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## Evaluation of a Psycho-educational Parenthood Transition Program<sup>1</sup>

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**Abstract:** This paper describes an assessment of needs and a process evaluation of a longitudinal support program to first-time parents. A couple participated in a longitudinal intervention, with nine home visits, focused on the development of parental skills and couple empowerment. The baby-parents interaction and the couple reactions to the intervention were video recorded and after registered into the Process Evaluation Protocol. The data analysis has shown that the couple felt satisfied with the program and used the information and strategies received, with a positive impact on the dimensions of conjugality, with better communication and interpersonal problem solving and parenthood, with the development of knowledge on the infant's development, change in beliefs related to violent parental educational practices, responsiveness in the relationship between the baby and the parents alongside lower parental stress. Replications of this study in bigger samples with follow-up evaluations are recommended.

**Keywords:** prevention, home attending programs, program evaluation, attachment behavior, family violence

## Avaliação de um Programa Psicoeducativo de Transição para a Parentalidade

**Resumo:** Este estudo teve por objetivo avaliar um programa longitudinal de apoio à transição para a parentalidade por meio da avaliação de necessidades e de processo. Um casal participou de uma intervenção longitudinal, com nove visitas domiciliares, focadas no desenvolvimento de habilidades parentais e empoderamento da dupla. As interações pais-bebê e reações do casal à intervenção foram gravadas em vídeo e posteriormente registradas no Protocolo de Avaliação de Processo. A análise dos dados evidencia que o casal sentiu-se satisfeito com o programa e fez uso das informações e estratégias recebidas, com impacto positivo nas dimensões da conjugalidade, com melhor comunicação e solução de problemas interpessoais e da parentalidade, com a construção de conhecimentos sobre o desenvolvimento do bebê, mudanças em crenças sobre práticas educativas parentais violentas, responsividade na relação com o bebê e menor estresse parental. São recomendadas replicações deste estudo em amostras maiores e avaliação de *follow-up*.

**Palavras-chave:** prevenção, programa de atendimento domiciliar, avaliação de programa, comportamento de apego, violência na família

## Evaluación de un Programa Psicoeducativo de Transición para la Parentalidad

**Resumen:** La finalidad de este artículo fue evaluar un programa longitudinal de apoyo a la transición hacia la parentalidad mediante la evaluación de necesidades y proceso. Una pareja participó en una intervención longitudinal que constituye una serie de nueve visitas domiciliares, focalizadas en el desarrollo de habilidades parentales y empoderamiento de la pareja. Las interacciones padres-bebé y las reacciones de la pareja a la intervención fueron grabadas en video y posteriormente registradas en el protocolo de evaluación de proceso. El análisis de los datos demostró satisfacción de la pareja con el programa y la utilización de las informaciones y estrategias recibidas, con impacto positivo en las dimensiones de la conjugalidad, con mejor comunicación y solución de problemas interpersonales; y de la parentalidad, con la construcción de conocimientos sobre el desarrollo del bebé, cambios en creencias sobre las prácticas educativas parentales violentas, sensibilidad en la relación con el bebé y menor estrese parental. Se recomienda que el estudio sea reaplicado en muestras con más participantes y con evaluaciones de seguimiento.

**Palabras clave:** prevención, programa de atención domiciliar, evaluación del programa, conducta de apego, violencia en la familia

Plenty of discussion on the transition to parenthood has been reported in the literature, including its impact on

the subsystem of couple relations (Berthould, 2002; Bradt, 1995; Menezes & Lopes, 2007) and parents-infant relations (Cia, Williams, & Aiello, 2005; Lopes, Menezes, Santos, & Piccinini, 2006). In the first dimension, conjugality, researchers have attempted to identify how the waiting period and arrival of the first child affect the quality of conjugal interactions and what factors are associated with a better or worse quality of these interactions at this moment in family life. Having a satisfactory marital relation before the

