Marital Health:

Towards a more complete account of functional and satisfying couple relationships

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GLOSSARY

Marital quality: A spouses' overall evaluation of his or her marital relationship (in this chapter, this term is used interchangeably with marital satisfaction, marital adjustment and marital distress)

Marital stability: The status of a marriage (whether it is continuing, or the spouses have separated or divorced)

Coercive escalation: The reciprocation and increasing aversiveness of behavioral responses between interacting spouses

Attributions: Causal inferences regarding partner behavior and marital difficulties

Affect: The subjective experience of a partner's behavior or the marital relationship (evidenced through subjective self-report or physiological arousal during interactions)

Physiological linkage: The degree to which each spouses' physiological activity can be predicted from the other's activity, controlling for the autocorrelation within each spouses' physiological responses

Introduction

In Western culture, the vast majority of people marry or cohabit, and expectations of couple relationships are high. In the mass media, for example, marriage is portrayed as providing lifelong companionship, romance, support, sexual fulfilment and commitment. A high proportion of couples experience an erosion of these positive qualities over time. For some, marital satisfaction erodes to the point where they evaluate their relationship as unhappy overall which may, in turn, lead to its termination. The proportion of couples who end their relationship through separation or divorce is high (e.g., about 42% of marriages in the United Kingdom, 55% of marriages in the USA, 35% of Australian marriages, and 37% of German marriages end in divorce). However, not all distressed couples make the decision to separate. For some, the barriers to separation, or the perceived absence of alternatives, may result in remaining married despite being unhappy with the relationship.

Relationship distress, separation, and divorce are associated with numerous adverse physical and mental health problems in both spouses. Not surprisingly, more people seek professional help in the USA for marital problems than for any other problem. Understanding why some couples remain happy while others deteriorate is therefore a critical public health issue.

The overall goal of the chapter is to advance understanding of what constitutes marital health. Towards this end, the chapter is divided into three sections. The first attempts to document what is currently known about healthy marriages. Although seemingly straightforward, this task is complicated by the fact that attempts to study the positive features of marriage are rare. The second section of the chapter therefore attempts to build on the first and offers an expanded view of marital health. Finally, we summarize the main themes of the chapter and identify promising avenues for future research and clinical interventions with couples.

I. What do we currently know about marital health?

Since the early part of this century, hundreds of scholarly studies on marriage have been conducted, the vast majority of which have focused on marital satisfaction, adjustment, success or some synonym indicative of the quality of marriage. It therefore would be reasonable to expect that the characteristics of healthy marriage have been thoroughly documented. However, this does not appear to be the case. In order to understand this state of affairs we need to examine research on the central construct of marital quality and uncover some of the assumptions underlying the marital literature more generally.

A. Marital quality

Anna Karenina Tolstoy states that “All happy families resemble one another; every unhappy family is unhappy in its own way”, and marital researchers appear to have accepted Tolstoy’s

observation. Marital research has focused on "unhappy" marriages, assuming perhaps that "happiness" in marriage is self-evident or does not require examination. With rare exceptions, marital quality has been studied via spouse self-reports. What are the self-reported characteristics of marriages that overcome the odds and stay happy over long periods of time?

1. Quantitative self-report measures of marital quality. Two major approaches have been used to document in quantitative terms the features of marital quality. On the one hand, some have viewed marital quality as a multidimensional construct that indexes dimensions of the relationship. These researchers have tended to favor use of such terms as marital adjustment to indicate that their measures include items that assess relational characteristics such as communication and conflict. On the other hand, are researchers who view marital quality in terms of spousal sentiments about the marriage. To understand these two viewpoints, it is useful to examine traditional and widely used measures of marital quality.

The most widely used quantitative measures of marital quality are the Dyadic Adjustment Scale (DAS) and the Marital Adjustment Test (MAT). The first striking feature of such measures is that they contain a mixture of differentially weighted items, ranging from reports of specific behaviors that occur in marriage to evaluative inferences regarding the marriage as a whole. For example, on the MAT, items include ratings of disagreement on 8 issues (most, but not all, of which are scored from 0 to 5), and questions like "Do you ever wish you had not married?" (scored as 0, 1, 8 or 10 depending on responses). The inclusion of behavioral and subjective categories and the number and weighting of items used to assess each category varies across measures of marital quality, makes it unclear what these tools actually measure. The aggregation of various dimensions of marriage in omnibus measures of marital quality (e.g. interaction, happiness) also precludes meaningful study of the interplay between such dimensions (e.g., interaction may influence happiness and vice versa). Consequently, while such omnibus measures have proven useful in identifying distressed and nondistressed couples they do little to enlighten us as to the nature and critical components of marital quality.

In light of such observations, several researchers have argued that marital quality should be limited to spouses' overall evaluations of the marriage. Although this approach to marital quality is conceptually clearer, it also tells us little about the content of high versus low quality relationships. This is perhaps hardly surprising as quantitative research on marital quality has been motivated more by practical than theoretical concerns. Nonetheless, the quantitative approach triggers an important theoretical issue concerning the properties of marital quality.

In contrast to Tolstoy's remark above, implicit in most previous research on marital quality is the view that a couples' score on a questionnaires indexes their marital quality. Marital quality has

traditionally been conceived of as a unidimensional continuum, ranging from the divorcing couple, to the blissfully married couple. Is marital quality a continuum, or are happy couples qualitatively distinct from distressed couples?

Some researchers have questioned the construct and heuristic validity of the assumption that marital quality is continuous and unidimensional. Several phenomena are difficult to explain from this perspective. For example, couples with the same score on the DAS may be ambivalent (both very positive and very negative), or indifferent (neither positive or negative) about the marriage. Also, why do some couples experience high variability in their moment-by-moment marital experience, whereas others do not? In clinical practice, it is easy to recall instances where a couple might show great sensitivity and affection at one moment and then intense hostility the next whereas another couple might show stable levels of satisfaction. Defining marital quality unidimensionality therefore fails to capture the richness of marital quality and its variation.

