AN ABSTRACT OF THE DISSERTATION OF

Mary J. Minten for the degree of Doctor of Philosophy in Counseling presented on October 23, 2017.

Title: The Impact of Relationship Wellness Checkups on LGBTQ Couples.

Abstract approved: _____
Cass Dykeman

Relationship health has many benefits, from physical and emotional health of the partners to their children's wellbeing. Early intervention programs protect relationships from decline. These programs represent growing public health initiatives. However, most studies on wellness or early intervention overlook lesbian and gay male couples. Research that assumes lesbian and gay relationships are the same as heterosexual cisgender relationships, or that ignores lesbian and gay couples completely, leaves practitioners in the dark on how to intervene successfully. Programs that seek to promote wellness and prevent decline for diverse groups must be able to attune to critical differences, appropriately adapt materials, combat social prejudice, and encourage practitioners to manage unintentional personal bias. Research sheds light on which direction to go to accomplish these tasks. Intervention research with sexual and gender minority couples also encourages existing programs to effectively open and adapt their programs to include lesbian and gay couples in the populations they serve. This study fills this gap in the research on lesbian and gay couples and wellness checkups, offering information about these often-overlooked couples and promoting their inclusion. The study examines the question, "What is the impact of a

relationship wellness checkup on gay and lesbian couples' satisfaction?" The two arms of the study capture different groups – one group is lesbian couples and one group is gay male couples. The method employs a multiple probe, nonconcurrent multiple baseline design. The independent variable is an established relationship health intervention based on motivational interviewing principles, The Marriage Checkup (MC). The dependent variable is relationship satisfaction measured by the Couple Satisfaction Index. Three lesbian couples and three gay male couples participate in the study. The findings show the checkup has a moderate effect on satisfaction for both lesbian couples (NAP =.66) and for gay male couples (NAP = .73). Visual analysis of the data supports these results. The outcome shows a relationship wellness checkup, based on the MC, had a positive benefit for these six couples. The results confirm a relationship checkup for gay and lesbian couples can improve their satisfaction, just as it improves heterosexual couples' satisfaction. In addition, these results suggest offering an MC to gay and lesbian couples specifically could be beneficial for these couples as wellness support operates in contrast to social stigma, discrimination, and prejudice.

The Impact of Relationship Wellness Checkups on LGBTQ Couples

by

Mary J. Minten

A DISSERTATION

submitted to

Oregon State University

in partial fulfillment of
the requirements for the
degree of

Doctor of Philosophy

Presented October 23, 2017
Commencement June 2018

Doctor of Philosophy dissertation of Mary J. Minten presented on October 23, 2017.

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I understand that my dissertation will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my dissertation to any reader upon request.

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Mary J. Minten, Author

ACKNOWLEDGEMENTS

I want to express my sincere appreciation to my advisor and mentor, Cass Dykeman, for encouraging me to write passionately. I also wish to thank Dr. Chuck Holt for his unwavering support and humor along the way. Finally, I want to acknowledge my beloved partner, Jae Jesse Lee, who's belief in me got me here.

CONTRIBUTION OF THE AUTHORS

Cass Dykeman assisted with the methodology, research design, and the narrative of the findings.

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DEDICATION

This dissertation is dedicated to the six couples who participated in this research, for opening their lives not only for the possibility of finding encouragement and support for their relationship but also, and for some primarily, to contribute to the larger LGBTQ community. They took a risk and shared their lives to improve their connection and to help other gay and lesbian couples.

Chapter 1: General Introduction

As the connection between relationship health and physical and mental health becomes more apparent, the value of wellness programs for couples is clear. Programs focused on relationship wellness or relationship distress prevention represent a growing target area for intervention in couple therapy. However, research in this area all but ignores the existence of gay and lesbian couples.

To date, intervention programs come in two general forms: education programs and checkups. First, for education programs, only two studies have examined relationship education programs with gay male couples. One study piloted an education program (Buzzella et al., 2012). The other employed an experimental design to examine the same educational program's impact on satisfaction as well as other variables (Whitton, Weitbrech, Kuryluk, & Hutsell, 2016). Second, in checkup research, only a small number of same-sex couples participated in just two studies (Cordova et al., 2014; Morrill et al., 2011). The researchers excluded the outcomes of these same-sex couples from the analysis and results. As such, this study aims to fill this gap in the research by offering a checkup, called the Marriage Checkup (MC), to gay and lesbian couples. Research on the Marriage Checkup has revealed a small positive impact on relationship satisfaction in studies with heterosexual couples (Cordova et al., 2014). Despite the MC's modest boost to satisfaction, its value may lie in how it prevents satisfaction decline (Cordova et al., 2014). Therefore, this study seeks to answer the question, "What is the impact of a relationship check-up on gay and lesbian couples' relationship satisfaction?"