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pregnancy (Menezes & Lopes, 2007), positive perceptions of the partner, having experienced secure attachment to one's own caregivers, sexual satisfaction in marriage, access to employment and social and cultural goods (Dessen & Braz, 2005) seem to act as protective factors in the quality of the conjugal relationship, particularly in the transition to the birth of the first child. In the second dimension, parenthood, the predictive factors of the quality of parents-infant relations and healthy childcare practices have been investigated. A consensus exists that being a direct victim of or having witnessed intra-family violence and having constructed insecure attachment to one's own caregivers represent important risk factors for parenthood (Bowlby, 1990; Silva, Le Pendu, Pontes, & Dubois, 2002; Wendland-Carro & Piccinini, 1995).

On the other hand, having access to education, information and health services furthers knowledge on the infant's development, which in turns contributes to the quality of childcare and, at bottom, to the child's healthy development (Moura et al., 2004). In addition, social support to first-time mothers (Warren, 2005) and the father's participation in pregnancy (Piccinini, Silva, Gonçalves, Lopes, & Tudge, 2004) have also been appointed as protective factors in this context.

Knowledge about risk and protective factors for family and child development in the transition to parenthood support early interventions to prevent maternal depression (Frizzo & Piccinini, 2005; Schwengber & Piccinini, 2003), infant developmental disorders (Cia, Williams, & Aiello, 2005; Granato & Aiello-Vaisberg, 2009), insecure attachment (Bowlby, 1990; Schmidt & Argimon, 2009; Wendland-Carro, Piccinini, & Millar, 1999) and intra-family violence directed at the partner and child (Ceconello, De Antoni, & Koller, 2003; Honig & Morin, 2001; Peterson, Tremblay, Ewigman, & Porkey, 2002). Evidence exists that the first five years of life represent the most risky and vulnerable period for neglect and physical abuse against the child. This is the phase of life when most fatal incidents resulting from these situations happen (Guterman, 1999). Therefore, parenthood transition programs and other early interventions are extremely relevant to help couples and primiparous mothers and fathers to adequately manage the stress and anxiety associated with this transition in life, and to establish responsive interactions and adequate care practices for the baby.

International literature contains a wealth of assessment studies on parenthood transition programs and early interventions to prevent child maltreatment (Gonzales & MacMillan, 2008; Gray & McCormick, 2005; MacLeod & Nelson, 2000; Olds, 2002). In Brazil, then, specific literature remains limited (Gravena & Williams, 2004; Wendland-Carro et al., 1999). Interventions in the area have been put in practice in different contexts, parenthood moments and formats. This range comprises interventions at health centers, homes and in hospitals, before and/or after the infant's birth, in groups or through home visits. A large part of these

studies adopts experimental or quasi-experimental designs, with pre and post-test assessments and a psycho-educative approach focused on the parenthood (Akai, Guttentag, Baggett, & Noria, 2008; Deyo, Skybo, & Carrol, 2008; Shute & Judge, 2005) or conjugality dimension (Hawkins, Fawcett, Carroll, & Gilliland, 2006), or less frequently on both (Doherty, Erickson, & LaRossa, 2006). The analysis of this literature shows that contents focused on parenthood include parental responsiveness training, children's developmental capabilities, parenting skills and newborn care. Contents on conjugality, in turn, include communication skills between partners, social support (with emphasis on the parent's involvement in newborn care), task division and management of different roles in marriage.

In a review of early childhood intervention programs, Gray and McCormick (2005) identified foci for improvements in prevention programs for this population and recommended that these programs use home visits integrated in health centers' services, monitor the quality of this practice, focus on family demands, incorporate cultural particularities and be more comprehensive in their variables and evaluation measures. In view of the findings from a meta-analysis on child mistreatment prevention and family wellbeing promotion programs, MacLeod and Nelson (2000) suggested that interventions in the area should include family empowerment, concentrate on family resources and protective factors, involve participants in planning the intervention, take six months or more or include at least 12 (home) visits and address multiple components.

