarital education through the media (newspaper, radio, or television) had lower levels of relationship quality than couples recruited through bridal shows (Rogge et al., 2006).

The differential impact of various methods of advertisement has two important implications. First, in research studies, recruitment methods should be selected that recruit samples that are representative of the couples with whom the intervention would ultimately be used. To date, many couple interventions contain participants that are disproportionately White, middle-class, and well educated (Carroll & Doherty, 2003). However, studies have found higher divorce rates in African American couples, couples that have not completed high school, and couples starting marriage with children (Raley & Bumpass, 2003). Such a disparity indicates that the current literature on relationship interventions has low real world applicability for couples that are at the greatest risk for divorce or separation. Second, when seeking to disseminate interventions in the community, knowledge of the most effective methods of advertisement can be used to improve the number of couples who receive those couple interventions. For example, if two advertising methods are approximately equal in their cost and staff burden, then the method that attracted the most couples or the couples at highest risk for developing

problems would be the preferred method. Alternatively, if one method of advertisement was significantly more burdensome than other methods, the effectiveness of its recruitment could be compared to other methods to determine whether it should be discontinued. By systematically improving our advertisements of couple interventions and attracting more, higher-risk couples, we can significantly improve the impact of our interventions.

The aim of this study is to discover how to increase the number of couples that receive couple-based interventions during the transition to parenthood. I will achieve this goal by developing an understanding of couples' help-seeking behavior and finding the most effective forms of advertisement that align with these behaviors. The gains made by this study will allow other researchers to increase the generalizability of their studies and increase the reach of couple interventions during the transition to parenthood offered in the community.

CHAPTER II

METHODS

Participants

A total of 351 heterosexual individuals (165 men and 184 women) were recruited and screened by phone for possible participation in the Our First Baby project, a longitudinal study measuring the efficacy of different types of help and support during the transition to parenthood. 324 out of the 384 individuals were screened with their partners while the remaining 29 individuals were screened without their partners. Most participants in our sample (n = 342) were married, while a smaller number (n = 37) were cohabitating with their partners. Participants were on average 28 years old (range 17-47).

Procedure

Study overview

These data come from a larger, longitudinal study looking at the effectiveness of three different types of help provided by project staff members during the transition to parenthood. In the larger study, couples are screened for eligibility and randomly assigned to a couple-focused intervention, a coparenting-focused intervention, or an information control condition. The couple-focused intervention consists of four meetings that are designed to help couples increase positive aspects of their relationship while decreasing relationship problems that may arise during the transition to parenthood. The coparenting-focused intervention consists of four meetings that are designed to help couples with issues that may arise in parenting their new baby. The control condition

consists of a single meeting designed to give them information that answers common questions that first-time parents may have.

The data used in the present study was obtained from each person's initial contact with the larger study. After expressing interest in the Our First Baby Project, couples were contacted via telephone by research assistants who provided potential participants with information about the study and then screened each participant to determine their eligibility. Each phone screen assesses a number of individual and relationship characteristics, which are described in more detail below.

Advertisement

The Our First Baby Project utilized six different methods of advertisement. First, pamphlets were distributed to local OB/GYN offices to place in waiting rooms and included in packets given to patients by medical professionals. Second, flyers were posted around town on message boards in coffee shops, restaurants, gas stations, and other local businesses. Third, staff members of the Our First Baby Project made announcements and distributed pamphlets at breastfeeding and childbirth classes offered by a local hospital. Fourth, flyers were posted at community agencies targeting lower income couples (e.g. WIC) and pregnancy crisis centers.

Measures

Individual depression

The six-item depression subscale of the Brief Symptom Inventory (Derogatis, 1993) was used to measure the level of depression in potential participants. The depression subscale has an alpha level of 0.85 and a test retest reliability of 0.84 (Derogatis, 1993).

Relationship satisfaction

To assess relationship satisfaction, the four-item Dyadic Adjustment Scale (DAS-4; Sabourin et al., 2005) was used. The DAS-4 is a four-item measure selected from the 32-item Dyadic Adjustment Scale using nonparametric item response theory. The DAS4 has an alpha level of 0.91 and a test retest reliability of 0.87 for men and 0.83 for women (Sabourin et al., 2005).