This topic, keeping healthy couples healthy, exemplifies a cross-section of interests. These interests include couple counselors, advocates for LGBTQ (Lesbian, Gay, Bisexual, Transgender, and Queer) people, and health practitioners in general. For couples' counselors,

prevention plays an important part in therapy. Couples find out about problems earlier and explore options, including therapy when indicated, in the checkup. Checkups boost help-seeking behavior (Gee, Scott, Castellani, & Cordova, 2002). For advocates of LGBTQ people, supporting their relational health adds another way to show care; that is, checkups offer support for sexual and gender minority couples who often lack social support (Meyer, 2003). Moreover, a relationship checkup can be a means to advocate for justice, as family wellness programs have in the past excluded sexual and gender minority couples.

Important work lies ahead in identifying wellness programs that work for all couples not just heterosexual couples. Relational health relates to many aspects of physical and emotional health and well-being. Relational health impacts depression, heart health, adherence to health behavior changes, children's health, and more (Goeke-Morey, Cummings, & Papp, 2007; Rappaport, 2013; Robles et al., 2014; Whisman & Uebelacker, 2006). Given the range of benefits that stem from relational health interventions, information and programs aimed at relationship wellness are becoming increasingly valuable to health practitioners.

Many couples do not seek therapy until they are highly distressed. Barriers include lack of time, lack of money, worry about being distressed enough to need therapy, and fears about the therapy process itself (Eubanks-Fleming & Cordova, 2012). Same-gender couples have additional barriers to overcome. When considering therapy, gay and lesbian couples reported fears about prejudice (Grove & Blasby, 2009). This protective stance makes sense as therapy could be more harmful than beneficial. According to Shelton and Delgado-Romero (2013), Sexual and gender minority couples and individuals experience microaggressions in therapy. These microaggressions include therapists' behaving as if sex and sexual orientation are taboo

topics, treating sexual orientation as the crux of all problems, or being over-familiar. The anticipation and experience of discrimination create additional barriers to getting help.

A checkup provides many benefits to couples with potentially additional benefits for sexual and gender minority couples. Theoretically, a checkup for these couples could provide the same benefits found for heterosexual couples, such as (a) an increase in relationship satisfaction and (b) a shorter time for couples to seek help if therapy is needed. Further, a checkup could have specific benefits for this marginalized population by (c) creating a bridge to finding an affirmative therapist if therapy is needed and (d) providing a practical venue to support the wellbeing of sexual and gender minority couples in an era of prejudice. These benefits have been inferred from existing research and it is also possible that checkups could offer additional important benefits that are, to date, unknown.

Several areas of existing research pertain to this topic. These include (1) prevention of relational distress and improving relational wellness, (2) the MC as prevention, (3) unique stressors for sexual and gender minority couples, (4) barriers to prevention for these couples, (5) the MC's usefulness in reducing barriers, (6) modifying the MC and (7) financial incentives for participation. The remainder of this chapter reviews each of these areas.

Prevention of Relational Distress and Improving Relational Wellness

In the early 2000s, the field of relationship wellness grew under an influx of funding. In 2005, a federal program called the Healthy Marriage Initiative started providing grants to state, local, and community agencies (U.S. Department of Health & Human Services, n.d.). These grants supported education programs, checkups, and other wellness programs available to heterosexual married couples (Cowan & Cowan, 2014). Prevention of relationship distress and the promotion of family wellness was a notable goal underlying these initiatives, and the

importance of relationship health and the political emphasis placed on family values benefited many couples and families.

Prevention programs operate at primary, secondary, and tertiary levels (Marchand, Stice, Rohde, & Black Becker, 2011). Primary, or universal, prevention targets the general population and aims to stop problems before they occur. Secondary, or selective, prevention targets a subset of the general population considered at risk. Secondary prevention aims to prevent or reduce problems at the earliest stages. Tertiary, or indicated, prevention targets groups that have concerns. The goal at the tertiary level is to prevent further decline.