Based on the recommendations by Gray and McCormick (2005) and MacLeod and Nelson, the general aim in this study was to assess a longitudinal parenthood transition support program. Hence, differently from – and in addition to – previous studies in the area, which used pre and post-test designs, the aim in this study was to describe the needs assessment and process of a support program to primiparous fathers and mothers. The needs assessment was specifically aimed at identifying the stressors and resources of the couple that was considered in the intervention. The process evaluation was aimed at answering the following questions: to what extent did participants practice the techniques and use the resources made available during the intervention? To what extent were participants satisfied with the program? To what extent were the intermediary targets set for the program achieved? To what extent did the contents and duration of the program offered comply with the program planned? What contextual variables facilitated or hampered the practice of the intervention?

## Method

### Participants

Study participants were a couple, Gilson and Vera (fictional names), recruited at a public maternity in a state

capital in the Brazilian Central-West. Gilson, 37 years, had not finished secondary education, was unemployed at the start of the study and, during the study, started to work in sales. Vera, 31 years old, had finished secondary education and was a housewife. The couple gained no fixed income at the start of the study and was living on revenues from selling shoes on an open market. They had been legally wed for five years and were expecting their first child, whose pregnancy had not been planned. At the start of the study, they were in the sixth month of pregnancy and, at the end, the infant, called Clara in this study, was three months old. Neither the couple nor the infant had any health problems. The participants self-reported that they used neither drugs, alcohol and tobacco nor controlled drugs and that there were no cases of psychiatric problems in the family.

### Instruments

The following instruments were used in the needs assessment:

*Interview script for needs assessment:* aimed at investigating demographic data, psychosocial risks, knowledge on the infant's development, experience of bonding with parents, parental educative practice experiences, coping and social support network and marital relation.

*Checklist of Stressors* (adapted from Rahe, 1998): contains 34 items, which address changes in health, work, family relations and losses. The respondent was asked to answer whether (s)he had experienced each of the events or not in the last 12 months.

*Social Network Map* (Sluzki, 1997): describes the couple's social support network, including the number of significant others, relationship context (family, friends, work and community) and degree of intimacy in the relation. This is a circle, divided in four parts, one for each relationship context, in which the respondent is located at the center, and the names of people in the network are written around him/her, situating them according to the type of relationship (whether friend, neighbor, relative or colleague, for example). The intimate social network members should be written closer, and the less intimate members further from the center, thus representing a greater or lesser degree of trust in the relation.

*Assessment Instrument of Marital Affection and Joint Life:* especially elaborated for this study, the instrument consists of 15 items that address the expression of affection and intimacy in the marital relation. The respondent was asked to indicate the occurrence of the behavior in the previous month, its frequency (never, hardly or sometimes) and who took the initiative of the behavior (man or woman).

The following instruments were used to evaluate the process:

*Process Evaluation Protocol:* the researchers completed this instrument at the end of each intervention

sessions, including data that were collected based on the observation of the recordings and the verbal and non-verbal behaviors observed during each visit. The Protocol evaluates six criteria (adapted from Linnan & Steckler, 2002): dose received (practice of skills made available in the intervention, assessed based on self-report); consumer satisfaction (participants' satisfaction with the intervention, assessed based on self-report); intermediary targets reported by the couple (discoveries and new learning the intervention provided) and observed in the interaction between the partners and between them and the infant (behaviors revealing the couple's interest in the intervention, the couple's intimacy and communication and the couple's interaction with the infant); fidelity (implementation of the program contents as planned) and context (daily observation of contextual variables that facilitated or hampered the evolution of the visit or the couple's involvement).

