The title of this blog was inspired by a remark that was made to Susan Stamberg NPR reporter, by a man in his seventies attending an art program designed for Alzheimer’s patients with his wife. Many health care professionals, and family caregiver advocates have heard similar remarks. It raises numerous complex questions for health care.

Too often couplehood is invisible to health care practitioners, and ignored in current health care reform discussions. The spousal/intimate partner relationship is fundamentally different from the relationship between an individual and other family members or close friends who may be providing care. It has unique legal, economic, intimate (emotional and sexual) and social aspects.

A growing body of research—gradually becoming better known and getting increasing media attention—demonstrates that the quality of a couple’s relationship can profoundly affect and be affected by the physical and emotional health of each individual over their life span. This research was reviewed by participants at our 2008 conference and they also made numerous recommendations about how to implement a couple focus across all aspects of health care (Staton & Ooms, 2011 & 2012, these links are pdf reports). They agreed that it is in the care of the chronically ill where the pay off of adopting a couple-focus could be most significant in terms of increasing the quality of care and reducing health care costs.

The couple relationship intersects with health care throughout the course of chronic illness, from the moment when the initial diagnosis is received, throughout the often protracted and bumpy course of managing treatment (when the patient is still largely independent). The relationship assumes even more importance at the caregiving stage when the partner’s health is severely compromised, other diseases may co-occur, and assistance from spouse or other caregiver is increasingly required for daily functioning. Spouses and partners indeed function as family caregivers, but they are so much more, and their relationship affects the course of a chronic illness long before "caregiving‘ in the current medical sense becomes an issue.

Health care systems need to recognize that at all these stages a strong couple relationship can be the health care professional’s best ally; an unsafe, unstable and emotionally destructive relationship is a major health risk. A systems paradigm maintains that when an individual adult becomes seriously ill or disabled, the couple needs to be viewed as the unit of treatment (if there is no partner, then other family members). What this means in practice will depend on the severity and stage of the illness. Yet the official medical establishment continues to
operate within an individualistic paradigm. For example, astonishingly the new Institute of Medicine report on *Living Well with Chronic Illness* (IOM, 2012) pays no attention to the spousal/partner/or family caregiver’s role.

Changing family demographics—the decline of marriage—is often cited as one of the reasons for ignoring the power of the couple relationship. Yet many chronic illnesses or conditions begin in mid-life—diabetes, MS, heart-disease, cancer, HIV/AIDS—when two thirds of adults are married. A recent Census report provides the numbers: In 2010 70% of men age 55-64 and nearly 71 % over 70 years are married. Women are less likely to be married: 61.2% of 55-64 year, and 41.6% of over 65 year old women are married (U.S. Census Bureau, 2010). If committed cohabiting partners, including GLBT couples, were included the proportion of adults married or with a partner would be even larger. These numbers strongly suggest that health care providers should be aware that it *is more likely than not* that their chronically ill patient has a spouse. (No national data is available on the marital/partner status of those diagnosed with chronic illness.)

The family caregiving community has made laudable efforts to be inclusive of all those (spouses relatives, friends etc) who provide care to the chronically ill, frail and old. The dominant model of family caregiving is to serve elderly patients, and the majority of these are indeed elderly single women, and for the majority of them their caregiver is an adult child. In the process however the specific issues that are unique to the large numbers of spouses or committed partners providing increasing levels of assistance to their chronically ill partner are seldom addressed.

Recent trials of psycho-educational interventions designed to improve partner communication and assistance in cancer and other chronic illness are showing promise of improving both patient and partner health (Porter et al. 2011; Baucom, 2012; Scott, Halford & Ward, 2004). Meanwhile numerous innovations are underway to improve the quality and cost effectiveness of health care: for example efforts to improve the management of care transitions, adherence to treatment protocols, coordinate care for those with multiple conditions, prevent unnecessary rehospitalizations (bounce-backs), and establish medical homes.

These innovations offer a window of opportunity to integrate couple relationship information, education and other couple-focused practice and management tools in current reforms and to find out, as seems very likely, whether they do help improve health care quality and reduce costs. Couple-focused approaches should be viewed as complementary to those focused on family caregivers more generally.

We invite readers of this blog to share examples of actual, or proposed practices or system changes in the primary care of chronic illness that exemplify taking a couple perspective. To jump-start this conversation here are a few suggested changes in practice at different stages of chronic illness, but they could be adapted to be used in health care more generally:

- In the initial medical examinations routinely collect and record information about the spouse/partners and his/her own health status; obtain permission to actively involve the partner in the patient’s care whenever it would be useful.
- Medicare now reimburses practitioners more if they conduct an Annual Wellness Exam (Center for Medicare & Medicaid Services, 2011) The exam is to include an assessment of the individual’s functioning ability and level of safety in the home. We propose the CMS circular should also require that if they learn that the patient is receiving assistance with medications or ADL, they find out who provides the patient with assistance, and if that person is a spouse/partner (or other relative), and what is the general status of their health.
- In the treatment and management of chronic or serious illness, routinely invite the spouse/partner to participate in diagnostic discussions, planning for discharge and involve the partner in explanations of post-discharge home-based treatment protocols.
- Provide the couple with written information (or CDs. DVDs) about how the chronic illness may affect the legal, economic, and intimate aspects of their relationship. Make referrals to additional education
and support services designed to address these issues, such as the National MS Relationship Matters program (see Staton & Ooms 2012, pp 15-16).

References, Links


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In 2008 Ooms and Staton coordinated a three day invitational conference at Wingspread designed to critically review the research on the connections between marriage and couple relationships and health, and make recommendations for changes in health care practice and policy.