Marital theorists have argued that conceptual understanding of marital quality is enhanced by reconceptualizing it as multidimensional. For example, Fincham and colleagues advocate a bidimensional approach in which marital quality is conceived of in terms of positive and negative components. They offer empirical information to show that these components provide nonredundant information about relationship quality. In a similar vein, Snyder developed the Marital Satisfaction Inventory (MSI), a psychometrically sophisticated instrument that offers a profile of marital quality much like the Minnesota Multiphasic Personality Inventory (MMPI) offers a profile of individual functioning. Like the MMPI, the MSI offers actuarial data to assist in its interpretation. Although promising for understanding marital quality, such tools have been underutilized in comparison to the DAS or the MAT.

Unidimensional quantitative measures of marital quality like the DAS have been used extensively to provide anchors (e.g., to form distressed and nondistressed groups) for the study of other self-reports thought to be important to happy marriages, such as love, commitment and acceptance. Before reviewing findings from such research, it is important to note that the heterogeneity of items in measures like the DAS make result in spurious findings. To illustrate, it is not surprising that self-report measures of commitment correlate highly with the DAS as the DAS itself contains items that measure related constructs (e.g., “If you had your life to live over, do you think you would marry the same person/a different person/not marry at all”). Some “correlates” of marital quality may emerge therefore simply because they are not independent at either the conceptual or empirical levels (Fincham & Bradbury, 1987). We turn to research on self-reported correlates of marital quality with this caveat in mind.

2. Self-reports of distressed and nondistressed couples. Using quantitative measures of marital quality as criteria for group membership, a variety of studies have attempted to pinpoint self-report characteristics that differentiate happy and unhappy marriages. One way of achieving a richer view of marital health this is to provide an unstructured setting for couples to report on what they think are the important aspects of their relationship. A basic premise here is that we are best able to increase our understanding of marital quality by examining the characteristics of couples who have demonstrated "expertise" in the maintenance of high marital. Despite its intuitive appeal, such methods have rarely been employed in the study of marital relationships. Happy couples married for over 20 years identify several components of happy marriage, the most commonly reported components being commitment, love, loyalty and companionship.

There is some convergent evidence to suggest that constructs such as commitment and love are important aspects of happy marriages. Commitment, defined as one's willingness to tolerate adversity in a relationship, significantly predicts marital satisfaction for both sexes, but most strongly for women. Rusbult and her colleagues define commitment as a psychological state consisting of beliefs and emotional components, representing one's long term orientation toward a relationship, and provide an impressive array of research suggesting that markers of commitment are significantly related to marital quality. Love, not surprisingly, has been shown to be associated with marital satisfaction. However, as already noted, the conceptual redundancy in these measures is likely to be high.

Summary. The vast majority of research has focused on quantitative conceptions of marital quality Although there are some qualitative studies, quantitative and qualitative approaches have had very little impact on each other and are seldom cross-referenced. The focus on marital quality reflects the applied origins of marital research and most likely continues to motivate interest because self-reported marital quality is thought to be the "final common pathway" that leads couples to seek professional help. However, self-reported marital quality gives us little information on what processes lead to this path and reflects a number of assumptions that require careful evaluation. Indeed, there are inherent limits to how much the study of self-reported marital quality can tell us about marital health.

Before examining such limits, we provide a brief overview of the large body of research that attempts to account for variance in marital quality. Much of this research evolved from the a behavioral theory of marriage in which it is assumed that rewarding or positive behaviors increase reports of satisfaction and aversive interactions lead to reports of dissatisfaction. Although a response to concerns about the use of self-report, behaviorally oriented research ironically retained self-reported marital quality as the criterion variable it sought to explain. From the 1980s, the focus on observed behavior expanded to include the study of intrapersonal variables such as cognition and emotion. In the next

three sections of the chapter we briefly summarize what is has been learned about behavioral, cognitive, and affective correlates of marital quality, recognizing that the distinctions among these three constructs are in many ways artificial.

B. Behavior and marital quality

Attempts to identify the behavioral correlates of marital quality have taken two major forms. Using spouses as observers of their partners' behaviors, researchers have attempted to examine behaviors that covary with daily reports of marital satisfaction. A second strategy entailed observation of the behaviors of couples who reported high and low marital quality in the laboratory. What does this research tell us about the behaviors associated with marital health?

The first point to note is that agreement between spouses in reports of daily marital behaviors is low and is not improved by training spouses. Such findings raise questions about the epistemological status of spouse reports of partner behavior suggesting that they may reflect more about the reporter's perceptions than the observed spouse's behavior. With this caveat in mind, it has been found that reported spouse behaviors covary only slightly with daily reports of satisfaction (the two variables share about 25% of their variance), the covariation remains slight even when lists of behaviors are customized for each couple, behaviors classed as affective are more highly related to satisfaction than other classes of behavior (e.g. instrumental), events experienced as displeasing (e.g., "spouse interrupted me") are more highly related to satisfaction ratings than events that are "pleasing", and the association between daily behaviors and satisfaction is higher in dissatisfied than satisfied couples.

Although their status as veridical reports of partner behavior are questionable, some of the results obtained for spouse reports of behavior are remarkably consistent with the findings that emerge from observed couple interactions. For example, negative behaviors appear to more consistently distinguish couples classified as satisfied versus dissatisfied on traditional measures of marital quality. In summary, distressed couples, when compared to nondistressed couples, show a range of dysfunctional communicative behaviors when they are observed discussing problem issues, including higher levels of specific negative behaviors such as criticisms and hostility, defensiveness, and disengagement, such as not responding or tracking the partner. Distressed couples also fail to actively listen to each other when interacting. We also know that these negative interactional behaviors are more likely to occur in some contexts than others. Diary studies show that stressful marital interactions occur more frequently in couples' homes on days of high general life stress, and at times and places associated with multiple competing demands. Furthermore the topics of marital disagreements often coincide with the activities partners are engaged in at the time.

