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The goal of this study was to determine predictors of children’s health care use in families that were presenting for couple and family therapy. Participants completed a battery of assessments addressing various aspects of biopsychosocial functioning. Best subsets multiple regressions were used to determine which variables were best suited as predictors of children’s health care use. Results suggest that parents’ marital cohesion and life satisfaction were significant predictors of their children’s medical use. Specifically, an increase in parents’ marital cohesion was associated with increased use of health care services by children. Also, lower life satisfaction reported by the parent was related to more use of health care services by the child. These two variables accounted for 46% of the variance in the children’s health care use. The identified predictors are valuable potential targets for therapeutic intervention in a family and couple therapy setting.

KEYWORDS health care, children, marriage and family therapy

INTRODUCTION

Throughout history, there has been significant debate about the mind-body relationship. Thomas Jefferson and John Adams may have argued about the reality of a connection between the mind and body (Robinson, 2003). The
notion of the mind-body relationship in individual health is also supported by modern research (Lotan, Merrick, & Carmeli, 2005; Rangell, 2002). For example, the brain is often considered the body’s first line of defense against illness (Oakley, 2004). Emotional hostility has been associated with poor survival in coronary artery disease (Boyle et al., 2004). Psychological and emotional support have been shown to improve the course of recovery from illness (Levenstein, 2002), to reduce risk of cardiac mortality after hospital discharge (Frasure-Smith, 1991), and to have positive effects on postpartum health and costs (Kennell, Klaus, McGrath, Robertson, & Hinkley, 1991). There is considerable evidence of a substantial link between psychological and biological functioning.

In addition to the mind-body connection, interpersonal family relationships have been shown to have an influence on an individual’s physical health and functioning. For example, marital satisfaction has been shown to be associated with almost all of the major psychiatric disorders (Whisman, 2007). Also, there have been many studies that suggest a negative relationship between physical illness and marital satisfaction (e.g., Strawbridge, Wallhagen, & Shema, 2007) and marital status (e.g., Blay, Andreoli, & Dewey, 2007). Marks and Lambert (1995) found that divorce was especially damaging to women’s mental health. They also noted an improvement in mental health for people who got married. Goodwin, Hunt, Key, and Samet (1987) found that unmarried surgical patients were more likely to die in hospitals than were married surgical patients. Additionally, Gordon and Rosenthal (1995) found that unmarried hospital patients had higher bills and longer stays compared to their peers who were married. Findings from Lillard and Waite (1995) suggest that married men and women live longer than unmarried people. Married people also report fewer occurrences of minor illnesses such as a common cold. This suggests that a healthy marriage may help sustain and improve individual immune responses (Kiecolt-Glaser et al., 1987).

In addition to studies that show an association between health and relationships in adults, there have been studies showing a connection between psychosocial functioning and health in children (Janicke, Finney, & Riley, 2001). Children with low perceptions of self-blame have been shown to be more protected against health problems than children with higher perceptions of self-blame (Harger, 2000). Children who struggle with attention-deficit/hyperactivity disorder (ADHD) have been found to use more outpatient visits, acute care services, and other general medical services than children without ADHD (Debar, Lynch, & Boles, 2004). Weimer, Hatcher, and Gould (1983) also found a relationship between family conflict and children’s physical health as indicated by use of health care services. Generally speaking, children who have difficulty with psychosocial functioning or who struggle with mental health issues also tend to have more difficulty with physical health–related issues.
Health Care Use by Children