### Procedure

**Data collection.** The study started with the team's preparation to work in the field. In this phase, theoretical studies were undertaken and the researchers responsible for the visits, who were undergraduate psychology students at the time, received training on educative social skills (Del Prette & Del Prette, 2001). The training included open questioning, empathetic listening, self-disclosure, clear instruction and assertive communication skills. Behavioral testing and video-feedback of the researchers' performance took place during weekly three-hour supervision sessions. These supervisions, under the coordination of the primary author, continued throughout the implementation of the program.

**Needs assessment and return.** First, the couple was contacted and clarifications were provided about ethical aspects. Then, four home visits were made for needs assessment purposes. The Interview script for needs assessment and the Checklist of Stressors, the Social Support Network Map and the Assessment Instrument of Marital Affection and Joint Life were applied. These interviews were recorded on tape.

At the end of the needs assessment, a session was held to return the results of the previous phase to the couple. The couple's protective and risk factors perceived in the interviews were discussed, as well as the resources and coping strategies, and the intervention proposal was presented. This session took approximately 105 minutes.

**Intervention.** The intervention, based on Bowlby's Attachment Theory (1990) and research on resilience (Masten & Coatsworth, 1998; Nettles, Mucherah, & Jones, 2000; Walsh, 2005) involved multiple components and addressed parenthood and conjugality dimensions through home visits, applying procedures to promote the participants' empowerment and analyze indicators

of change observed throughout the intervention. From a methodological viewpoint, the intervention was based on the program evaluation research area, which includes data collection before, during and after the program (Posavac & Carey, 2003).

Nine psycho-educative home visits of approximately 90 minutes each took place. The first session was held before the infant's birth. The second happened about 15 days after Clara's birth. The third session took place 30 days after birth and the remainder at intervals ranging between one and two weeks, according to the couple's availability.

The intervention was based on a guide with text and illustrations on six main themes: coping with the stressors of delivery and the postpartum period, the marital relation and the couple's communication skills, the infant's developmental capabilities, the affective bond between the parents and the infant, prevention of mistreatment and resilience, risk and protection (Murta, Rodrigues, Rosa, Paulo, & Furtado, 2008). Before each session, the interview script was planned, considering the information obtained in the needs assessment, the analysis of the previous session and the general themes planned for the intervention and included in the information folder. The techniques used to address these themes were dialogued exposure, behavioral rehearsal, visualization and presentation of a video (Camargos & Paes, 2007), besides the guide itself and particularly its illustrations.

**Process evaluation.** The process evaluation started with the second session. At the end of each session, the couple was asked about what they had thought, planned or accomplished since the last session with regard to the themes discussed during the visit (assessment of dose received). At the end, the participants were invited to present their opinions, criticism or suggestions about the session (consumer satisfaction) and to describe any discoveries (e.g., new information) resulting from that visit. Data on other process criteria were collected through behaviors observed during the sessions (intermediary targets for the criteria couple's interest in the intervention, couple's intimacy, couple's communication, parents-infant interaction, and fidelity), as well as the facilitators' judgment (context).

All visits were filmed. After each intervention session, based on the observation of the recordings, the two facilitators completed the Process Evaluation Protocol, after discussing any doubts and disagreement. Only agreements were registered.

**Data analysis.** The needs assessment data collected from the interview were analyzed through the creation of categories, while the data collected through the other instruments were submitted to visual inspection. Process evaluation data were analyzed through the creation of verbal and non-verbal behavior categories, except for data on intermediary targets, which were marked on a numerical scale ranging from one to five, on which the higher the

score, the greater the frequency or intensity of the behavior during the session held that day, according to the participants' reports (discoveries and new learning) or the researchers' observation (interest, intimacy, communication and parents-infant interaction).

## Ethical Considerations

This study received approval from the Research Ethics Committee at Pontifícia Universidade Católica de Goiás (Protocol 0220).

## Results and Discussion

The results and discussion will be presented per assessment phase, subdivided into needs and process.

