"Something Important is Going on Here!" Making Connections Between Marriage, Relationship Quality and Health

Implications for Research and Healthcare Systems, Programs and Policies

Wingspread Conference Proceedings 2012

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national healthy marriage resource center

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This report is based on the proceedings of the conference, *Making Connections: Effects of Marriage and Couple Relationships on the Health of Infants, Adolescents and Older Adults*, sponsored by the National Healthy Marriage Resource Center (NHMRC) held on October 20-22, 2008 at the Wingspread Conference Center, Racine, Wisconsin. Jana Staton and Theodora Ooms, senior consultants to the NHMRC, coordinated the conference and are the authors of the report.

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Three companion documents published by the NHMRC are available at the website, http://www.healthymarriageinfo.org. They provide greater detail about the numerous studies and reports on which the conference conclusions are based.

1. *Making the Connection Between Healthy Marriage and Health Outcomes: What the Research Says.* Research brief by Jana Staton (2009).

2. The *Collection by Topic on Marriage and Health*, an annotated listing of key references and resources.

3. *Marriage and Relationship Factors in Health: Implications for improving healthcare quality and reducing costs*. Issue brief by Jana Staton and Theodora Ooms (2011).

This conference report and its companion documents have benefited from the thoughtful comments and suggestions of the Wingspread *Making Connections* conference participants who were given the opportunity to review and comment. However the authors bear sole responsibility for the final content and recommendations. Further, the findings and conclusions presented in this report are those of the authors alone and do not necessarily reflect the opinions of the Annie E. Casey Foundation, the Office of Family Assistance or the Johnson Foundation.

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Overview

The health benefits of marriage have been much commented upon in recent years by scholars, public officials, health and human service practitioners, and the media. Married people, we are told, are healthier and live longer, but the significance and practical use of this finding is not clear. Should healthcare professionals and advocates pay attention to this fact? Why is it important to examine the connections between marriage, relationship quality, and health? What can the fields of marriage and relationship education and healthcare contribute to each other?

This report summarizes some preliminary answers to these questions reached by healthcare and marriage and relationship experts, brought together for the first time at a conference, held on October 20-22, 2008, at the Wingspread Foundation, and sponsored by the National Healthy Marriage Resource Center (NHMRC). This conference was titled *Making Connections: The Effects of Couple Relationships on Health Outcomes for Children, Teens & Adults*. It was designed to critically examine the current state of research linking marriage and relationship quality to health outcomes; consider implications for healthcare practice; and examine the potential of research-based relationship education tools and programs to improve healthcare. The meeting was a bridge-building, informal, rich conversation among experts from a wide range of academic disciplines and program perspectives who, for the most part, did not know each others' fields. Despite these differences, broad agreement was reached on the important findings and issues, and on many useful suggestions for next steps.

The researchers noted that the nexus between marriage and health represents a new and still quite undeveloped area of research, constrained by various methodological limitations. Nevertheless, they agreed that the number and variety of studies all finding strong relationships among marriage, marital quality and health outcomes for children and adults were impressive and intriguing, and pointed in the same direction. One scholar summed up the general consensus by saying, "Clearly there is something important going on here!" Researchers used to ask, "Is being married protective for health?" Today, now that we understand that it is the quality of the couple relationship that matters, the important questions are, "What are the dynamic pathways by which marriage has positive impacts on health?" and "Are there practical interventions which could improve relationship quality?"

Conference participants enthusiastically recommended investment in a more carefully planned, interdisciplinary agenda of theory building and research. They agreed that the pilot healthcare interventions presented at the conference, which focused on strengthening relationship quality at critical life transitions, suggested practical new strategies for integrating relationship education into healthcare services and public health promotion. Investment in replicating such programs and in new types of demonstrations is needed, as is the development and testing of practice tools and strategies that can be integrated into the healthcare system.

This conference was held in late 2008, just as the national healthcare reform debate was heating up. Participants acknowledged that the research they had reviewed provided encouraging evidence that understanding and investing in the marriage/health connection could help contribute to two of the major goals of healthcare reform: improving healthcare quality and reducing healthcare costs. They recommended taking advantage of several windows of opportunity in order to move this convergence of two fields forward on multiple fronts.

The report ends by recommending that national and state leaders in the private and public sectors take a series of steps to inform the public and educate healthcare professionals of what we already know about the important connections between marriage, relationship quality, and health. It also recommends specific activities designed to learn more: implementing a cross-disciplinary research agenda, and launching new pilot demonstrations that test whether and under what conditions a couple focus and increased father involvement in healthcare delivery will promote better, and more cost-effective, healthcare outcomes. (This report has been revised and updated to incorporate reference to the goals and some current developments related to the Affordable Healthcare Act of 2010).

This report is intended to be of interest to healthcare and marriage education researchers and practitioners, professional educators in both arenas, and public health officials and administrators and policymakers, particularly those concerned with moving the healthcare system toward a stronger focus on achieving the "Triple Aim" of better population health, improved patient care, and reduced healthcare costs (http://www.ihi.org).

Conference Background

During the last decade a growing number of studies have found that married adults are physically and emotionally healthier and live longer than adults who are never married, divorced, separated or widowed. Any "disruption" in a committed, intimate adult relationship carries some increased health risk. We know that the children of married adults are also healthier during their childhood and as adults, than children raised in other family circumstances. We also know that older adults with chronic illnesses requiring complex care have lower health costs, and better quality of care, and of life, if they have a spouse or partner able to provide care management (Bodenheimer, 2009).

However, when we take into account the *quality* (both positive and negative) of the couple relationship, the connections become even stronger. These findings are generally welcomed by leading marriage professionals and advocates since they bolster their case for putting the issue of how to increase healthy marriages on the public agenda. The healthcare community by and large has either not been aware of, or paid scant attention to these findings, or has greeted them with a degree of skepticism. Consequently, the relevance of the connection between healthy marriages and health outcomes has not generally been understood by healthcare professionals.

The good news is that the recent publication of several useful syntheses and critiques of the extensive body of research on the connections between marriage and health, has made it easier to step back and assess how convincing the evidence is and what more we need to know (Carr & Springer, 2010; Staton, 2009; Wood et al., 2007).

The marriage/health connection potentially has important implications for both healthcare services delivery and for marriage and relationship education programs. Aware of these implications, the NHMRC planned an invitational conference in October 2008 to review and critically examine the research linking marital status and relationship quality with health outcomes across the life course, to learn about ongoing demonstration programs, and to consider implications for future research, practice, and policy. The thirty-five invited experts were a diverse interdisciplinary group of scholars, administrators, educators and practitioners, from both the marriage and health fields (see Appendix A).

These participants met at the Johnson Foundation's Wingspread Conference Center in Racine, Wisconsin, for two and a half days in plenary and work group sessions, to wrestle with the following questions:

- How robust and convincing is the evidence documenting linkages between marriage, relationship quality and mental and physical health outcomes?
- Do we understand the causal factors and pathways of the marriage/health connection? What more do we need to know?
- To what extent is this link a factor in explaining healthcare disparities for disadvantaged and minority populations?
- Are there particular life transitions, diseases, or population groups for whom attention to improving relationship quality has the most payoff?
- What are some apparently promising pilot programs that are trying to integrate this knowledge into the healthcare arena?
- What are the implications of this research for disease prevention, primary care and for the management of chronic disease?
- What are the implications for healthy marriage programs and initiatives?
- What is known in general about the effectiveness of marriage and relationship education?
- Is there any evidence that interventions designed to take the marriage/health connection into account can improve healthcare quality and reduce healthcare costs?

See Appendix A and B for the participant list and conference agenda. Selected quotations from participants are highlighted throughout the document.

I. Key Research Lessons and Recommendations. The conference participants collectively and critically assessed what is currently known about the interrelationships among marriage, couples' relationship quality and health outcomes. They identified the methodological challenges and limitations of this growing but disconnected body of research, and recommended an investment in a national cross-agency, cross-disciplinary strategy of research and pilot demonstrations. They also suggested some specific research strategies to remedy the gaps, especially to help translate research into replicable practices in public health and healthcare.

II. New Directions: Examples of Promising Demonstrations that Adopt a Couple Relationship Perspective. The research evidence suggests that the healthcare delivery system needs to expand its lens from focusing on individuals in isolation, to recognizing the importance of the individual's marital or partner relationship, and the value of practical interventions to support healthy relationship behaviors. Practitioners are beginning to act based on what is already known about the connections of marriage and couple relationship to health. At the conference, new pilot demonstrations that integrate relationship education or information into a healthcare setting were described, each targeting a different vulnerable population. These pilots offer strong glimpses of new directions and strategies in healthcare delivery that need to be more widely applied and tested.

III. Windows of Opportunity to Improve Healthcare*:* The Potential of a Couple/Partner Relationship Focus. Conference participants recommended taking advantage of a number of promising avenues—windows of opportunity— that have recently opened up as a result of the efforts to reform the healthcare system. These opportunities were suggested as natural vehicles for testing a range of innovative relationship education and information strategies. These "windows" include growing efforts to establish multidisciplinary teams to better coordinate healthcare; to transform physician practices into patient-centered "medical homes;" to involve the partner/family caregiver in managing chronic illness and end-of-life care; to involve men and fathers more actively in the care of infants and children; to improve healthcare professional training and continuing education, and to expand current public health education programs and campaigns for youth and adults. Each of these existing healthcare or public health "windows" could become a vehicle for strategic interventions to strengthen or form healthy couple relationships.

IV. Taking the First Steps Toward a More Couple and Family-Centered Healthcare System. The evidence suggests that moving this agenda forward could make positive contributions to improving healthcare quality and reducing costs. Thus, the report ends with recommending to private and public leaders three broad implementation strategies:

- ***Build bridges with natural allies.*** Those individuals, organizations and coalitions who share similar, overlapping views need to get to know each other and explore ways of working together to achieve the changes they collectively identify to improve the healthcare system. These organizations include those representing a couple/family caregiver perspective in healthcare, and those primarily focused on fathers, and domestic violence prevention advocates.

- ***Launch a national cross-agency/discipline agenda of research and pilot demonstrations.*** Find ways to modify or redesign design current studies and pilot demonstrations and integrate couple-relationship and father-involvement tools and strategies into current efforts for healthcare reform.

- ***Educate healthcare professionals widely about the couple perspective.*** In their professional education and ongoing continuing education, healthcare professionals need to be informed about marriage/relationship health connections and their implications for healthcare delivery and practice.

What is a Healthy Marriage?

The conference sponsors clarified at the outset that the basic assumption underlying the conference was the need to promote "healthy" marriage and couple relationships, not just "marriage," per se. The emerging research into the connections between marriage, couple relationships and health outcomes is founded on the basic understanding that quality matters.

Marriage and couple relationships range on a continuum from "healthy" to "unhealthy" to even damaging. Thus, the aim of policy and program interventions should be to reduce "unhealthy," and promote "healthy" marriage and couple relationships. The term "healthy marriage" is relatively new and needs to be explained.

Healthy, long lasting marriages can take many different forms. Many healthy marriages go through difficult periods and experts agree there is no single "cookie cutter" approach to having a healthy marriage. However, researchers have identified the following core characteristics that most healthy marriages share (see Moore et al., 2004, and NHMRC website http://www.healthymarriageinfo.org:

- commitment to each other over the long haul
- positive communication
- ability to resolve disagreements and handle conflicts nonviolently
- emotional and physical safety in interaction
- sexual and psychological fidelity
- mutual respect
- spending enjoyable time together
- providing emotional support and companionship
- parents' mutual commitment to their children

From a research and healthcare perspective, these aspects help define "relationship quality," identifying intrinsic qualities and processes of healthy marriages which may contribute to health, and pointing out risk factors in marriages and relationships (lack of physical safety, poor conflict resolution, lack of emotional support) that may contribute to illness and poor health outcomes.

Throughout this report the terms "partners" and a "couple-focus" are intended to be inclusive of any intimate, committed couple relationship including same-sex couples.

I. Key Research Lessons and Recommendations

Four overarching conclusions emerged from the research reviews, presentations and work group discussions at the Wingspread *Making Connections* conference.

1. There is clearly "something important going on here" that needs to be better understood. The evidence reviewed suggests there are strong associations between marriage and relationship quality and health outcomes across the life cycle.

2. Four groups of factors help to explain the positive (or negative) effects of marriage and relationship quality on health. Some of these appear to be amenable to intervention.

3. These issues are complex. To better understand these relationships and the causal pathways, in our research we need to pay attention to the many complex, dynamic dimensions of marriage and couple relationships, programs and practice.

