THE SUPPORTING HEALTHY MARRIAGE EVALUATION

A FAMILY-STRENGTHENING PROGRAM FOR LOW-INCOME FAMILIES

Final Impacts from the Supporting Healthy Marriage Evaluation

OPRE Report 2014-09A
January 2014

Supporting Healthy Marriage

Executive Summary

A Family-Strengthening Program for Low-Income Families: Final Impacts from the Supporting Healthy Marriage Evaluation

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Overview

The Supporting Healthy Marriage (SHM) evaluation was launched in 2003 to test the effectiveness of a skills-based relationship education program designed to help low- and modest-income married couples strengthen their relationships and to support more stable and more nurturing home environments and more positive outcomes for parents and their children. The evaluation was led by MDRC with Abt Associates and other partners, and it was sponsored by the Administration for Children and Families, in the U.S. Department of Health and Human Services.

SHM was a voluntary, yearlong, marriage education program for lower-income, married couples who had children or were expecting a child. The program provided group workshops based on structured curricula; supplemental activities to build on workshop themes; and family support services to address participation barriers, connect families with other services, and reinforce curricular themes. The study's random assignment design compared outcomes for families who were offered SHM's services with outcomes for a similar group of families who were not but could access other services in the community. This report presents SHM's estimated impacts about 30 months after couples entered the study.

Key Findings

- **SHM did not lead more couples to stay together.**
- **SHM produced a consistent pattern of sustained small positive effects on couples' relationships.** Compared with the control group at 30 months, the program group reported higher levels of marital happiness; lower levels of marital distress and infidelity; greater warmth, support, and positive communication; and less antagonistic and hostile behaviors in their interactions with their spouses. The program group also reported experiencing less psychological abuse than the control group. These impacts are similar to the impacts reported at 12 months. Reports of physical assault at 30 months were not prevalent and were not significantly affected by SHM.
- **SHM reduced women's feelings of sadness and anxiety, but it did not significantly affect the outcome for men at 30 months.** While the impact for women is small, the improvement is of interest because parental distress is linked with less positive parenting and with increased behavior problems for children.
- **SHM had little effect on indicators of coparenting, parenting, or child well-being.** Of the outcomes examined, only a few of the impact estimates are significant. Moreover, the magnitudes of these impacts are very small, and the results did not remain statistically significant after additional statistical tests were conducted to adjust for the number of outcomes examined.

Overall, SHM was well implemented, but it was fairly expensive to operate, and it did not achieve some of its central objectives — increasing the likelihood that parents stayed together or measurably benefiting children living in such households. As policymakers consider possible future directions for programs that support marriage and relationships, it will be important to focus on how best to target services to those most likely to benefit, which aspects of SHM should be included in future tests, and which should be altered in an effort to bolster program impacts and reduce costs.

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We are grateful to the program directors and staff at the eight local SHM programs that participated in this evaluation. They worked tirelessly to deliver high-quality services that met the needs of their communities and to recruit and retain couples in program services, and they generously gave their time to help MDRC and our research partners collect the data needed for the evaluation.

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Finally, we are deeply grateful to the couples and families in the study sample. Whether participating in the SHM program or as members of the control group, these families went through random assignment, participated in multiple waves of data collection, and granted us access to confidential information about themselves as part of the research effort. Without these families, this research would not have been possible.

The Authors

Executive Summary

The Supporting Healthy Marriage (SHM) evaluation was launched in 2003 to test the effectiveness of an approach to improving well-being for low- and modest-income parents and children: strengthening marriages as a foundation for supporting stable, nurturing family environments and the well-being of parents and children. The U.S. Department of Health and Human Services, Administration for Children and Families (ACF), sponsored the evaluation as part of its family-strengthening research agenda. The evaluation is led by MDRC in collaboration with Abt Associates, Child Trends, Optimal Solutions Group, and Public Strategies as well as academic experts, including Thomas Bradbury, Philip Cowan, and Carolyn Pape Cowan.