### Needs Assessment

In general, the data collected in the needs assessment phase indicated some difficulties the couple faced during pregnancy, including financial difficulty due to Gilson's unemployment, Vera's deficient social skills (difficulties to express displeasure, criticize and ask for help, with hostile expressions), the couple's poor coping skills repertoire with a problem focus (fights as a way to solve problems) and emotion focus (absence of strategies related to leisure, distraction and relaxation), sexual relationship difficulties (dissatisfaction, little frequency of sexual contact and feelings of insecurity) and traditional beliefs on the wife's gender roles (for example, Vera believed that starting sexual interaction was solely the man's duty). On the other hand, in this phase, the couple already displayed different protective factors, like the couple's union to seek solutions to problems in the marital relation, the wife's acknowledgement that she needed to change her communication, the couple's opening and trust to address sexual difficulties, optimism about their daughter's arrival, good evaluation of marriage, description of good dating relationship, available relatives and participation in a church group.

The needs assessment permitted the identification of relevant risk and protective factors in the couple's life, as well as stressors associated with the parenthood transition, as appointed in earlier studies (Menezes & Lopes, 2007; Piccinini et al., 2004). This set of information permitted personalizing the psycho-educative intervention, with modules focused on the marital role (stress management, couple's sexuality and communication skills) and the parental role (infant's sensory competences, responsiveness and construction of safe bonding, prevention of mistreatment and resilience). This differs from most studies published in the area (Akai et al., 2008; Deyo et al., 2008; Shute & Judge, 2005), which are only focused on the parenthood dimension.

On the other hand, although the needs assessment was useful, it was very long (three sessions). This demanded

greater availability from the participants. In future studies, minimal assessment is possible, concentrating on fundamental variables (like the type of attachment established with the caregivers, the parental educative practices they received and marital satisfaction), including the use of shorter instruments that are faster to respond. This could be useful in new implementation contexts, in which the families and professional teams have less time for home visits.

### Process Evaluation

The evaluation of the criterion dose received showed that the couple used different coping strategies and information offered during the intervention, in their marital relation (conjuality dimension) as well as in their relation with the infant (parenthood relation). In the conjuality dimension, the couple reported on behavioral changes in communication, intimacy, gender-related beliefs, stress coping and mutual support. The practice of marital social skills permitted more effective exchanges with a view to problem solving, according to Gilson: "We are more conscious, we used to fight a lot... we didn't talk, fought, fought and got... now we're talking more. It seems that a problem that used to weight 100 kg now weighs 10". The reports showed the wife's greater self-control, less inadequate criticism, charges and hostility, as demonstrated in Vera's report: "We change our way of talking, it is no longer that altered...". Regarding the couple's intimacy, only the wife reported a change in her husband: "He is more caressing, more careful". This shows some use of the tools made available in the intervention, but with insufficient range to solve the sexual difficulties the couple experienced. Before the intervention, Vera used to share traditional gender roles, believed that only the husband should start sexual interactions and she should be the main responsible for childcare. Changes in this respect were also verified, according to her report: "I liked the idea of asking help, when I want to rest...". Another intervention use category was mutual support. In this sense, Gilson reported: "I've already undressed the baby for her to give her a bath". Regarding stress coping, the use of emotion-focused strategies was reported, according to Gilson: "We've gone out more".

In the parenthood dimension, reports on the use of the intervention indicated adequate interaction with the infant, learning about the infant's sensory competences, self-observation with regard to risky parental educative practices and changes in beliefs about parental educative practices. The parents' greater interaction with his daughter was verified through statements, care, which was one of the mother's complaints during pregnancy and in the first month after birth. In this respect, Gilson reported: "I arrive in the late afternoon, take her, put her on the couch, play with her, if she's hot I take of her socks... in