Relationship aggression

To assess relationship aggression, a short form of the Revised Conflict Tactics Scale (Straus & Douglas 2004) was used; in the present study, the psychological aggression, physical assault, and injury subscales were used. Correlations of the short form with the full revised conflict tactics scale range from 0.72 to 0.94 (Straus & Douglas 2004).

Relationship characteristics

Two one-item measures were used to assess the status of the couple's relationship. Each participant was asked if they were currently living with their partner and if they were currently married to their partner.

Pregnancy characteristics

Two one-item measures were used to determine attitudes toward the pregnancy. Each participant was asked if the pregnancy was planned and, "if they could do it over again, would they want to be having a baby".

Family of origin

One-item measures were also used to assess for both history of divorce and violence in each participant's family of origin.

Individual characteristics

Participants also responded to one-item measures concerning individual characteristics, such as age and a history of previous marriages.

CHAPTER III

RESULTS

To analyze the data and determine which methods of advertisement brought significantly more at risk couples, ANOVA tests were used to measure the significance of the continuous dependent variables and Chi-Squares were used to measure the significance of dichotomous dependent variables. After looking at omnibus results across all four groups and finding a significance level of ($p < 0.10$), tests were run on each individual recruitment method to determine which methods were significantly different from the other groups. To assess the significant omnibus Chi-Squares, 2x2 Chi-Square tests were run for each type of recruitment method. For significant omnibus ANOVA results, a post hoc Tukey test was performed to find individual group differences.

Family of origin

For men, a preliminary assessment of the overall group differences in history of parental divorce suggested that there is a significant difference between recruitment methods for the number of men with a history of parental divorce ($\chi^2(3, 159) = 11.96$, $p < 0.01$; Table 1). A test of individual group differences further suggested that, for men, flyers distributed around the community brought in more men with a history of parental divorce than pamphlets in doctor's offices ($\chi^2(1, 63) = 3.93$, $p < 0.05$) and announcements made at childbirth classes ($\chi^2(1, 100) = 6.46$, $p < 0.05$). Similarly, information placed in community agencies targeting lower income couple also brought

in more men with a history of parental divorce than pamphlets in doctor's offices ($\chi^2(1, 60) = 4.82$, $p < 0.05$) and announcements made at childbirth classes ($\chi^2(1, 97) = 7.39$, $p < 0.05$). Preliminary assessment of the overall group differences in history of parental divorce revealed a similar trend for women ($\chi^2(3, 171) = 6.52$, $p < 0.10$).

Table 1
Individual recruitment group means and Chi-square valid percentage of dichotomous risk factors

	Doctors office	Childbirth classes	Community Flyers	Community agencies
		Men		
Not Married	3.6%[a]	3.3%[a,c]	45.5%[b]	25.0%[c]
Previous Marriage	3.8%[a]	6.7%[a]	0.0%[a]	12.5%[a]
Parental Divorce	24.5%[a]	20.0%[a,b]	54.5%[c]	62.5%[b]
Violence in Family of Origin	7.5%[a,b]	5.6%[a]	27.3%[a,b]	0.0%[a,b]
Father to Mother Violence	7.5%[a,b]	4.5%[a]	27.3%[a,b]	0.0%[a,b]
Insulted by Partner	59.6%[a]	65.6%[a]	63.6%[a]	62.5%[a]
Sprain, Bruise, or Small Cut because of a fight with Partner	0.0%[a]	2.2%[a]	0.0%[a]	12.5%[a]
Partner Pushed or Shoved	0.0%[a]	6.7%[a]	0.0%[a]	12.5%[a]
Partner Slapped, Punched, or Kicked	1.9%[a]	2.2%	9.1%	12.5%[a]
Physical Pain that Still Hurt the Next Day because of a Fight with Partner	0.0%[a]	0.0%[a]	0.0%[a]	0.0%[a]
		Women		
Not Married	11.5%[a,b]	5.90%[a]	53.80%[b]	22.2%[a,b]
Previous Marriage	6.9%[a]	7.30%[a]	18.20%[a]	0.0%[a]
Parental Divorce	19.0%[a,b]	25.00%[a]	54.50%[b]	33.3%[a,b]
Violence in Family of Origin	1.8%[a]	6.30%[a]	0.00%[a]	0.0%[a]
Father to Mother Violence	0.0%[a]	4.20%[a]	0.00%[a]	0.0%[a]
Insulted by Partner	58.6%[a]	56.40%[a]	54.50%[a]	55.6%[a]
Sprain, Bruise, or Small Cut because of a fight with Partner	0.0%[a]	0.00%[a]	0.00%[a]	0.0%[a]
Partner Pushed or Shoved	5.2%[a]	0.00%[a]	0.00%[a]	0.0%[a]
Partner Slapped, Punched, or Kicked	1.7%[a]	0.00%[a]	0.00%[a]	0.0%[a]
Physical Pain that Still Hurt the Next Day because of a Fight with Partner	0.0%[a]	1.10%[a]	0.00%[a]	0.0%[a]

Note. Means that do not share superscripts are significantly different ($p < .05$).