4. A comprehensive, multi-disciplinary planned agenda of rigorous research and demonstration is needed to move this important area of inquiry forward. There are many gaps in our knowledge that need to be filled. Importantly, we need to find out much more about what kinds of couple relationship interventions have positive effects on health outcomes, and how these could be integrated into the healthcare system.

Readers are cautioned that studies about the marriage/health connection receiving increasing attention in the media are of uneven quality. Many studies use only cross-sectional data, typically assess a limited range of health outcomes, and do not directly assess couple relationship quality, treating all marriages as equal. Many report on associations (correlations) between marriage and health without controlling for other background factors, which independently and directly influence health outcomes. In this review, we have relied heavily on meta-analyses when available, and whenever possible on studies that directly measured positive or negative marital or relationship quality (not just status), and those which test for effect size of significance, rather than just statistical differences.

Lesson 1: "*Something Important is Going on Here!*"

Based on the discussion of the two research reviews and the findings of their own and other ongoing studies presented at the conference, participants agreed that "Something important is going on here!" The research exploring marriage and health connections, however, was described as being at an undeveloped stage. Many studies have various methodological weaknesses and limitations, and have simply "bubbled up" in different disciplines, emerging from independent analyses of general population health surveys, from research on specific diseases, or from small laboratory or clinical studies, and are published in numerous professional journals. Further, new, more rigorous studies of the effectiveness of relationship education interventions to affect mate selection and improve marital and relationship quality have occurred in non-health settings and have not been funded to collect data on health outcomes.

> ***"This body of research is 'immature'….full of promise for development, raising many questions and puzzles with respect to understanding the (causal) pathways and potential mediators of the observed effects."***
>
> **- Liz Nielsen, PhD**

Yet there was general agreement that strong evidence of links between marital status, relationship quality and health are emerging. Decades of research have suggested that a stable and enduring marriage protects adult partners overall against premature death and illness, and provides children with the best physical health outcomes. The two published research reviews summarize this conclusion as follows:

> "The evidence for the effects of marriage and marital quality on health, although largely correlational, is strong and even convincing. This conclusion comes more from the robustness of this relationship across many different studies, than from the particular results of any single study" (Wood et al., 2007).
>
> "An increasing number of studies suggest that it is the quality of the marital relationship, rather than simply being married, that affects health…Having a marriage with relatively low levels of negative interactions appears to be what leads to lifelong cumulative health benefits" (Staton, 2009).

While many of the studies based on large surveys have found only modest effects of marriage on health, this appears to be in part because of the "masking effect" of treating all marriages as the same, and failing to acknowledge that marriages may be of very different quality. Thus, research needs to separate out and examine the very different health consequences of positive and negative marital relationship quality. In the most recent nationally representative longitudinal studies that include measures of relationship quality, the associations appear to be considerably stronger.

The conclusion that, *"Something important is going on here!"* arose from agreement on a number of findings. Two examples of specific studies are presented for each of the key findings. [See References; Appendix C summarizes findings from a selection of studies, organized by life stage and illness.]

- **Marital status and relationship quality have effects on health outcomes across the life cycle, and overall, some benefits persist even when other factors known to affect health outcomes are taken into account (i.e., health status prior to marriage, income levels, education, and race/ethnicity).** Children raised by two biological married parents who have a reasonably good relationship, have better health during their childhood and as adults, than do children growing up in other family arrangements, while children of divorce score lower on health, behavioral and emotional outcomes, on average. Adolescents raised by continuously married parents are less likely to engage in behaviors that pose health risks, such as premature sexual activity and substance abuse. Young adults reduce health risk behaviors on entering a permanent lifelong relationship. The health of adults in mid-life is increasingly affected by the quality of marital and intimate relationships, including both unhappy marriages and marital disruptions. Health outcomes for aging adults are better on many dimensions, including adherence to medical regimens, when adults have a stable, supportive relationship with a spouse or significant other.

  Selected Findings

  - Low birth weight (LBW) has been consistently linked to unmarried parenting (Barrington, 2010). New data show that low birth weight is more likely for children born to low-income "social father" families, in comparison to those in biological father families (Fragile Families & Child Wellbeing Study, Berger & McLanahan, 2011). Father support and cohabitation with the mother decrease the likelihood of LBW for unmarried mothers in the Fragile Families population (Padilla & Reichman, 2001).

  - Children of low-income cohabiting parents, even in "stable" unions, have worse health at age five, in a large representative sample (Fragile Families study), than children of matched, stably married low-income parents (Schmeer, 2011).

  - The noted Adverse Childhood Experiences (ACE) study documents lifetime health risks (both for morbidity and mortality) strongly associated with the incidence of 10 adverse childhood events, including abuse, neglect, and loss of a parent through divorce or abandonment. These in turn reflect family instability, multiple partner fertility, and relationship turmoil (Brown et al., 2009).

- **The disparities in health associated with race and income are partly explained for African Americans by differences in rates of stable, long-lasting marriages across Social Economic Status (SES) levels**. Stable, long-lasting marriages are increasingly associated with higher levels of education and income. Thus, lower rates of marriage, higher rates of marital disruptions and fragile co-parenting relationships may play an important role in the health disparities experienced by adults and children from African American and other minority populations. While African Americans are more likely to be economically and educationally disadvantaged, poorer health outcomes are not explained simply by education and income levels alone. Variation in marital quality, in addition to the known variation in marriage rates, may be particularly important to examine in African American marriages in relation to partner health.

  Selected Findings

  - A major review of links between African American marriage and health finds that African American children living with married parents have better health, and adults experience better mental health when they are in a high-quality marriage across income levels (Koball et al., 2010).

  - In African American couples, marital satisfaction, a measure of higher quality marital relationship, appears to offer protection from psychological distress, and buffers the negative effects of unfair treatment and financial strain (Lincoln & Chae, 2011).

- **The effects of marriage and couple relationship quality on health differ by gender.** In general, when they get married, men's physical health shows immediate benefits: their health status improves, negative physical symptoms decrease, and they reduce their risky behaviors. By contrast, the health advantages of marriage for women appear to increase with the duration and quality of marriage. On the negative side, married men are more likely to become obese and overweight than single men. Women's health seems to be more generally susceptible to marital discord than does men's (Keicolt-Glaser & Newton, 2001).

Selected Findings

- Women in less satisfying relationships are more likely to develop early signs of heart disease (i.e., metabolic syndrome) than women in satisfying marriages (Gallo et al., 2003); and women are more likely to suffer a major coronary event from marital stress than are men (Orth-Gormer et al., 2000).

- Research indicates that any "disruption" in marital history shortens the lifespan significantly more for men than for women and undermines men's self-reported health (Lillard & Waite, 1995; Williams & Umberson, 2004).

- **Relationship status and quality has direct and indirect effects on mental as well as physical health.** For example, a review of decades of research on depression strongly supports the conclusion that entering into marriage reduces depressive symptoms for both men and women, while marital dissolution increases them (Wood et al., 2007).

  Selected Findings

  - Those who remain stably married have fewer depressive symptoms, and there is little evidence that those with fewer depressive symptoms are more likely to marry, reducing the "selection effect" as an explanation for the effect of marriage on depression (Wood, et al., 2007).

  - Depressive symptoms after divorce are long-lasting, and tend to occur first, preceding physical illness, when adult couples are studied over a ten-year period (Lorenz et al., 2006; Wickrama et al., 1997).

- **The most dramatic evidence for the strength of the marriage/health connection emerges as people grow older**. While the causes are likely complex, elderly persons who are still married are likely to be physically and mentally healthier. Overall, marriage appears to protect the elderly from the onset of physical limitations in carrying out their daily activities. The health benefits of having positive close relationships and support, and the negative effects of stressful, negative relationships, increase with age in numerous ways.

  Selected Findings

  - Marital quality has much more impact on adult health as we age (Umberson et al., 2006), and poor health in older adults is directly correlated with *negative* spousal interactions (Bookwala, 2005).

  - Men and women in "high-quality" marriages live longer with cardiovascular disease, independent of severity of illness, than do those in "low quality" marriages (Coyne et al., 2001; Rohrbaugh et al., 2006).

- **Married persons are less likely to enter a nursing home or to pay for costly long-term care.** It is important to understand that spousal caregiving in later years can be a health benefit for the ill spouse, but may also pose health risks for the caregiver.

  Selected Findings

  - Having a spouse in old age reduces nursing home and hospital admissions, and protects against loss of activities of daily living (ADLs) (Schoenborn, 2004).

  - The impact of extended pre-loss caregiving by a spouse, and the neglect of one's own health concerns, may explain some of the health declines for widows and widowers (Carr et al., 2001).

- **Intimate partner violence (IPV) affects millions of children and adults each year.** Twenty percent of women and 7% of men report lifetime experiences of intimate partner violence (Tjaden & Thoennes, 2000). As a result, an estimated three million children witness a serious episode of violence in the home each year (Straus, 1992).

Selected Findings

- Children experiencing violence in the home grow up to have negative lifetime health effects, according to the Adverse Childhood Experiences Study; the risk of poorer health increases directly with the frequency of the experience reported (Anda et al., 2006; Dube et al., 2002).
- Women who have experienced IPV have a much higher risk of developing chronic health problems, including depression, obesity, chronic pain, migraine, and gastrointestinal disorders (Coker, 2000; Healthy People 2010).

- **There are emerging insights into causal pathways.** Clinical and laboratory studies are now beginning to identify some of the psycho-physiological pathways by which both positive and negative marital interactions impact health, through their effects on the immune systems, blood pressure and heart rate, and levels of stress hormones. Epigenetics, the study of gene-environment interactions, is reshaping our understanding of how family and social processes may directly affect the expression or suppression of genes known to shape health-related behaviors.

  Selected Findings

  - Research on the causal pathway from social stress to the immune system and subsequent chronic inflammation indicates that chronic illnesses, known to be connected to the body's inflammatory response, may be triggered or exacerbated by marital conflict and distress (Robles & Keicolt-Glaser, 2003).
  - Research from the National Study of Adolescent Health has demonstrated that families that "eat meals together" appear to suppress the gene variant in their adolescent male children associated with delinquent and violent behavior (Guo et al., 2008).

- **Studies pinpoint several key transition points when the couple relationship is most vulnerable**, and where efforts to strengthen relationship quality and stability have the most potential to pay off in terms of health outcomes**.** These include when having a baby, when forming first romantic relationships during adolescence, when managing chronic illness, and when coping with the frailty and illnesses of aging. The promising demonstrations highlighted at the conference illustrate the research in this area and are discussed in Part II: *New Directions.*

Lesson 2: Several different factors help to explain the positive (or negative) health effects of marriage and relationship quality.

Participants agreed that at least four clusters of factors associated with marriage seem to explain the observed effects of marriage on health outcomes, both positive and negative (Staton, 2009; Wood et al., 2007). Some of these factors, particularly social support and intimacy, are now known to be amenable to intervention through information and relationship education.

- **The "selection" effect.** As noted earlier, people who are inherently healthier both mentally and physically may be more likely to be chosen as marriage partners, stay married, and have healthier children. While selection plays a role, the contemporary consensus of scholars is that it does not explain all of the strong associations between marriage and health. A wave of new studies highlighted several other potential explanatory factors (Carr & Springer, 2010).
- **The "economic" effect**. Married people on average create and/or have access to increased economic resources associated with better health. They and their children are more likely to have health insurance and access to healthcare services and other sources of social and economic support.
- **The "protection" effect.** When people marry they change behaviors that in turn influence long-term health outcomes, both for adults and for any children. Spouses also influence what their partners and children eat, drink and whether they smoke; they help create safe (or unsafe) environments and encourage or discourage responsible health behaviors. Spouses/partners play an important role in the extent to which their partners seek medical services, take medication, and follow exercise, diet and other medical regimens.

- **The "intimacy" effect.** The couple relationship is the most common source of intimate support and caregiving, especially as people age. In adults, a committed, intimate couple relationship is the major source of social support, companionship, sexual health, and caregiving, which numerous studies have found to be linked to better health and longevity. For older individuals who are not married, having other close supportive relationships from friends or adult children seems to provide similar kinds of health benefits.

> ***"The mechanisms by which good (couple) relationships affect health status are not well explored or understood. Sorting this out is important both for convincing healthcare providers about the importance of attending to relationships, and for guiding public policies, including health insurance benefits and reimbursements."***
>
> **- Ed Schor M.D.**

Lesson 3: We need to pay attention to the complex dimensions of marriage and couple relationships in our research, programs, and practice.