There are also particular sequences of behavior that tend to occur in distressed couples. For example, they show coercive escalation, and gender-skewed effects of female demand behaviors coupled with male withdrawal behaviors. Gender-based demand-withdraw patterns occur in many couples, regardless of marital satisfaction, but are notably strong in distressed couples.

While there is considerable agreement on the behaviors displayed by unhappy couples, much less is known about the behaviors of happy couples. Compared to distressed couples, short interactions on problem issues in nondistressed couples show more positive behaviors, such as empathy, pinpointing and verbalizing problems in a noncritical way, and generation of solutions to problems. It is likely that rewarding and intimate verbal interactions and activities are critical components of happy couple relationships. Happy couples report that spending positive shared time together is a major reason for the rewarding nature of their relationship, and happy couples also actively share and build on experiences communicated by their mate.

In summary, research on marital behavior has focused primarily on communication micro-behaviors and couple activities. We know a considerable amount about the behavioral characteristics and processes of distressed couples. In contrast, we know very little about the behavioral processes or dynamics that occur between happy partners. The available research has focused on the frequencies of specific behaviors, and is only just beginning to investigate processes such as active sharing of positive memories and events.

Although the study of interactional behavior has proven to be fruitful in understanding marital quality, its explanatory power is limited. The statistical variability shared by measures of interactional behavior and measures of marital satisfaction is relatively small and, as noted, spouses do not agree very well on the occurrence of positive and negative behavior. These findings point to the importance of how couples perceive and interpret their partner's behavior. We therefore turn to consider what is known about cognition in marriage.

C. Cognition and marital quality

The role of cognition in understanding marital quality has received considerable empirical attention in the last decade. Most research has studied the content of cognitions. For example. dysfunctional and unrealistic relationship beliefs (e.g., Disagreements are destructive, partners cannot change, as measured in the Relationship Beliefs Inventory) are related to observed spouse behavior, and significantly predict therapy outcome. However, like global measures of marital quality, such measures have been criticized because of conceptual distinctions between items, and statistical independence of underlying constructs, complexities which are lost in the amalgamation of responses into total scores.

In contrast to the focus on dysfunctional unrealistic beliefs, other research focuses on functional unrealistic beliefs. The extent to which idealized spousal qualities (e.g., kindness, affection, openness, patience, understanding, responsiveness, tolerance and acceptance) are characteristic of happy dating and married couples. Happy couples view their partners in a more positive light than their partners viewed themselves, and individuals are happier in their relationships when they idealize their partner and their partners idealize them. Very little is known about how idealization of the partner develops or erodes over the course of a relationship.

The most extensively investigated cognitions studied in marriage are the attributions spouses make for marital events. A large number of studies have shown that distressed spouses, relative to nondistressed couples, make maladaptive causal attributions that accentuate the impact of negative marital events and minimize the impact of positive events. For example, a distressed spouse may attribute their partner's failure to complete a chore to a stable and global factor located in the partner (e.g., laziness), whereas a nondistressed partner may attribute such behavior to an unstable, specific, external factor (e.g., an unusual work demand). The distinction between causal attributions (who or what produced an event) and responsibility attributions (who is accountable for the event) has also proved useful in differentiating distressed from nondistressed spouses; distressed spouses are more likely than their nondistressed counterparts to attribute negative partner behavior to selfish motives, to see it as intentional and as blameworthy. Finally, "attribution style" or variability in attributions has been linked to marital quality. Less variable responses have been associated with marital distress, although attempts to replicate this finding have only been partially successful.

The importance of attributions in understanding marital quality is further highlighted by evidence that attributions may play a role in the initiation and maintenance of marital distress. Establishing the causal role of attributions in marital distress is a difficult task as ethical and practical considerations rule out experimental studies. Perhaps the closest one can reasonably get to establishing causality is to demonstrate that attributions predict later satisfaction, while controlling for initial satisfaction. Attributions, but not unrealistic beliefs, have been found to predict marital satisfaction 12 months later after statistically controlling for earlier satisfaction. This longitudinal association has been replicated and has been shown to independent of spousal depression and marital violence. Any causal relation between attribution and marital satisfaction is hypothesized to occur through the influence of attributions on behavior. It is therefore noteworthy that maladaptive attributions are related to less adaptive problem-solving skills observed during a discussion, to greater anger and blame during a problem solving discussion, to greater rates of negative behavior and increased reciprocation of negative behavior, and that attributions account for approximately the same amount of variance in

behavior as marital satisfaction and depression. Finally, it is noteworthy that the attribution-behavior link is not a function of the association between marital quality and either of these two variables.

Although the study of behavior and cognition in couples has proven fruitful, intuitively we know that these phenomena fail to capture the full experience of marriage. What is missing from our picture thus far is what is often most evident in couple interactions, the smiles, laughs, affection and warmth which happy couples show and report and the anger, tears, distress, agitation and coldness often shown by distressed couples. In the next section, we therefore briefly turn to the literature on emotion in marriage.

D. Emotion and marital quality

A variety of indices of emotion have been applied in the study of married couples. These indices vary in the aspect of subjective emotional experience that is tapped (self-reported affect, observed affect, physiological arousal), the degree to which affect is tied to actual interactions (global self-report questionnaires versus "on-line" ratings of behavior), and the complexity in which emotion is conceived (e.g., the dimensionality of emotion, individual versus dyadic unit of analysis). This variability perhaps reflects the range of theories regarding emotion, a review of which is beyond the scope of this chapter. To simplify this section, we provide a brief overview of the most common methods used to assess emotion, and review central findings about the role of emotion in the phenomenology of happy and unhappy relationships.

An index of emotion which has long been utilized in the assessment of marital dyads is nonverbal behavior. Simple coding systems where voice tone, facial expressions and body posture are used to code affect as positive, neutral, or negative are an integral part of several coding systems. While such assessment of affect is clearly simplistic, several fascinating findings are evident which support the centrality of affect in couple relationships. For example, affect codes are more powerful than verbal codes in discriminating distressed and nondistressed couples. Further, groups were distinguished by their use of neutral and negative, rather than positive affect, with nondistressed couples being more likely to agree with neutral affect than were distressed couples. Other research reinforces the importance of observed affect. While distressed couples are able to alter verbal behavior if instructed to pretend to be happily married, they were unable to change their nonverbal behavior.