Upon further examination of this trend, individual group tests suggested that flyers posted around the community recruited significantly more women with a history of parental divorce than both doctor's offices ($\chi^2(1, 68) = 6.30$, $p < 0.05$) and childbirth classes ($\chi^2(1, 106) = 4.27$, $p < 0.05$).

Omnibus tests showed an overall trend that suggested that there is a difference in history of violence in family of origin for men ($\chi^2(3, 159) = 7.42$, $p < 0.10$), but not for women. Upon examining individual group differences in men with a history of violence in their family of origin, a significant difference was found between flyers posted around town and childbirth classes, with flyers posted around town yielding more men with a history of violence in their family of origin ($\chi^2(1, 100) = 6.34$, $p < 0.05$). Individual group differences in history of violence in one's family of origin also revealed a trend toward significant differences between doctor's offices and flyers posted locally, with flyers posted locally attracting more men with a history of violence in their family of origin ($\chi^2(1, 63) = 3.64$, $p < 0.10$).

Concerning father to mother violence, omnibus tests gave significant differences for men ($\chi^2(3, 158) = 8.61$, $p < 0.05$), but not for women. Examination of individual group means revealed that men recruited from flyers posted around the community yielded significantly more men with a history of father to mother violence in their family of origin than did men recruited from childbirth classes ($\chi^2(1, 99) = 7.80$, $p < 0.01$). A trend was found toward flyers posted around the community having significantly more

men with a history of father to mother violence in their family of origin than men that were recruited by doctor's office ($\chi^2(1, 63) = 3.64$, $p < 0.10$).

Individual characteristics

An initial omnibus test revealed no significant differences for depressions levels of both men and women across the four different recruitment methods (Table 2). Additionally, an initial omnibus test also revealed that there were no significant differences found for an individual's history of previous marriages across recruitment methods.

Table 2
Recruitment group means and Standard Deviations of continuous risk factors

	Doctors office	Childbirth classes	Community Flyers	Community agencies
			Men	
Pregnancy Desirability	1.89[a]	1.90[a]	1.82[a]	1.63[a]
	(0.46)	(0.40)	(0.40)	(0.74)
Planned pregnancy	0.89[a]	0.81[a]	1.09[a]	0.88[a]
	(0.54)	(0.54)	(0.70)	(0.64)
Depression	1.40[a]	1.06[a]	0.82[a]	0.75[a]
	(1.69)	(1.79)	(0.98)	(0.71)
Relationship Satisfaction	18.32[a]	18.85[a]	18.36[a]	19.00[a]
	(2.88)	(1.58)	(2.54)	(2.27)
			Women	
Pregnancy Desirability	1.90[a]	1.82[a]	1.77[a,b]	1.33[b]
	(0.36)	(0.50)	(0.60)	(1.00)
Planned pregnancy	0.86[a]	0.85[a]	0.85[a]	0.67[a]
	(0.54)	(0.58)	(0.90)	(0.71)
Depression	1.67[a]	1.34[a]	2.00[a]	2.56[a]
	(1.67)	(1.80)	(2.57)	(2.24)
Relationship Satisfaction	18.58[a]	19.17[a]	18.50[a]	17.67[a]
	(2.30)	(1.77)	(2.20)	(3.46)

Note. Means that do not share superscripts are significantly different ($p < .05$).

Current relationship

Upon examination of overall group differences in relationship satisfaction, a trend toward significant differences among recruitment methods was found for women with low relationship satisfaction ($F(3, 169) = 2.12$, $p < 0.10$), but not for men. However, examination of individual group means did not reveal any significant group differences.