Conference participants pointed out that the complexity of marriage and couple relationships must be taken into account as a factor affecting health outcomes. Until recently, research on adult or children's health treated marriage as a dichotomous entity with two categories: married versus not married. More recently researchers have contrasted four distinct categories: married, never married, divorced/separated, and widowed. There is a growing body of research on cohabiting unions, with some attention paid to health indicators. (There is also some emerging research on health issues in same sex unions, but these were not reviewed at the conference).

However, these categories are still typically viewed in most research as monolithic and static entities. Couple relationships are in fact very fluid and even when stable can vary considerably in terms of quality over time. We know that many long-term marriages go through highs and lows: two-thirds of couples who rated themselves as 'unhappy' but avoided divorce or separation ended up happily married five years later (Waite et al., 2002). Some couples survive a serious crisis—such as infidelity or bad health—and may even grow stronger, while others do not.

Lesson 4: Many gaps remain in our understanding of these connections: A comprehensive, planned national agenda of rigorous basic and applied research is needed which should, whenever possible, be integrated into current research efforts and ongoing intervention programs.

Newly emerging fields of inquiry go through several stages in the process of translating research into action. The Wingspread conference first discussed lessons learned in the initial "discovery" phase, building the knowledge base about the marriage/health connection through basic research. The second part of the discussion focused on the "translational" stage, when interventions to change individual and/or couple behavior, informed by the basic research, are developed and then tested in a real-world setting as a basis for replication on a wider scale.

Recommendations for Research

Participants were unanimous in recommending that a more comprehensive, planned agenda of rigorously designed research should be launched at the national level. They proposed several substantive and practical suggestions, many of them involving making cost-effective use of existing research or survey programs:

- **Collect data over time.** More longitudinal studies are needed, especially studies that collect baseline data on health status prior to marriage, in order to disentangle the selection factors determining who marries from the protective factors resulting from marriage itself, especially healthy marriages that last a lifetime.

- **Make efficient use of existing surveys**. Nationally representative and carefully designed health surveys—for example, the new National Children's Study from NICHD/EPA/CDC, National Longitudinal Survey

of Adolescent Health (AddHealth), the MIDUS II Survey of Health at Midlife in the US, and the Health & Retirement Study—some of which already collect data on marital status, could add a few questions that measure parent or couple relationship quality**.**

- **Sharpen measures of "marital quality."** More work is needed on defining measures of marital/relationship quality and developing sophisticated, consistent, and practical measures to be used in general surveys for assessing both positive and negative quality. Currently, surveys that do examine relationship quality use different measures, and some measure only positive and others only negative indicators of quality. This makes it difficult to compare the results of similar studies.

- **Improve measures of health.** Most large scale surveys use general measures of health, such as self-rated health or depressive symptoms. Likewise, most studies of child well-being focus on problem behaviors, rather than health symptoms or healthcare. Future studies would document a range of illnesses, symptoms, health behaviors, and even access to care.

- **Collect family and dyadic level data.** The vast majority of studies that collect data on marital quality obtain such measures from one spouse only. These responses may be biased by one's current mental health or other factors. Future studies should collect information from both partners and explore similarities and differences in spousal assessments, and how these indicators affect the health of both spouses and their children.

- **Conduct analyses of adult and child health outcome data** in already-funded research projects, such as the data collected in the two multi-site federal experiments on relationship education, *Building Strong Families* and *Supporting Healthy Marriage*. These demonstration-evaluation projects have good baseline data, random assignment of couples to treatment and control groups, and follow couples for three years after initial participation in marriage and relationship education (MRE) programs. Any new evaluations of marriage & relationship education programs with funding from HHS should include health measures.

- **Examine relationship factors in health disparities.** Data is needed on the role of marital and couple relationships in health disparities in African American, Hispanic, and other minority populations. This is a topic not well understood or studied. An important first step toward understanding health disparities in the African American populations was taken when the Assistant Secretary for Planning and Evaluation, HHS, commissioned a set of research papers, published in two special issues of Journal of Family Issues (Koball, et al., 2010), that examined different aspects of the marriage/health connection for African American couples. The questions addressed in these papers create a model for new research on other minority populations and all couples.

- **Build theory.** To help this area of research mature, more work needs to be done on building theoretical models of the potential causal pathways from the marital/couple relationship to health outcomes over time, and then testing them with data. There are numerous research outcomes, often with only correlational findings, which need to be fit into an overall model identifying mediating factors, including cultural, social, economic and program design, in order to better understand how to design effective interventions. Such models are being developed for other areas of public health, such as domestic violence and child maltreatment, to provide a solid theoretical foundation, generate causal hypotheses, and connect basic research with efficacy and effectiveness studies.

"I have learned that I need to be much more thoughtful about the consequences of variables we use; people are going to base policy on the 'marital quality' factors in our research."

- Fred Lorenz, PhD.

What Are Marriage and Relationship Interventions and Do They Work?

Marriage and Relationship Education (MRE) interventions teach couples and individuals the information, skills, and attitudes that help them have positive, supportive, partner relationships at different stages of their lives. MRE is a preventive and educational approach, distinct from couple counseling or therapy which focus on dealing with crises or serious problems in the relationship that have already occurred. Originally primarily provided to middle class, white, engaged couples, increasingly MRE is being offered to racially and economically diverse populations and individuals and couples at many different stages of life.

Most commonly, MRE programs refer to structured classes and workshops provided to groups of couples, offered on a voluntary basis in a variety of community settings. However MRE is also provided to the general public through media campaigns, websites, DVDs, brochures, and self-guided Internet courses and social media outlets. The best MRE curricula are evidence-based, grounded in decades of research into risk and protective factors and laboratory studies identifying interactions that help marriages succeed or cause failure. Rigorously designed program evaluations have demonstrated that couples can learn new positive behaviors and skills, such as improving communication—a core, essential relationship skill—problem solving and conflict resolution as well as improving other measures of relationship quality (Hawkins & Ooms, 2010; Markman & Rhoades, 2012).

Since 2002, when the Administration for Children and Families, HHS launched the Healthy Marriage Initiative, MRE interventions have been funded with substantial federal and some state support. Most were designed for social service or education settings, and to date have not been funded to try to improve or track health outcomes. However, a handful of innovative demonstration programs that combined relationship education skills with a focus on general or specific health issues have been funded. Some of these were presented at the Wingspread conference (see Part II, New Directions) and helped fuel the discussion of how to translate basic research on the couple relationship-health connection into practical MRE strategies that could be integrated into the healthcare system.

II. New Directions: Examples of Promising Demonstrations That Adopt a Couple/Partner Relationship Perspective in Health Settings

In summary, two main themes emerged from the early sessions of the Wingspread conference which focused on lessons from research on the associations between the marriage relationship and health. First, the research demonstrates strong connections between health outcomes and couple relationship quality. Second, studies have shown that relationship quality is a dynamic variable, not a fixed category, and that it is amenable to low-cost educational interventions for prevention or reduction of potential health-damaging behaviors, and for the acquisition of health-enhancing ones. The participants then proceeded to discuss the initial step in the "translational" stage from basic research to action, when interventions to change individual or couple behavior informed by the basic research are developed and then evaluated in real-world settings as a basis for replication on a wider scale. Presentations of these promising demonstration programs were made by conference participants (Appendix B).

Four evidence-based demonstration programs were presented that provide relationship education to two groups of vulnerable populations—those with chronic illness (multiple sclerosis and diabetes), and disadvantaged, at-risk, unmarried parents caring for newborn babies. A fifth program employed a public health prevention approach to providing relationship and marriage education through a wide range of activities offered to the general population across the state. All of these programs taught knowledge and skills for healthier relationship choices, relationship development and maintenance in the face of health and other risks. Four of these were substantial field interventions and two were more tightly controlled clinical research projects. All had evaluation components, including one randomized controlled trial, and were funded by various federal agencies as individual multi-year grants. These five interventions were presented by conference participants as examples of promising practices that integrated both streams of research.

Promising Relationship Demonstrations for Patients and Partners Coping With Chronic Illness: Multiple Sclerosis and Diabetes

Relationship Matters is a psycho-educational program for couples living with multiple sclerosis (MS), to help them increase relationship satisfaction, protect their intimacy, and learn teamwork skills for managing a chronic, progressive, debilitating, and stressful illness. The program is managed by the National Multiple Sclerosis Society and was funded by a five-year Healthy Marriage Initiative grant in 2006. It served couples throughout a 50-state network of chapters.

The Society developed the proposal after realizing that although it provides a wide range of information, education and support activities to couples living with MS, none of these specifically address the complex ways in which this illness affects the couple relationship. The program's rationale is that the quality of the couple relationship itself is crucial to patient functioning, disease management and partner health, and that couples need more than information about the disease, and can benefit from learning good communication and teamwork skills. A second major rationale for relationship education for couples experiencing chronic illness like MS is that strengthening the couple relationship helps improve wellness and reduces health risks for the non-MS partner. To assure that the program was accessible to those who had transportation or mobility problems, couples could be involved in one of two ways: (1) in-person workshops ranging from a one-day class to a weekend retreat, drawing on local facilitators and resources; (2) A four to six week series of tele-classes offered once a week in the evenings. The program also offered three ancillary online classes to delve more deeply into subjects of intimacy, work/life balance and careers, and financial planning as a couple.

An overarching aim of the demonstration was to provide a model for couples' education which other national organizations serving patients with chronic illness—such as heart and respiratory disease, diabetes—could use, adapting the design and curriculum content to meet the specific needs of the disease.

Relationship Matters recruited 2000 couples between 2007 and 2011 who participated in either weekend workshops or 4- or 6-week teleconference classes. The evaluation compared a representative sample of participants at three months post-treatment to an untreated control group of MS couples. It found significant improvement for participants in their relationship satisfaction, quality of life rating, and ability to handle MS-specific relationship issues; both patients and spouses reported equal gains. In addition, the MS patients showed some improvement in cognitive functioning. (The project was not funded to collect longer-term health or relationship outcomes.) The final evaluation report will be published by the NMSS by the end of 2011.

Chinese Coping Skills Training for Type 2 Diabetes is a family-centered, culturally based training intervention for Chinese-American immigrant patients with Type 2 diabetes. The program was designed to adapt and test a behavioral diabetes intervention to address specific family and cultural issues in immigrant Chinese patients with diabetes. The program is a collaboration of the University of California at San Francisco School of Nursing and local community agencies, and was funded in 2008 by a grant from the NIH National Institute of Nursing Research. The project's rationale is that diabetes patients need more than just disease information, because relationship problems—with their spouses and other members of their family—can directly interfere with their capacity to effectively manage their disease.

The program recruited and enrolled 148 individual participants, and provided family-centered relationship skills in communication, problem-solving, conflict resolution and emotional management. The project proved highly successful in that 98% of those recruited agreed to participate, and more than 80 % of participants reported the project met their needs for new skills and learning about "caring for my diabetes" within a spousal/family context The principal investigator concluded that the study provides a basis for developing new field interventions for couples (patients and their spouses or other family members) to teach both general communication and relationship skills, and to provide diabetes-specific information and management skills for diabetic regimens, in the context of couple teamwork (Chesla, personal communication, April 2011).

Implications for Chronic Illnesses

These interventions illustrate the value of going beyond simply providing information about an illness to couples when one partner is chronically ill. Patients now get extensive information about their illness, but simply providing both partners with the same information has not resulted in desired changes in health outcomes (Trief, 2011). These demonstrations thus support the importance of acknowledging and directly addressing couple concerns about the effects of the illness on their relationship and on the non-ill partner's health. Both projects explicitly address skills for reducing health-damaging interactions and increasing positive support. Providing the knowledge and tools to maintain and enhance relationships despite an illness, and prevent negative interactions from damaging the health of either partner, can create a strong foundation for health management. The Chinese Coping Skills project also illustrates the potential for educational interventions on family interactional patterns and relationship skills, when only the individual patient participates.

As noted, an explicit goal of the NMSS *Relationship Matters* grant was to provide other chronic diseases a model of relationship education for couples. *Relationship Matters* demonstrates the acceptability, practicality, and effectiveness of a couple-based approach to managing chronic illness and improving relationship quality. To date, no national chronic disease association had shown interest in replicating the project. A promising development, however is the new partnership emerging between a large federally funded healthy marriage project in the Ozarks and a major healthcare system (Baker et al., 2011). Plans are underway to offer a program to provide relationship and coping skills, along with information specific to Type II diabetes, to couples in the rural Ozarks with possible funding from NIH/NICHD. It will adapt the NMSS *Relationship Matters* curriculum and draw on UCSF and other diabetes-specific psycho-educational materials.