In terms of preventative approaches to children’s health, it is valuable to understand predictive factors of children’s health care utilization. Most research on children’s health care utilization focuses on specific populations defined by demographics and medical diagnoses, such as children among particular racial groups (Moon, Farmer, & Tilford, 2005), children living in rural areas (Probst, Moore, & Baxley, 2005), children of immigrant families (Guendelman, Angulo, Wier, & Oman, 2005), children in vulnerable situations such as poverty (Kelly, Binckley, Neace, & Gale, 2005; Wong, Galbraith, Kim, & Newacheck, 2005), children with sickle cell disease (Shankar et al., 2005), and children with HIV (Rutstein et al., 2005). There have also been studies designed to examine the parental factors that contribute to children’s health care use. For example, Sills, Shetterly, Xu, Magid, and Kempe (2007) found that children with at least one depressed parent are likely to use more health care services than children whose parents are not depressed. Jhanjee, Saxeena, Arora, and Gjerdingen (2004) found that children whose parents struggled with depression were more likely to experience noncompliance with well-child visits. In other words, depressed parents were less likely to take their children to scheduled preventative care appointments even though all parents in the same study report believing that well-child visits are important, especially for preventative purposes such as receiving immunizations. Although the design of their study does not permit conclusions related to causality, there is strong evidence that parent’s mental health influences how children receive health care services.

In addition to exploring the influence of parent’s mental health, researchers have studied children’s health care use from the perspective of parental motivation and preparedness (Ertmann, Soderstrom, & Reventlow, 2005). The researchers conducted qualitative interviews by diary with 20 families who had recently experienced the birth of a child. The diaries were kept for 3 months, when the infant was 9 to 12 months old. The researchers also used retrospective information from birth to the age of 9 months. Their findings suggest that parents who feel afraid, overburdened, or inadequately prepared to provide appropriate care for an ill child are more likely to use health care services.

Further research has suggested that caregiver mental distress is also a predictor of emergency care visits (Dybdahl, 2001). Mothers who are more emotionally distressed tend to take their children for emergency care treatment more frequently than mothers who are experiencing less distress. Although research has identified several predictors of children’s health care use related to parent’s functioning, there are potential predictors related to social functioning, mental health, quality of life, and general relationship functioning that remain unexplored. Identifying additional predictors of
children’s health care use is an important area of study that warrants additional exploration.

Purpose of the Study

Despite extensive research exploring children’s health care use in specific populations, few studies have examined predictive factors related to family relationships. In a conceptual context that recognizes a biopsychosocial integration of health, it is reasonable to propose a connection between healthy marriages and the physical and mental health of family members. Because of this connection, it is also reasonable to propose that psychosocial interventions such as marriage and family therapy (MFT) may negatively influence the use of medical services by family members, including children, which may result in a decrease of unnecessary health care utilization by family members. It is likely that there are biopsychosocial variables related to marital and family relationships, such as social functioning, mental health, quality of life, and relationship skills, that may be used as effective predictors of health care utilization. The purpose of the current study was to determine which specific variables related to marital and family functioning may predict children’s health care use. It was generally hypothesized that issues that are typically addressed in couple and relationship therapy, such as aspects of parent’s psychosocial functioning, will be among the most important predictors of their children’s health care use. It is expected that a well-functioning family will be more connected to internal and external resources and therefore may be better capable of appropriately managing minor health care needs on their own, whereas a distressed family may be more overwhelmed and rely more on external health care resources in order to manage minor health needs.

METHOD

Design

The study used a longitudinal design. A battery of assessments was used to collect participant information. Approval to conduct the study was obtained from the university institutional review board (IRB). The data were analyzed using best subsets multiple regression.

