Commitment as a Predictor of Participation in Premarital Education

Jonathan M. Blair
James V. Córdova
Clark University

The efficacy of premarital education programs has been well established; yet few studies have attempted to identify factors that may lead to increased participation. The current study examined questionnaire data from 46 engaged couples to determine whether marital commitment is a unique predictor of both interest in premarital education and intent to participate in premarital education. Analyses suggest commitment to marriage, spirituality, and health beliefs were all uniquely predictive of women's interest in premarital education and intent to participate in a premarital education program. Men's intent to participate in a premarital education program was only predicted by women's interest in premarital education. Implications and recommendations for increasing participation in premarital education programs are discussed.

Keywords: *premarital education; marital commitment; spirituality; marital satisfaction; engaged couples*

Despite growing interest in preventative approaches to marital dysfunction by researchers, most couples have yet to recognize the potential benefits of the programs and services that mental health professionals are able to provide (Silliman & Schumm, 2000; Sullivan & Bradbury, 1997). Even in the midst of severe marital distress, most couples still choose not to seek professional help, and some studies suggest upwards of 80% of couples who divorce do so without consulting a mental health professional (Johnson et al., 2002). Research has yet to tell us much about why some couples are more attracted to premarital education than others and what characteristics of the programs contribute to this disparity.

Participation in skills-based premarital education programs has emerged as an effective means for engaged and newlywed couples to maintain their marital satisfaction (Carroll & Doherty, 2003; Silliman & Schumm, 2000). Simply defined, premarital education is "knowledge and skills based training that provides couples with information on ways to sustain and improve their relationship once they are married" (Senediak, 1990). These programs provide a nonthreatening educational environment for couples to learn the skills that research has been shown to be associated with healthy marital relationships. The most common topics covered in these programs include communication, conflict resolution, commitment, and expectation management (Halford, Markman, Kline, & Stanley, 2003). Couples who learn to effectively utilize these skills early and maintain their use throughout their relationship consistently report being more satisfied than couples who do not (Carroll & Doherty, 2003).

There are several examples throughout the literature that reveal couples' general attitude toward marital health. Many couples perceive their marriage as a relationship that they should inherently know how to navigate successfully (Epstein & Eidelson, 1981; Karney, McNulty, & Frye, 2001; Millward, 1990). As a result, these couples do not view skills training or premarital counseling as a priority. They believe they are already equipped with the skills they will need to maintain a satisfying relationship. However, with a divorce rate that steadily hovers between 40% to 50% (Clark, 1995), there is clearly a disconnect between couples' expectations and outcomes. Research suggests that couples benefit from being taught skills that have been shown to sustain healthy marital relationships (Halford & Behrens, 1996), and premarital education programs can provide the training couples need.

Until recently, the literature has primarily focused on the efficacy of premarital education programs. However, now that efficacy has been repeatedly supported (Carroll & Doherty, 2003; Halford, 2004; Jakubowski, Milne, Brunner, & Miller, 2004; Larson, 2004), attention can be shifted toward the utilization problem. There are two important questions that have yet to be fully answered: (a) How are people who choose to utilize premarital education programs different from those who do not, and (b) how can utilization of premarital education programs be increased.

Authors' Note: Correspondence concerning this article should be addressed to Jonathan M. Blair, Department of Psychology, Clark University, 950 Main Street, Worcester, MA 01610; e-mail: jblair@clarku.edu.

THE FAMILY JOURNAL: COUNSELING AND THERAPY FOR COUPLES AND FAMILIES, Vol. 17 No. 2, April 2009 118-125
DOI: 10.1177/1066480709332634

PREVIOUS PREDICTIVE MODELS

To date, most of the work attempting to determine who attends premarital education programs has focused on two types of variables, static and dynamic. Static variables represent demographic characteristics (Carroll & Doherty, 2003), whereas dynamic variables represent such characteristics as the physical and psychological barriers that influence one's desire and ability to attend (Sullivan, Sullivan, Pasch, Cornelius, & Cirigliano, 2004). Both of these approaches have added greatly to our knowledge of premarital education participants. Room remains, however, for further investigation of the factors that determine service utilization of premarital education.