SHM is motivated by two strands of research. One growing body of correlational research shows that parents and children tend to fare better on a range of outcomes when they live in low-conflict, two-parent families; that parent-child relationships are more supportive and more nurturing when parents experience less distress in their marriages; and that children are less likely to live in poverty when they grow up in two-parent families. A different strand of random assignment research points to the potential effectiveness of preventive, skills-based relationship education curricula for improving the quality of marriages. Yet, as of 2003, this research had focused primarily on middle-income couples, and policymakers were motivated to test strategies that could improve relationship stability and quality for low-income parents and, thereby, improve the outcomes for parents and their children.

Three key SHM reports were released in 2012: the final implementation report[1] and the 12-month impact report and its technical supplement.[2] The implementation report details the characteristics and participation patterns of couples enrolled in SHM and documents how eight local programs delivered SHM services. The implementation study demonstrates that the SHM model can be implemented in a variety of contexts and that a diverse group of couples can be enrolled and engaged in marriage education services over time. The 12-month impact report presents estimated effects of SHM on outcomes that were short-term targets of the intervention and is accompanied by a technical supplement that provides more detailed information about the analysis. After 12 months, the SHM program produced a consistent pattern of positive, but small, effects on several measures of marital quality and adult psychological distress. However, the program did not lead more couples to stay together; nor did it decrease spouses' reports of infidelity or improve the quality of their coparenting relationships, compared with their control group counterparts who were not offered SHM services.

[1]Miller Gaubert, Gubits, Alderson, and Knox (2012).
[2]Hsueh et al. (2012a); Hsueh et al. (2012b).

The current report examines longer-term impacts of SHM on the likelihood that couples stayed together, the quality of marital and coparenting relationships, and adult individual psychological well-being.[3] It also examines impacts on parenting and child well-being outcomes, which were not examined in earlier reports. In brief, SHM produced small but sustained improvements in program group couples' marital functioning, reductions in psychological abuse between spouses, and improvements in psychological well-being for women relative to their counterparts in the control group. These impacts, however, did not translate as hypothesized into significant impacts on the longevity of couples' marriages at the 30-month follow-up. Nor did they translate into substantial impacts on coparenting, parenting, or outcomes for children ages 2 to 17.

The SHM Program Model

In eight locations across the United States, the SHM evaluation tested a voluntary, yearlong program for low- and modest-income married couples who, at study entry, had children or were expecting a child. The program comprised the three complementary components described below.

The program's central and most intensive component was *a series of relationship and marriage education workshops for groups of couples* that was offered in the first four to five months of enrollment in the program. Longer than most marriage education services and based on structured curricula shown to be effective with middle-income couples, the workshops were designed to help couples enhance the quality of their relationships by teaching strategies for managing conflict, communicating effectively, increasing supportive behaviors, and building closeness and friendship. Workshops also wove in strategies for managing stressful circumstances commonly faced by lower-income families (such as job loss, financial stress, or housing instability), and they encouraged couples to build positive support networks in their communities. The eight local programs selected one of four curricula for their workshops, which provided a total of 24 to 30 hours of curriculum.

Complementing the workshops was a second component, offered for the year after enrollment, that consisted of *supplemental activities:* educational and social events that were intended to build on and reinforce lessons from the curricula.

[3]Like the 12-month impact report, this report also is accompanied by a technical supplement that provides more detailed information about the study design, analytic approach, construction of outcome measures, nonresponse bias analyses, sensitivity analyses, and subgroup analyses; it also includes copies of the adult and youth survey instruments. See Lowenstein et al. (2014).

The third component, *family support services*, paired couples with a specialized staff member who maintained contact with them and facilitated their participation in the other two components throughout the duration of the program. Because programs sought to keep couples engaged in services for one year, family support staff helped to meet family resource needs by connecting participants with other needed services, which also helped address participation barriers. Staff also reinforced the workshop themes and skills in their one-on-one meetings with couples.

The final implementation analysis found that the eight local programs participating in the study operated the full SHM program model in adherence with established guidelines.[4] Moreover, a substantial number of couples with diverse backgrounds were enrolled and participated in SHM services. According to program information data, on average, 83 percent of program group couples attended at least one workshop; 66 percent attended at least one supplemental activity; and 88 percent attended at least one meeting with their family support workers. Overall, program group couples participated in an average of 27 hours of services across the three components, including an average of 17 hours of curricula, nearly 6 hours of supplemental activities, and 4 hours of in-person family support meetings.