the morning before I leave I play, talk to her..." Gilson also reported on the identification of the infant's sensory competences: "I am able to identify her crying, symptoms of pain, heat, cold". During the visits, at different times, Vera demonstrated some behaviors that indicate non-responsiveness towards the infant (discussed further ahead) and stressful supervision. This was targeted in the intervention, with a view to enhancing their awareness on this practice and its possible negative implications for the child's development. In this respect, Vera reported: "You're talking about this stressful supervision and it's really like that, to the point that, when my mom comes to take her, some time goes by and I go after them. She says: there's the watchdog, she also calls me an owl". Finally, the participants highlighted changes in their beliefs on parental educative practices, as they used to believe that hitting was essential for the sake of discipline. They evolved from the certainty of hitting as an educative practice to other possible forms of education, according to Vera: "I always thought you should hit children but now, in view of what you said, I'm thinking more! Now I think about talking first!"

These results appoint different benefits of the intervention for the participating couple, in the parenthood as well as in the conjuality dimension. In the first dimension, the intervention allowed the parents to gain information on the infant's sensory competences, increase parental responsiveness and question their beliefs in punitive practices as fundamental and appropriate in children's education. In the conjuality dimension, gains in marital social skills were obtained, in the solution of daily problems and in mutual support, possibly through a reduction in the couple's stress. Sexual difficulties continued as a source of dissatisfaction, but with a more feasible solution, as communication skills were developed. Data are promising and suggest the strengthening of protective factors for the infant's development (Dessen & Braz, 2005; Moura et al., 2004).

The assessment of the consumer satisfaction criterion indicated that the participants were satisfied with the intervention. This satisfaction was classified in the following subcategories: (a) bond with the researchers, expressed through trust in the researchers: "I always think it's good, you're patients, you listen carefully, I feel quite at ease!"; (b) contentment, demonstrated through reports of satisfaction with the help received in the intervention: "If it weren't for this monitoring with you everything would be worse, because I'm agitated and kind of stressed, I think I'd end up in an asylum or hospital!"; (c) relevance of the contents, considering the appropriateness of the themes for the moments the participants experienced: "What we saw today is what we are going through, the stress, the problems, the nervousness, the suggestions. So I thought it was good!"; (d) trust: there was freedom to share the difficulties experienced: "The problems we have at first [about sexuality], I won't say they have been solved

100%, but they are no longer a target for use now. If Clara had been born amidst these problems, this would have caused stress, worsened the situation.”; (e) new information: all sessions were evaluated as interesting and attractive: “This thing of correction, spansks, explanation helped a lot”; (f) communication: “I think it was very clear, your conversation is very objective, and you say what you need to say.”; (g) Positive attitude: feeling of pleasure and incorporation of the intervention into routine: “We were already missing it, it has turned into a commitment for us...”; (h) broadening the perspective: “It exceeded expectations, regarding talking about the problem and seeing its solution... without any dialogue” .

These data, deriving from the evaluation of participants’ satisfaction, revealed that the participants perceived the intervention as positive, considering both the contents (perceived as new, relevant and applicable in life) and the relation between researchers and participants. The appropriateness of the contents is based on the authors’ preliminary research, which permitted the identification of needs to put in practice parenthood transition programs (Murta, Rodrigues, Rosa, Paulo, & Furtado, 2011), as well as on the needs assessment undertaken immediately before the intervention. This indicates that needs assessment contribute to adjust the intervention to the target public, and are therefore recommendable when putting in practice prevention programs, permitting customized interventions and better use of the (human, material, time) resources involved.