Several other indices hypothesized to capture aspects of emotion have been applied to the marital dyad, including verbal report methods, "on-line" affect rating methods, and most recently physiological measures such as heart rate. What do studies using these methods find?

Arising from the observation that married individuals consider love (or the overall level of positive affect an individual feels for his or her spouse) to be a highly important characteristic of a good

marriage, paper-and-pencil measuring this latent variable have been developed. These measures discriminate between clinic and nonclinic couples, and share about half of its variance with the MAT, suggesting that love is an important component of marital satisfaction (although this latter finding is not surprising given that affect-related items appear in the MAT). Such measures probably focus on more stable and global affect-laden beliefs operating within married individuals (e.g., honesty, trustworthiness, attraction and friendship), and the degree to which these measures reflect the experience of couples while they interact is unknown.

To investigate affective experience during interactions, other methods have involved couples making continuous ratings of affect as they review a videotape of their interaction. Typically these consist of a rating dial used to represent how they felt (ranging from very negative to very positive). Such devices reliably discriminate between distressed and nondistressed couples, with happy couples experiencing problem solving interactions with their partner as more positive than distressed couples. These studies also show that spouses' negative feelings are likely to be followed by negative feelings from the partner, whereas nondistressed spouses are likely to validate a partner when they expressed negative feelings.

These findings have been extended to the domain of physiological measures of affect. This research assumes that the sympathetic branch of the autonomic nervous system (which controls four physiological systems; heart, vasculature, sweat glands, and muscle activity) controls affect during marital interactions. Research on the patterns of physiological responses between couples provides good preliminary evidence of the role of emotion in understanding couple interactions.

Gottman and colleagues took "on-line" measurements of autonomic nervous system activity during the course of low and high conflict discussion tasks and temporally matched them with self-reported affect ratings (using the affect rating dial system) taken while the couple viewed a videotape subsequent to the interaction. Physiological interrelatedness (or "physiological linkage") occurred at the times when negative affect was reported as occurring and being reciprocated, it was higher in the high conflict task compared to the low conflict task, and was inversely related to marital satisfaction. Perhaps the most salient finding is that physiological linkage during the high conflict task explained 60% of the variance in marital satisfaction, and self-reported affect added a further 16% of variance explained. When comparing this finding to the 25% shared variance between marital satisfaction and observed behavior alone, this finding is impressive.

Gottman and colleagues assessed the role of current self-reported affect in determining future marital quality. Marital satisfaction 3 years after the initial assessment was predicted by specific gender-imbalanced patterns of affective exchange or reciprocity. Declines in satisfaction were

predicted by more reciprocity of the husband's negative affect by the wife, and by less reciprocity of the wife's negative affect by the husband. These findings suggest that as marital satisfaction declines, partners may increasingly behave in a way which further decreases marital satisfaction. Male partners may become more emotionally withdrawn, leading to increased dissatisfaction from the female partner, which results in increased negative affect reciprocity from the female. This pattern of affect reciprocity may have a considerable negative impact on marital quality in the long term. Although intriguing, these findings still await replication.

In sum, happy couples score more highly on measures of affect-laden relationship beliefs, such as love, affection, trustworthiness and honesty. As regards observed affect, even highly simplified coding systems show that unhappy couples are not only characterized by negative affect but also find it difficult to "turn off" or modify negative affect. Happy couples are distinguished from unhappy couples more by their relatively few displays of negative affect, rather than excesses in displays of positive affect. While the mapping of observed and reported affect onto physiological measures is far from perfect, affective processes (both self-reported affect and physiological indices) are strong predictors of concurrent marital quality and long term marital quality..

E. Conclusion

In this section, we have examined the construct that dominates research in the marital literature and reviewed research on its correlates. Although it receives considerable research attention, the construct of marital quality is poorly understood, which reflects, in part, the practical nature of research with elements of theory introduced on an incidental and ad hoc basis. Notwithstanding the relative lack of theoretical development, a number of behavioral, cognitive and emotional correlates of marital quality have been identified. Although important, research on marital quality provides limited information on marital health owing to some of the assumptions made in the research literature.

The problem with conceptualizing marital quality as a continuum is that marital health may not simply be the opposite of marital distress. A closely related problem is the assumption that marital health is not just the opposite of marital dissatisfaction, but the *absence* of marital dissatisfaction. Marital theorists note that such a conclusions is illogical and state emphatically that "*Marital harmony is not just the absence of whatever it is that dissatisfied couples do.*" Although the focus on pathological aspects of marriage has been helpful in defining what happy couples do not do, we know remarkably little about what happy couples do that is functional.

Even if some of the assumptions underlying research on marital quality withstand close scrutiny, there are inherent limits to the extent to which self-reports of marital quality can inform us

about marital health. This is because marital health presumably consists of more than spousal reports. In the next section of the chapter we therefore attempt to offer a more complete view of marital health.

II. Towards a more complete picture of marital health

In marital therapy and marital prevention/enrichment programs attempts are made to intervene in a couples' life to bring about or enhance marital health. These attempts are presumably based on explicit models of healthy marriage and it therefore behooves us to begin by examining these literatures in expanding our view of marital health.

A. The marital therapy literature

Marital therapy involves the professional application of psychological theories and psychotherapeutic techniques to move couples from a state of marital dysfunction to one of marital health. Therapeutic change therefore presumably provides a key to understanding marital health. Emanating from a variety of theories of marriage (e.g., behavioral marital theory; family systems theory, insight-oriented marital theory), several major therapies have been proposed, but relatively few have been subjected to controlled and replicated experimental scrutiny. An exception is behavioral marital therapy (BMT) where efficacy is thought to be well established. This mode of therapy therefore places us in a strong position to evaluate the keys to moving couples from a state of distress to a state of marital healthy.