The average SHM operating cost per couple was $9,100, ranging from $7,400 to $11,500 per couple across the local programs. These calculations include the cost of program infrastructure and administration systems, facilities, staffing, and other operating costs that local programs incurred during a steady state of implementation. Costs for SHM may be somewhat higher than for a typical marriage education program for a number of reasons. First, SHM sought to test fairly intensive services over a longer period of time, and the costs reflect the intensity of these services, which were designed to be more comprehensive than most marriage education programs. Moreover, given a context in which all enrollees counted for the purposes of the impact analysis, programs devoted substantial resources and staff attention to engaging and retaining couples in services once they were enrolled in the program. Lastly, because SHM was brand new in most locations, average costs might be higher than costs of other relationship education services, which are embedded in larger organizations or delivered as add-ons to existing programs, whereby economies due to shared space or administrative systems might be possible.

[4]Miller Gaubert, Gubits, Alderson, and Knox (2012).

Intake and Characteristics of Couples and Children in the Research Sample

To be eligible for the study, couples were supposed to be low income, married, at least 18 years old, and either expecting a child or parents of a child under age 18 who was living in their home — though couples were not required to provide any documentation verifying that they met these eligibility criteria. They also had to understand one of the languages in which SHM services were offered (English or, in some locations, Spanish) and have no indication of domestic violence in the relationship.

From February 2007 to December 2009, a total of 6,298 couples meeting these eligibility criteria were recruited into the study and were randomly assigned into one of two research groups: (1) a program group, which was offered the package of SHM services, or (2) a control group, which was not provided SHM services but was not prevented from accessing other services available in the community.

Because couples applying for SHM services were allowed to self-report whether they met the study's eligibility criteria, it is important to assess the extent to which the characteristics of the study's sample reflect its targeted population. At study entry, all couples were expected to be married. But when asked about their marital status on later follow-up surveys, only 82 percent of couples reported in retrospect that they had been married when they entered the study.[5] This varied somewhat by location — in part, because some programs asked couples whether they considered themselves to be married rather than whether they were legally married, while other programs placed more emphasis on legal marriage as an eligibility criterion. As would be expected, given that SHM targeted low-income couples, the SHM sample is economically disadvantaged. At study entry, most couples had low to modest incomes: 43 percent had incomes below the federal poverty level, and 39 percent had incomes between 100 percent and 200 percent of the threshold.

To further characterize the sample, couples in the SHM evaluation are quite diverse. About 43 percent of couples are Hispanic; 21 percent are white; 11 percent are black; and 25 percent either are of another race or the spouses differ in racial or ethnic backgrounds.

Many of the couples reported marital distress and other stressors that can undermine relationships. Couples had been married or in committed relationships for about six years, and more than a quarter of couples reported that a stepchild was living in the household. Couples

[5]The impact analysis includes couples who enrolled in the study, regardless of their marital status at study entry. Couples who reported being in a committed relationship are considered "married" in tables in the report. As a sensitivity check, the impact estimates were compared for those who reported being married and those who did not report being married when they entered the study; there was not strong evidence that the effects of SHM differed for these two groups (not shown).

reported high rates of marital distress; more than half of them reported thinking that their marriage was in trouble in the year before entering the study. About one-fourth of couples had at least one spouse who was experiencing psychological distress. Similarly, about one-fifth of couples had at least one spouse who reported a substance abuse problem.

Compared with low-income married couples with children from two nationally representative samples, SHM couples were substantially less likely to be happy with their marriages and more likely to think in the past year that their marriages were in trouble. These comparisons suggest that the typical SHM couple may be more vulnerable to relationship instability than an average low-income married couple with children in the United States.[6]

Lastly, at the 30-month follow-up point, focal children in the SHM sample ranged from 2 to 17 years of age.[7] Focal children in the control group showed levels of adjustment and well-being at the 30-month follow-up that were similar to those of national samples of children and somewhat higher than those of other low-income samples.

The Impacts of SHM on Services Received

The first step in understanding the effects of the SHM program is to examine its impacts on service receipt.

- **As expected, program group couples received substantially more group relationship and marriage education services than control group couples.** As reported by study participants, about 90 percent of program group couples, compared with 23 percent of control group couples, received any relationship and marriage education services in a group setting in the year after entering the study. About 43 percent of program group couples reported attending more than 10 group sessions, compared with less than 3 percent of control group couples.