The assessment of the intermediary target criterion included the couple’s report about the discoveries and new learning experienced in the intervention (target 1) and the facilitators’ observation of the couple’s interest in the intervention (target 2), communication (target 3) and interaction between the partners (target 4) and interaction between the partners and the infant (target 5). In the first target, the couple’s discoveries and new learning, participants scored the degree of novelty in each session between 3.5 and 5. They highlighted the sessions about the infant’s sensory skills, stress coping and prevention of mistreatment as the main discoveries. In all sessions, however, they emphasized the importance and novelty of the topics addressed. As for the second target, related to the couple’s interest in the intervention, the couple maintained a good level of interest, always attentive and participatory, presenting doubts, asking for clarifications and offering positive feedbacks about the sessions. In the fifth, sixth and seventh sessions, the interest score dropped from five to five, when some visits were cancelled, justified by crying, the infant’s endless crying and momentary demands. Regarding the third target, observation of communication between the partners, some difficulty was observed in the couple, initially marked by verbal exchanges with criticism, accusations, the wife’s charges and some degree of passiveness in the husband. This became more evident as the sessions evolved, when the bond and trust in the

therapists grew, which coincided with moments of greater stress after the infant’s birth. The couple’s social skills were discussed and grew in the final sessions, identified through assertive statements, comprehension and negotiation. As for the fourth target, marital intimacy during the sessions, evaluated through caresses, looks, smiles, jokes, this remained stable during the first sessions. Despite reporting difficulties in their intimate relation, the couple preserved its good mood. After the infant’s birth, they displayed some instability, in a period marked by great stress. The topic was addressed further on and progress was observed in the couple’s interaction, returning to the smiles and jokes.

What the final target is concerned, the parents’ interaction with the infant, the frequency of the parents’ responsive and non-responsive behaviors towards the infant was considered in each session. The mother displayed more responsive (nine) and non-responsive (24) behaviors towards the infant than the father (four responsive and no non-responsive behavior). Both parents’ responsive behaviors reacted to the newborn’s crying and included taking her out of the stroller, holding, rocking, talking, singing, caressing, breastfeeding, putting her in the burping position, returning the infant to the stroller (mother), taking her out of the stroller, holding, rocking and talking (father). The mother’s non-responsive behaviors referred to overstimulation and intrusiveness (cleaning the face, cleaning the ear, smelling, arranging the infant’s clothes). Using video-feedback, these behaviors by the mother were targeted in the eighth intervention session, as well as the need for her to permit, request and encourage the father’s greater participation in childcare.

The observation of the mother’s non-response behaviors towards the newborn was one of the most relevant data in the process evaluation. This permitted the early identification of the mother’s intrusive behaviors towards the infant, which is an important precursor of a harmful parental educative practice, stressful supervision, characterized by overprotection (Gomide, 2004). The use of video-feedback seemed useful to enhance the mother’s awareness about her intrusive behavior and its possible negative implications for the child’s development (e.g., insecurity and shyness) and for the mother-daughter relation (e.g., overprotection, conflicts and insecure attachment). This evidences the relevance of process evaluation as a source of support to improve the intervention and, consequently, to reach its distal and proximal goals.

The fidelity assessment demonstrated that the program followed the contents programmed for the intervention: stress management, marital social skills, infant’s developmental capabilities, development of secure attachment and prevention of mistreatment. The techniques programmed and total duration of the program were not followed though. In one session, a relaxation activity had been programmed and, due to lack of time, this did not happen.

Regarding the duration, the time programmed for each session and the total intervention time were exceeded. Five intervention sessions had been programmed but, according to the participating couple's needs, this was expanded to nine sessions. One of the reasons to extend the duration of the intervention were the infant's demands (which caused interruptions and extended the sessions) and the couple's sexuality-related demands (which required specific sessions to address the theme).

The program's fidelity with regard to the contents and adaptation to the timetable, techniques and dose provided in each module (greater emphasis was placed on the couple's affective and sexual relation) raises questions on the nature of fidelity (total compliance with standardized procedures) versus adaptation (change in contents, techniques or duration of the intervention). Program fidelity has been a relevant variable, discussed in the dissemination of innovations and replication of prevention programs (Elliot & Mihalic, 2004; Pentz, 2004). In the replication of prevention programs in larger samples and with more solid designs as well as in the dissemination of proven effective programs, active ingredients of the intervention should be preserved, instead of adaptations that void the program of its key elements. As a proposal deriving from this case study, in the replication of studies that use procedures deriving from manuals or instructions, the active ingredients of the program should be considered and preserved while changing the technique or duration if necessary. Fidelity is proposed as a continuous variable, with strict fidelity independently of the context against reinvention or free adaptation (both extremes are undesirable), at risk of losing the program's essence. This discussion, however, should be deepened in further research aimed at replicating and disseminating innovations.