Upon examination of marital status, omnibus tests resulted in a significant difference across the four different methods of recruitment for both men ($\chi^2(3, 163) = 30.95$, $p < 0.001$) and women ($\chi^2(3, 181) = 26.06$, $p < 0.001$) who were not married to their partner. For men, comparisons of individual group differences yielded some important conclusions. More men that were not married to their partner were recruited from flyers posted around the community than both pamphlets distributed in doctors' offices ($\chi^2(1, 65) = 16.91$, $p < 0.001$) and childbirth classes ($\chi^2(1, 102) = 24.42$, $p < 0.001$). Similarly, information distributed at community agencies targeting lower income couples recruited significantly more men that were not married to their partners than men recruited through pamphlets received from doctors' offices ($\chi^2(1, 62) = 5.36$, $p < 0.05$) and men that were recruited through announcements at childbirth classes ($\chi^2(1, 99) = 7.32$, $p < 0.01$). For women, individual group comparisons revealed that flyers posted around the community recruited significantly more women that were not married to their partners than women that were recruited by pamphlets received from doctors offices ($\chi^2(1, 73) = 12.54$, $p < 0.001$) and by announcements made in childbirth classes ($\chi^2(1, 113) = 26.16$, $p < 0.001$). In addition, individual group differences in marital status in women showed

a trend toward significance between flyers posted around town and information placed in community agencies targeting lower income couples, with higher numbers of women that were not currently married to their partner recruited from community agencies targeting lower income couples ($\chi^2(1, 18) = 3.25$, $p < 0.10$).

Omnibus tests did not reveal any significant differences among recruitment methods for levels of domestic violence for both men and women.

Pregnancy characteristics

For women, a test of overall group differences revealed a significant difference among the four recruitment methods in pregnancy desirability, or whether or not a woman wanted to be currently having a baby ($F(3, 172) = 3.29$, $p < 0.05$). Upon further analysis, community agencies targeting lower income couples attracted significantly more women who did not want to be currently having a baby than both doctor's offices ($p < 0.05$) and childbirth classes ($p < 0.05$). Omnibus tests did not reveal a significant difference for men who were unsure about their partner's pregnancy.

For both men and women, tests of overall group mean differences did not reveal any significant differences across the different recruitment methods for amount of reported unplanned pregnancies.

CHAPTER IV

DISCUSSION AND CONCLUSIONS

The present study explored ways to increase the number and diversity of couples who receive couple- and parent-focused interventions during the transition to parenthood. Results indicated that flyers posted around town and information distributed to community agencies targeting lower income couples were more effective than pamphlets distributed by doctors' offices and announcements made in childbirth classes in recruiting couples at higher risk for developing relationship and parenting difficulties after birth.

Specifically, results from the present study indicated that couples who were not married to their partner right before the birth of their baby were more likely to be recruited from flyers posted around the community than from OB/GYN offices and childbirth classes. Similarly, men with a history of parental divorce, parental violence, or a history of father to mother violence were more likely to be recruited from flyers posted around the community than OB/GYN offices and childbirth classes. Likewise, a significantly higher number of men with a history of parental divorce and men not married to their partner right before the birth of their baby were recruited from community agencies targeting lower income couples than doctor's offices and childbirth classes. For women, a significantly higher percentage of women that were unsure of whether they wanted to be having a baby were recruited from community agencies targeting lower income

couples than doctor's offices and childbirth classes. Also, a trend toward significant differences was found for both women with a history of parental divorce and women with low relationship satisfaction.

The results of the present study largely replicated the findings of a previous study that examined differential effectiveness of recruitment strategies for pre-marital education (Rogge et al., 2006) in that couples recruited through forms of community advertisement (e.g. in the present study, posting flyers on community massage boards and in local businesses) brought in a significantly higher amount of high-risk couples than other forms of advertisement. However, in contrast with the findings of Rogge and colleagues, advertisement through the use of important others (e.g. OB/GYN, project staff member, or other community leader) did not bring in a significantly higher number of at-risk couples.

A number of factors may have contributed to the differences in the effectiveness in recruiting at-risk couples among the recruitment methods used in the present study. One factor that may have driven some of the differences is an income differential across the types of recruitment. A cross-sectional meta-analysis performed by Twenge and colleagues found that couples with higher levels of income also have higher levels of relationship satisfaction than couples with lower levels of income (2003). Given that OB/GYN doctors in the present study were affiliated with health maintenance organizations or private insures, couples seeing those physicians likely had a higher

household income than couples receiving care from community agencies that target lower income couples. Also, since couples had to pay to attend the childbirth classes from which the present study recruited, lower-income couples may be less likely to attend them. In addition, although this data was not collected, our impression during recruitments was that a lower percentage of African-American couples attended these childbirth classes than the percentage of African-American couples who delivered babies at the county hospital that sponsored these classes. Previous studies have found higher divorce rates in African American couples (Raley & Bumpass, 2003), making them an important group with whom to intervene.