BMT is built on the premise that if the natural contingencies in couples' interactions are changed, then a couples' relationship will become more reinforcing. Traditionally, however, BMT has only partially fulfilled this premise as it has tended to focus on extinguishing destructive interactional patterns, and much less on imparting skills aimed at enriching interactions (although promising behavioral interventions focusing on enhancing tolerance and acceptance are currently under trial). It appears that BMT has focused on a model of pathology, rather than on a model of marital health.

While we later argue that such a model is inadequate, this state of affairs enables us to address an important issue raised earlier: Is marital happiness the inverse of marital distress? For example, if therapeutic intervention results in partners who are nonviolent, do not have regular escalations of negative behaviors and affect, and do not have dysfunctional patterns of demand-withdraw behavior, are they happy? In other words does BMT produce marital happiness?

Numerous empirical reviews have evaluated over 20 controlled trials of BMT, where BMT contained combinations of behavior exchange, communication and problem solving training. BMT is clearly more effective than either no treatment or nondirective counseling. However, a significant proportion of couples (25% to 30%) do not evidence improvement at the end of therapy, and only about half are no longer marital distressed. For those couples that do show improvements in marital

satisfaction, there is substantial relapse, with less than half of presenting couples maintaining clinically significant gains longer than 2 years after therapy.

One possible reason for the limited efficacy of BMT is that it has failed to adequately provide for the development of the skills or characteristics of happy couples, and instead has focused on eliminating distressing characteristics. Perhaps for a high proportion of distressed couples, BMT interventions move couples in the right direction (i.e., by removing negatives), but fall short by not fostering whatever characterizes happy relationships. For example, little research attention has been paid to how commitment and love might be enhanced in distressed couples who wish to stay together, constructs which, as noted earlier, are associated with high marital quality. However, interventions that focus on couple intimacy have been shown to be comparable in treatment effects to conventional BMT. Also, other research has found that one the primary issues raised by marital therapy clients is their waning love for their partner. To date, there has been no clear demonstration that clinical change in these constructs occurs.

Even the interventions in conventional BMT which ostensibly enhance positive dimensions of marital experience (e.g., positive communication skills) are of questionable face validity. Do happy couples naturally use open-ended questions, reflective statements, summarize their partners' point of view, and check for understanding? Probably not as much as we think they might. The limited efficacy of BMT and its focus on extinguishing interactional patterns characteristic of distressed couples reinforces the clear need to take a step back and pay further empirical attention to qualities that make for happy relationships. What can be concluded from the BMT literature is that removal of dysfunctional behavioral patterns does not seem to work very well in the long term, and this suggests that there is more to marital health than the absence of features that characterize distressed relationships.

B. Prevention and enrichment programs

Work on the prevention of marital distress and the enrichment of existing happily married couples is somewhat more promising, with a large body of literature demonstrating that prevention programs are efficacious in the short term, and possibly in the long term. Examination of this literature may help us to understand the core processes important for the maintenance or enhancement of high marital quality.

A metaanalytic study of some 85 prevention and enrichment programs found that the average participant improved from pretest to posttest more than did 67% of those in corresponding control. This effect represents a modest increment of 17% improvement relative to an ineffective treatment (in which the average participant is better off than 50% of the controls). While these results tell us that,

broadly speaking, prevention and enrichment programs are effective in the short-term, our primary interest is in what specific interactional processes are associated with sustained marital quality. To speak to this interest, we need to examine studies that describe intervention content in sufficient detail, and which follow couples up for a period of many years (since marital distress is most likely to occur in the first 7 years of marriage).

Very few studies have examined the long term benefits of prevention and enrichment programs. Markman and colleagues evaluated a prevention program which consisted of therapy techniques used in communication-oriented marital enhancement programs (e.g., training in speaker and listener skills, expressing negative feelings and managing conflict, problem solving, expectations and relationship beliefs, and sexual enhancement). The emphasis of this program was on the future of the relationship, rather than directly addressing current problems. Although the group receiving the program and a no treatment control did not differ immediately after the intervention, couples receiving the intervention reported significantly higher relationship satisfaction 19 months later. These effects were maintained at later follow-ups. At 3 years, couples receiving treatment reported significantly higher sexual satisfaction, less intense marital problems, and higher relationship satisfaction than control couples. Five years after the intervention, couples receiving treatment reported more positive and fewer negative communication skills and less marital violence than control couples. It appears that imparting skills for dealing with future potential problems may be an important aspect of enhanced marital well-being.

What degree of confidence can we have in the conclusion that these sorts of preparative interventions contain skills important to the maintenance of satisfying relationships? Unfortunately, the Markman et al. study lacked an attention-only control condition, making it unclear whether the interventions used were responsible for the effects, or whether the effects were due to some general attention factor. Also, several researchers have raised questions about the selection biases that occur in these programs, and question whether they reach those at high risk of marital deterioration. Perhaps such couples would have had successful marriages regardless of participation in a prevention program.

Recent work has evaluated prevention programs specifically targeting couples at risk of marital distress. Using a program highly similar to Markman and colleagues' program, Van Widenfelt and colleagues recruited couples who were currently mildly maritally distressed, and couples were included if at least one partner had experienced parental divorce (two previously identified risk factors). At both 9 month and 2-year follow-ups, participation in the preventive intervention did not appear to have a protective influence on decline in relationship functioning for couples in which at least one partner had experienced parental divorce.

Conclusion. The literatures on marital therapy and on prevention/enhancement offer comparatively little to guide us as to what constitutes marital health or even what comprises a happy marital relationship. These bodies of literature suggest that there are likely to be a variety of *necessary* characteristics and skills associated with high marital quality, including good communication skills, ability to successfully and mutually anticipate and resolve problem issues, anticipation and preparation for future marital stressors, and maintaining a high ratio of positive to negative interactional behaviors. There is not convincing evidence to suggest that these characteristics are *sufficient* to produce high marital quality. Behavioral marital interventions designed to rectify or prevent such problems have modest effects in producing long term high marital quality. A significant problem with determining the critical components of prevention programs relates to ambiguity regarding the degree of risk shown by couples participating in them. We therefore turn to offer some building blocks for a more complete picture of marital health.