These three levels of prevention occur in relationship education programs and relationship checkups. Relationship education is offered in a group format and focuses on skill development. Checkups are brief, often lasting only two sessions, providing assessment and feedback for the couple. One checkup program, the MC, aims to reach couples across these three prevention levels.

The Marriage Checkup as a Prevention or Wellness Program

By design, the MC supports a wide range of couples and effectively moves many couples, most of whom would not seek support, toward health (Cordova, 2013). The MC is based on motivational interviewing and a program called the "Drinker's Checkup" – a program geared toward early intervention for alcohol use disorders (Cordova et al., 2001; Miller & Rollnick, 2013). The MC program is open to all wellness-seeking couples, thus, satisfying primary prevention goals, but it also has a specific objective to support couples who may be at risk for dissolution (Cordova et. al, 2001). As a secondary prevention goal, the MC offers support at the early stages of distress. A tertiary prevention goal for the MC is to reach couples who are already having problems. Depending on the level of distress these couples experience,

the MC encourages help-seeking or directs couples in the most suitable direction (Cordova, 2013).

The MC continues to gain support as a prevention program. Currently under the name "Relationship Rx," the project now seeks to reach unmarried couples (Cordova, 2013). Researchers also are working to reach lower income families, offer the MC as a home-based program, and develop an online option (Cordova, 2013). The MC has been effective with military couples (Cigrang et al., 2016) and in private practice settings (Trillingsgaard, Fentz, Hawrilenko, & Cordova, 2016).

Wellness Support for Sexual and Gender Minority Couples

Despite research on the efficacy of checkups and the social movement advocating increased access to them, no outcome research exists on checkups for sexual and gender minority couples. These couples are a well-suited population for secondary prevention because they are more at risk for concerns with physical and mental health (Meyer, 2003). Also, despite more similarities than differences, gay and lesbian couples are more likely to separate than heterosexual couples (Kurdek, 2004). A checkup could help these marginalized couples manage the effects of discrimination. Offering a checkup to sexual and gender minority couples as a secondary prevention strategy potentially reduces barriers to therapy. A checkup for sexual and gender minority couples also provides an antidote to social messages that gay and lesbian couples are not important.

As noted, primary prevention helps healthy couples stay healthy. Sexual and gender minority couples are a suitable group for primary prevention as well. Research shows some sexual and gender minority individuals and couples develop strength and resilience in finding their way through hardship. Some same sex couples believe facing the challenges of

discrimination strengthened their connection (Frost, 2014). Other studies demonstrate that resilience, strength, and courage are positive outcomes that emerge from managing prejudice (Riggle, Rostosky, McCants, & Pascale-Hague, 2011; Vaughan & Waehler, 2009). Couples develop strengths such as equality in roles, flexibility, and cohesion (Connelly, 2005). A wellness checkup, when used as a primary prevention tool, potentially develops these strengths in sexual and gender minority couples.

Checkups work as tertiary prevention when they assist couples in getting back on track or seeking help sooner (Cordova et al., 2014). Getting therapy when needed is an important outcome for sexual and gender minority couples given the struggle to find competent therapists (Grove & Blasby, 2009; Kurdek, 2004). Checkup clinicians can help these couples find affirmative and qualified therapists. Thus, a tertiary prevention goal is to help these couples find good care.

In summary, a relationship wellness checkup provides support for same-gender couples at any prevention level. As a primary prevention goal, a checkup boosts relationship satisfaction, builds on existing strengths, and prevents decline. As secondary prevention, a checkup is a feasible way to reach sexual and gender minority couples, a group more at risk for dissolution. Finally, as part of tertiary prevention, if additional treatment is needed, the checkup links couples to affirmative therapists. The breadth with which MC can operate as a preventive program makes it an intriguing option to explore in-depth in a population that has been traditionally under-represented in the research.

Barriers to Prevention for Sexual and Gender Minority Couples

In addition to common barriers to therapy introduced previously, sexual and gender minority couples report specific concerns related to accessing prevention services. In response to

relationship education programs, couples report fears that (a) they will not be comfortable in the mixed group setting, (b) the leader will not be competent with sexual and gender minority couples' concerns, and (c) the material will not reflect their needs (Scott & Rhoades, 2014). These thoughts reflect realistic concerns. Some education programs aim to reach sexual and gender minority couples, but these programs are not widely available (Buzzella, Whitton, & Tompson, 2012).