Sample

Participants were recruited from an MFT training clinic in the western United States. To be eligible to participate, participants had to be parents with children aged 0 to 18, they must have requested therapy specifically related to relationship problems, and they must have agreed to release a copy of their medical records. Due to the high levels of health care use associated with
pregnancy and the resulting potential to skew the data, couples who were pregnant during the study period were not eligible to participate. Twenty-six men (43%) and 34 women (57%) participated in the study. Power analysis for multiple regression indicated that an N of 60 was sufficient to achieve statistical power at the .8 level assuming a moderate effect size. Ages ranged from 20 to 52 ($M = 31.04$, $SD = 10.041$). Of the 60 participants, 57 (95%) were currently married and 3 (5%) were separated or divorced. Forty participants (75.5%) were in their first marriage, 3 (5.7%) were in their second marriage, and 10 (18.9%) did not indicate. The number of years married ranged from 1 to 30 ($M = 8.14$, $SD = 8.53$). Fifty-seven (95%) of the participants were Caucasian. The mean number of years of education was 15.89 ($SD = 1.672$), with roughly half (52%) of the participants having completed a college degree. Participants' annual household income ranged from $5,000 to $110,000 ($M = $26,099.41, $SD = $25,920.74). Ninety-eight percent of the participants indicated Christian as their religion. The number of children per household ranged from 1 to 5 ($M = 1.85$, $SD = 1.65$). The mean number of total self-reported physician visits in the last 6 months for participants' children was 2.42 ($SD = 2.84$). For completing and returning the assessments, participants were compensated between $25.00 and $35.00. The compensation amount was increased part way through the study in order to recruit more participants.

Procedure

Clients requesting therapy were informed about the study during an initial telephone contact with the clinic. Participants who gave verbal consent to be contacted regarding the study were mailed an assessment packet and return envelope. The assessment packet included copies of the study measures, as well as an informed consent agreement. Of the participants who had given verbal consent to participate in the study and agreed to complete the information packet, approximately 50% returned the packets. It was not known whether differences existed between those who returned the packets and those who did not.

A number of steps were taken to protect the confidentiality of the participants in the study. All identifying information provided by participants was kept in a locked cabinet and could only be viewed by the principle investigator. In addition, each participant was assigned a code number and all identifying information was removed from the assessments. All data entry was done using the confidential version of the assessments.

Measures

Participants were asked to complete a demographic questionnaire that was developed for this study. The questionnaire collected information on
gender, age, race, income, education, marital status, number of years married, number of times married, number of children living at home, and religion. The participants were also asked to fill out six measures addressing different aspects of biopsychosocial functioning. The measures were the Modified Patient Assessment Questionnaire, the Multidimensional Health Profile-Psychosocial Functioning, the Brief Symptom Inventory, the Family Assessment Device, the Revised Dyadic Adjustment Scale, and the Family Emotional Involvement and Criticism Scale.

MODIFIED PATIENT ASSESSMENT QUESTIONNAIRE (MPAQ)

The MPAQ is a modified version of the Patient Assessment Questionnaire (PAQ) (Wells, 1999). The MPAQ assesses subjects’ reports of medical care utilization of at least one child and a spouse in the last 6 months. In the MPAQ, the PAQ questions were changed to reflect the subject of each of the items to be the person for whom the subject was reporting. The MPAQ asks parents to recall for a 6-month period, the number of overnight hospital stays, the number of physician visits, the number of emergency department visits, and the number of prescriptions for their oldest child. To date the MPAQ has no known psychometric qualities that can be reported. However, prior research suggests that self-report, spouse reports, and parent reports of medical visits are significantly correlated with actual medical records (Jakubowski et al., 2008). This suggests that self and family member’s reports of medical visits may be as reliable as a manual review of medical charts.

MULTIDIMENSIONAL HEALTH PROFILE-PSYCHOSOCIAL FUNCTIONING (MHP-P)

The MHP-P assesses aspects of psychosocial functioning (Ruehlman, Lanyon, & Karoly, 1998). The MHP-P assesses coping skills, social resources, mental health, and life stress. Analyses suggest that the MHP-P has a stable factor structure and there is evidence of convergent and discriminant validity for the scale. Significant correlations ($p < .001$) were found on test-retest procedures for each of the scales.