Demographic variables. The first phase of research in this area relied heavily on samples already enrolled in premarital education programs and looked to demographic variables to predict participation. In most of the studies conducted, discerning who was attending was of secondary concern to demonstrating the efficacy of premarital education as an intervention strategy. Although the studies addressed well the demographic characteristics of who attends premarital education programs, they were not designed to address how couples who attended premarital education differed from those who did not in a dynamic rather than descriptive manner. Knowing *why* rather than *that* a particular subset of the population is drawn to these programs will be what ultimately leads to successful dissemination.

Another limitation of this type of data is that demographic variables are generally static in the sense that clinicians and educators cannot be reasonably expected to influence them. Factors such as religiosity, age, income, parental history of divorce, and education level may all be well-established risk factors for divorce and education utilization; however, this information provides little in terms of addressing how these factors directly affect participation in premarital education (Sullivan & Bradbury, 1997). This leaves the unanswered questions regarding the salient factors that lead some couples to take preventative steps to maintain their marital satisfaction while other couples remain secure in their own ability to maintain marital success, despite a growing body of evidence that suggests otherwise. Although we may not be able to directly address the specific demographic factors that limit premarital education service utilization, more can be done to identify the more dynamic factors that may hold sway over such decisions.

Health beliefs model. In response to the call to shift toward more dynamic constructs (Halford et al., 2003) in determining who attends premarital education programs, recent research has proposed new models that include more malleable variables (Sullivan et al., 2004). One theoretical model that lends itself particularly well to this area of research is the health beliefs model (Sheeran & Abraham, 1996; Strecher, Champion, & Rosenstock, 1997). Within this model, individuals are driven to engage in preventative behaviors to the extent that (a) they perceive that they are susceptible to the potential problem, that is, divorce (perceived susceptibility); (b) they believe that the problem has serious consequences (perceived severity); (c) they perceive few barriers to taking the preventative action, that is, marriage education (perceived barriers); and (d) they believe that the preventative action will be effective in minimizing the risk (perceived benefits; Sheeran & Abraham, 1996; Sullivan, 2004). This model is not only a theoretically sound addition to the literature but also one that lends itself well to practical use. The health beliefs model has been shown to predict participation that contradicts the commonly used demographic variables (Sullivan et al., 2004).

In a recent study, Sullivan et al. (2004) found that perceived susceptibility to marital problems, perceived susceptibility to divorce, and perceived barriers were all significant predictors of women's intent to participate in a premarital counseling program. However, for men, perceived barriers and expense were the only significant predictors of intent to participate after controlling for demographic variables. These results suggest that women's health beliefs are more amenable to intervention than are men's. To the extent that clinicians and educators can influence women's awareness of their susceptibility to marital problems or divorce, they may be able to influence the service utilization of premarital education. Although gender itself is a static demographic variable, perceived risk is not.

The addition of the health beliefs model has perhaps mitigated an ongoing limitation in the current literature. It provides a dynamic model, in that its' components can be influenced by educators and clinicians in a way that could reasonably be expected to increase couples' interest in participating in premarital education programs. However, we believe that there may be other models and constructs that can add even more to our understanding of what interferes with participation in premarital education. Many of these constructs, such as commitment and relational maintenance strategies, are specifically targeted within the programs themselves. However, we suggest that a large proportion of couples' lack information about the importance of these programs' content and therefore have little or no motivation to participate.

COMMITMENT

One construct that is generally a standard component of premarital education and might strongly influence couples' interest and willingness to participate in premarital education is commitment (Carroll & Doherty, 2003). In this context, we define *commitment* as an attitude that encourages behaviors that serve to maintain and improve relationship quality. These behaviors have been referred to in the literature as relational maintenance behaviors (Canary & Stafford, 1992). Of the topics commonly covered in

premarital education, we suggest that commitment is the most theoretically sound predictor of interest in premarital education because it is in many ways synonymous with relationship maintenance.

Researchers have developed many theories and models in an attempt to capture the phenomenon of marital commitment. Stanley and Markman (1992) posited that marital commitment is composed of two components, personal dedication commitment and constraint commitment. Personal dedication commitment is the desire of an individual to maintain or improve the quality of his or her relationship for the joint benefit of the participants, and constraint commitment incorporates the forces that constrain individuals to maintain relationships (Stanley & Markman, 1992). Higher dedication commitment is exemplified through attitudes that foster relationship primacy, couple identity, and satisfaction with sacrifice. Constraint commitment, however, is exemplified through extraneous pressures placed on individuals by family, friends, or mutual investments that impose barriers to relationship dissolution. Together, these two components form a model of commitment in personal relationships that extends beyond traditional views of commitment as solely the desire to remain indefinitely in a relationship.