To date, no studies have explored the barriers for checkups for sexual and gender minority couples. It is likely that some of the more general concerns for entering therapy apply to checkups. However, it is equally as likely that these couples encounter unique obstacles. For example, based on research on therapy and education, sexual and gender minority couples may (1) fear the consultant is prejudiced, (2) doubt about the consultant's competence, (3) worry that the checkup does not cover concerns these couples face, and (4) hesitation to broach topics that may create discomfort for the consultant. However, no research exists on whether, or to what degree, these obstacles are encountered in this population.

The MC's Effectiveness in Reducing Barriers

As mentioned, the MC aims to reduce barriers to help-seeking for all couples (Cordova, 2013). Its brief, personal, and private format attracts couples who would not seek therapy or education. Research shows that MC improves satisfaction and, for couples who need additional support, promotes help-seeking behavior (Cordova et al., 2014). Further, couples cite a wide range of reasons for attending the checkup. According to Morrill et al. (2011), the top five reasons are (1) believing they would have a chance to talk to each other, (2) learning about their relationship, (3) having worries about their relationship they wanted to check out, (4) thinking the checkup could be fun or interesting, and (5) wanting to keep their relationship strong. Thus,

the MC effectively reaches couples who do not need therapy, are in the early stages of considering support, or are actively looking for support for problems (Morrill et al., 2011).

The MC reaches heterosexual couples who might not have otherwise sought support; additional efforts may be needed however to reduce barriers for sexual and gender minority couples. These couples report concerns about facing discrimination in therapy and in relationship education programs (Grove & Blasby, 2009; Scott & Rhoades, 2014). They will likely experience these barriers when considering a checkup. Therefore, this study reframes the MC as a "relationship checkup." Advertisements directly state the checkup is for lesbian and gay couples. The flyer, advertisements, and professional announcement are in Appendix A and Appendix B. These steps seek to address couples' doubts about being welcome. Additional changes are worth consideration.

Modifying the MC

This study required minimal changes to the MC. All changes reduced heterosexism and bias. First, language referring to "marriage" reads "relationship." This change occurs in the name of the program and the name of one of the surveys. Second, one question in the assessment refers to difficulties with an affair. The traditional definition of an affair is a breach in a monogamous sexual relationship. A small language change accommodates couples that have a non-monogamous agreement but still experienced a break in their agreement. The initial language reads, "Our relationship is suffering the effects or aftereffects of an affair." The language for this study reads, "Our relationship is suffering the effects or aftereffects of a breach in our sexual or intimacy agreement, such as an affair." These two changes are the only changes to language (Appendix C).

These small changes do not compromise the core elements of the MC. Research shows the primary mechanism for change in the MC revolves around increasing intimacy. The discussions in the on-site sessions provide an opportunity for increased vulnerability, which supports intimacy and connection (Cordova et al., 2014; Cordova et al., 2005). The conversations, not the surveys, are the core elements. The instruments themselves are not empirically tested (Cordova, 2013). Changes in names and surveys likely do not impact the efficacy of the MC.

The delivery of assessments also differs from the original MC. Historically, MC measures were completed using pencil and paper. For this study, the assessments are done online using Qualtrics software (Qualtrics, February 2017). This shift is unlikely to change the outcome. One study comparing paper and computer versions of quality of life measures revealed no significant differences between use of paper compared to computer versions (Campbell, Ali, Finlay, & Salek, 2015). This study also showed most people preferred the computer version (Campbell et al., 2015). The study from Campbell et al. suggests that the impact of converting the MC surveys from paper to online is low. Given the MC surveys have not been validated, no comparison validity exists for this study. The Couple Satisfaction Index Four Item (CSI (4)) was developed as an online assessment (Funk & Rogge, 2007), so no validation was needed for this assessment.

Finally, researchers provided a handout on local resources for LGBTQ couples. The MC program does not provide a list of resources. The list has legal resources, family planning and parenting resources, affirmative therapists, networking groups, employment resources, and other local contacts (Appendix D). Providing additional resources fulfills some of the community outreach goals of the checkup (Buzzella et al., 2012). The three changes – language changes,

medium of administration, and the resource distribution – reduce the existing heterosexism in the MC and increase its potential social impact. None of these changes run counter to the core elements of the checkup.