BRIEF SYMPTOM INVENTORY (BSI)

This measure is composed of three main global measures of mental health (Derogatis, 1993). They are the positive symptom total, the positive symptom distress index, and the general severity index. There are also nine subscales that measure interpersonal sensitivity, obsessive-compulsivity, somatization, depression, anxiety, phobic anxiety, hostility, psychotism, and paranoid ideation. Higher scores indicate greater distress, with a clinical cutoff score of 63. Derogatis investigated the psychometrics of the nine subscales in the
BSI and found internal consistency coefficients ranging from 0.71 for psychoticism to 0.85 for depression. Test-retest analyses were also performed. The consistency coefficients ranged from 0.80 for the positive symptom total to 0.90 for the general severity index. These findings suggest that the BSI has good internal consistency. Additionally, results from factor analyses and correlation studies attest to the validity of the BSI (Derogatis, 1993).

**FAMILY ASSESSMENT DEVICE (FAD)**

The FAD is a 60-item, seven-scale self-report measure that assesses family functioning by using a Likert-type scaling system (Epstein, Baldwin, & Bishop, 1983). Higher FAD scores are correlated with clinically unhealthy families, which indicates poorer family functioning. The FAD measures overall family functioning in six key areas: roles—which assesses beliefs about how household and family responsibilities are defined and how well they are achieved, affective involvement, behavior control, problem solving, communication, and affective regulation. In general, an overall family functioning score is calculated. The behavior control scale and the general family functioning scale measure independent aspects of family functioning (Ridenour, Daley, & Reich, 2000). The subscales of the FAD have been shown to have good internal consistency with Cronbach’s alpha scores ranging from .72 to .92 (Epstein et al., 1983).

**REVISED DYADIC ADJUSTMENT SCALE (R-DAS)**

The R-DAS is a measurement that assesses dyadic adjustment (Busby, Crane, Larson, & Christensen, 1995). It is a 14-item scale based on the DAS scale developed by Spanier (1976). The measure provides scores for the following three subscales: cohesion ($\alpha = .80$), consensus ($\alpha = .81$), and satisfaction ($\alpha = .85$), as well as a total R-DAS score (range 0 to 69, $\alpha = .90$). The R-DAS has a cutoff score of 48. Scores below the cutoff indicate marital distress (Crane, Middleton, & Bean, 2000). Factor analyses provide evidence for construct validity of the R-DAS. Furthermore, correlation research with other marital instruments provide evidence of construct validity for the R-DAS; criterion validity has been demonstrated by discriminant analyses, and internal consistency estimates and split-half reliability estimates provided evidence that the R-DAS is reliable (Busby et al., 1995).

**FAMILY EMOTIONAL INVOLVEMENT AND CRITICISM SCALE (FEICS)**

This is a 14-item measure that assesses emotional involvement (EI) and perceived criticism (PC) (Shields, Franks, Harp, McDaniel, & Campbell, 1992). It was designed to examine expressed emotion or the ability of the family
to talk about emotions with one another. A high score on the FEICS represents higher family functioning and less criticism between family members. Analysis found Cronbach’s alpha for this measure to be .82 for the PC subscale and .74 for the EI subscale. A confirmatory factor analysis showed that all questions loaded on its proposed factor with loadings greater than .50. Analysis of the FEICS suggests that it has construct validity, criterion validity, and acceptable levels of reliability (Shields et al., 1992).

Data Analysis
Best-subsets multiple regression was used to test the hypothesis that aspects of parent’s psychosocial functioning would be among the most important predictors of their children’s health care use (MINITAB 13). Best subsets regression was used because it reduces the number of variables in a model by excluding those that do not help explain the majority of the variance in the dependant variable. The result is a subset of variables that are best suited as predictors. A two-step process was used to determine the most significant predictors of children’s health care use. The first step used best subsets multiple regression as a way of limiting the number of potential predictors of children’s health care use. The possible predictors were divided into five groups that represent: demographics, social functioning, mental health, health-related quality of life, and relationship functioning (Table 1). A best subsets regression was run for each of the five groups to determine which predictors should be retained for each group. Consistent with Janicke, Finney, and Riley (2001), a predictor was considered significant so long as the $p < .15$.

The second step involved placing the significant variables for each group into a single group of predictors of children’s health care use. Combining the significant group variables for final best subsets regression is known as an “across-component” analysis (Janicke et al., 2001). For the final regression model, variables that were determined to have a significance level at $p < .05$ were considered significant.