In line with this conceptualization, we view commitment as an implicit attitude that motivates an individual to act in ways that maintain and improve relationship quality. Whereas an individual will not always feel particularly committed to their partner at an emotional level, we suggest that a strong attitude of commitment will encourage behaviors that maintain relationship stability regardless of an individual's particular feelings at a given point in time. Couples who choose to participate in these programs are doing so to ensure the future health and stability of their relationship. We suspect that participation in a premarital education program is a behavioral manifestation of an internal attitude of commitment. We propose that strongly committed couples will be more likely to regularly employ relational maintenance strategies, whether habitually or strategically, and will be more willing to participate in preventative marital interventions than those who are less strongly committed. Theoretically, marital commitment should influence willingness to participate in premarital education to the degree that commitment is associated with the desire to maintain and improve the quality of marital relationships. It follows therefore that couples who are initially more committed will be more likely to participate in a premarital education program because such programs serve their goal of relationship maintenance and improvement.

Given the potential for commitment to add to our ability to predict premarital education participation, we conducted a study that adds commitment to the models previously studied. Modeled after Sullivan (2004), the current study replicates and extends existing models predicting marriage education participation by including the construct of commitment.

In the current study, *interest* was defined as the self-reported likelihood that an individual would request more information about premarital education. *Intent* was defined as the self-reported likelihood that an individual would attend an offered premarital education program. Previous studies have shown a moderate to strong relationship between intent and actual participation (Sullivan et al., 2004). By using hierarchical linear regression, we propose to test the following models for their ability to predict interest and intent to participate in a premarital education program. The demographic model was composed of the demographic characteristics that have been found to predict participation in premarital education programs. These characteristics include age, income, spirituality, and education. We hypothesized that this model would predict intent to participate and interest in premarital education. The health beliefs model added the health beliefs previously tested by Sullivan et al. (2004) to the demographic model as a predictor of intent and interest. The commitment model added commitment to the demographic and health beliefs models. We hypothesize that the inclusion of commitment will add significantly to the prediction of intent to participate and interest in participating in premarital education. Although we expect all couples to score relatively highly on measures of commitment, given that most of the couples were in the process of planning a wedding, we predict there will still be enough variation to detect a meaningful relationship between commitment and participation in premarital education.

METHOD

Participants

Engaged couples from the northeast region of the United States were recruited from local churches, bulletin board postings, and from a larger ongoing university study on couples' transition to marriage to complete a series of questionnaires. The couples recruited individually and those recruited from within the ongoing study were recruited from the same general population. Each partner within the couple was separately mailed the questionnaires to complete individually along with a stamped envelope to return their completed material. Of the 65 packets that were mailed to participants, 46 (71%) were returned completed by both partners. The average relationship length for the couples was 3.88 (SD = 2.13) years with a range from 1 to 9 years. This was the first marriage for all (n = 46) of the wives and 92% (n = 41) of the husbands. Table 1 contains demographic information from the sample.

Measures

The Commitment Inventory. The Commitment Inventory (Stanley & Markman, 1992) is a widely used 60-item, 10-subscale self-report questionnaire, which is designed to measure commitment in marital relationships. The subscales corresponding to personal dedication commitment include

TABLE 1
Descriptive Statistics for Engaged Couples ($N = 44$)

Variables	*M*	*SD*
Women		
Age	25.78	6.84
Years of education	16.48	2.83
Annual income	21,313	15,856
Spirituality[a]	3.89	1.46
Proportion White	0.90	
Proportion cohabiting	0.93	
Proportion parents divorced	0.34	
Proportion required counseling	0.29	
Men		
Age	26.95	6.44
Years of education	16.07	2.45
Annual income	36,839	27,094
Spirituality[a]	3.59	1.52
Proportion White	0.80	
Proportion cohabiting	0.93	
Proportion parents divorced	0.33	
Proportion required counseling	0.29	

a. Spirituality was rated on a 7-point scale (1 = *not at all spiritual*, 7 = extremely spiritual).