The 30-Month Impacts of SHM

Table ES.1 presents the estimated effects of SHM on core measures of the stability and quality of marital relationships, individual psychological distress, coparenting and parenting, and child

[6]Karney and Bradbury (1995).

[7]One child — who was under age 14 (or could have been in utero) — was selected for each family as the *focal child* for each of the follow-up data collection activities.

The Supporting Healthy Marriage Evaluation

Table ES.1

Estimated Impacts on Primary Outcomes at the 30-Month Follow-Up

Outcome	Program Group	Control Group	Difference (Impact)	Effect Size		Standard Error
Relationship status						
Married[a](%)	81.5	81.5	0.0	0.00		1.0
Marital quality						
Couple's average report of relationship happiness[b]	5.94	5.79	0.15	0.13	***	0.03
Either spouse reported marriage in trouble (%)	42.8	47.3	-4.5	-0.09	***	1.3
Men's report of warmth and support[c]	3.55	3.50	0.05	0.09	***	0.01
Women's report of warmth and support[c]	3.45	3.40	0.05	0.10	***	0.02
Men's report of positive communication skills[c]	3.29	3.22	0.06	0.10	***	0.02
Women's report of positive communication skills[c]	3.24	3.18	0.06	0.10	***	0.02
Men's report of negative behavior and emotions[c]	2.07	2.15	-0.08	-0.09	***	0.02
Women's report of negative behavior and emotions[c]	2.04	2.13	-0.09	-0.12	***	0.02
Neither spouse reported infidelity (%)	92.4	90.9	1.5	0.05	*	0.8
Psychological abuse and physical assault						
Men's report of psychological abuse[c]	1.26	1.30	-0.05	-0.10	***	0.01
Women's report of psychological abuse[c]	1.24	1.28	-0.04	-0.07	***	0.01
Men's report of any physical assault (%)	9.4	10.4	-1.0	-0.04		0.9
Women's report of any physical assault (%)	7.0	8.2	-1.2	-0.04		0.8
Individual psychological distress[c]						
Men's psychological distress	1.90	1.93	-0.03	-0.05		0.02
Women's psychological distress	1.98	2.04	-0.06	-0.09	***	0.02
Coparenting and parenting[a]						
Men's report of cooperative coparenting[c]	3.45	3.42	0.03	0.05	*	0.02
Women's report of cooperative coparenting[c]	3.28	3.25	0.03	0.04		0.02
Paternal supportiveness of child	—	—	—	-0.02		0.03
Maternal supportiveness of child	—	—	—	0.02		0.03
Paternal responsiveness to child	—	—	—	0.03		0.03
Maternal responsiveness to child	—	—	—	0.04		0.03
Paternal hostility toward child	—	—	—	0.00		0.03
Maternal hostility toward child	—	—	—	0.01		0.03
Paternal harsh discipline[c]	1.23	1.27	-0.04	-0.07	**	0.02
Maternal harsh discipline[c]	1.26	1.29	-0.03	-0.05	*	0.02

(continued)

Table ES.1 (continued)

Outcome	Program Group	Control Group	Difference (Impact)	Effect Size	Standard Error
Child adjustment and well-being[d]					
Self-regulation	—	—	—	0.03 *	0.02
Internalizing behavior problems	—	—	—	-0.03	0.02
Externalizing behavior problems	—	—	—	-0.04 *	0.02
Cognitive and academic performance	—	—	—	0.04	0.03
Sample size[e]					
Men	2,182	2,304			
Women	2,413	2,464			
Couples	2,497	2,537			
Children	2,263	2,285			

SOURCES: MDRC calculations based on the SHM 30-month adult and youth surveys and direct child assessments.

NOTES: Estimates were regression-adjusted using ordinary least squares, controlling for pre-random assignment characteristics of sample members.

Statistical significance levels are indicated as follows: *** = 1 percent; ** = 5 percent; * = 10 percent.

Rounding may cause slight discrepancies in sums and differences.

[a]This includes couples who, at the 30-month follow-up, were still married or in a committed relationship with the partner they had when they entered the study.