RESULTS

Step One

GROUP 1: DEMOGRAPHICS

The following six demographic variables were entered into a best subsets regression: gender, age, race, income, education, and religion. The best subsets regression indicated that religion, parent’s age, and parent’s race should
TABLE 1 Description of the Variables

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Stressors and Social Support</th>
<th>Mental Health</th>
<th>Health-Related Quality of Life</th>
<th>Relationship Functioning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (1)</td>
<td>Total social support (3)</td>
<td>Phobic anxiety (4)</td>
<td>Social functioning (2)*</td>
<td>Perceived criticism (7)</td>
</tr>
<tr>
<td>Age (1)</td>
<td>Number of stressful events (3)*</td>
<td>Paranoia (4)</td>
<td>Physical functioning (2)</td>
<td>Emotional involvement (7)*</td>
</tr>
<tr>
<td>Race (1)</td>
<td>Informational support (3)</td>
<td>Somatization (4)</td>
<td>Role limitations—emotional problems (2)</td>
<td>Marital cohesion (6)*</td>
</tr>
<tr>
<td>Income (1)</td>
<td>Global stress (3)*</td>
<td>Interpersonal sensitivity (4)</td>
<td>Role limitations—physical health (2)</td>
<td>Marital satisfaction (6)*</td>
</tr>
<tr>
<td>Education (1)</td>
<td>Emotional support (3)</td>
<td>Obsessive-compulsive (4)</td>
<td>Health change (2)</td>
<td>Marital consensus (6)</td>
</tr>
<tr>
<td>Religion (1)*</td>
<td>Perceived stress (3)*</td>
<td>Anxiety (4)</td>
<td>Emotional well-being (2)</td>
<td>General family functioning (5)</td>
</tr>
<tr>
<td></td>
<td>Total coping (3)</td>
<td>Hostility (4)</td>
<td>General health (2)</td>
<td>Problem solving (5)</td>
</tr>
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<td></td>
<td>Negative social exchange (3)</td>
<td>Psychoticism (4)*</td>
<td>Pain (2)</td>
<td>Communication (5)</td>
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<td></td>
<td></td>
<td>Depressive affect (3)*</td>
<td>General health (2)</td>
<td>Roles (5)</td>
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<td></td>
<td></td>
<td>Guilt (3)*</td>
<td>Pain (2)</td>
<td>Affective regulation (5)</td>
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<td></td>
<td></td>
<td>Motor retardation (3)</td>
<td>Energy/fatigue (2)</td>
<td>Affective involvement (5)</td>
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<td></td>
<td></td>
<td>Life satisfaction (3)*</td>
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<td>Behavior control (5)</td>
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<td>Somatic complaints (4)</td>
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<td>Cognitive disturbance (3)</td>
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<td></td>
<td></td>
<td>Depression (4)*</td>
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<td>Anxious affect (3)</td>
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</tbody>
</table>

*Indicates that the variable was associated with the highest correlation squared values and were included in the final model.
Numbers in () denote the assessment from which the variable was obtained. (1), Demographic questionnaire; (2), MPAQ; (3), MHP-P; (4), BSI; (5), FAD; (6), RDAS; (7), FEICS.
be included in the model. The variance explained was 15.4% \[F(3,45) = 2.56, p > .068\]. The adjusted multiple correlations squared for this model was .09.

**GROUP 2: STRESSORS AND SOCIAL SUPPORT**

To determine which variables should be included as predictors of children’s health care use, eight variables were entered into the best subsets regression: total social support, number of stressful events, informational support (which is a subscale that focuses on social availability, support satisfaction, and enacted support), global stress, emotional support, perceived stress, total coping (which refers to a person’s attempt to deal with threats caused by perceived environmental stressors), and negative social exchange (which is a subscale of four items that explores negative social ties). Global stress (\(\beta = -0.497, p < .05\)), number of stressful events (\(\beta = -0.300, p < .15\)), and perceived stress (\(\beta = 0.100, p < .05\)), were found to have a positive correlation with children’s use of medical services and were included in the regression model (\(R_{adj}^2 = 0.077\)). The variables in this model accounted for 15.9% of the variance in health care use \([F(4,41) = 1.94, p < .15]\). Because these variables represent different metrics, all reported beta values are standardized.