The evaluation of the contextual factors that influence the intervention resulted in two main categories: facilitating and constraining variables. The first were the couple's welcoming attitude, enthusiasm, relaxation and interest. The couple's opening and trust were also extremely relevant to develop the program, by sharing their experiences and the problems they were going through. The latter, constraints, were: (a) visits by friends of the couple, resulting in delays to start the session; (b) time of the visits, which took place at night, when the participants were tired, mainly the husband who got home from work, and sometimes did not have time to freshen up or have dinner before starting the session; (c) the infant's crying during the session; (d) the postpartum interval; (e) after the infant's birth, the couple became more focused on responding to her needs; (f) the father started to work close to the infant's birth and started to arrive home later, making the couple cancel or postpone some sessions, resulting in intervals of 15, 20 and even 30 days between one session and the other.

The analysis of the contextual factors that affected the intervention indicates gains (for example, the participants'

access is easy, as they do not have to move to another location) and costs (for example, possible interventions by family members or external members may happen) related to home interventions. The accomplishment and evaluation of home visits has not been frequent in psychological interventions in Brazil (Brandão & Costa, 2004), considering the lack of publications. This has been one of the most important intervention strategies in Brazilian public health and social service policies though. Home visits are crucial in primary health care programs like the Family Health Program (Souza & Carvalho, 2003), and in basic social protection programs like the Social Service Reference Center (Murta & Marinho, 2009). These are activity contexts for health professionals, including psychologists, demanding research to develop and evaluate interventions based on home visits, considering their feasibility and effectiveness. Another factor that stood out in the assessment of contextual factors that influenced the intervention was the infant's crying, so that the participants had to divide their attention between her and the researchers. This raised the hypothesis that, if the intervention had fully taken place before the infant's birth, this would have permitted greater adherence by the couple. This can be tested in future studies.

## Final Considerations

In summary, the data reveal that the couple felt satisfied with the program and used the information and strategies received, positively influencing the conjugality dimension, including better communication and interpersonal problem solving, and the parenthood dimension, with knowledge construction on the infant's development, changes in beliefs about violent parental educative practices, responsiveness towards the infant and reduced parental stress. As opposed to what has usually been done in the area, these findings rest on a process evaluation based on multiple criteria and originate in an intervention supported by a needs assessment, focused on the conjugality and parenthood dimensions.

This study comes with some limitations. A case study design was adopted, without any follow-up to check whether the changes were maintained or any relapse had occurred (this had been programmed but the couple could no longer be contacted after the end of the intervention). Since the start, the couple presented different protective factors and a high degree of motivation to participate. Hence, the question remains how this intervention would work in less motivated samples that are more exposed to risks, and the effect of this intervention over time is not known either. Therefore, additional studies with larger samples, control groups and follow-up are needed to clarify the results and impact of this intervention. The inclusion of quantitative variables is needed with a view to pre and post-test evaluation. In this case, marital social skills



measures could be adopted (Villa, Del Prette & Del Prette, 2007), given that this is one of the key variables in the conjugality dimension.

In view of the research findings, besides the use of more favorable research designs with a view to internal and external validity, future studies could benefit from: (a) needs assessment for the sake of adequate intervention planning, (b) inclusion of the couple in the intervention and of the parenthood and conjugality dimensions, (c) accomplishment of the intervention before the infant's birth, (d) monitoring of the process indicators evaluated here per session. Process evaluation can support the quality of the intervention and, consequently, the achievement of its proximal and distal goals.

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