C. Some building blocks for an expanded view of marital health

Although existing literatures on marriage fail to provide a clear conception of marital health, they provide valuable ideas for formulating ideas for future research in this area. In this section we present some essential elements for an expanded view of marital health guided, in part, by extant research findings.

1. Marital quality. It is difficult to imagine a definition of marital health that does not include spouse reports of marital quality. At a minimum, then, we argue that marital health will include a subjective sense of well-being about the relationship. This is a theoretically simple index of marital quality that can be used as a component of marital health, however, subjective reports of marital quality are, by themselves, insufficient as an index of marital health. What else might be needed?

2. Commitment. In view of its emergence in research on positive dimensions of marriage, it is prudent to include commitment in any definition of marital health. Although there is widespread agreement regarding the phenomena accounted for by commitment, the construct of commitment has been the subject of considerable debate among social psychologists. In the present context it suffices to note that many of the conceptions can be traced to social exchange theory and, very crudely stated, amount to variations concerning the definition of and ways of combining the pros and cons of remaining in the relationship. However defined and combined, the pros of being in the relationship must outweigh the cons for commitment to exist. Marital health would be incompletely specified if we did not go further and state the commitment must be realized in the form of a marriage that lasts over time for it to be considered healthy.

3. Marital stability. At a minimum, then, marital health includes not only subjective marital satisfaction and commitment, but also marital harmony or success over time (indexed, in part, by positive spouse reports). Although most research on marital quality is motivated by the attempt to understand marital success over time, studies of marital quality are, by themselves, inadequate for gaining insight into the causes and consequences of marital success and failure. As noted earlier, marital quality and marital stability may be related but they are not synonymous. Unfortunately, the substantial literature that has developed on marital stability adds little to our understanding of marital health. Practical concerns again lead to an emphasis on the negative with most studies attempting to identify predictors of relationship dissolution with the implicit assumption that these same variables lead to understanding of marital stability.

Research on marital stability is only part of a broader and emerging emphasis on the longitudinal study of marriage. This emphasis has grown out of the recognition that concurrent correlates of marital quality may be different from those that predict marital quality over time. A recent empirical review of 115 longitudinal studies of risk factors for marital distress found that couples with a lower age at marriage, lower income, lower education, parental divorce, lower marital satisfaction, higher levels of neuroticism, and higher levels of stress may be more likely to experience marital difficulties than couples without these factors.

4. Adaptation to stress: The centrality of spousal support. In their recent analysis of longitudinal predictors of marital distress, Karney and Bradbury suggest that marital outcomes are a joint function of enduring vulnerabilities, exposure to stress, and adaptation to the stress. Because few couples can avoid exposure to stress, which is a significant risk factor for declines in marital quality, we argue that marital health must include consideration of a couples' adaptation to stress. Further, we suggest that the support each spouse offers to the partner is central to their adaptation to stress.

Most couples will experience numerous stressors during the course of their relationships. Stressors vary enormously across many dimensions, including severity, chronicity, degree of spousal care needed, and the predictability of the stressful event. For example, unemployment and work stress are common stressors associated with decreases in marital quality and increases in negative interactional behavior. Similarly, a variety of developmental transitions are often associated with stress and declines in marital satisfaction, such as parenthood, children leaving home, and retirement experience. Finally, some couples experience stress outside the norm of marital experience, such as infertility, having a child with physical or intellectual handicap, or illness/injury that may profoundly impact marital quality.

Couples vary in their ability to adapt to stress. For example, some couples might report that their relationship was severely and negatively affected by a stressful event whereas others might report a healthy adaptation to significant stress, and may even report an enhanced relationship as a consequence. Moreover, an event considered to be highly stressful to most people, may be perceived as minimally stressful by certain couples. What leads to differences in outcomes for couples? Although individuals differ in their ability to cope with stress, we argue that supportive behavior for a partner is central to the couple's adaptation to stress. In view of this claim, we turn to examine briefly social support within marriage.

Within the marital context, it has proven difficult to isolate the topography of behaviors thought to be "supportive". Clearly, social support in marriage contains a behavioral element, and the list of potentially supportive behaviors is endless. Providing problem-focused coping strategies aimed at managing or eliminating the source of stress (such as providing information about coping options, planning coping strategies, providing instrumental assistance) as well as emotional support (such as providing opportunities to debrief, responding with unconditional regard to distress, and physical affection) are all potential examples of supportive acts within the marital context. However, the essential element of social support, the sense of being supported, or "perceived support" is not well captured in purely behavioral topographies of social support.

This problem has lead marital researchers to consider the role that cognitive representations of partner behavior have in determining perceived social support. Marital theorists argue that the reason inferred for a partner behavior is likely to be a major factor in determining whether it is perceived as supportive. For example, if a spouse in need perceives a supportive partner behavior as something that was involuntary, unlikely to occur again, and selfishly motivated, perceived support may be low or absent. Conversely, if the same behavior was perceived as freely and unselfishly performed, perceived support may be high.

In summary, we make two points about the role of social support in marriage. First, perceived support (i.e., behavior independently coded as supportive, as well as attributions about the behavior) is likely to covary with marital satisfaction and facilitate successful adaptation to stress. Second, a couples' capacity to provide support in the event of stress may not be readily evident until stress arises. For example, marital satisfaction may be high, but partners' resources for coping with stress and providing support may be poor when significant stress occurs.

Thus far we have identified three central components of marital health and have briefly noted what is know about each from the available literature. Thus, marital quality, marital success or

stability, and adaptation to stress have all been identified as important elements of marital health. But do these components alone define marital health?

5. Individual well-being. We argue that a complete account of marital health requires consideration of individual well-being. Until recently, the interaction of marital and individual well-being has been underplayed. We hypothesize that the degree to which a marital relationship promotes or impedes individual well-being is a critical component of marital health. A functional and healthy marital relationship is one which contributes to individual well-being for both partners. In contrast, an unhealthy relationship is one which detracts from or impedes individual well-being in one or both partners. We turn to offer an overview of evidence (most of which is limited to the investigation of marital quality) to support this view.