**GROUP 3: MENTAL HEALTH**

To determine which mental health variables should be included as predictors of children’s health care use, the following 16 variables were entered into a best subsets regression: phobic anxiety, paranoia, somatization, interpersonal sensitivity, obsessive-compulsive, anxiety, hostility, psychoticism, depressive affect, guilt, motor retardation, life satisfaction, somatic complaints, cognitive disturbance, depression, and anxious affect. The best subsets regression showed that psychoticism (\(\beta = 0.771, p < .05\)), depressive affect (\(\beta = -0.714, p < .15\)), guilt (\(\beta = 0.142, p < .15\)), life satisfaction (\(\beta = -0.185, p < .05\)), and depression (\(\beta = -0.304, p < .05\)) were statistically significant and were included in the model (\(R_{adj}^2 = 0.209\)). Together, these variables accounted for 29.7% of the variance in health care use \([F(5,40) = 3.37, p < .05]\).

**GROUP 4: QUALITY OF LIFE**

To determine which quality of life variables should be included in the final model, the following nine variables were entered into a best subsets regression: social functioning, physical functioning, role limitations-emotional problems, role limitations-physical health, health change, emotional well-being, general health, pain, and energy/fatigue. Emotional well-being, social functioning, and pain were associated with the highest multiple correlation
squared ($R^2_{adj} = 0.048$). Only social functioning ($\beta = -0.027, p < .15$) was shown to be a statistically significant predictor of children’s health care use.

**Group 5: Relationship Functioning**

To determine which of the parent’s relationship functioning variables should be included as predictors of children’s health care use, the following 12 variables were entered into a best subsets regression: perceived criticism, emotional involvement, marital cohesion, marital satisfaction, marital consensus, general functioning, problem solving, communication, roles, affective regulation, affective involvement, and behavior control. Marital cohesion, marital satisfaction, and emotional involvement were associated with the highest multiple correlation squared. The adjusted multiple correlation squared for these variables was ($R^2_{adj} = 0.110$). In the final model, marital cohesion ($\beta = 0.182, p < .05$), parent’s emotional involvement ($\beta = 0.092, p < .15$), and marital satisfaction ($\beta = -0.174, p < .05$) were shown to be positively correlated with and were significant predictors of children’s health care use.

**Step Two: Final Model Results**

The analyses conducted in step one suggested that religion, number of stressful events, global stress, perceived stress, psychoticism, depressive affect, guilt, life satisfaction, depression, social functioning, emotional involvement, marital cohesion, and marital satisfaction should be used to develop the best model of children’s use of health care services based on parent’s functioning. When these 13 variables were entered into the across components best subsets regression, depressive affect, guilt, life satisfaction, depression, marital consensus, marital satisfaction, and emotional involvement were returned ($R^2_{adj} = 0.344$). This final model accounted for 46% of the variance in children’s health care use [$F(8,37) = 3.95, p < .01$]. Of the variables in the model, religion ($\beta = 2.192, p < .01$), marital cohesion ($\beta = .213, p < 0.01$), and life satisfaction ($\beta = -0.181, p < .05$) were found to be significant. Marital cohesion was shown to have a positive correlation with children’s use of health care services ($\beta = .213, p < .01$). Life satisfaction (of parents) was shown to negatively correlate with children’s use of medical services ($\beta = -0.181, p < .05$).