Promising Relationship Education Demonstrations for New Parents

Family Expectations/Becoming Parents Program. The *Family Expectations* program in Oklahoma City is part of a large-scale national experimental intervention with low-income unmarried parents *(Building Strong Families)* designed to strengthen and stabilize the relationships of low-income unmarried couples around the time of the birth of their baby, and ultimately improve the health and wellbeing of their child. The program was funded in 2006 by HHS Administration for Children and Families (OFA & OPRE) and is operated by Public Strategies Inc.

Family Expectations adapted the Becoming Parents Program (BPP) as the basic curriculum for the 30 hours of weekly group educational workshops offered to the pregnant and new parents. The *Becoming Parents* curriculum is a preventive educational program developed by Dr. Pam Jordan at the University of Washington School of Nursing, for couples expecting the birth of a child, with a strong focus on involving fathers, emphasizing couples learning relationship skills and parenting skills, and on working with the couple before and after the birth.

The rationale for Family Expectations/BPP is that research has clearly identified the birth of the first child as a very stressful and challenging life stage, at which time many couple relationships begin to unravel and start on a path toward breakup or divorce. For low-income couples uncertain about the value of marriage and struggling with fewer financial resources, childbirth brings additional challenges to an already fragile relationship. Without the knowledge and skills to form a strong couple bond, research shows that the relationship is unlikely to last.

The BPP curriculum draws on the Prevention and Relationship Enhancement Program (PREP®), and focuses on teaching communication and problem solving, skills, and protecting the couple's fun, friendship and intimate relationship at the time of transition to parenting. PREP® has been rigorously evaluated and found to improve couple communication and relationship satisfaction, as well as reduce divorce rates and, in one study, episodes of intimate partner violence (Markman & Rhoades, 2012; Stanley et al., 2010).

Family Expectations enrolled 1,010 volunteer couples expecting a child; these low-income couples came from Caucasian, African American, and Hispanic populations. Half were randomly assigned to comprehensive couple relationship education using the Becoming Parents Program, and half to a control group. The curriculum covered communication, conflict management, self-care for parents, trust, and considering marriage as permanent commitment. FE/BPP also provided an array of additional support services and an emphasis on father involvement. *Family Expectations* was one of eight program sites participating in a federal evaluation and the only one to show a consistent pattern of positive effects (Wood et al., 2010).

The project had very high participation and research retention rates, indicating strong acceptance of relationship education by low-income, unmarried couples. The *15-month* impact evaluation, using a rigorous "intent to treat" design, found a consistent pattern of significant positive effects for relationship quality of participating couples, including improved happiness, increased support and affection, increased use of constructive conflict behaviors, and avoidance of destructive conflict behaviors, compared to nonparticipating couples (Devaney and Dion, 2010). Health-related outcomes that were measured included significant reduction in maternal post-partum depression, higher co-parenting scores, and greater father involvement (co-residence and cost contributions), compared to controls. (Infant birth outcome data was not collected). Positive relationship improvement outcomes were especially strong for the African American couples compared to controls. Child outcomes are being assessed at three years and have not yet been published.

"The challenge is that relationship quality earlier in the couple's life is what leads to long-term added value, by preserving the relationship, avoiding the disruptions of separation and divorce, resulting in better health outcomes later in life. Relationship effects on health, positive and negative, are long-lasting and cumulative, not immediate fixes."

- James Coyne, PhD

Enhanced Nurse/Family Partnership Study (ENFPS) provides a preventive intervention component to reduce unsafe relationships among high-risk teenage mothers who were already enrolled in a Nurse Family Partnership (NFP), home-based child abuse prevention program in Portland, OR, with funding from the Centers for Disease Control and Prevention (CDC) to Portland State University, beginning in 2007.

The rationale for relationship education for these young mothers is that without knowledge and skills, they will repeatedly choose or "slide" into physically or emotionally unsafe romantic relationships which carry known health risks for both mother and child as a result of experiencing intimate partner violence (IPV). The specific goals of ENFPS were to reduce the risk of present or future IPV and to teach the skills to form a safe, high-quality intimate adult relationship with a life partner.

The study involved a randomized controlled trial enrolling 238 mothers, half assigned to the Enhanced NFP which included intimate partner violence and relationship education, and half to the regular NFP protocol (NFP does not include an IPV focus or provide relationship education). Participants were enrolled in their second trimester and visited for two years post-birth. Intervention participants received: 1) regular and ongoing discussion and assessment of IPV; 2) IPV information including safety planning, referrals and advocacy; and 3) an individually delivered version of *Within My Reach (*WMR), an evidence-based skills curriculum developed by the PREP® program at University of Denver. WMR teaches low-income mothers to understand the importance of healthy partner relationships for their children and them, and the skills for finding and then maintaining safe, healthy intimate relationships (Sparks, 2008).

The notable outcome at two-years post-partum was a significant reduction in psychological aggression for women who entered the program already experiencing high levels of psychological abuse in partner relationships, by comparison to their control counterparts enrolled in the standard NFP program. Women who entered free from physical abuse at intake continued to stay free of abuse at the one year mark, and even two years later, although not as significantly, in comparison to controls. No significant differences from controls were found in reduction in physical abuse incidences that were present initially. Additional analyses of the data will be conducted (Feder, personal communication, June 2011).

Implications for Reaching and Educating New Parents

These two projects demonstrate the potential for teaching single parents the knowledge and skills to form safer, healthy two-parent families for themselves and their children, and for teaching low-income couples who may not be married how to strengthen and maintain their existing relationships around the time of their baby's birth. The *Building Strong Families* experiment was funded through Federal welfare and social services and only collected a limited range of health outcomes. These types of interventions need to be replicated and tested in partnership with health institutions and services with support for collecting useful health outcome data on parents and children. They have the potential to contribute to major public health goals of reducing rates of prematurity, infant mortality, and child abuse as well as improving children's health, especially among disadvantaged, high-risk families across a lifetime.

EFNPS also is an example of the growing effort by the marriage and relationship education field to develop effective curricula for single adults, including single mothers, as well as to incorporate new educational content related to the prevention and reduction of "unhealthy" relationships, i.e. intimate partner violence and child abuse.

Informing the Public: Statewide Healthy Relationship Education

The California Healthy Marriage Coalition (CHMC), now a division of a new nonprofit organization, Healthy Relationships California**,** works with a network of community partners and coalitions around the state to provide the public with basic information about healthy marriage and relationships; increase the awareness of MRE services; and increase the supply of accessible, research-based relationship education programs throughout the state for couples, singles and youth. The coalition's rationale is that increasing the number of stable, committed two-parent families is a public health goal, which needs to be approached using a cost-effective public health "saturation" model of widespread, accessible information and education for the general population. The coalition uses a variety of strategies and is built around Internet resources for dissemination and management.

Funded in 2006 by a five-year Healthy Marriage Demonstration Grant from HHS, ACF/Office of Family Assistance, the coalition has:

- trained several hundred local agency staff from 850 local coalition partnering agencies, including faith-based organizations, schools, hospitals, social services, and other community based agencies.
- provided research-based relationship education programs to more than 100,000 participants (singles and couples), tailored to the various ages and stages of relationships—dating, pre-marital, marriage enrichment, and help for troubled marriages.
- offered 22 different research-based skills curricula in many languages including English, Spanish, Korean, Chinese, Hmong, Armenian, and Farsi.
- established an online clearinghouse listing relationship education classes and related resources by location (http://www.camarriages.com).
- raised public awareness statewide through comprehensive multi-media campaigns, utilizing electronic and social media, including brochures about positive health outcomes for adults and children of healthy relationships.
- made available 100 relationship education classes at any time statewide.

CHMC completed a multi-year, multi-site, multi-program evaluation of relationship education in 2011 with one-month and six-month follow-up outcomes. Results show program effects at the one-month period, with increasing improvement at six months and significant improvement among highly distressed couples. CHMC is also developing data on the cost benefits of relationship education.

Implications for Educating the Public

The California Coalition has demonstrated that there is widespread public interest by couples and local agencies and organizations in accessible, affordable, Internet-managed relationship education. A wide spectrum of couples, across different ethnic groups and socioeconomic statuses, apparently find this information acceptable and desirable. It also demonstrates that existing resources—local agencies, religious institutions, and the Internet—can be harnessed to provide in-person relationship education and computer-based learning at a relatively modest cost. Finally, it is one of several healthy marriage and relationship organizations that has pioneered the development and marketing of public health information and education materials to be widely distributed on the Internet, through social media outlets, through poster campaigns, and so forth.

Summary

Together, these five demonstration projects provide a glimpse of some of the promising interventions and tools that could become a part of the healthcare system and result in integrated patient, couple and family-centered care. For example, information about the connection between couple relationship quality and health could be added as a component of "medical homes." The following section (III: *Windows of Opportunity*) describes these and other emerging healthcare innovations which conference participants viewed as "windows of opportunity" for introducing couple-centered relationship approaches into the healthcare system.

III. Windows of Opportunity to Improve Healthcare: The Potential of a Couple/Partner Relationship Focus

Conference participants were intrigued by the promise of the demonstration programs presented, but agreed that not enough is known yet about these and similar programs to recommend any major nationwide replications. However, there was a consensus that we know enough to move forward with the next steps toward transferring current knowledge into action. The discussions identified a growing number of "windows of opportunity" for integrating and then testing a focus on couple relationships and health. These windows are emerging primarily as a result of current efforts to pursue the goals of healthcare reform—providing better patient care, reducing costs and improving the health of the population. In this report we group these "windows" under three broad headings: innovations in primary care, management of chronic illness and disability and aging/end-of-life care. Conference participants identified these broad areas as providing immediate openings for testing a range of innovative educational and informational practices or strategies that would lead to a more couple-/partner-focused healthcare system.

Participants made clear that their ultimate goal was not that the healthcare system would expect to be able to help make MRE programs widely available. Even if desirable, this would not be realistic. In addition to the recommendations for more research, the conference participants proposed a two-fold vision:

1. Introduce a new way of thinking, and some tools and practices about patient care, into the healthcare system, that acknowledge the powerful influence of couple relationships, which should lead to more effective care.

2. Identify especially vulnerable populations and key transition points where brief relationship education interventions could be most usefully provided directly or by referral.

A New Way of Thinking About Healthcare

Research clearly demonstrates that individuals' abilities to protect and promote their own health and wellness, recover from sickness, and manage chronic illness and the process of dying, depend in part on the nature of the relationship they have with their spouses, intimate partners or other close caregivers. When the couple's relationship is strong and supportive, the individual's partner can be a critical ally; when the relationship is weak, negative or abusive, the relationship can be a major barrier to positive health outcomes. We now better understand some of the ways that the healthcare system can support, reinforce, and even strengthen the ability of a spouse or partner to play a constructive role in achieving good health outcomes, and thereby in some cases reduce costs.

This insight implies an important shift in how we think about the ways we deliver healthcare. Currently, healthcare services are essentially focused on the individual—the individual child, woman or man is the unit of diagnosis and the focus of treatment. Some persons indeed are truly solitary for some or all of their lives, and for them this current healthcare approach may work reasonably well. But most people's lives are linked closely to spouses or cohabiting partners.[1] We are also often closely connected to parents, children or other family members, and close friends— and they may substitute for, counteract or complement the role of spouses/partners. The current movement to reform the healthcare system needs to understand and incorporate the importance of paying attention to these close relationships.

Adopting a new paradigm that takes into account the couple/partner relationship implies making both small and major changes in the behavior of healthcare providers, as well as in the design of healthcare systems. The evidence to-date suggests that such changes *have the potential* to improve health outcomes and reduce costs. We now have

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1 The lifetime chance of marrying in the U.S. remains high: Currently 60% of all men and 85% of all women age 60 are or have been married. A majority of adults (54%) are currently married or in cohabiting unions. A majority of adults in America currently will spend at least some period of time cohabiting with a intimate partner. Goodwin, P. Y., Mosher, W. D., & Chandra, A. (2010). *Marriage and cohabitation in the United States: A statistical portrait*. National Center for Health Statistics, Vital Health Stat 23 (28); Kreider, R. M., & Ellis, R. (2011). U.S. Census Bureau. (2011). *Number, timing and duration of marriages and divorces: 2009* (Current Population Reports P70-125).

some promising educational tools and service strategies developed by marriage and relationship educators that could readily be adapted and integrated into some of the ongoing healthcare innovations being sponsored and encouraged by the Institute for Healthcare Improvement, the Center for Medicaid and Medicare Innovation, the CDC, and private foundations. These innovations include efforts to coordinate primary care, create a "medical home," lessen the rates of re-hospitalization, and increase adherence to medical regimens (Health Affairs March 2011). Four examples of limited interventions using new tools/practices that could be integrated widely into the delivery of healthcare are:

- Across all types of healthcare, providers should routinely collect basic information on the patient's spouse/partner (if there is one), as well as on the baby/child's other parent, whether married or not. On medical information forms, when the "next of kin" question is posed, it should also ask whether the person lives with the patient, or is close by. The family medical history section typically asks about the health history of blood relatives, but it should also request the health status of the spouse, current partner, and an absent parent, asking whether these individuals have any major health conditions or disabilities.