6. Psychological health. There is now a large body of research linking marital quality to the etiology and/or maintenance of psychopathology. The largest body of research shows that depressive symptoms are related to marital quality. Longitudinal studies suggest that marital quality and interactional behavior may have a causal role in the etiology and maintenance of depressive symptoms. In community samples, high proportions of women who experience a significant negative marital event, and who have no history of prior depression, evidence depressive symptomatology one year subsequently. Also marital therapy interventions appear to be an effective intervention for depressed individuals and marital therapy added to existing treatment regimes (e.g., pharmacotherapy) shows added improvements in marital quality.

There is also evidence that marital quality may be associated with prolonged and dependent use of alcohol. People presenting for marital therapy report high levels of substance abuse, and people presenting for alcohol dependency treatment report high levels of marital distress. Marital distress is often a precipitant of problem drinking, and increases the chance of relapse in recently treated alcohol dependent women. Incorporating conjoint maritally focused interventions for heavy drinking males has short term efficacy (at 6 months posttreatment), providing further support for the potential role of marital problems in maintaining alcohol problems. However, the effects of these interventions are less clear in the long term (at 2 year follow-up).

7. Physical health. There is growing evidence that marital quality influences physical health outcomes, either directly or through the mediation of psychological or behavioral processes. Marital problems may impact psychological and physical health via several mechanisms. The first and perhaps most obvious is the accentuated risk of verbal and physical violence and associated physical and psychological trauma amongst distressed couples partners. Although the frequency of acts of physical aggression is similar across genders, the risk of physical and psychological sequelae are the most

serious for female partners, and the frequency of violence is accentuated where alcohol abuse is present in one or both partners.

Marital interactions may impact on physical health less directly through social control (regulation, modeling, selective reinforcement) of positive and negative health related behaviors such as smoking, drinking, diet, exercise, leisure time, and may provide a mechanism by which early detection, encouragement to seek treatment, are provided.

A third possible mechanism by which marital quality impacts on health is through persistent alterations to cardiovascular functioning, and endocrine functioning that mediates immunological changes. Predominant psychosomatic models of cardiovascular disease suggest that cardiovascular responses to environmental stressors are an important mediating mechanism. These models assume that individuals with consistently more pronounced, frequent or enduring increases in blood pressure or heart rate in response to stressors are more likely to develop cardiovascular diseases.

What support is there for the association of marital quality with cardiovascular responses and the subsequent development of cardiovascular disease? The work of Kiecolt-Glaser and colleagues suggests a positive correlation between marital distress, conflict and marital termination and biological indices of stress and physical health problems. For example, Kiecolt-Glaser and colleagues compared degree of loneliness, physical health (frequency of illness) and immunodeficiency in separated/divorced and married men (both distressed and nondistressed). Separated/ divorced men were more distressed and lonelier, had more recent illness, and had poorer values on two indices of immunity (antibody titers to two herpes viruses) compared to married men. Among married men, poorer marital quality was associated with greater distress and poorer response on one immunological measure.

Other work in this laboratory has examined the association of marital quality (poor/high/separated-divorced) with physiological indices of stress and psychological functioning amongst women. Using a cross-sectional design, and controlling for negative life events, poorer marital quality was associated with greater depression and a poorer response on these qualitative measures of immune function. Women who had been separated for a year or less had poorer immune functioning that their matched married counterparts. This study selected for those who did not abuse alcohol or drugs, addressing the criticism that nonmarried individuals may have riskier lifestyles than married people . Without longitudinal data, it is not known how the small changes but presumably consistent decreases in immunological functioning in this study affect actual health.

While there is evidence that marital quality is associated with various indices of stress and stress-related health problems, there is little guidance about what sorts of marital problems are associated with these problems. Physiological mechanisms have been proposed, but interactional

mechanisms have not. A problem with these models is that they do not elude to the processes or mechanisms by which marriage affects physical and psychological health. A few recent studies help to give a clearer idea of what types of marital problems might have an impact on physiological stress responses.

There is preliminary evidence that specific types of marital interaction processes are associated with cardiovascular response. The effects of exerting social influence or control within marital interactions impacts systematically on cardiovascular response. Compared to female partners, male partners attempting to influence, dominate, or persuade their wives display higher systolic blood pressure before and during interactions. These physiological effects are associated with increases in anger and a more hostile interpersonal style. Female partners who engage in social control behaviors do not show these elevations in systolic blood pressure. Kiecolt-Glaser and colleagues replicated this "nasty versus nice" effect on blood pressure, its gender-biased pattern, and also found that the effect holds for immune responses.

Two important observations need to be made in interpreting the research reviewed. First, the links between marital quality, interactional behavior, physiological arousal, immune functioning and the development of physical health problems are clearly in need of replication with larger sample across different laboratories. Second, the relationship between marital quality and well-being may be spurious as prior states may affect both the tendency to get married and current well-being. Without controls for pre-existing psychological states, the possibility that people with the best psychological health are selected into marriage with the most distressed remain unmarried cannot be ruled out.

Nevertheless, the research on marital quality and physical well-being points to some exciting areas for future research. There is some preliminary support for drawing together two fields of marital inquiry that have until now been explored independently. The first field is the potential bidimensionality of marital quality (positive versus negative). The second field is the findings of differential physiological responses across different interactional styles (e.g., "nasty" versus "nice", overt hostility and dominance versus withdrawal). Applying more recent conceptualizations of marital quality as bidimensional (relatively orthogonal dimensions of positive and negative behavior/affect) may clarify the relationship between marital quality and physical health. Different dimensions of marital quality may be more closely linked to physiological arousal and resultant physical stress than others, and, while there is evidence that specific interactional patterns are associated with high arousal, research to date has retained a unidimensional view of marital quality.