Relationship Agenda (the degree to which a person wants the relationship to continue over time), Primacy of Relationship (priority level the relationship holds in relation to other activities), Couple Identity (the degree to which a couple identifies as a single entity), Satisfaction With Sacrifice (enjoying doing things that are beneficial to their partner), Alternative Monitoring (the degree to which an individual is aware of alternative partners), and Metacommitment (the degree to which an individual is committed to keep their commitments). Subscales corresponding to constraint commitment include Structural Investment (the degree to which possessions and monetary investments keep an individual in a relationship), Social Pressures (pressure from family and friends to remain with their partner), Availability of Partners (availability of other potential partners), and Morality of Divorce (moral acceptability of divorce; Stanley & Markman, 1992). In the current study, Cronbach's alpha values for the various subscales ranged from .70 to .74.

The Health Beliefs Model Questionnaire. The Health Beliefs Model Questionnaire used in this study was revised slightly from the questionnaire developed by Sullivan et al. (2004). For use in the current study, all references to counseling were changed to education in an attempt to more accurately capture the primary variables of interest. The 36-item questionnaire was designed to measure individual's knowledge about divorce, their beliefs about marriage and premarital education, social norms related to premarital education, and intentions to participate in premarital education. Our primary dependant variables of intent to participate and interest in premarital education were measured by the questions "How likely is it that you will attend a premarital education program before you get married?" and "How likely is it that you will inquire more about premarital education?" Participants were intentionally not informed as to the time commitment or curriculum of premarital education programs to obtain the most accurate and unbiased measurement of the participant's attitudes. All items used a 6-point scale ranging from *not at all likely* to *very likely*. Cronbach's alpha values for the scales perceived susceptibility to problems, perceived severity of problems, perceived barriers, and perceived benefits were .59, .83, .83, and .76, respectively.

RESULTS

Demographics model. To test our first model, multiple regression analyses were conducted to determine the ability of the demographic model to predict interest and intent to participate in a premarital education program. A significant predictive relationship was found between women's demographic characteristics, specifically spirituality, and both their intent to participate and interest in participating in premarital education. The demographic model was not predictive for men's intent to participate and only predicted men's interest in participating at a trend level (see Tables 2 through 5).

Health beliefs model. To test the health beliefs model's predictive ability beyond what was predicted by the demographic model, the health beliefs variables were added to the model subsequent to the demographic variables. Again, only the women's health beliefs were predictive, accounting for a significant portion of unique variance in interest and intent to participate in a premarital education program. Men's health beliefs were not predictive of their interest or intent to participate (see Tables 2 through 5). However, 93% of men and 100% of women surveyed stated that they were already equipped with the skills to handle any conflict that could arise in their relationship.

Commitment model. A third series of hierarchical multiple regression analyses were run to determine whether commitment significantly added to the ability to predict intent to participate or interest in premarital education. The analysis of the third model was conducted using global commitment as the sole additional predictor after accounting for the first two models. Women's commitment added significantly to the prediction of intent to participate in premarital education. Commitment did not add to the ability to predict men's intent or to predict interest for men or women (see Tables 4 and 5).

The third model was able to account for 56% of the variance in women's intent to participate but did not capture any significant variance in men's intent to participate in premarital education. The model was also able to account for 47% of women's and 5% of men's interest in participating

TABLE 2

Summary of Hierarchical Regression Analysis for Variables Predicting Men's' Intent to Participate in Premarital Education ($n = 39$)

	Model 1			Model 2			Model 3		
Variable	***B***	***SE B***	**β**	***B***	***SE B***	**β**	***B***	***SE B***	**β**
Age	–.03	.04	–.15	–.03	.04	–.15	–.04	.04	–.17
Education	–.15	.10	–.24	–.17	.11	–.27	–.18	.11	–.29
Income	.00	.00	.03	.00	.00	.07	.00	.00	.08
Spirituality	.34	.16	.34*	.28	.22	.28	.25	.22	.25
Susceptibility to problems				–.03	.40	–.02	–.12	.40	–.06
Susceptibility to divorce				–.28	.49	–.12	–.51	.52	–.22
Severity of problems				–.11	.33	–.06	.01	.34	.01
Severity of divorce				–.04	.34	–.02	.12	.36	.07
Barriers				.34	.38	.18	.41	.38	.21
Benefits				.03	.39	.02	.04	.39	.02
Commitment							–.73	.60	–.26
Adjusted R^2	.05			.06			.06		
F for change in R^2	1.53			0.37			1.06		

*$p < .05$. **$p < .01$.