[b]The scale ranges from 1 to 7, where 1 = "completely unhappy" and 7 = "completely happy."

[c]The scale ranges from 1 to 4, where higher scores indicate higher levels of the outcome.

[d]Multiple measurement sources were used to measure all parenting and child outcomes except for coparenting and harsh discipline. The outcomes were standardized by measurement source using control group means and standard deviations. Standard errors were adjusted to account for nonindependence of measures at the family level. Program and control group means are not presented for these outcomes because they are less relevant to the interpretation of program impacts.

[e]The sample sizes in this table reflect the sample sizes for the outcomes with the least missing data. Some outcomes in the table have smaller sample sizes because the criteria used to determine respondent eligibility varied for different survey items.

well-being outcomes, approximately 30 months after couples enrolled in the study. (Box ES.1 provides additional details about how to read the tables showing impact estimates.) The results are summarized below.

- **SHM did not lead more couples to stay together.** In both the program group and the control group, the percentage of couples who remained married or in a committed relationship dropped from 100 percent at baseline to 90 percent and 82 percent at the 12-month and 30-month follow-up points, respectively. This points to fairly high rates of relationship instability among couples in the SHM sample, even considering that some couples were not married when they entered the study.

Box ES.1

How to Read Table ES.1

The effects, or *impacts*, of the SHM program shown in Table ES.1 are estimated by comparing outcomes for the program and control groups, adjusted for background characteristics of the sample members. This table presents a series of numbers that are helpful for interpreting the estimated impacts of the SHM program. The first two columns of numbers show the mean values of outcomes for the program and control groups. The excerpt from Table ES.1 below shows the percentage of program and control group couples who reported thinking, in the three months before the survey interview, that their marriage was in trouble. Over 47 percent of control group members reported thinking this, compared with nearly 43 percent of program group members.

Estimated Impacts on Marital Quality at the 30-Month Follow-Up (Excerpt)

Outcome	Program Group	Control Group	Difference (Impact)	Effect Size	Standard Error
Marital appraisals					
Either spouse reported marriage in trouble (%)	42.8	47.3	-4.5	-0.09 ***	1.3
Sample size					
Couples	2,249	2,291			

The number in the "Difference (Impact)" column displays the estimated impact — or the difference between the average outcomes for the program group and the control group. As shown in the table, the estimated impact on couples' reports of their marriage being in trouble is –4.5 percentage points (42.8 percent in the program group *minus* 47.3 percent in the control group).

The impact estimates are translated into standardized *effect sizes* by dividing the impact estimate by the standard deviation* of the outcome for the control group. Translating impact estimates into effect sizes can make it easier to compare the magnitude of effects across different studies. One way to interpret the substantive significance of the impact estimates is by using a rule of thumb whereby effect sizes of about 0.20 or less are considered "small," effect sizes of about 0.50 are considered "moderate," and effect sizes of about 0.80 or more are considered "large."†

The number of asterisks shown in the table indicates whether an estimated impact is *statistically significant* (or that the impact is large enough that it is unlikely to have occurred by chance). One asterisk corresponds with an estimated impact that is statistically significant at the 10 percent level; two asterisks reflect the 5 percent level; and three asterisks reflect the 1 percent level, meaning there is less than a 1 percent chance that a program with no effect would have generated such a large difference.

The *standard errors* in the table are estimates of the variability (or statistical imprecision) of the impacts of the SHM program. Larger standard errors indicate greater uncertainty in the magnitude of the impact estimates.

NOTES: *The *standard deviation* is a measure of how widely dispersed data are around their mean.
†Cohen (1988).

- **The SHM program produced a consistent pattern of small but statistically significant positive effects on the quality of couples' marital relationships that were sustained 30 months after couples entered the study**. Program group members reported higher levels of marital happiness, lower levels of marital distress, greater warmth and support, more positive communication skills, and fewer negative behaviors and emotions in their interactions with their spouses, relative to control group members. The pattern and magnitude of impacts on these outcomes are strikingly similar to those identified at the 12-month follow-up. At the 30-month follow-up, men and women in the program group also reported less infidelity in their relationships than their control group counterparts.