- In acute care situations, hospitalizations, discharge, and rehabilitation planning— especially for post-cardiac care and major surgery—information should be provided directly to the patient and any spouse/partner about ways the partner can be most helpful in the process of diagnosis, treatment, and rehabilitation management. The patient, however, needs to give permission to involve the spouse/partner in specific ways.

- In perinatal, well-baby, and pediatric care, providers can identify "teachable moments" to educate both parents about the importance of the father's involvement and the couples' relationship to the health and development of their infant/child(ren). For example, in the One Plus One project, posters are placed on the wall in well-baby clinics and general practitioners offices with the arresting heading "*How are you (two) getting along?",* a graphic of a couple with a child between them, and the tag line "*Because your relationship matters to your child."*[2] Parents can then be referred to programs or other sources of parent and couple relationship information and education (available in printed form, on the Internet, or in community classes and workshops).

- In routine contacts with partnered patients (or with a child's parents), healthcare providers should informally assess the quality of the couple's relationship, and especially be alert for any red flags that might indicate there was an abusive, or very controlling relationship. Healthcare providers need to learn how to make appropriate referrals to domestic violence services. Medicare now requires an annual wellness screening program for all patients which includes the question, "Do you feel safe at home?" (The American Academy of Pediatrics has developed a booklet and practice guidelines for healthcare professionals that address being alert to and assessing the parent-child relationship for abuse (AAP, 20007).

Window 1: Innovations in the Delivery of Primary Healthcare

Primary healthcare provides several "windows of opportunity" to integrate/incorporate simple information about relationships or more participatory educational opportunities into healthcare. Pregnant and new parents and other adults encompass large populations concerned with their own health and the health of their children.

Two of the windows discussed were the growing interest in responsible, engaged fatherhood, and the movement to reorganize patient care into more coordinated, multi-disciplinary "medical homes." A couple focus at these key points offers the potential to reduce future healthcare costs by increasing the number and quality of safe, stable two-parent families, by lowering stress levels and increasing support for couples throughout the lifespan. Participants stressed that new innovative strategies need to be evaluated specifically for cost-effectiveness in relation to improving health outcomes or behaviors which are known to bear substantial healthcare costs, i.e., child maltreatment in the case of strategies for new parents and father involvement, and adherence to medical regimens in the case of primary care.

2 http://www.oneplusone.org.uk

Promoting Responsible, Engaged Fatherhood

The growing interest in promoting engaged, responsible fathers is a window of opportunity for introducing couple-focused interventions and approaches, and was discussed at some length at the conference. The interest is fueled by studies emphasizing the importance of father involvement in their children's health and development. There is persuasive research evidence that engaging the couple together, and especially focusing on their relationship before and around the time of birth, is the most successful strategy for helping fathers become more involved with their children, and is associated with better maternal and child health (Cabrera et al., 2008; Cowan et al., 2009; Texas Attorney General Child Support Division, 2009; Bronte-Tinkew et al., 2009; Teitler, 2001). The *Building Strong Families* multi-site experiment, exemplified by the Family Expectations program site discussed in Part II, was designed to address the "magic moment" of birth. Efforts to engage fathers actively in their child's health, however, can face entrenched barriers and resistance by healthcare providers.

The current Administration's interest in promoting engaged, responsible fatherhood provides a very timely opportunity for challenging and incentivizing healthcare providers to involve fathers more actively in routine healthcare visits for their children at every stage in the prevention, diagnosis and treatment of illnesses, and to be alert to opportunities to promote cooperative parenting.

To address this issue, Wingspread conference participants strongly recommended that the federal *Maternal and Child Health Bureau* be renamed the Parental and Child Health Bureau. This new designation would have more than symbolic importance. It should be followed by an internal audit designed to identify ways that primary healthcare providers could effectively reach out to involve men and fathers in perinatal, and child health and reproductive related services. The planned expansion of Medicaid in 2014 to cover low-income, "childless" individuals (i.e. those not living with a child) will provide numerous opportunities to bring young adults, including men and non-custodial fathers, into the publicly funded healthcare system.

Additional practical strategies suggested by participants to help involve fathers more actively in their children's health were:

- Experiment with providing incentives to mothers and/or fathers for consistent father involvement, along the lines of incentivized approaches to encouraging positive health behaviors used in Central American countries (Glassman, et al., 2009).
- Learn from the example of fatherhood programs how to make the office/clinic environment more male and father-friendly to overcome the common reluctance of men in general, and low-income men in particular, to participate in healthcare services.
- Provide practitioners with guidelines about how to comfortably talk about how the parents "get along," as a key factor in child health, and provide information and/or referral resources to give them if the relationship is in difficulty.
- When parents live separately and/or are divorced, establish models for providing information about the child's developmental progress and any medical problems to both the mother and the father (as many schools now do).
- When the parents' relationship appears to be "unhealthy," healthcare providers need to address the parents' roles separately, rather than in conjoint visits, and information should be provided that addresses safety issues for parents and the child.

Integrating a couples' focus into the "medical home" and other practice innovations

There is a growing interest nationally in the concept of creating a "medical home" – which is a broad term used to describe a group primary care practice setting that provides comprehensive, coordinated, patient-centered care, using updated information technology. Several demonstration programs are in development or are already funded. The models differ in emphasis, but advocates of the medical home model are united in agreeing that some type of payment system reform will be required to make primary care function more effectively.

Conference participants mentioned that encouraging a focus on couple relationships in the medical home model demonstrations now being tried would be a natural fit, and a great opportunity to test out integrating a couple relationship approach. Some participants pointed out that many of the current medical home models are very provider-centered, focusing on centralizing and coordinating treatment and computerizing medical record keeping, but not including a focus on the relationships—spouse, partner, family—which may be central to the patient's life and effective care.

> ***"The Medical Home being talked about now is the clinic, the provider's office as a medical home, NOT the patient's home and family. We should ensure that services provided embrace the individual's whole healthy life, i.e. mind, body and spirit, including healthy interactions with the family and community. When necessary, a patient's home can be a place of service."***
>
> **- Martha Okafor, PhD**

A recent profile of innovative healthcare reforms around the country being implemented since 2008, highlights a number of medical home models that have primary care teams working with patients and their families on chronic illness management (*Health Affairs*, March 2011). The Vermont medical home model has found that one immediate benefit of their approach has been the integration of behavioral health specialists and social services able to provide immediate assistance if a patient says, "Things are chaotic at home" (Bielasker-Vernay, 2011). It appears that any direct couple focus is still subsumed under the heading of "family" in the available descriptions, and it is difficult to ascertain if any models are working directly with couples or understand the potential of the couple relationship to affect health.

Window 2: Improving Patient Care and Reducing Costs in Chronic Illness and Disability

Chronic illness management and treatment has become the current biggest concern in healthcare as our population ages. Among the major problems are non-adherence to treatment regimens which contributes to frequent, unnecessary rehospitalizations. Chronic diseases are the biggest cost drivers in the healthcare system. A growing body of research finds that couple and family interventions show promise of improving the management of chronic illness (Baucom et al., 2012; Shields et al., 2011).The research reviewed at the conference offers tantalizing indications of how strengthening couple/partner relationships has the potential to improve adherence to prescribed treatment regimens, reduce rehospitalizations and reduce patient and caregiver stress. For example, involving the spouse in a heart disease rehabilitation program reduced the risk of repeat attacks and hospital readmissions (Sotile, 2003). Reducing parental conflict when children have disabilities or problematic behaviors, diabetes or anorexia can lead to fewer pediatric visits and fewer hospitalizations (Eisler, 1997; Minuchin et al., 1975). Improving adherence for type II diabetes, especially in early stages when the regimen is more behavioral than medication–oriented, has the potential to help reduce or control the per capita cost of care (DiMatteo, 2004b).

Focus on Caregiving: Supporting the Intimate Partner's Role in Management and Care of Chronic Illness and Disability

Chronic illness requires patient's self-care, and the key phrase used at Wingspread was, "self-care is *social*." There is no biomedical, pharmacological or institutional "fix" for the biggest (and most costly) health problems we face: diabetes, depression, cardiovascular disease and the diseases of aging—dementia and frailty. These are socially grounded illnesses, and consequently, cost-effective interventions require continued behavioral change, involvement, and support from spouses, partners, family and friends, and community. The primary caregiver for adults with chronic medical conditions most typically is the spouse/partner or an adult child.

New research identifies the specific kinds of social support skills that increase adherence to regimens and potentially improve treatment outcomes (DiMatteo, 2004b) and also the negative controlling behaviors sometimes employed by the partner that actually decrease compliance (Fekete et al., 2006). Targeted couple interventions, that teach communication and conflict management skills focusing on effective social support, could improve and protect the couple's relationship, reduce caregiver stress, and contribute directly to improved health outcomes for both.

It is also important to note that the experience of providing care and support can place tremendous stress on the caregiver's health and on the couple/parents relationship; it can lead to breakup and divorce which leads to more stress and poorer health (Martire et al., 2004; Martire et al., 2005).

> ***"I am pretty sure that the active ingredients of 'self management' are creating support and reinforcement for changed behaviors that are necessary. The couple, family, the intimate social group has got to be the place where that happens…in terms of diseases that cost the system the most in misery, disability and dysfunction: diabetes, depression, cardiovascular disease."***
>
> **- Frank deGruy, M.D.**

Current Examples

Participants brought up several encouraging examples of a growing awareness of the importance of including spouses and family in both prevention and treatment of chronic disease for adults as well as children.

- Psychosocial interventions for couples coping with a partner's medical condition are beginning to integrate knowledge for understanding the condition with specific attention to skills for maintaining healthy relationship functioning (Baucom et al, 2012). The National Cancer Institute (NCI) has funded interventions to teach coping, communication and relationship skills to cancer patients employing randomized controlled trials for efficacy (Porter, et al., 2009, 2011). NCI is also funding studies of couple-based interventions for smoking cessation and weight loss.
- The Substance Abuse and Mental Health Agency National Registry of Evidence-based Programs and Practices (NREPP) now recognizes couple-focused treatment for alcoholism and drug abuse as an effective, evidence-based practice.
- The Institute for Family-Centered Care has been a pioneer in developing detailed recommendations and tools for helping healthcare professionals in hospitals and primary care settings, work in partnership with parents and family members, on the care of seriously and chronically ill children.
- The Oklahoma Marriage Initiative, funded by the Oklahoma State Department of Human Services, conducts bimonthly, weekend-long couple retreats for married couples throughout the state who are caring for, fostering or adopting children with special healthcare needs (developmentally disabled, autistic and others). The retreats are an opportunity to learn how to protect and strengthen the caregiver couple's relationship, exchange information and support with other couples, and have some much needed respite and fun together.
- The National Multiple Sclerosis Society program *Relationship Matters* (described in Part II) was funded with the goal of encouraging other chronic disease associations to adapt this model of couple relationship education for their members.

Medical Care at the End of Life: Hospice and Palliative Care

The care provided by a home- or institution-based hospice team, or hospital-based palliative care team, is an excellent example of the benefits from including caregiving partners in patient care. The goal of palliative care is to relieve pain, symptoms and stress and provide the best possible quality of life for people suffering from serious or terminal illness. It is appropriate for patients in all disease stages, including those undergoing treatment for curable illnesses, and can be complementary to curative or life-prolonging approaches. A partner or family-centered

approach is an essential component of end-of-life care, providing a model that can be consciously integrated into primary and acute care for community- or home-based care of chronic illness. End-of-life or palliative care provides quality, compassionate care for patients facing life-limiting illness and their families. The multi-disciplinary team-oriented approach to medical care, pain management, and psychosocial and spiritual support, is tailored to the patients' needs, and includes those caring for the person as well. Hospice care involves the family in all aspects of care, and it offers assistance for family caregivers as persons of equal worth to the patient.