In the discussion so far, we have highlighted several components of a healthy relationship. These include subjective report of marital quality, commitment, marital success or stability, adaptation

to stressful events, and a positive or at least neutral impact on physical and psychological well-being. It is reasonable to hypothesize that the weight accorded to each dimension will vary according to the marital life cycle. While a percentage of couples will remain in a state of overall satisfaction with their relationship, the nature of marital quality may change according to developmental phases of marriage (e.g., having no children and few financial obligations, become parents, retirement). Also, changes in social networks, work patterns, leisure activities, and physical changes as partners grow older may lead to variation in the phenomenology of marital experience. In the next section we briefly address the changing picture of marital health over the lifespan.

D. Changing picture of marital health over the lifespan

Does the initial glow that accompanies the beginning of a relationship remain for those couples who stay together and are happy in the long term? To evaluate this question, numerous studies have examined marital satisfaction in different age, or have examined marital satisfaction retrospectively. However, methodological problems such as the confounding of age/years married, cohort differences, and memory bias, are best avoided by following couples longitudinally. Interestingly, these methods yield different findings. For example, cross-sectional research of age group cohorts, shows that marital satisfaction is high initially, lower in mid-life, and in later life shows a partial return to initial levels. When long term marriages are investigated prospectively however, this "U-curve" of marital satisfaction becomes nonsignificant. What does seem to vary longitudinally is perceptions of the ease with which disagreements are resolved, with female partners reporting that this becomes more difficult with time.

Again using cross-sectional studies of age cohorts, researchers have compared the moment-by-moment interactions of younger and older couples. Couples have been found to vary in the overall level of interactional positivity and negativity as years of marriage increase. Two studies have found that behavioral negativity tends to decrease as couples age together, and there is evidence that negative sentiment is a variable which may act independently of relationship satisfaction in older happily married couples.

In other cross sectional research these findings have been extended to the study of self-reported affect, autonomic and somatic physiology during positive, neutral, and aversive discussions in distressed and nondistressed couples. This study found higher self-reports of positive affect during marital interaction in older couples than in younger couples, and older couples found discussion of difficult issues less physiologically arousing, even after controlling for overall greater positivity. Finally, the degree to which partners are able to provide emotional and practical support to a spouse may become increasingly important in older couples, as the risk of illness increases.

As the research reviewed illustrates, there may be changes in the subjective reports of marital quality, the topography of behavior, physiological arousal and so on across the life span. Thus we should not expect the components of marital health to remain static but to reflect changes in the marital life cycle. For example, that fact that older couples, compared to their younger counterparts, show less negative affect, more positive affect, and less physiological arousal independent of marital satisfaction, suggests that any definition of marital health requires flexibility to accommodate developmental differences among married couples.

III. Summary and conclusions

In an attempt to understand marital health, we reviewed a large body of research on marriage much of which focused on marital quality. Our examination of marital quality and its behavioral, cognitive and emotional correlates provided some useful clues regarding marital health but overall it appears that we know a considerable amount about marital distress and relatively little about marital health. We argued that this reflects, in part, the tacit but mistaken view that healthy marriages are the inverse or mirror image of distressed or unhealthy marriages. As a consequence, we concluded that marital health needs to be investigated as an end in itself.

In the second section of the chapter we therefore attempted to develop a more complete picture of marital health. Our starting point was the literature on couple therapy and on prevention/enrichment as the involvement of professionals in couple relationships is presumably designed to bring about, maintain or enhance a state of marital health. There is some evidence that anticipation and preparation for future, perhaps inevitable, marital problems are an important dimension of marital health, as highlighted in research on prevention of marital distress. Overall, however, professionals' activities did not appear to be informed by explicit models of marital health but instead seemed to be based on a tacit view similar to that found in basic research; marital health is achieved by the removal or avoidance of factors associated with marital distress (e.g., poor communication). Although this may be necessary for marital health, research data do not provide convincing evidence that this strategy is sufficient for ensuring marital health.

Drawing on the basic and clinical research literatures, we went on to offer some building blocks for an expanded view of marital health. First, we identified marital quality as an important component. Its centrality for understanding marital health suggests that the examination of richer self-report measures of marital quality will pay handsome dividends. Not only will it inform more fully our conception of marital health but it will also facilitate the development of more sophisticated and clinically informative assessments of marital quality. Second, several constructs (e.g. love, idealization) investigated in social psychological research on relationships appeared to be relevant to marital health

and we included one of them, commitment, as an important building block in our analysis. A possible problem here, though, concerns the variety of approaches that have been taken to investigating this construct and we therefore recommend a clear focus on the ideas common to them.

Third, the need to realize commitment in an ongoing relationship led us to identify time as a relevant factor for understanding marital health and to propose marital stability as another important building block. As with the preceding two building blocks, the current one is meaningful for understanding marital health only when it is viewed in the context of the others. Fourth, we argued that marital health can only be understood when marriage is viewed in a broader environmental context that includes examination of stressors and couples' adaptation to them. We proposed that such a view necessarily leads to consideration of spousal support as such support seems central to successful adaptation. Fifth, our attempt to develop a more complete view of marital health lead us to propose that the influence of the marriage on individual psychological and physical health needs to be considered. Although the mechanisms linking marital functioning to individual health are complex and under explored, there is enough evidence to justify individual health variables being a marker of marital quality and, in our view, of marital health.

Finally, the broader view taken in this chapter emphasizes the need for marital health to be considered in terms of the stage of development in the marital life cycle. For example, it is quite likely that the presence of stressors external to the relationship, resources and skills for dealing with stress, and the impact of individual health problems are all linked with the longitudinal development of marital health. It is also likely that the differential weights of each component of marital health vary according to the developmental stage of a couple.

In this chapter we trust we have reinforced the clear need to enrich and widen our conception of marital quality. While traditional conceptions of marital quality have proven fruitful, it is now time to consider utilizing richer measures of marital quality, turning attention to marital health in addition to marital pathology, to more systematically assess the ways in which broad environmental forces impinge on marital relationships, the ways in which couples respond to these forces, and the mechanisms by which marital problems impact on individual health.

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