Significant events also happened within our organization. As we reported in the last *tBT*, we hired a consulting company to evaluate our organization. The idea has long been floating in the air. During one of our financial committee meetings, Mike Petronko noted that, since our organization was in excellent financial health, it might be time to seriously look into hiring a consulting firm to address lingering questions about growth, membership, direction, operations, structure, location, etc. After some careful deliberation, we quickly agreed that it might be time to get serious about hiring a consulting company. This was not indicative of a crisis. To the contrary, hiring consulting firms is good practice for any organization that wants to remain responsive to membership needs and to the current and future challenges ahead. Given the profound—and necessary—changes in health care our country is undergoing, we thought it was high time to go ahead with the organizational assessment.

Thanks to the recommendation of Lynn Bufka, who is working for the American Psychological Association, we added McKinley Advisors to the possible consultants we considered. After interviewing McKinley Advisors (as well as a few others), we knew that we found the right partner. McKinley Advisors are experienced consultants who specialize in nonprofit organizations and work with many related health-care organizations, including the American Psychological Association. We were very satisfied with their work.

Many people were involved in this process and volunteered their time—too many to acknowledge here. Instead, I want to say a general and hearty thanks to all of you who spent countless hours on the phone and in meetings with us and who helped develop and implement the report. The process through which we accomplished our goals made it crystal clear to all of us that our organization is in excellent health, not only financially, but also structurally and . . . well, emotionally. The consultants often commented on our exceptional commitment to the organization, which is not just any professional organization but our academic and professional home and family.

I would like to thank the central office; the Board, and especially Denise Davis, Deb Hope, Bob Klepac, and Dean McKay, who were closely involved in this data-gathering process. Working with you and many others has been a real privilege. You are an amazing bunch. I would also like to thank many of our Past Presidents for their guidance and advice and to the many members who participated in the membership survey that McKinley conducted. We will, of course, provide updates of our progress as we move ahead.

ABCT is like a big tanker sailing in a rough and constantly changing sea; any change in direction requires careful maneuvering; and its effect won't be noticeable in the immediate future. It looks like our ship is on course to a bright future. It's been an amazing journey. Thank you!

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Clinical Forum

The Marriage Checkup: A Public Health Approach to Marital Well-Being

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Marital health is a public health concern. Ever since the earliest days of marital relationship research, the focus of the science has been on marital adjustment, marital satisfaction, and marital interaction. Years of relationship science, however, have clarified that the phenomenon at the heart of our research is relationship health. As we look across the accumulated data in the field, it has become increasingly clear that marital health is as fundamentally and legitimately a public health variable as physical health and mental health. Though perhaps more difficult to readily see because relationship ill health does not fit our classic individual-level conceptualization of health, the accumulated research has become virtually indisputable: the health of our relationships is intimately intertwined with every other aspect of our overall health (e.g., Jaremka et al., 2013; Kiecolt-Glaser & Newton, 2001).

The serious physical, mental, and emotional health effects associated with marital distress and divorce have been well documented in the research literature over the past few decades. This research has shown that marital health is inextricably linked with other health concerns; those who are recently divorced or unsatisfied with their relationships are more likely to experience a range of physical health issues such as high blood pressure, problems with alcohol and substance abuse, and higher rates of psychological disorders such as depression and anxiety (Broadhead et al., 1983; Kiecolt-Glaser & Newton, 2001; Whisman, 2007). Marital distress and divorce also have a negative impact on children, who are more likely to develop behavioral and emotional issues and struggle in school when their parents are distressed or divorced (Amato & Sobolewski, 2001; Cummings & Davies, 2010). Given that the lifetime probability of divorce in the United States is between 40% and 50%, and about 20% of married couples are experiencing significant distress at any given time (Beach, Arias, & O'Leary, 1986; Cherlin, 2010), it is evident that a large percentage of our population is at risk for the damaging psychological and physical effects of marital distress and divorce. Thus, the public health need for developing effective interventions in this area remains essential.

When marital relationships are considered a health domain, we begin to consider how it might be addressed using systems that have been developed to support health in other domains. Health issues are primarily addressed through three types of care. Typically, the most pervasive type of care is tertiary treatment in response to injury, illness, or dysfunction. When a health system has broken down, we intervene to attempt to bring that system back to health. Our society has developed a variety of tertiary physical, dental, mental, and relationship health treatments. Tertiary treatments for dysfunctional marital relationships have been empirically tested, and repeatedly

demonstrated to be efficacious (e.g., Shadish & Baldwin, 2005).