The improvements in patient and family satisfaction and quality of life from palliative care at the end of life are well known and recognized. Palliative care points to the potential for improved patient and family satisfaction, reduced healthcare costs (such as reducing hospital readmissions after discharge), and improved health outcomes for both the patient and the caregiving spouse/partner.

- A 2008 study of eight large hospital-based palliative care programs, using cost data from hospital-based "usual" care matched to comparable palliative team care (not comparing hospital costs to home-care programs), found substantial cost savings, worth thousands of dollars per patient in end-of-life care (Morrison et al., 2008).
- A large study of 30,000 couples receiving end-of-life palliative care from hospice, compared to a matched cohort receiving usual medical attention, found a small but significant effect on spousal survival for the hospice group. Survival benefits were even greater for wives than for husbands. Palliative healthcare can have positive, group-level health "externalities," that is, it can improve the health not only of patients but also of patients' family members (Christakis & Iwashyna, 2003).
- A review of the literature on palliative/hospice care concludes that while hospice is a model for family-centered care in principle, in practice providers find they need more specific training in family dynamics, couple communication, problem-solving, and specific tools for assessing the patient's relationships with spouse and other family members (King & Quill, 2006).

Window 3: Health Promotion and Disease Prevention

There is growing interest in the corporate, non-profit, and public sectors in finding effective ways of helping individuals live healthier lifestyles, including practicing good nutrition, exercise and avoiding behaviors that pose serious risks to their health, longevity and well-being. The research reviewed and discussed at the Wingspread conference suggests that learning how to make good relationship choices and create and maintain strong healthy relationships with intimate partners, should be an essential component of health promotion and disease prevention activities. If these efforts were successful, the results would be more people having stable, satisfying, long-lasting relationships and raising their children together, which could prove to be an enormously profitable investment of public health dollars.

Conference participants referred to the availability of numerous resources, tools, strategies and field-tested, evidence-based programs for youth and young adults, as well as for the general population, designed to promote and strengthen healthy marriage and relationships. Some have been adapted for low-income, ethnically diverse groups. These need to be thoughtfully expanded and critically evaluated for scalability and effectiveness in terms of specific public health outcomes for diverse populations.

Educating the Public

Public health campaigns have had considerable success in recent decades in changing health-related attitudes and behaviors with regard to smoking, seat belt use, HIV prevention and cancer prevention. (The Advertising Council, for example, has an ongoing contract with HHS to plan and implement many of these health-related media campaigns). These campaigns use the full range of social marketing strategies, including public service announcements on television, radio and the Internet, public transit ads, and written information and posters at healthcare institutions. These efforts not only give the public information they need to understand what to do to safeguard and promote their own and their children's health, but such sustained efforts also can change the cultural norms which have supported unhealthy behaviors. Healthcare newsletters and journals and the media

are becoming increasingly interested in this topic, and articles in newspapers and programs on television now frequently cover the topic.

Conference participants recommended experimenting with similar broad public health strategies to inform the public about the connections between their couple relationships and their children's health and the importance of high-quality, committed marital or partner relationships, and to suggest resources for further information and help. They stressed that there are now many opportunities for inserting a focus on strengthening intimate relationships into current national health promotion activities conducted by HHS and CDC, which include the new CDC public health initiatives focusing on child maltreatment (such as the Triple P Partnership program), dating violence and the prevention of unintended pregnancy. In addition, the Surgeon General's Office and the HHS Office of Disease Prevention and Health Promotion, which manages *Healthy People 2020*, have included reducing the incidences of *unhealthy* relationships leading to intimate partner violence as an important public health goal. The HHS offices could also play a leadership role in promoting healthy relationships and marriages.

Currently, a number of healthy marriage initiatives have already begun to use some of these social marketing strategies, using interactive, online technology to deliver the information and messaging. However, these efforts to provide information to the general public about healthy marriages and relationships are generally being conducted independently of healthcare agencies and the public health system. Likewise healthy marriage initiatives typically do not focus on the health benefits of strengthening marriage and couple relationships.

Current Examples

- In 2009, the NHMRC, funded with federal dollars, launched a national media campaign using social marketing research. Radio and TV ads, posters, etc., aimed at launching a national conversation about marriage among 18-30 year olds, were created. The campaign was designed to provide positive healthy relationship and marriage messaging and information to young people and to direct them to NHMRC's http://www.twoofus.org for further information. In addition, as part of its technical assistance to healthy marriage grantees, the NHMRC established a central clearinghouse of public service announcements including posters, videos, and printed materials produced by community-based programs.

- As noted in Part II, the California Healthy Marriage Coalition activities provide information about the marriage/health connection to the general population. There are similar activities conducted by other healthy marriage programs and faith-based and community coalitions around the country.

- The National Campaign to Prevent Teen and Unplanned Pregnancy, funded by private foundations, takes the position that "your sex life is not neutral" (Whitehead & Pearson, 2006). The campaign is now using the Internet, social networking sites, and media to encourage young adults to form responsible, healthy relationships and avoid unplanned pregnancies, and thus achieve their future family and career goals.

- One sign of the growing understanding of the importance of a good, healthy marriage is the new Huffington Post's Divorce Blog, which overall contains an honest look at what makes marriages work, and what does not. Such Internet sites may be doing more to educate the public about healthy relationships, and do so more quickly than funded programs.[3]

Promoting Couple Wellness in the Workplace. An increasing number of public agencies and mid-to-large size corporations have decided to invest in wellness programs, offered as an employee benefit. Originally, a recruitment and retention tool, employers increasingly see that wellness and health promotion programs reduce healthcare costs, reduce absenteeism and increase productivity. Each employer typically decides on the content of its own program, which can range from offering free flu shots and nutrition advice, to smoking cessation seminars, to providing breast feeding centers and memberships in fitness centers. To further promote this concept, the Centers for Disease Control has launched a Healthier Worksite Initiative.[4]

Workplace health promotion and wellness programs offer a potentially welcoming venue for promoting relationship

3 http://www.huffingtonpost.com/divorce/the-blog

4 http://www.cdc.gov/nccdphp/dnpao/hwi/index.htm

education. When offered to healthcare and social service professionals, programs can have the additional benefit of helping them understand the relationship issues that may be affecting the health and well-being of their patients and clients. The following are three examples of what could become a growing trend.

- The Kaiser Permanente healthcare organization introduced relationship education through its Physician and Employee Wellness programs, which focus on all aspects of employee health. The initial effort at Kaiser Permanente Northern California is a yearly relationship event, in collaboration with Sacramento-area marriage and relationship educators, for their practicing physicians and staff. Nationally known marriage educators and researchers have been invited to present marriage and relationship concepts for hundreds of physicians, employees and their partners.

- Kaiser Permanente-Northern California's Behavioral Wellness Program now includes couple communication classes and offers relationship skills classes for new parents, drawing on evidence-based relationship research and nationally recognized educational interventions.

- The Change Companies® is a national publishing, consulting and training company focused on promoting change in many areas of life. One of its programs, *Healthy Quarters*, is an employee health improvement system that applies the best current research on motivation and behavior change to engage employees and their family members in making small daily changes that will improve their overall mental and physical health. Within the program, employers can choose to focus for three months (i.e., "Quarter") on one of four following topics – "Move More," "Eat Smart," "Managing Stress," and "Good Relationships." Staff coordinators, typically human resource personnel, work from modules to guide discussions with employees on the various topics. The relationship modules cover core issues and skills that apply to work, family and other relationships.

Relationship Education for Youth and Young Adults

Conference participants agreed on the value of providing relationship education starting in early adolescence, which is a critical developmental stage where decisions are made with long-term health consequences for avoiding unplanned pregnancy and sexually transmitted infections. Relationship education for youth and young adults, whether dating or not, may be the most "open" window of opportunity for marriage and relationship education in the current climate. Adolescence and young adulthood is the key period for learning basic relationship skills and preventing unwanted pregnancies and unhealthy, dangerous relationships. Preventing unwanted pregnancies and intimate partner violence are both major public health goals, and both are associated with billions of dollars in health costs. The important contribution of relationship education is to provide positives. This has been recognized by the Affordable Care and Patient Protection Act, or Healthcare Reform, with new funding for "Personal Responsibility Education" for youth, which includes healthy relationship skills.

Preventing teen pregnancies through healthy relationship education for youth, including a focus on delaying sexual activity and pregnancy by both males and females, could decrease the number of the low birth weight babies and the number of infants and children with high risk of poor health outcomes often associated with teen parents, as well as save billions of dollars in public and private healthcare expenditures. There is already a significant national effort to reduce dating and intimate partner violence by teaching youth that it is "never OK" to use physical coercion or violence; what is missing in current efforts is teaching knowledge of safe, healthy relationship characteristics and skills to develop and maintain them.

> ***" Healthy marriage education could become a movement to have interventions occur at younger ages; these interventions can be conceptualized as a series of 'immunizations' over the life course, anticipating predictable stresses and possible risks to the relationship, and to everyone's health, as opposed to curing a problem that is already started."***
>
> **– Pam Jordan, PhD, RN**

Current Examples

Marriage and relationship educators can be on the front lines to provide assistance and train those working with high school students, at-risk youth, and young adults. A number of innovative research-based relationship education curricula have recently been developed, promoted and published by The Dibble Institute in Berkeley, California. Until recently, most school-based relationship education programs were typically taught by family science educators as part of an elective family science/home economics course. However, in several states—for example, Maine, Alabama and Oklahoma—relationship education curricula have been modified to become part of state-mandated health education programs. Wingspread discussions supported the need for a broad public health effort in youth relationship education, beginning in early adolescence. We highlight several of these emerging efforts, including new curricula now available nationwide.

- ***The Maine "Teen Talk" program***, funded by a five-year grant from the Office of Family Assistance, HHS, is training high school health educators statewide in a curriculum designed to teach healthy relationship communication skills and concepts in health classes, and has launched an innovative website and social media networks for teens and parents in support of the program goals.

- ***Relationship Smarts PLUS*** is an evidence-based, field-tested curriculum evaluated through a federally funded research grant in a statewide Alabama program with 1,054 participants from diverse ethnic groups and income levels, matched to a comparison group. Outcome results showed significant differences in relationship beliefs and expectations, significant increases in relationship knowledge, and decreases in destructive verbal and physical conflict strategies through the one-year follow up period (Kerpelman et al, et al., 2009).

- ***Healthy Choices, Healthy Relationships*** is a new health education curriculum for younger teens, launched in Oklahoma in 2009. It is aligned with the national health education curriculum standards, and was commissioned by the Oklahoma Marriage Initiative using state Temporary Assistance for Needy Families (TANF) funding.

- ***Love Notes*** addresses older, at-risk youth up to age 22, who may be sexually active or already parenting. Also a curriculum developed by The Dibble Institute, it builds on the success of Relationship Smarts PLUS and focuses more directly on preventing risky behaviors that affect adult and child health: relationship pacing, sexual meaning, dating violence, unplanned pregnancy, family formation, child health outcomes, and unhealthy relationship choices. It is being assessed as an innovative pregnancy prevention approach for at-risk youth through a five-year pregnancy prevention grant (HHS Office of Adolescent Health) awarded to the University of Kentucky-Louisville.

- ***Los Angeles School District.*** A demonstration project funded in 2011 targets youth in Los Angeles, California. The Los Angeles Unified School District (LAUSD), the Dibble Institute, the Century Center for Economic Opportunity-Youth Build (CCEO-YB) and Public Strategies have partnered to provide relationship skills education for high school youth and relationship skills education with intensive employment services for young adults in a community centered model. Over a three year period, the objectives of the grant are for LAUSD to reach 13,000 high school youth with 11 hours of relationship skills education and 300 teens and young adults (16-24) with 90 hours of relationship, parenting and financial management education through CCEO-YB.

- ***Project RELATE*** at Florida State University (FSU) incorporates relationship education for the general population of college-age adults into an established course that meets graduation requirements for social science (Fincham, Stanley & Rhoades, 2011). Doctoral students facilitate breakout groups once a week on relationship expectations, making healthy decisions about relationship progress, physical and emotional safety, communication skills and conflict management. Materials are based on PREP® and other healthy relationship education programs, particularly stressing partner selection and health risks of "sliding" vs. "deciding." Project RELATE's goal is to reach 10,000 students (25% of undergraduates) from all majors in a five-year period. To provide increased access for more young adults, FSU developed a one-hour online program, ePREP, to teach about static risk factors affecting partner choice, and dynamic risk factors which can be overcome by learning skills in communication, conflict management and problem-solving. Both programs have been evaluated and found to change attitudes and behavior even months later. Strikingly,

ePREP in randomized clinical trials showed participants had improved communication, less physical aggression, less depression, and healthier relationship functioning ten months post-treatment.