- **Compared with spouses in the control group, spouses in the program group reported experiencing slightly less psychological abuse, but physical assault was not significantly affected.** Men and women in the program group reported less psychological abuse in their relationships than their control group counterparts — a potentially important finding, since any abuse in the home can have important ramifications for adult and child well-being. SHM did not significantly affect men's or women's reports of physical assault at the 30-month follow-up. About 10 percent of men and less than 8 percent of women reported that their spouse had physically assaulted them in the three months before the survey.

- **Women in the program group reported slightly lower levels of psychological distress than their counterparts in the control group, but the effect on men's psychological distress is not statistically significant.** The estimated impacts on women's psychological distress (such as feelings of sadness or anxiety that interfered with daily activities) are small in magnitude but of interest, since parental depression and distress are often linked with less positive parenting practices and increased problem behaviors for children.[8]

- **SHM had little effect on coparenting, parenting, or child well-being.** Out of the 10 coparenting and parenting outcomes examined, only three impacts are statistically significant. The magnitudes of these impact estimates are very small. Out of the four child well-being outcomes examined, only two impacts are statistically significant, and the magnitude of the impact estimates is extremely small. These findings did not remain statistically signifi-

[8]Hoffman, Crnic, and Baker (2006); McLoyd (1990); Conger and Elder (1994).

cant after additional statistical tests were conducted to adjust for the number of outcomes examined.

- **SHM's estimated impacts are generally consistent across the eight local programs in the evaluation (not shown).** Although the estimated effects are larger in some programs than in others, the differences across programs are too small to conclude that they result from true differences in the programs' effectiveness rather than from chance variation.

- **Some evidence suggests that SHM's positive effects may be larger for couples who reported moderate or high levels of marital distress at study entry and for the youngest children in the sample (not shown).** Caution is needed when interpreting these results, however, as the differences across subgroups are not statistically significant once adjustments are made for the number of outcomes and subgroups examined.

Discussion

At the outset of the Supporting Healthy Marriage project, scarce information existed about the effectiveness of programs focused on strengthening marriages and improving the prospects for children in low- and modest-income families with diverse racial and ethnic backgrounds. This report provides some of the first rigorous evidence and insights into the longer-term effects of these programs on such families.

SHM adds new information to what has been learned in three recent random assignment evaluations of family strengthening interventions targeting lower-income couples: the Building Strong Families evaluation, a large-scale evaluation of a relationship skills education program for *unmarried* parents; the Supporting Father Involvement intervention, a preventive couples-focused program aimed at strengthening family functioning and fathers' involvement; and, the PREP for Strong Bonds intervention, which is a study of the Prevention and Relationship Enhancement Program (PREP) curriculum delivered by Army chaplains to married couples. SHM's findings generally align with the results of these evaluations, given that two of them also found positive effects on marital quality, but the studies collectively show inconsistent or limited effects on other domains of interest — marital stability, parenting, and child well-being.[9]

In sum, SHM was a fairly expensive program that did not consistently achieve some of its central objectives: increasing the likelihood that parents would stay together and benefiting

[9]Stanley et al. (2010); Cowan et al. (2009);Wood et al. (2012).

children living in such households. While SHM did improve marital quality for program group couples, these effects were likely too small to appreciably affect marital stability, parenting, and children's adjustment and well-being. The findings suggest that it may be challenging for family-strengthening programs, as currently designed, to sufficiently change aspects of family functioning to improve children's lives in low- and modest-income families when they are delivered on a large scale.

Looking forward, there may be ways to build on SHM's foundation and better serve low-income two-parent families. The subgroup analysis, for example, suggests that SHM's effects may be larger among couples experiencing higher levels of marital distress when they entered the study and among the youngest children in the sample. While these findings should be viewed with caution because statistical tests indicate that they could have occurred by chance, the results point to potential areas for further investigation in terms of effectively targeting services. Thus, future research could aim to better understand who is likely to benefit from more highly targeted services. Moreover, given fairly high dissolution rates among couples in the sample, the findings also draw attention to the need for tailoring services to better address the vulnerabilities of couples who are already close to dissolution. In addition, it will be important to consider which aspects of SHM should be included in future tests of relationship-strengthening services and which should be altered in an effort to bolster program impacts and reduce costs.

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NOTE: A complete publications list is available from MDRC and on its Web site (www.mdrc.org), from which copies of reports can also be downloaded.

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