While tertiary care is a critical component of a comprehensive health care system, for many types of health dysfunction, waiting until a disease process has already damaged health is waiting too long. This appears to be the situation with regard to many cases of marital relationship health dysfunction. Though treatment appears to benefit about 50% to 60% of couples who present for treatment (Shadish & Baldwin, 2005), for many couples treatment is too little, too late. Furthermore, most couples who suffer from severe marital dysfunction never seek treatment at all (Johnson et al., 2002).

Another type of health care is primary prevention, which aims to prevent problems before they start. An example of this is health care education. We have developed many tools for educating the public about how to maintain optimal health and prevent disease across the domains of physical, dental, and mental health. Within the domain of marital relationship health, health education programs such as the Prevention and Relationship Education Program (PREP; Markman, Stanley, & Blumberg, 2010) have also been developed, empirically tested, and demonstrated to be efficacious (e.g., Renick, Blumberg, & Markman, 1992).

Education as a preventative technique and treatment for existing problems, however, is typically considered to be insufficient as a fully realized health-care system. Marital relationship health education, while measurably beneficial, is limited in reach and has not been shown to arrest dysfunctional processes that are already in progress (Notarius & Buongiorno, 1992, as cited in Gottman & Gottman, 1999).

Between the preventative functions of health education and the health recovery functions of treatment lay the early detection and early intervention functions of health checkups – a type of secondary prevention care. The advent of annual health checkups in the physical health arena has allowed us to catch and intervene with disease processes early as well as to regularly repeat the messages of health education. For example, women over the age of 40 who have a mammography screening every 1 to 2 years die of breast cancer less frequently than women who do not have mammography screenings (Humphrey, Helfand, Chan, & Woolf, 2002). Similarly, the advent of regular dental checkups has contributed substantially to the probability that people will keep most of their teeth for life (e.g., Cunha-Cruz, Nadanovsky, Faerstein, & Lopes, 2007).

The Marriage Checkup

Based on these successful models, our lab has developed and empirically tested a marital relationship health checkup that is intended to serve the same prevention, early detection, and early treatment functions of existing physical, dental, and mental health checkups. The Marriage Checkup (MC; Córdova et al., 2005) was designed as an annual, two-session "checkup" model. Like regular physical health or dental checkups, couples at all levels of relationship health are suitable to receive an MC annually in order to assess the ongoing health of their marriage, regardless of whether they are experiencing distress or not.

The MC consists of two visits that last approximately 1 to 2 hours each. The MC assessment and feedback session format is based upon both the Drinker's Checkup (Hester & Squires, 2008) and the assessment and feedback model proposed by Worthington and colleagues (1995). MC therapists use Motivational Interviewing (MI; Miller & Rollnick, 2002) techniques to activate couples in the service of their marital health and Integrative Behavioral Couples Therapy (IBCT; Jacobson & Christensen, 1998) techniques to promote increased acceptance, intimacy, and satisfaction.

The MC assessment session includes both self-report questionnaires and an in-person conjoint interview. The questionnaires, which are completed prior to the assessment visit, measure variables associated with marital health, including intimacy, communication, finances, sex, and co-parenting. The in-person assessment session begins with a short interview about the history of the couple's relationship (Buehlman, Gottman, & Katz, 1992), and then guides the couple through a social support exercise and a problem-solving discussion, with the therapist as an observer. Next comes the most substantial portion of the assessment session, the therapeutic interview, which prompts the couple to discuss their most significant strengths and their primary areas of concern. By paraphrasing and reflecting the couple's strengths, the clinician reinforces the positive qualities of the couple's relationship and sets a positive tone for the subsequent concerns portion. The therapist then introduces the areas of concern by noting the three most significant concerns that each partner indicated on their questionnaires. Then each partner is asked to choose his or her most salient issue to discuss in more detail. During this conversation, the therapist focuses on three main therapeutic objectives: (a) building intimacy bridges, (b) fostering mutual acceptance, and (c) building a collaborative set. These techniques, adapted from IBCT, reframe issues in terms of their "softer" emotional content, compassionately identify the reasons underlying disagreements, and recognize how partners may have come to feel stuck in the same mutual trap.