The conference participants saw these "windows of opportunity" as already open, and ended with some thoughtful brainstorming about immediate steps and natural allies for implementing the recommendations and translating the research into do-able and worthwhile efforts. These are outlined in Part IV, *Taking the First Steps Toward a More Couple and Family-Centered Healthcare System*.

IV. Taking the First Steps Toward a More Couple and Family-Centered Healthcare System

Both the research rationale for a more couple-focused healthcare system and the innovative tools, programs and practices to implement this new direction need to be more widely known to take advantage of the windows of opportunity and implement the conference suggestions and recommendations. Participants at the Wingspread conference discussed three overarching and ambitious strategies to bring the information and ideas discussed at the conference to the medical community and the public.

Strategy 1: Build Bridges with Natural Allies

A key first step is to begin to create bridges with other individuals, organizations, and coalitions who share similar views and perspectives, to explore whether they can work together on changes that need to be made to improve the healthcare system. These include both those representing a family perspective in healthcare, and those primarily focused on fathers and promoting responsible, involved fatherhood.

1. ***Family Centered Healthcare Advocates.*** In recent years, many healthcare practitioners and organizations have called for the healthcare system to focus on patients' social and behavioral context, and most often this means the patients' family. This particularly includes physicians and nurses who practice family-centered medicine, family-centered pediatric care, and those who support family-caregiving of the disabled and frail elderly. Some of the relevant organizations include The Collaborative Family Healthcare Association, Family Caregiver Alliance, The National Institute for Family-Centered Care, National Alliance for Caregiving, and the National Family Caregivers' Association. (Other groups who may share some common ground are The National Coalition on Care Coordination, the Partnership to Fight Chronic Disease, the newly formed Partnership for Patients, and the National Council on Patient Information and Education.)

   For these organizations, "family" is an umbrella term to include any relative (or person serving as de facto family) who is in a position to play a key role in the patient's health. The use of this broad and flexible term has, however, meant that the relationship between the patient and his or her spouse/partner, or between the child's two parents, is generally overlooked or ignored. Thus, leaders from these organizations and those from the marriage and relationship education field need to get to know each other better and discuss the lessons of the emerging research on the couple relationship/health connections. They can exchange ideas about whether and how the emerging tools and practices to strengthen couple relationships could be usefully integrated into current reforms to strengthen and support family-centered healthcare and practice. Further, they can work together with relevant health officials to coordinate and strengthen reform efforts.

2. ***Advocates for involved, responsible fatherhood.*** The fatherhood movement to date has been concerned primarily with increasing low-income, often non-custodial fathers' access to jobs and with fathers becoming more financially responsible and engaged with their children. Some have focused on teaching these fathers how to have better, more healthy and committed relationships with partners who typically serve as the gatekeepers to their involvement with their children. Much less attention has been paid by these advocates to increase fathers' involvement in their children's health or to access healthcare for themselves (with the exception of a handful of advocates for providing men, especially teen men, more access to reproductive health services). Men in general, and low-income fathers especially, are less likely to obtain healthcare services than women and mothers and be

seen by healthcare providers.

3. ***Domestic Violence Advocates.*** As a result of decades of efforts to protect women from violence and abuse, intimate partner violence (IPV) is now recognized as an important national public health issue affecting too many women and men, as well as millions of children who are exposed to IPV. For the past five years, healthy marriage programs funded by the federal government have been required to consult closely with domestic violence experts to learn how to recognize and address IPV among the couples they serve. Increasingly, there are now calls for domestic violence and healthy marriage advocates to join forces to work together on preventive, educational approaches aimed especially at youth, to teach them the knowledge and skills to form healthy, non-violent dating and intimate adult relationships (Ooms et al. 2006).

Strategy 2: Create a Cross-agency Working Group to Develop a National Agenda of Research and Pilot Demonstrations

As noted in Part I, participants at the Wingspread conference unanimously called for a comprehensive, coordinated, planned agenda of rigorously designed research and demonstration programs to be launched at the national level to move this field forward. Given current serious fiscal constraints, they felt that relatively modest investments in adding a couple component to research and innovation experiments already planned or underway, could have significant payoffs.

They envisioned the formation of an HHS inter-agency working group to consist of senior representatives from the National Science Foundation and the relevant research units within the National Institutes of Health:

- National Institute on Aging (NIA)
- National Institute of Child Health and Human Development (NICHD)
- National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)
- National Heart, Lung, and Blood Institute (NHLBI)
- National Institute of Mental Health (NIMH)
- National Institute on Alcohol Abuse and Alcoholism (NIAAA)
- National Institute on Drug Abuse (NIDA)
- National Institute on Minority Health and Health Disparities (NIMHD)

Members should also include representatives of federal agencies and units that support applied intervention research consisting of:

- Centers for Disease Control and Prevention (CDC)
- Administration for Children and Families, Office of the Assistant Secretary for Planning and Evaluation (ASPE)
- Administration for Children and Families, Office of Planning, Research and Evaluation (OPRE)
- Office of the Assistant Secretary for Health (ASH), Office of Population Affairs (OPA)
- Office of Minority Health (OMH)

After an initial review of the status of the research on the marriage/relationship and health connection, the working group should proceed to develop a two-part agenda:

1. Plan how to fill in the gaps in research by adding this component to existing or planned research or survey programs, improving measures used to describe marital/relationship quality, and building and testing theoretical models.

2. Identify opportunities for translating the current research and evaluation findings into modifying existing or designing new pilot demonstration projects, and where possible, adding health outcomes to existing social interventions. Demonstration projects found to have positive health results should be considered for replication on a wider scale.

Strategy 3: Inform and Educate Healthcare Professionals Widely

Wingspread participants felt strongly that efforts should be made at many levels to educate healthcare professionals—doctors, nurses, social workers, physical therapists and others—about the marriage/relationship health connection, and its implications for healthcare delivery and practice. This needs to happen both in academic, professional training programs and credentialing processes, as well as in continuing education.

Many opportunities are beginning to open up as some medical and nursing school curricula are placing an increased emphasis on the social and behavioral context of health and disease, and teaching students how to develop better relationships skills with their patients and patients' families. The national associations of healthcare professionals—such as American Association of Medical Colleges, American Academy of Pediatrics, American Nurses Association, and many others—should encourage the piloting of new curriculum modules about the research evidence for the connections among marriage and relationship quality and health outcomes and implications for practice in their professional training curricula, as well as offer the modules at seminars and workshops in continuing education settings. As these curricula begin to be more widely available, the relevant associations involved in the credentialing and licensing reviews could consider adding some relevant questions to the examinations that would assess knowledge about the couple and family context's effect on health outcomes.

Development associations and organizations representing marriage and family professionals, such as the American Academy of Family Physicians, the National Council of Family Relations, Family Psychology (Division 43 of the American Psychological Association), and the American Association of Marriage and Family Therapy, should actively disseminate information on the relationship/marriage health connections among their own members in their education, training and CEU activities.

Conclusion

An extensive, growing body of research demonstrates a strong link between marriage, relationship quality and health outcomes for children, adults and the elderly. For the large majority of Americans, their ability to protect and promote their health and well-being, recover from sickness, and manage chronic illness, frailty and the process of dying, is influenced by the kind of relationship they have with their spouses, partners, parents or close relatives. The first conference recommendation was to launch a more comprehensive, coordinated research agenda, with cost-effective use of many existing health surveys and ongoing demonstration programs. While more research is clearly needed, the findings are sufficiently compelling for the Wingspread conference participants to urge that healthcare providers and healthcare reformers pay attention to these connections now, and learn what they and others can do to support and strengthen couple relationships while providing healthcare.

Happily, some promising practices, tools and programs, developed by relationship and marriage educators, are now available that could be adapted, tested and integrated into the healthcare system with the help of natural allies like advocates for family-centered healthcare, fatherhood, and domestic violence prevention. If implemented widely, these have the potential to strengthen current innovative efforts to improve patient care, reduce the costs of healthcare, and increase the effectiveness of public health education.

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APPENDIX A

List of Conference Participants

Debbie Barrington, Columbia University School of Public Health (New York, NY)

Jamila Bookwala, Dept. of Psychology, Lafayette College (Easton, PA)

Thomas Campbell, Dept. of Family Medicine, Univ. of Rochester (Rochester, NY)

Deborah Carr, Dept. of Sociology, Rutgers University (New Brunswick, NJ)

Catherine Chesla, Dept. of Family Healthcare Nursing, Univ. of California-San Francisco (CA)

James C. Coyne, Depts. of Psychology & Psychiatry, Univ. of Pennsylvania (Philadelphia, PA)

Diann Dawson, Office of Regional Operations, Admin. for Children & Families, HHS, (Washington, DC)

Frank deGruy, Dept. of Family Medicine, University of Colorado (Denver, CO)

William Doherty, Family Social Science, University of Minnesota (St. Paul, MN)

Jeff Evans, Demographic and Behavioral Sciences Branch, Eunice Kennedy Shriver, National Institute of Child & Human Development/NIH (Bethesda, MD)

Lynette Feder, Portland State University (Portland, OR)

Courtney Harrison, Public Strategies (Denver, CO)

Kathi Heffner Johnson, Dept. of Psychiatry, Univ. of Rochester Medical Center (Rochester, NY)

Carolyn Tucker Halpern, Dept. of Maternal & Child Health, Univ. of North Carolina (Chapel Hill, NC)

Patty Howell, California Healthy Marriages Coalition (Leucadia, CA)

Pam Jordan, Dept. of Nursing, University of Washington (Seattle, WA)

Heather Koball, Mathematica Policy Research (Princeton, NJ)

Jane Koppelman, The Lewin Group (Falls Church, VA)

Thomas LaVeist, School of Public Health, Johns Hopkins University (Baltimore, MD)

Frederick Lorenz, Institute for Social & Behavioral Research, Iowa State University (Ames, IA)

Irene Luckey, Institute for Families in Society, University of South Carolina (Columbia, SC)

Susan H. McDaniel, University of Rochester Medical Center (Rochester, NY)

Kristin Moore, Child Trends (Washington, DC)

Mary Myrick, National Healthy Marriage Resource Center (Oklahoma City, OK)

Lis Nielsen, Division of Behavioral & Social Research, National Institute on Aging/NIH (Bethesda, MD)

Martha Okafor, Georgia State Division of Public Health, now at Satcher Institute, Morehouse School of Medicine (Atlanta, GA)

Theodora J. Ooms, Consultant, National Healthy Marriage Resource Center (Bethesda, MD)

Gilbert R. Parks, MD, Parks and Parks Healthcare (Topeka, KS)

Lara Rezzarday, Relationship Matters, National Multiple Sclerosis Society (Denver, CO)

Edward Schor, Commonwealth Foundation, now at Lucille Packard Foundation for Children's Health (Palo Alto, CA)

Jana Staton, Consultant, National Healthy Marriage Resource Center (Missoula, MT)

Luis H. Zayas, Center for Latino Family Research, Washington University in St. Louis (MO)

APPENDIX B

Conference Agenda

NHMRC Wingspread Conference Johnson Foundation Conference Center
Racine, Wisconsin
October 20-22, 2008

Making Connections: Effects of Marriage and Couple Relationships on the Health of Infants, Adolescents and Older Adults

MONDAY, October 20

2:30 pm Hospitality

3:00-4:00 pm **Welcome**

- Carole Johnson, Program Officer, Johnson Foundation
- Mary Myrick, Project Director, National Healthy Marriage Resource Center (NHMRC)

Roundtable Introductions

Background and Goals for this meeting – Mary Myrick, NHMRC

4:00-6:00 pm **What is the Healthy Marriage Field?**

- Overview: Emergence of HM Field and ACF HM Initiative (Mary Myrick & Courtney Harrison)
- Scope and Limits of Conference: (Theodora Ooms)
- Issues concerning domestic violence, same-sex unions, role of government costs, stigmatizing single parents
- What is Marriage and Relationship Education? (Jana Staton)

  Video Sampler illustrating programs

6:00 pm Hospitality

6:30 pm Dinner

7:45- 9:00 pm **Laying the Ground Work, Clarifying Terms**

Moderator of Evening Discussion – Bill Doherty

- **Frank deGruy**, Collaborative Family Healthcare Model—What is it and how does it challenge the current system? How can it "fit?"
- **Bill Doherty**, Importance of the Couple and the Continuum of Couple-Focused Interventions.