The decision to keep the existing program weighs heavily against the potential benefits of more significant changes. The case for change is compelling, and though no further changes to the MC were made for this program, future studies may do so. Research has demonstrated that adapting interventions, such as education programs, for sexual and gender minority couples does not compromise the effects (Buzzella et al., 2012). Further, changes may engage participation, affirm these couples' daily struggles, and further temper heterosexist bias (Buzzella et al., 2012; Scott & Rhoades, 2014). For example, adding topics relevant to these couples such as (1) coping with prejudice, (2) getting social support, (3) managing roles, (4) handling legal issues, (5) handling relationship disclosures, and (6) family planning, among others, could be helpful (Scott & Rhoades, 2014; Buzzella et al., 2012). Once topics appear on the checkup surveys, they integrate easily into the sessions. In fact, with thoughtful wording, the checkup remains appropriate for use with heterosexual couples. For example, a potential question for coping with discrimination could read, “As a couple, how do you cope with any outside judgments from others about your relationship?”

In general, this study seeks to closely follow the MC for two reasons. First, using existing programs builds on the current research. Replicating the MC compares how the existing reliable intervention works with sexual and gender minority couples – this study extends the checkup to a new population. An initial comparison provides a baseline which then determines the need for any changes. The second reason relates to accessibility. A new program cannot be offered as widely as an existing program. Clinicians delivering the MC, if they are not already, can extend

the existing checkup to sexual and gender minority couples in good faith. By modifying an existing checkup, more sexual and gender minority couples can benefit more quickly.

Financially Incentivizing Participation

Cordova (personal communication, August 16, 2016) noted recruiting couples for MC research was a consistent challenge. This study shared a similar concern. During initial recruitment, from July to November, only two couples enrolled. To prompt more interest, the recruitment strategy included a financial incentive in early January. By March, five more couples enrolled.

The decision to use a financial incentive stemmed from MC research conducted by Cordova et al. (2014). Cordova et al. offered financial incentives to couples to complete follow-up surveys (Cordova et al., 2014). They paid couples over a two-year period with amounts starting at $25 and reaching $100. Couples received up to $575 over the two-year period if they completed all the surveys. Also, in a qualitative study following up on another MC study, eight out of the ten couples described how a small incentive of $20 and the advertisement of a "free" service factored into their reasons for enrolling (Mock, 2014).

In a review of relationship education research, incentives for participation proved useful. In an eight-site RTC study, only one site had significant positive outcomes. Markman and Rhodes (2012) noted, "One reason Oklahoma's program may show positive outcomes, while others do not, is that they have a higher-than-average rate of intervention completion. This high rate of completion may be partly attributable to the fact that Oklahoma uses material incentives for program participation" (p. 187). The Oklahoma program offered a range of financial incentives to improve attendance and ease financial and logistical burdens (Devaney & Dion, 2010). For completing an intake, they offered a $10 gas card to offset transportation cost and $20

gift card. For participants who attended the program, they offered vouchers for taxis or gas cards for transportation, onsite childcare, and meals (dinner for evening classes, lunch for Saturday classes). They offered up to $200 in cash and up to $150 in vouchers called “crib cash” for store purchases for children (Devaney & Dion, 2010, p. 33). They also held weekly drawings for baby items such as strollers. Incentives were given for tasks, such as creating a healthy menu or a family budget. In terms of financial benefits, a couple could earn up to $800 over a year participating in various aspects of the program. The program offered much more than financial incentives too – they made sure the participants were treated like family with holiday celebrations with gifts for their children, reunions with participants from their groups, and program settings with comfortable reclining chairs, blankets, and quality audio and video components for the trainings.

Reviewers of relationship education programs encouraged the use of incentives following Oklahoma’s model. They noted that, for conducting wellness programs, it is difficult enough to encourage couples who experience difficulties to seek help. The task of encouraging couples to seek help when they were not experiencing any difficulties was even more challenging. Incentives supported the recruitment and attendance process (Markman & Rhoades, 2012).