TABLE 3

Summary of Hierarchical Regression Analysis for Variables Predicting Men's Interest in Premarital Education ($n = 39$)

	Model 1			Model 2			Model 3		
Variable	***B***	***SE B***	**β**	***B***	***SE B***	**β**	***B***	***SE B***	**β**
Age	–.04	.04	–.17	–.02	.04	–.10	–.02	.04	–.10
Education	–.20	.10	–.31*	–.22	.11	–.35*	–.22	.11	–.34*
Income	.00	.00	.21	.00	.00	.24	.00	.00	.24
Spirituality	.37	.16	.37*	.31	.21	.30	.31	.22	.30
Susceptibility to problems				.35	.38	.18	.35	.39	.18
Susceptibility to divorce				–.52	.47	–.22	–.51	.51	–.22
Severity of problems				–.22	.32	–.12	–.22	.34	–.12
Severity of divorce				–.23	.32	–.13	–.24	.35	–.13
Barriers				.00	.36	.00	–.01	.37	.00
Benefits				.35	.37	.18	.35	.38	.18
Commitment							.02	.59	.01
Adjusted R^2	.12			.08			.05		
F for change in R^2	2.35†			0.71			0.27		

*$p < .05$. **$p < .01$. †$p < .1$.

in premarital education. Given the lack of predictability for men, another set of analyses were conducted to test the relationship between women's interest and men's intent. Forty-seven percent of the variance in men's intent was accounted for by wives' interests.

DISCUSSION

The current study was conducted to extend the literature on the prediction of participation in premarital education programs. The results of our analysis produced findings in which our hypotheses were supported for women but not for men. Our first hypothesis sought to test the predictive value of demographic models in relation to participant's interest and intent to participate in premarital education. Although previous studies have found that a demographic model composed of variables that reflect religiosity/spirituality, age, and income were predictive for both men and women, the current study found such a model to be predictive only for women. The demographic model was only predictive of

TABLE 4

Summary of Hierarchical Regression Analysis for Variables Predicting Women's Intent to Participate in Premarital Education ($n = 41$)

	Model 1			Model 2			Model 3		
Variable	***B***	***SE B***	β	***B***	***SE B***	β	***B***	***SE B***	β
Age	.04	.03	.17	.01	.03	.04	–.01	.03	–.05
Education	–.11	.08	–.18	–.07	.07	–.13	–.09	.06	–.15
Income	.00	.00	.02	.00	.00	–.10	.00	.00	–.13
Spirituality	.65	.15	.57**	.32	.16	.28[a]	.21	.16	.18
Susceptibility to Problems				.22	.35	.09	.39	.34	.16
Susceptibility to Divorce				–.31	.43	–.10	–.03	.42	–.10
Severity of Problems				–.28	.26	–.14	–.34	.25	–.17
Severity of Divorce				.29	.35	.10	–.15	.39	–.05
Barriers				.65	.34	.39*	.59	.33	.35
Benefits				.41	.35	.26	.43	.33	.27[†]
Commitment							1.09	5.00	.36[†]
Adjusted R^2	.32			.51			.56		
F for change in R^2	5.75**			3.36*			4.70*		

[†] >.1.

*$p < .05$. **$p < .01$.

TABLE 5

Summary of Hierarchical Regression Analysis for Variables Predicting Women's Interest in Premarital Education ($n = 41$)

	Model 1			Model 2			Model 3		
Variable	***B***	***SE B***	β	***B***	***SE B***	β	***B***	***SE B***	β
Age	.05	.03	.23	.01	.03	.06	.00	.03	.00
Education	–.10	.08	–.18	–.04	.07	–.08	–.05	.07	–.10
Income	.00	.00	.09	.00	.00	–.03	.00	.00	–.05
Spirituality	.53	.15	.48**	.20	.16	.18	.12	.17	.11
Susceptibility to problems				.68	.36	.29*	.80	.36	.34*
Susceptibility to divorce				–.58	.43	–.20	–.39	.44	–.13
Severity of problems				–.13	.27	–.07	–.17	.26	.09
Severity of divorce				–.20	.35	.07	–.52	.41	–.19
Barriers				.77	.35	.48*	.72	.34	.45*
Benefits				.17	.35	.11	.18	.35	.12
Commitment							.79	.52	.27
Adjusted R^2	.26			.45			.47		
F for change in R^2	4.66*			3.09*			2.28		

*$p < .05$. **$p < .01$.

intent and interest for women, with spirituality accounting for the majority of the unique variance. Although the demographic model in its entirety was not predictive for men, the subscale of spirituality was found to predict both interest and intent for men. Strong spiritual beliefs appear to be a powerful part of the demographic model and the most predictive of intent to participate and interest in premarital education regardless of sex.