Open Discussion and Questions

TUESDAY, October 21

8:30-10:00 am **The Connection between Healthy Marriage/Couple Relationships and Health Outcomes Across the Life Span — What Do We Know From Research?**

Moderator: Jana Staton

Panelists:

Deborah Carr Associate Professor of Sociology
Rutgers University

James Coyne Professor of Psychology
Department of Psychiatry
University of Pennsylvania

Carolyn Tucker Halpern Associate Professor
Department of Maternal and Child Health
The University of North Carolina at Chapel Hill

Thomas LaVeist William C. and Nancy F. Richardson Professor in Health Policy,
Johns Hopkins Bloomberg School of Public Health,
Hopkins Center for Health Disparities Solutions

Discussion

10:15- 12 noon **Work Group Session I**
Leaders: Susan McDaniel, Heather Koball, Lis Neilsen
Group I: Studio
Group II: Board Room
Group III: Mezzanine

- Is the research evidence of the linkage convincing?
- What does it mean for children? For teens? For older adults?
- How does marital and relationship quality affect health disparities, especially among minorities?
- How does it fit into the broader role of social support and isolation?
- Do we know how marriage and couple relationship quality affects healthcare costs?
- What more do we need to know?
- What are the implications for professional and continuing education (for marriage/relationship and healthcare professionals)?

12:15-1:30 pm Lunch

2:00-3:30 pm **Emerging Program Models**

Moderator: Theodora Ooms

Catherine Chesla, University of California San Francisco
Lynette Feder, Portland State University
Patty Howell, California Healthy Marriage Coalition
Pam Jordan, Becoming Parents Program/Family Expectations
Lara Rezzarday, Relationship Matters, National Multiple Sclerosis Society

Discussion

3:45-5:30pm **Work Group Session II**
Group I: Studio
Group II: Board Room
Group III: Mezzanine

- What approaches seem most promising and for whom?
- How can these approaches be integrated into the healthcare delivery systems?
- What additional types of interventions/demonstration need to be tested?
- Who are the potential partners/allies for couple-focused healthcare strategies?
- How does this focus fit within behavioral/lifestyle-focused strategies for health promotion/ disease prevention?
- How can we get these issues included in Healthy People 2020?

5:30 pm Hospitality and Tour of Wingspread House

6:30-8:00 pm Dinner – Wingspread House

Post-dinner hospitality in Guest House (Work group leaders prepare their summaries and list of recommendations)

Wednesday, October 22

8:30-10:15 am **Moving Forward: Turning Ideas into Action**

Moderator: Diann Dawson

- Work Group leaders present their short and long term recommendations
- Discussion of implementation strategies—high and low cost

10:30- 11:45 pm **Summing Up and Next Steps**

Participants representing different perspectives share brief remarks on conference highlights:

- **Kristin Moore** (research)
- **Ed Schor** (health professionals and primary healthcare)
- **Tom Campbell** (health system reform)

Participants are invited to share their one big "take away": what they will do as a result of the conference.

Closing Remarks: Mary Myrick

12:00 pm **Lunch and Goodbyes**

APPENDIX C

Guide to Research on the Connections Between Couple Relationships and Health, by Life Stage and Disease

This selection of findings from the strongest recent studies illustrate different dimensions of the marriage/health connection. For additional information on many of the research citations given here, see the two companion documents located at http://www.healthymarriageinfo.org, NHMRC Collection on Marriage and Health and *Making the Connection Between Healthy Marriage and Health Outcomes: What the Research Says* (Staton, 2009).

Infant & Maternal Health

- Marriage provides increasing protection against infant low birth weight across generations for African-American women, the population most vulnerable to LBW (Barrington, 2010**).** New data show that low birth weight is more likely for children born to low-income "social father" families (whether cohabiting or married), in comparison to those in biological father families (Fragile Families & Child Wellbeing Study, Berger & McLanahan, 2011). Father support and cohabitation with the mother decrease the likelihood of LBW for unmarried mothers in the Fragile Families population (Padilla & Reichman, 2001).

- Improved couple relationship skills for unmarried low-income parents resulted in significantly lower post-partum depression, in a randomly controlled trial of relationship education (Devaney & Dion, 2010).

- Infant mortality rates are 1.8 times higher for infants of unmarried mothers, than for married mothers. (Matthews et al., 2010).

- A father's prenatal involvement in pregnancy care or relationship education predicts father's post-natal involvement and interactions with the child three years later, by increasing motivation to live together and make relationship commitment (Cabrera et al., 2008; Cowan et al., 2006, 2009).

Children

- Children raised to adulthood by two biological parents have better health during childhood and as adults than children growing up in other family arrangements, including stable cohabiting unions (Bramlett & Blumberg, 2003: Wood et al., 2007). This advantage holds even among low-income populations with controls for parental education, maternal health, and low birth weight (Schmeer, 2011).

- Children of low-income cohabiting parents, even in "stable" unions, have worse health at age five, in a large representative sample (Fragile Families study), than children of matched, stably married low-income parents. Parental marriage after birth confers some health advantages for children by age five, while marital dissolution before age three results in the same health disadvantages as cohabitation (Schmeer, 2011).

- Young children in high-conflict families have high levels of stress hormones, a marker of chronic stress (Gottman & Katz, 1989).

- Children of divorce have more acute and chronic illness as adults (Maier & Lachman, 2000).

- Conflictual marriages and divorces are both associated with poorer health outcomes for children and teens (Amato, 2010; Furstenberg & Kiernan, 2001; Kaye et al., 2009).

- The noted Adverse Childhood Experiences Study (ACE) documents lifetime health risks (morbidity and mortality) directly associated with the incidence of 10 adverse childhood events reflecting family instability, multiple partner fertility and turmoil, including abuse, neglect, and loss of a parent through divorce or abandonment (Brown et al., 2009).

- Family instability in low-income populations, whether from separation and divorce or from unstable cohabitation, exacerbates children's health problems, relative to comparable stable low-income families. Stability may be the crucial factor in children's health (Craigie et al., 2010).

- Among low-income dads, lower rates of father involvement are associated with poorer health status (as reported by mothers) for children by age three, compared to children whose fathers remain involved in their lives and care (Bronte-Tinkew et al., 2009).

Adolescents

- Increased adolescent health risk behaviors such as early sexual activity, aggression, etc., are linked to family transitions in and out of adult partnerships, and to marital/parental conflicts; this finding appears to be more likely for middle-class than low-income youth (Feinberg, 2007; Kaye et al., 2009).

- Healthy family processes, such as eating meals together, may suppress the expression of inherited genetic tendencies such as aggression in adolescents (Guo et al., 2008).

- The longer a girl lives in a stable two-parent family, the lower her risk of early sexual activity. Father absence and non-involvement in a daughter's life during adolescence increases her risk of early teen pregnancy five times, with attendant health risks, and public health costs, for mother and child (Ellis et al., 2003).

Adult Health & Well-Being

- *Marital quality*, in addition to marital status contributes to the health benefits - and risks - of marriage for both children and adults. Frequent *negative* interactions – criticism, demands, and emotional withdrawal – are the biggest risks for poor health outcomes. Positive or supportive behaviors show little association with *better* health (Bookwala, 2005; Umberson et al., 2006; De Vogli, 2007).

- Poor marital quality can wipe out the impact of other health benefits of marriage (Umberson et al., 2005; Bookwala, 2005).

- Couples in very unhappy, distressed marriages have *worse* health outcomes over 12 years than do equally unhappy couples who divorce in that period (Hawkins & Booth, 2005).

- Any disruption in the marital biography affects health outcomes, independent of other factors (Hughes & Waite, 2009).

Heart Disease

- Married men and women are less likely to die from heart attacks and are more likely to return to health (Zhang & Hayward, 2006; Johnson et al., 2000).

- Men and women in "*high-quality*" marriages live longer with cardiovascular disease, independent of severity of illness, than do those in "low quality" marriages (Coyne et al., 2001; Rohrbaugh et al., 2006).

- Women are more likely to develop early signs of heart disease (i.e., metabolic syndrome) if they are in less satisfying relationships (Gallo et al., 2003).

- Marital stress worsens the risk of having a major coronary event for women, unlike men, for whom work-related stress is more dangerous (Orth-Gomér et al., 2000).

Diabetes

- One year after Type II diabetes diagnosis, a majority of couples in an observational study moved from teamwork or spouse involvement in diet management, to complete disengagement, with the diabetic spouse solely responsible for his or her diet (Miller & Brown, 2005).

- Marital quality and spouse support predict diabetic patient adherence with self-care, dietary regimen, and exercise (Beverly et al., 2007; Beverly et al., 2008).

- Marital quality (intimacy and adjustment measures) were associated with better dietary self-care over two years, although not with blood glucose control (Trief et al., 2004).

- Patients with diabetes now get extensive information about their illness, but to date, simply providing both partners with the same medical information has not resulted in desired changes in health outcomes (Trief et al., 2011).

Immune & Hormone Systems

- Research on causal pathways from social stress to the immune system and subsequent chronic inflammation indicates that chronic illnesses, known to be connected to inflammatory response, may be triggered or exacerbated by marital conflict and distress (Robles & Keicolt-Glaser, 2003).

- Couples experiencing hostile interactions have higher levels of stress hormones, and open wounds heal more slowly (Keicolt-Glaser et al., 2005).

- Support from husband (holding a hand) blocks pain and lowers stress response in happily married wives undergoing experimental electric shocks (Coan et al., 2006).

Depression

- A review of decades of research on depression strongly supports the conclusion that entering into marriage reduces depressive symptoms for both men and women, while marital dissolution increases them. Those who remain stably married have fewer depressive symptoms, and there is little evidence that those with fewer depressive symptoms are more likely to marry, reducing the "selection effect" as an explanation (Wood et al., 2007).

- Depressive symptoms after divorce are long-lasting, and tend to occur first, preceding physical health declines (Lorenz et al., 2006; Wickrama et al., 1997).

Adherence to Medical Regimens

- Non-adherence to medical regimens is a major factor in healthcare effectiveness and costs. It is estimated at 25%, based on decades of research (DiMatteo, 2004a). Studies are emerging that suggest that the quality of couple relationships may have an important role to play in either limiting, or improving adherence.

- A recent meta analysis of research since 1950 found that adherence is almost twice as high in patients from cohesive families, and significantly lower from families in conflict. Relationship quality, as measured by the presence of functional social support (practical, emotional, and family cohesiveness) is significantly stronger than just structural support (marital status and living arrangements) provided by "just living with someone" (DiMatteo, 2004b).

Health Disparities

- A major review of links between African American marriage and health finds that African American children living with married parents have better health, and adults experience better mental health when they are in a high-quality marriage across income levels. In contrast, marriage seems to have inconsistently negative or no effects on physical health outcomes for adults as measured by diagnosed conditions and biometric markers), except for increasing risk of obesity for men (true for whites as well) (Koball et al., 2010).

- For African American couples, marital satisfaction, a measure of higher quality marital relationship, appears to offer protection from psychological distress, and buffers the negative effects of unfair treatment and financial strain (Lincoln & Chae, 2011).

- Historically, research has shown that African American unions are more stressed and report lower marital quality than white couples, or couples from other ethnic populations (Broman et al., 2005).

Aging

- Marital quality has much more impact on adult health as we age (Umberson et al., 2006).

- Poor health in older adults is directly correlated with *negative* spousal interactions (Bookwala, 2005).

- Remarriage brings health benefits, making up for negative impacts of divorce. However, remarriages do not carry the same health benefits across the lifespan as continuous first marriages (Sbarra, 2008; Hughes & Waite, 2009).

- Having a spouse in old age reduces nursing home and hospital admissions and protects against loss of activities of daily living (ADLs) (Schoenborn, 2004).

- When an older adult has no spouse, studies suggest that the interest and support of other intimates (partners, relatives, children, friends) also has strong health benefits (Uchino, 2004).

- Spousal caregiving in later years can be both a health benefit for the ill spouse and a health risk for the caregiver (Carr & Springer, 2010).

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The National Healthy Marriage Resource Center (NHMRC) is a clearinghouse for high quality, balanced, and timely information and resources on healthy marriage. The NHMRC's mission is to be a first stop for information, resources, and training on healthy marriage for experts, researchers, policymakers, media, marriage educators, couples and individuals, program providers, and others.

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