In contrast, flyers that were posted around town were posted in highly visible areas, such as public community boards in coffee shops and gas stations. As such, this information about the interventions was more assessable to a larger audience and a sample of couples with more diverse demographic characteristics than those recruited from doctor's offices and childbirth classes. Additionally, our announcements and pamphlets in childbirth and OB/GYN offices were both aimed directly at couples having their first baby. However, for flyers at least, other people (friends, family members) could become aware of the study and encourage the couple to attend. Therefore, couples who were less likely to enroll in the interventions may be convinced by someone they respect.

The present study has several important limitations. One important limitation is that the total number of couples who were exposed to each method of advertisements (e.g.,

number of couples who received a pamphlet from their doctors) is unknown. Therefore, it is possible that more people were presented with opportunities to participate in the study through one method versus another method. Therefore, an estimate of the overall success of each recruitment method at bringing in interested couples cannot be fully determined. Future studies should obtain more specific information about the total number of couples exposed to each advertisement method, in addition to the final number of at-risk couples recruited for the interventions from each method. Such information would help measure the rates of recruitment for each method, in order to provide a more detailed understanding of each method's relative success. Another limitation of the present study is that each method of recruitment was initiated at different times throughout the study, creating a difference among each recruitment method in potential audience exposure. As a result, it was not possible to use the total number of couples recruited through each method as a measure of that method's ability to recruit differing numbers of couples to the study Future studies may benefit from initiating and managing all forms of recruitment at the onset of the study. Despite these limitations, the present study is an important first step in understanding how to effectively reach a diverse sample of at-risk couples during the transition to parenthood. Such knowledge, if applied successfully, will allow couple-based interventions to reach more couples that would benefit the most from them.

The results of the present study also suggest several directions for future research. First, future research can investigate the most effective ways to recruit couples in other stages

of life, such as couples entering retirement, for couple-focused interventions. By increasing the reach of interventions disseminated to high-risk couples at other stages of life, it would be possible to expand the reach and overall population-level impact of couple-focused interventions. Second, future research can explore how to effectively recruit demographically diverse sample of couples. The current literature concerning relationship interventions is often only generalizable to a White, middle-class population (Carroll & Doherty, 2003). With an understanding of how to reach a demographically diverse (e.g., different ethnicities, socio-economic statuses) sample of couples, conclusions from future studies concerning the effectiveness of couples-based interventions will, in turn, be generalizable to a wider range of couples. Finally, future research can analyze additional methods of recruiting couples, such as advertisements through the Internet, radio, television, magazines, and billboards. Knowledge of the effectiveness of a wide array of recruitment and advertisement methods will help researchers achieve the most effective methods of advertisement and recruitment, adding to the efficiency of their studies.

The present study examined methods of advertisement to determine which methods most effectively increase the number of at-risk couples involved in couple-based interventions during the transition to parenthood. Analyses of the data revealed a pattern of individual and couple risk factors that were mainly recruited from advertisement through flyers posted around town and community agencies targeting lower income couples. These findings demonstrated an association between recruitment methods and factors that have

been found to put couples at-risk for separation or termination of their relationship. The present study was an important first step toward a better understanding of the most effective methods of advertisement for couple-based interventions and it raises additional questions for future studies to further explore.

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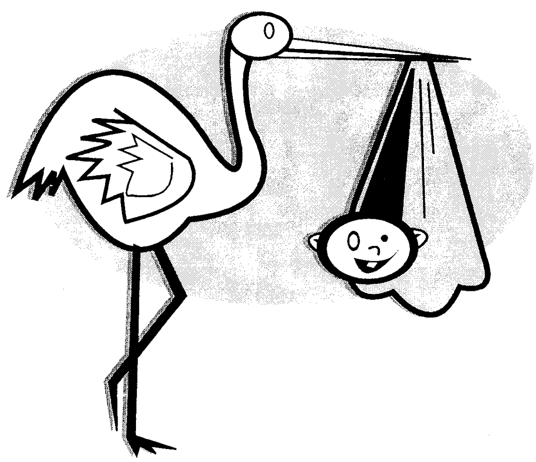
APPENDIX A

Having your first baby?