The information gathered during the assessment is then consolidated into a report that serves as the centerpiece of the feedback session, which is typically held about 2 weeks later. The MC therapist guides the couple through the feedback report, which summarizes the couple's relationship history, celebrates their strengths, lists their questionnaire scores and interpretations, and addresses their areas of concern. During this conversation, the therapist works with the couple to integrate therapeutic interpretations of their areas of concern. The therapist also presents partners with a menu of suggestions—based on the current treatment and research literature—for how they might actively address their specific issues and helps the couple to generate several of their own solutions. At the end of the session, each partner receives a finalized copy of the feedback report. Based on MI, the goal of the feedback session is to provide partners with objective information about their strengths and concerns in order to increase their motivation to take deliberate care of their marital health. The MC uses MI techniques to facilitate partners' movement through the successive stages of change toward behavioral activation (Prochaska & DiClemente, 1983). Couples' existing strengths are highlighted as the foundation of relationship health and for positive growth. Areas of concern are discussed empathically yet objectively by noting discrepancies between partners' long-term relationship goals and the known effects of any detrimental patterns. The key to a successful MC is to build intimacy bridges and activate the couple in the service of their own marital health. Full details of how to conduct an MC can be found in the recently published treatment manual (Córdova, 2013).

Previous pilot studies of the MC have indicated that the MC has high treatment tolerability and is safe for use with at-risk couples (Córdova et al., 2005; Córdova, Warren, & Gee, 2001). Longitudinal follow-up from these studies has suggested that MC couples, as compared to control

couples, showed improvements across a range of marital health variables both in the short term and at 2-year follow-up (Córdova et al., 2001). Our recently completed 5-year NIH-funded randomized controlled trial of the MC recruited a much larger sample (N = 215 couples) than we had in the previous pilot studies. This study also included a "booster" MC assessment and feedback session after 1 year for treatment couples so that we could assess the benefit of additional annual checkups. We have recently analyzed this 2 longitudinal data of change in distress, intimacy, and acceptance (Córdova et al., submitted).

In this study, we assessed couples' outcomes based on change in distress, and the two phenomena targeted to mediate changes in distress, intimacy and acceptance. Treatment couples showed a sharp and sustained improvement in intimacy, an improvement that gradually tapers off throughout the follow-up period for acceptance. For distress, couples also showed a quick improvement that was mostly sustained throughout the first year of follow-up, and gradually tapered off throughout the second year of follow-up. We describe this pattern of waxing and waning as a "climbing m" where couples improve after visits, show some decline in the year following the initial visits, and then improve again at the booster and, again, show some decay as the year passes. The trajectories demonstrated significant differences in distress between MC treatment and control couples through the first year of follow-up and through 6 months after the booster session. Effect sizes were all in the small to medium range. The treatment and control group showed significant separation in intimacy throughout all 2 years of follow-up, and all effect sizes were of medium size. For acceptance, women showed statistically significant small to medium effect sizes throughout the entire follow-up period, whereas treatment male partners were no longer statistically distinguishable from control male partners at 1 year, 6 months, and 2 years. The results of this study are currently under review and available from the seventh author.

These results suggest that the MC significantly increases intimacy and acceptance, and decreases distress across the broad spectrum of couples seen in the MC. The quick and sustained change in intimacy is heartening, suggesting a brief intervention can have meaningful and lasting effects for couples. The more pronounced waxing and waning pattern of acceptance and distress suggests the potential importance of an annual checkup format.

Another paper investigated the most recent MC study's effectiveness in recruiting an at-risk population (Morrill et al., 2011). We found that the MC attracted couples across the continuum of distress, and that in terms of distress, the average of the MC couple sample fell between the means for community couples and distressed therapy-seeking couples. We also found that the MC attracted a substantial number of couples for whom the MC was the first form of help-seeking on an individual or couple-level. Over 63% of MC participants had not previously sought a couple-level intervention, and over 32% of MC participants had not previously sought any type of mental health service. Couples noted that the MC was more accessible than other options because of its brevity and lower level of commitment compared to therapy. Thus, the MC appears to reach an important at-risk population of couples who may be beginning to feel the effects of distress, but who have not yet recognized the need to actively attend to their marital health.