**Discussion**

Previous research suggests that health status only accounts for about 17% of the variance in health care use (Kelleher & Starfield, 1990; Starfield et al., 1985). Results from the current study lend support to these findings.
Variables that are not directly related to the child’s physical health contribute significantly to children’s use of health care services. Additionally, results of the current study suggest that parent’s marital cohesion and life satisfaction are important predictors of children’s use of health care services. These findings support the hypothesis that issues typically addressed in relationship therapy are important predictors of their children’s health care use.

Previous research shows marital distress to be associated with the mental health of each spouse (Whisman, 2007). Parent’s mental health has also been shown to be a positive predictor of well-child visits; parents with better mental health are more consistent in taking children to well-child visits (Jhangee et al., 2004). It is therefore likely that an improvement in marital quality may lead to an improvement in spousal mental health, and thereby increase the amount of well-child visits to a physician. Results from the current study lend support to this theory. It suggests that marital cohesion can be used as a predictor of children’s health care use. As marital cohesion increases, so too does the use of children’s health care. While the current study does not allow us to explore the type of health care use that increased, given the results of prior research (Jhangee et al., 2004), it is hypothesized that this increase may be related to preventative health care use including well-child visits.

Another possible explanation for the increase in the use of health services is that parents whose cohesion improves as a result of MFT are more able to make unified decisions about the medical needs of their children. Research has shown that a positive relationship between partners is related to better parental efficacy (Krishnakumar & Black, 2003). In addition to being more unified and effective, parents may in turn feel less afraid and less overall burden related to child care. This would likely result in a decrease of parents taking children in for health care services unnecessarily (Ertmann et al., 2005). It is probable that establishing and maintaining a strong and unified relationship between parents may result in better decisions related to the health of their children.

The current research suggests a significant negative relationship between parental life satisfaction and children’s health care use. These results are supported by Berra et al. (2006), who found that low life satisfaction was a significant predictor of more health care visits for children. Although the current study does not allow for assessment of type of health care use, based on previous findings (i.e., Dybdahl, 2001; Ertmann et al., 2005; Jhanjee et al., 2004) it is hypothesized that parents with low life satisfaction overuse health care services and take children in for medical treatment for conditions that do not necessarily warrant medical attention. This may lead distressed parents to become overwhelmed and burdened by the additional stress added by even minor health care needs. The distressed parents may then rely on health care resources to help alleviate not only the health care
symptoms but also the general stress of life. Such reliance on health care resources may be considered inappropriate.

The idea that life satisfaction can help predict health care use may be particularly useful to therapists. For example, marriage and family therapists may find it beneficial to include a measure of life satisfaction in their use of assessments. Doing so may allow therapists to determine issues affecting parents’ life satisfaction. By addressing these issues, the therapist will likely be able to help the client increase life satisfaction, which may lead to a reduction in the use of unnecessary health care services by their children.

The greatest limitation of the study is the inability to differentiate between different types of children’s health care use. For example, going to the doctor because of illness is different than going in for a routine checkup or to receive vaccinations. In the current study, it was not possible to determine the extent of the use of preventative health care services. Preventive care is considered an important aspect of children’s health care utilization. This is different from seeking medical attention for minor illnesses or distress that does not necessitate health care services. Future studies could test how the predictors identified in the current study inform on the type of health care that is used by children.

The findings of this study may be useful in helping marriage and family therapists determine which variables have a negative effect on the children’s use of health care. They may also be useful in determining factors that offset medical costs. These factors may be useful in helping to make couple and family based therapy more appealing to third-party payers such as insurance companies. Future studies would also benefit from assessing how predictors of children’s health care utilization influence health care costs. Additionally, future studies would benefit from including larger and more diverse samples. This may help improve the generalizability of the findings. There is also a need to distinguish between the types of medical services used by all family members. Predictors may be more effectively applied in a clinical setting once we have a better understanding of how predictor variables influence multiple aspects of family health care use. The current study represents a beginning effort to affirm a multifaceted integration of mental and physical health among all members of a family unit. It also continues to identify factors related to couple and relationship therapy that can help predict children’s health care service utilization.

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