Researchers working with sexual and gender minority people have used different forms of recruitment incentives. These marginalized people often balance benefits of participation with the risk of trusting a system that had often not served their needs and, historically, had even done harm. Financial incentives have helped tip this balance. In the past, incentives to recruit sexual and gender minority people have been useful and, at times, necessary to get a diverse community sample (Meyer & Patrick, 2009). Various recruiting strategies have been tried, including offering incentives for community members to spread the word about a study and incentives for

participation in the study. Reviewers determined no one method was ideal, and each study had to find the best fit for incentive plans (Meyer & Patrick, 2009).

No studies identify an ideal amount and form of incentives. Therefore, the incentive for this study was informed by an MC study and a local study recruiting a similar population sample (lesbian and transgender women). The MC study gave amounts of $25-$100 for completing follow-up surveys (Cordova e al., 2014) and the local study provided $60 for an hour qualitative interview. Thus, this study incorporated a $50 honorarium for the ten-week study with an additional $10 honorarium for the completion of the six-month follow-up survey. The incentive was described to couples as a small thank you for their contribution to research.

Study One: Relationship Wellness Checkup with Lesbian Couples

The first manuscript, Chapter Two, focuses on using a checkup with three lesbian couples. The chapter provides an additional literature review, describes the methodology, and discusses results and limitations. The study seeks to answer the question, "What is the impact of a relationship wellness checkup on lesbian couples' relationship satisfaction?" and fills a key gap in the research framed by the absence of checkup studies on this population.

A single subject approach with a multi-probe multiple-baseline design was employed (Barlow, Nock, & Hersen, 2009; Biglan, Ary, & Wagenaar, 2000; Christ, 2007). The independent variable was a checkup. The dependent variable was relationship satisfaction. Three lesbian couples received the checkup at randomly assigned times over the course of ten weeks. The random assignment provided control for history and maturation. Non-random assignment – such as the first couple to enroll or the first couple who could do the checkup based on their schedule – would have opened the study to confounding variables (e.g., more eagerness for the program, a flexible schedule which may reflect higher SES, greater access to information about

health services, etc.). Random assignment reduced the potential that these variables influenced the results. To determine the effect of the intervention, a visual analysis of graphs of satisfaction scores across the phases of the study (baseline, intervention, post intervention) was used. The effect size was determined by calculating the percentage of non-overlapping data (NAP) (Gast & Spriggs, 2010; Scruggs & Mastropieri, 1998; Spriggs & Gast, 2010).

With regard to external validity, one concern with the single subject design was low generalizability. With so few subjects, results could not be generalized to the larger population of sexual and gender minority couples. In addition to a small sample size, couples came from the same local area and had the same therapist. Generalizability for the intervention has to be established through replication. Replication with some differences – such as having a different therapist and in different areas of the country – will strengthen generalizability.

The target journal for this study is the *Journal of Counseling Psychology*. The journal reaches an audience of counselors through the American Psychological Association. The journal publishes quantitative and qualitative research about counseling activities, including intervention and prevention, as well as articles on diverse groups. Their website reads, "Extensions of previous studies, implications for public policy or social action, and counseling research and applications are encouraged" (*Journal of Counseling Psychology*, n.d.). This study extends work from previous MC studies, relates to the existing public policy to support healthy relationships, and addresses the need for social action to include sexual and gender minority couples in practice, and, as such, aligns with the journal's objectives.

The journal has an impact factor of 2.516. It ranks 19 out of 80 (Q1) in applied psychology and 10 out of 58 (Q1) in educational psychology (Thomson Reuters, 2017). The journal historically publishes articles on gay and lesbian relationships. For example, a recent

article from the journal is titled, “Romantic attachment and relationship functioning in same-sex couples.” This study replicates findings from previous research on heterosexual couples and explores the links between attachment and relationship functioning (Mohr, Selterman, & Fassinger, 2013). The *Journal of Counseling Psychology* is a reasonable match for this study because of the journal’s focus on public policy, advocacy, prevention, and diversity.

Study Two: Relationship Wellness Checkup with Gay Male Couples

The second manuscript, Chapter Three, parallels the first study by using the same method but applies it to a different population. As noted by Gottman et al. (2003), couples tend to have more similarities than differences in relationship functioning and health; however gay male, lesbian, and heterosexual couples exhibit some differences. For example, for heterosexual couples low physiological arousal correlates to higher satisfaction and lower risk for separation. Gay and lesbian couples tend to benefit from high levels of arousal. Gay male couples differ from lesbian couples in some respects as well. For example, in lesbian relationships affection correlates with satisfaction more than for gay male couples. Also, for gay male couples, validation has a stronger correlation with satisfaction than for lesbian couples (Gottman et al., 2003).