Disseminating the Marriage Checkup

Given these promising findings, our focus is now shifting toward ways in which the MC can be disseminated more broadly. For example, we have been collaborating with colleagues at the University of Tennessee–Knoxville to deliver the MC (retermed "Relationship Rx" to be more overtly inclusive of nonmarried partners) through a large community-based integrative health-care organization in rural East Tennessee. This project has received federal funding from the DHHS Administration for Children and Families' Healthy Marriage Initiative and aims to make relationship checkups accessible to low-income couples by recruiting through the primary care system. One of the unique long-term goals of this particular project is to support couples' efforts to improve their economic well-being through teaching skills on financial self-efficacy and collaborative decision-making around finances, in the service of building financial stability. This facet of the project is an example of the myriad ways in which the MC can be adapted to address the unique needs of various populations. Similarly, given the barriers to treatment that many low-income couples experience, such as difficulty with transportation and child care, we are offering the MC as a home-based intervention through this project. We anticipate that these adaptations of the original MC protocol will enable the intervention to not only reach low-income rural populations, but to also be of specific value to the unique issues faced by couples in this population.

We are also collaborating with the U.S. Air Force to tailor the MC to a military population. Similar to the project in Tennessee, this study also seeks to integrate mental health treatment resources into a primary care setting. While on- and off-base marriage resources exist for airmen and their partners, these resources do not reach all couples for a variety of reasons. Some of these programs, such as the Family Advocacy Program, are utilized only by a small minority of families where maltreatment has occurred and relationships are severely distressed, while others are underutilized due to the limited availability of counselors. The MC holds promise in this setting in part due to the ease with which it can be delivered by the Air Force's Behavioral Health Consultants (BHCs), mental health providers embedded in a primary care setting. Because it is both brief and customizable, the MC is well suited to be delivered in the primary-care context during three 30-minute behavioral health consultation appointments with content tailored to the unique stressors experienced by active-duty personnel.

We are also exploring web-based platforms that would enable clinicians and couples alike to access much of the MC content and questionnaires online. As much of the field has recognized, translating evidence-based treatments to a web-based delivery system would enable us to disseminate effective interventions to populations that traditionally experience significant barriers to treatment, including geography, income, and insurance.

The Uncertain Future of Marital Health Research

Despite the promising results of the MC and other new directions for relationship health research, and despite the clear need for effective interventions to maintain relationship health as part of an overall public health system, continued and future federal funding for relationship research is currently in doubt. Sources of funding for couples-focused issues at NIH have become nonexistent, as both NIMH and NICHD have narrowed their research foci to the exclusion of relationship health research. Historically, NIH has been the major source of federal funding for relationship health research. The field now finds itself at a critical

juncture, with substantial relationship health issues remaining to be adequately studied and cutting-edge advances that may be left unfunded.

NIH spends a half-billion dollars per year on research related to mood disorders that have a 12-month prevalence of 5.2% and lifetime prevalence of 28.8% of the population (Kessler et al., 2012; Kessler et al., 2005). By comparison, the estimated 12-month prevalence of severe marital health deterioration is 20%, and the lifetime probability for divorce is between 40% and 50% (Cherlin, 2010). NIH as of next year will spend almost nothing on marital-health-focused research.

Our view is that this defunding has been an unintentional result of a curtailment of spending within the Institutes of Health, with NIMH restricting its focus to mental disorders and NICHD narrowing its focus to child outcomes. Marital health research is well respected in the field at large and has contributed substantially to the nation's health and well-being. Grant applications submitted to NIH continue to receive very high-priority scores and yet go unfunded because marriage and couple research no longer has a home at NIH. It is our hope that as this funding issue and its potential consequences become more widely known, efforts will emerge to reestablish a home for relationship health research at NIH.

Conclusion

We have summarized in this paper three of the goals of our ongoing work. First, it is our hope that the broader culture will continue to shift toward an understanding of relationship health as one of the most important foundational health systems alongside physical and individual mental health. Second, we plan to continue our work to develop, empirically support, and disseminate the MC as an efficacious and effective approach to sustaining and improving the nation's overall marital health. Previous research has indicated that the MC is a user-friendly intervention that significantly increases marital satisfaction and intimacy. The MC also has great potential for public dissemination, and is adaptable to specific population needs (e.g., low-income and military couples). Finally, we wish to call attention to the emerging funding crisis for relationship health research in the hopes that efforts can be made to reestablish a home for research into this fundamental area of public health.

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