Our second hypothesis, which proposed that health beliefs were predictive of premarital education interest and participation, produced similar results. Our findings provide more support to the trend in which women's intent and interest have generally been more predictable than that of men. Specifically, to the extent to that women perceived that there were barriers involved in participating they were less likely to report an interest or intent to participate in marriage education. This suggests that the more convenient and accessible these programs are, the more likely that women will attend, presumably accompanied by their partner.

The third hypothesis, which proposed a predictive model including commitment, was supported for the women. Women's global commitment was a significant predictor of intent to participate in premarital education after accounting for the variance associated with the other two models.

Overall, these findings present evidence that suggests that wives are the dynamic force behind couples' participation

in premarital education programs. Given the preventative intent of premarital education, it is likely that many men are especially unmotivated to seek assistance in an area where they perceive no problem, regardless of their level of commitment. These findings are consistent with the prevalent literature citing men's general resistance to preventative intervention and disposition away from help-seeking behavior (Galdas, Cheater, & Marshall, 2005). Our data suggests that wives' interest is the most predictive factor of men's participation in premarital education. Therefore, the dissemination of premarital education programs may be best targeted directly at soon-to-be wives, which could be expected to increase participation by husbands. Hence, not only do we know the factors that influence women's participation but we also know that their interest is one of the most motivating factors for men.

In addition to predicting intent and interest in premarital education, the current study collected data that highlight the uphill battle premarital educators face when attempting to increase participation. Nearly all of the participants in the current study felt they were already equipped with the necessary skills to successfully navigate most, if not all, of the problems that may arise within their marriage. In other words, almost all couples endorse the mistaken assumption that they have nothing to learn about how to maintain their marital health. Given the current rate of divorce and what we know about the general trajectory of marital satisfaction, it appears that couples are not aware that they may not be equipped with the skills that will buffer their relationship from the trials that dissolve many marriages. Also, the repeatedly replicated finding that marital education results in measurable improvements in marital health provides further evidence that couples' bias toward believing they know all they need to know about marital health is too often unfounded. Unfortunately, this information has not made its way into the populace at large. Although it is expected that couples in this phase of their relationship are optimistic about their future and their ability to handle conflict, we should work to prevent their optimism from disguising potential areas of vulnerability. Premarital education gives couples an opportunity to realign their expectations and address potential problems before they become a serious threat to their marital health. In much the same way that public education about the negative health effects of smoking helped to change public perceptions of invulnerability, public education about benefits of marriage education and risks of marital ignorance might be necessary to effect an equal change in public perceptions of marital invulnerability.

Nevertheless, it is encouraging that, in the current sample, half of the participants believed that, overall, attending a premarital education program would be beneficial to their relationship. However, the fact that couples see the benefits but still will not attend suggests the various barriers (i.e., money, time, etc.) outweigh the benefits that couples believe they will receive. Complementing previous research, this suggests that removal of barriers is one of the most important aspects of increasing participation.

Implications

The findings of the current study have many implications. First, they corroborate findings that health beliefs do play an important role in couples' intent to participate in premarital education. As suggested by Sullivan et al. (2004), lowering the cost, reducing the time commitment, and making counseling as convenient as possible are strategies that need to be vigorously employed to encourage more couples to take advantage of premarital education programs. By addressing the barriers that exist (i.e., expense, convenience, and comfort) and making programs that produce the same effects with as little inconvenience to the couple as possible, we can tackle what appears to be a major factor in whether couples are interested in premarital education.

Second, these findings introduce a new dynamic predictor for participation in premarital education. They suggest that women who are more committed to maintaining and improving their marriage even before the marital relationship begins are more likely to attend a premarital education program. Commitment is often a topic covered in marital education programs, but this finding suggests that it may also be a self-selecting precursor for participating couples. As a result, many marriage education programs are composed of the most committed couples. Although the aim is to provide less committed couples an opportunity to strengthen their relationship, premarital education is providing an opportunity for more committed couples to display their commitment. To increase participation, along with the removal of barriers, educators should appeal more to the importance of a commitment that involves the ongoing maintenance and enhancement of the relationship.

Third, these findings raise many questions pertaining to the interest and participation of men. Can these programs be successful if only one partner attends? If only one partner is interested, what are the chances that the couple will attend? Most importantly, if these models are not predictive of intent and interest for men, which—if any—constructs are predictive of participation for men? Future studies will need to be done to determine the answers to these questions.