Chapter Three reviews the existing research and includes an added section on help-seeking. This study fills the gap in the research by examining the impact of checkups on gay male couples. The second manuscript addresses the question, “What is the impact of a relationship wellness checkup on gay male couples’ relationship satisfaction?”

Study Two uses a non-concurrent multiple-baseline and multiple-probe design (Barlow et al., 2009; Biglan et al., 2000; Christ, 2007). The independent variable is the same checkup. The dependent variable is couple satisfaction. Three gay male couples participated in the study. Data

analysis includes a visual analysis of graphs depicting the CSI (4) scores over the duration of the study. Nonoverlap of all pairs (NAP) estimated effect size (Parker & Vannest, 2009; Vannest, Parker, & Gonen, 2011). Similar to the study with lesbian couples, generalizability will be established with replication of this research with additional couples who receive the intervention from different therapists in different geographical areas.

The second manuscript will be submitted to the *Journal of Marital and Family Therapy*. This journal holds a focus on treatment and prevention of couples' concerns. The journal reaches counselors through the American Association for Marriage and Family Therapy (*Journal of Marital and Family Therapy*, n.d.). The journal's impact score is 2.528, and it ranks 32 out of 119 in clinical psychology (Q2) and 4 out of 40 in family studies (Q2) (Thomson Reuters, 2017). The journal routinely publishes articles on gay and lesbian couples and families. For example, one relevant article is titled, "Outness and relationship satisfaction in same-gender couples." This article investigates how self-disclosure of sexual orientation impacts couple satisfaction (Knoble & Linville, 2012). The *Journal of Marital and Family Therapy* fits this study because of its appeal to couple therapists and its focus on relationships.

Glossary of Specialized Terms

Current terminology captures little of the complexity of gender, gender identity, sexual orientation, and relationships (Elizabeth, 2013; Lenius, 2011). One writer on the language of orientation and identity states, "I believe we're on the verge of a post-GLBT world, where the terms for which those initials stand will have faded into irrelevance" (Lenius, 2011, p. 424). Given the changing landscape, the terms here reflect the language for these studies only. These terms aim for definition and precision for these studies; they do not reflect consensus among sexual and gender minority people.

LGBTIQ. The letters stand for lesbian, gay, bisexual, transgender, intersex, and queer. A newer acronym, LGBTIQAP (adding asexual and pansexual) is an emerging term. These acronyms capture the diverse range of sexual orientation, gender identity, and gender experience. Individuals self-identify with these terms.

Lesbian and gay. These two terms refer to sexual orientation. Lesbian refers to women who are attracted to women; gay refers to men who are attracted to men as well as women who are attracted to women. For this study, two women simply need to identify their relationship as a lesbian relationship. The same idea applies to two men who identify their relationship as a gay male relationship. Personal identities within these relationships may include gay, lesbian, bisexual, pansexual, transgender, questioning, queer, and others.

Bisexual. Bisexual refers to a person who experiences attraction to men and women.

Transgender. Transgender is an adjective that describes individuals whose internal gender identity does not match their chromosomal sex or at-birth assigned sex. Similar terms include enby (derived from phonetic of "NB," for non-binary), gender non-conforming, genderqueer, gender fluid, gender independent, and gender creative. These terms are often used to describe a mix of gender characteristics and experiences that do not fit the binary concepts of male and female. Agender, referring to having neither gender, and bi-gender referring to having both genders, describe additional non-binary experiences.

Questioning. This term refers to people who are unsure of where they may fall under the LGBTQ umbrella – they are exploring their identity and orientation.

Genderqueer and Queer. Queer is a reclaimed term that was once used pejoratively. The APA (n.d.a) concurs that queer is now an acceptable term. Queer conveys a range of sexual orientation and gender identity combinations. For example, a person born with male sex

characteristics, who identifies as female, who is in transition to living as a woman, and who is in a relationship with a cisgender man may self-identify as queer. As Lenius (2011) writes, "Many prefer the word queer, and the more specific genderqueer, to describe their increasingly fluid expressions of gender and affectional preference" (p. 424). Thus, queer is a synonym for genderqueer, as Lenius indicates, as well as a reference to gay and lesbian people. Queer is used for gender identity, sexuality, and combinations of identity and sexuality. Again, individuals apply the term to themselves.