The "*Our First Baby*" *Project at*
Texas A&M University
can help you adjust to life after your baby by providing ***1 to 4 free, individual meetings*** offering information and support.

Also, you and your partner will
receive a total of $500
for completing follow-up assessments.

Interested couples should call the "Our First Baby" project office at **(979) 862-6538** or e-mail ourfirstbaby@psych.tamu.edu. Project staff will be happy to answer any questions.

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Figure 1. Our First Baby Project flyer posted in local businesses.

APPENDIX B

WHERE'S MY BABY'S INSTRUCTION MANUAL ?!?

FREE personalized information and support before and after the birth of your first baby

TEXAS A&M
PSYCHOLOGY DEPARTMENT
nd the National Institute of Child Health and Human Development

Brian D. Doss, Ph.D.
(979) 862-6538

OUR FIRST BABY!

A FREE program at Texas A&M can provide you the information and support you're looking for.

For more information, call:

(979) 862-6538

You've done a great job preparing for the delivery of your baby.

But are you ready for what happens after you bring your baby home?

Congratulations on having your first baby! This will certainly be a time of great joy for you and your partner. But it will also probably be a time of great changes and challenges for the two of you as well. Not to mention some sleepless nights! We'd like to help!

How can the "Our First Baby" Project help you and your partner?

You may be eligible to receive various kinds of information and support through this new study funded by Texas A&M. If you participate, you and your partner will receive one to four meetings with project staff offering information and support. These meetings will involve only you, your partner, and a project staff member. Also, if you complete six assessments after the birth of your child as scheduled, you and your partner will receive a total of $500 for participation.

What does this project involve?

To help couples navigate the changes and challenges that come with having their first baby, we are offering three different types of help. We expect all three types of help to be useful to couples. However, the central aim of the study is to see if couples find one type of help especially beneficial.

If you and your partner participate, you'd be assigned to meetings focusing on one of three topics: 1) detailed information about common questions couples have during this period, 2) challenges and solutions to common problems you might encounter in parenting your baby, or 3) information and support about changes many couples see in their relationship with their partner.

What is the cost of these meetings?

There are no charges for the meetings or any other part of the project.

When and where will these meetings take place?

The information and support meetings will be held on the Texas A&M campus. Meeting times are available during the day and early evenings.

Who can participate in the project?

All couples who are pregnant with their first child are potentially eligible to participate. You and your partner do not have to be married to be part of the study; however, you both have to participate in the study. Couples from all ethnic backgrounds are encouraged to participate.

How can we determine if we're eligible to participate in this project?

The first step is to call our research office and receive more information about the study. Couples who are interested in participating in the project will be asked some questions about themselves and the present state of their relationship to see if they are appropriate for our project.

Eligible couples will then be asked to attend an appointment at Texas A&M where you will be asked to fill out a series of questionnaires and be randomly assigned to one of the three types of meetings. After this appointment is completed, you will schedule your first information meeting with a staff member.

How can I get more information about the "Our First Baby" Project?

Interested couples should call our project office at (979) 862-6538. Project staff will be happy to answer any questions. Depending on your due date, you may also begin the screening process at that time to determine your eligibility for the project.

You may also contact a staff member at ourfirstbaby@psych.tamu.edu for more information. We look forward to hearing from you!

Figure 2. Our First Baby Project pamphlet distributed at OB/GYN offices, childbirth classes, and community agencies targeting lower income couples.

APPENDIX C

"OUR FIRST BABY" PHONE SCREEN

Screened Woman _____ eligible/ineligible/pending Screened Man _____ eligible/ineligible/pending If eligible, risk factor for eligibility: _____ If ineligible, rule out: _____	Other Contacts and Notes:

Couple ID Number: _____ Spoke to first: Man / Woman (circle one)

Demographics:

	Woman	Man
Name		
Home Address		
Home Phone		
Work/Cell # (optional)		
E-mail address (optional)		
How did you hear about this study? (Ask for specifics)		

	Woman	**Man**
Are you and your partner legally married? (**RISK** if not married)		
Are the two of you currently living together? (**RULE OUT** if physically separated)		
Are either or both of you planning on moving in the next year? (**RULE OUT** if moving out of Bryan / CS)		

Information about the baby:

	Woman	Man
What is the approximate due date?		
Is this your first child, including biological, step or adopted? (**RULE OUT IF NO**)		
Is this your partner's first child (biological, step, or adopted)? (**RULE OUT IF NO**)		
Any problems in the pregnancy so far?		
If you had it to do over again, would you want to be having a baby right now? (Yes, No, Don't Know) **RISK if say "No" or "Don't Know" or "Maybe"**		

Information about the individual:

	Woman	Man
How old are you? **(RULE OUT IF NOT 18-65)**		
Have you ever been married (to someone other than your current partner?) **(RISK if yes)**		
Did your parents divorce? **(RISK for Women only)**		
Was there any physical violence between your parents when you were growing up? IF YES: Was your father violent towards your mother? **(RISK for Men only if he answered both questions above with "yes",)**		
Are you currently being treated for any psychological problems. If so, what? (**RULE OUT**: psychotic, bipolar, organic brain disorder; borderline, schizotypal, antisocial personality disorder)		

I'm going to read you some questions and I want you to tell me: HOW MUCH THAT PROBLEM HAS DISTRESSED OR BOTHERED YOU DURING THE PAST 7 DAYS INCLUDING TODAY:		
	Woman	**Man**
FEELING BLUE. Has that bothered you: Not at all (0), A little bit (1), Moderately (2), Quite a bit (3), or Extremely (4)?		
FEELING LONELY: Has that bothered you: Not at all (0), A little bit (1), Moderately (2), Quite a bit (3), or Extremely (4)?		
FEELING NO INTEREST IN THINGS: (in general) Has that bothered you: Not at all (0), A little bit (1), Moderately (2), Quite a bit (3), or Extremely (4)?		
FEELINGS OF WORTHLESSNESS: Has that bothered you: Not at all (0), A little bit (1), Moderately (2), Quite a bit (3), or Extremely (4)?		
FEELING HOPELESS ABOUT THE FUTURE: Has that bothered you: Not at all (0), A little bit (1), Moderately (2), Quite a bit (3), or Extremely (4)?		
THOUGHTS OF ENDING YOUR LIFE: Has that bothered you: Not at all (0), A little bit (1), Moderately (2), Quite a bit (3), or Extremely (4)? NOTE: IF THEY SAY "MODERATELY" OR MORE, CONTACT DR. DOSS IMMEDIATELY. IF YOU CANNOT REACH HIM, CONTACT KRISTEN WHO WILL GET INTOUCH WITH ANOTHER CLINICAL FACULTY MEMBER.		
RISK = A SCORE OF <u>3 or more FOR MEN</u> OR A SCORE OF <u>4 or more FOR WOMEN</u>		

Information about the couple relationship:

	Woman	Man
How often do you discuss or have you considered divorce, separation, or termination of your relationship? Would you say that happens all the time (0), most of the time (1), more often than not (2), occasionally (3), rarely (4), or never (5)?		
In general, how often do you think that things between you and your partner are going well? Would you say that happens all the time (5), most of the time (4), more often than not (3), occasionally (2), rarely (1), or never (0)?		
How often do you confide in your partner? Would you say that happens all the time (5), most of the time (4), more often than not (3), occasionally (2), rarely (1), or never (0)?		
Now, on a 0 to 6 scale with 0 being extremely UNhappy, 3 being Happy, and 6 being Perfect, how happy would you say you are in your relationship, all things considered? Again, 0 is extremely UNhappy, 3 is Happy, and 6 is Perfect.		
TOTAL SCORE (RISK = either partner < 13)		

No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, are tired, or for some other reason. I'm going to read you a list of things that might happen when you have disagreements. Please tell me if they've happened in the past year and, if so, how many times they've happened in the past year.

	Woman	Man
My partner insulted or swore or yelled at me.	Happened? Freq. in past year?	Happened? Freq. in past year?
I had a sprain, bruise, or small cut because of a fight with my partner. **(RISK)**	Happened? Freq. in past year?	Happened? Freq. in past year?
My partner pushed or shoved me. **(RISK)**	Happened? Freq. in past year?	Happened? Freq. in past year?
My partner slapped, punched, or kicked me. **(RULE OUT)**	Happened? Freq. in past year?	Happened? Freq. in past year?
I felt physical pain that still hurt the next day because of a fight with my partner. **(RULE OUT)**	Happened? Freq. in past year?	Happened? Freq. in past year?

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