Limitations

The findings of the current study are limited by the relatively small sample size. Due to the size of our sample, we were limited in the number and type of tests that could be run. Analyses were performed at a global level on most scales to reduce the error associated with producing multiple linear regression models. The current study was also limited in terms of diversity. Although the current sample is more diverse than many samples that have been used previously, it is still not an adequate representation of both the ethnic and regional diversity within the broader community of couples. However, the current study provides preliminary

data that lends support to shifting the focus to dynamic factors, such as commitment and health beliefs, to help influence participation in premarital education.

REFERENCES

Canary, D. J., & Stafford, L. (1992). Relational maintenance strategies and equity in marriage. *Communication Monographs, 59*, 243-267.

Carroll, J. S., & Doherty, W. J. (2003). Evaluating the effectiveness of premarital prevention programs: A meta-analytic review of outcome research. *Family Relations: Interdisciplinary Journal of Applied Family Studies, 52*, 105-118.

Clark, S. C. (1995). Advance report of final divorce statistics. *Monthly Vital Statistics Report, 43*, 1-20.

Epstein, N., & Eidelson, R. J. (1981). Unrealistic beliefs of clinical couples: Their relationship to expectations, goals and satisfaction. *American Journal of Family Therapy, 9*, 13-22.

Galdas, P. M., Cheater, F., & Marshall, P. (2005). Men and health help-seeking behaviour: Literature review. *Journal of Advanced Nursing, 46*, 616-623.

Halford, W. K. (2004). The future of couple relationship education: Suggestions on how it can make a difference. *Family Relations, 53*, 559-566.

Halford, W. K., & Behrens, B. C. (1996). Prevention of marital difficulties. In P. Cotton & H. Jackson (Eds.), *Early intervention & prevention in mental health* (pp. 21-58). Carlton South, Australia: Australian Psychological Society.

Halford, W. K., Markman, H. J., Kline, G. H., & Stanley, S. M. (2003). Best practice in couple relationship education. *Journal of Marital & Family Therapy, 29*, 385-406.

Jakubowski, S. F., Miline, E. P., Brunner, H., & Miller, R. B. (2004). A review of empirically supported marital enrichment programs. *Family Relations, 53*, 528-536.

Karney, B. R., McNulty, J. K., & Frye, N. E. (2001). A social-cognitive perspective on the maintenance and deterioration of relationship satisfaction. In J. Harvey & A. Wenzel (Eds.), *Close romantic relationships: Maintenance and enhancement* (pp. 195-214). Mahwah, NJ: Lawrence Erlbaum.

Larson, J. H. (2004). Innovations in marriage education: Introduction and challenges. *Family Relations, 53*, 421-424.

Millward, C. (1990). Expectations of marriage of young people. *Family Matters, 28*, 1-12.

Senediak, C. (1990). The value of premarital education. *Australian and New Zealand Journal of Family Therapy, 11*, 26-31.

Sheeran, P., & Abraham, C. (1996). The health belief model. In M. Conner & P. Norman (Eds.), *Predicting health behavior: Research and practice with social cognition models* (pp. 121-162). Buckingham, UK: Open University Press.

Silliman, B., & Schumm, W. R. (2000). Marriage preparation programs: A literature review. *Family Journal: Counseling and Therapy for Couples & Families, 8*, 133-142.

Stanley, S. M., & Markman, H. J. (1992). Assessing commitment in personal relationships. *Journal of Marriage and the Family, 54*, 595-608.

Strecher, V. J., Champion, V. L., & Rosenstock, I. M. (1997). The health belief model and health behavior. In D. S. Gochman (Ed.), *Handbook of health behavior research 1: Personal and social determinants* (pp. 71-91). New York: Plenum Press.

Sullivan, K. T., & Bradbury, T. N. (1997). Are premarital prevention programs reaching couples at risk for marital dysfunction? *Journal of Consulting and Clinical Psychology, 65*, 24-30.

Sullivan, K. T., Pasch, L. A., Cornelius, T., & Cirigliano, E. (2004). Predicting participation in premarital prevention programs: The health belief model and social norms. *Family Process, 43*, 175-193.

Jonathan M. Blair, *Department of Psychology, Clark University, Worcester, Massachusetts.*

James V. Córdova, *Department of Psychology, Clark University, Worcester, Massachusetts.*