Intersex. Intersex refers to chromosomal, reproductive, anatomical, and hormonal mixes that do not fit neatly into "male" or "female" biological sex. The term intersex encompasses a large range of natural biological variations that may or may not be apparent at birth. Some people can go through life without knowing about an intersex state (http://www.isna.org).

Asexual. Asexual describes a sexual orientation of low to no interest in sex or sexual relationships.

Pansexual. Pansexual describes sexual orientation outside the binary or dualistic labels of heterosexual, lesbian, gay, or bisexual. Pansexual individuals often describe a range of attractions to people not necessarily based on sex, gender, gender identity, or gender expression (Elizabeth, 2013). For example, a cisgender woman identifies herself as pansexual because she finds her sexual attractions include cisgender men, transgender men, and transgender women. In another example, a transgender man who identifies as pansexual describes his attractions as not related to gender but to the personal qualities of the person he is dating.

Terms for couples. The American Psychological Association (APA) guidelines provide guidance on terms related to identity, "Whereas the terms lesbian and gay refer to identities ('a gay man'), the terms heterosexual and bisexual refer to both identity and behavior" (n.d.b., p. 1).

APA guidelines also offer suggestions for describing behavior, “Same-sex, male-male, female-female, and male-female sexual behavior are appropriate terms for specific instances of sexual behavior, regardless of the sexual orientation of the partners” (p. 1). However, APA offers no clear guidance for how to describe relationships (v. sexual activity) (APA, 2012; APA, n.d.a., APA, n.d.b.). For example, a couple comprised of two women who self-identify as lesbian women may describe themselves as a lesbian couple. However, if the women identify as pansexual or bisexual the term lesbian couple may not describe their personal identity and orientation (Elizabeth, 2013). APA (n.d.b.) recommends use of the phrase “same-sex couple.” However, current shifts in language aim to reduce the use of the word sex when referring to gender. The term same-gender couple may offer a broader definition that includes all women, including transgender women.

Given the limitations of language, for this study lesbian and gay refers to two women in relationship or two men in relationship respectively. "Lesbian" and "gay" here do not describe identity or sexual orientation, but rather the partnership. The individuals do not need to identify with these labels, merely tolerate the label applied to their relationship. The phrases "lesbian and gay male couples," "same-gender couples," and "same sex couples" are interchangeable in this document.

Lesbian couples. This term describes couples composed of two female-gender individuals. The women do not have to self-identify as “lesbian” (i.e. they may identify as pansexual, bisexual, queer, etc.). Female-gender includes all women – cisgender, transgender, and genderqueer women.

Gay male couples. This term describes a couple composed of two male-gender individuals. The men do not have to self-identify as “gay” (i.e. they may identify as pansexual,

bisexual, queer, etc.). Male-gender includes all men - cisgender, transgender, and genderqueer men.

Same-gender couples. This term includes any couple with two people of the same gender or same sex as identified by the person.

Same-sex couples. This term includes any couple with two people of the same gender or the same sex as identified by the person. This study does not make the distinction between same sex couple and same gender couple, except if a couple self-identifies and expresses one term is needed or preferred over the other.

Genderqueer or transgender couples. This term includes any couple with at least one person in the relationship who identifies as transgender, genderqueer, gender fluid, gender creative, gender independent, agender, non-binary, etc.

Sexual and gender minority: This phrase describes couples or individuals who may not be heterosexual and cisgender and who may identify as one or more of the above terms including gay, lesbian, transgender, genderqueer, bisexual, same-gender loving, same-sex loving, pansexual, asexual, polyamorous, and other identities that are marginalized or treated with prejudice based on gender identity and sexual orientation.

Cisgender. This term refers to a person whose chromosomal sex or assigned birth sex matches their internal sense of gender closely. These individuals align with their chromosomal or birth sex and do not identify as genderqueer or transgender.

Cisgender heterosexual couples. The APA offers no clear guidance on how to refer to cisgender male – cisgender female couples (APA, 2012; APA, n.d.a., APA, n.d.b.). The phrase cisgender heterosexual couple or heterosexual couple will be used in this study. The couples in

past MC research are mostly cisgender women partnered with cisgender men – at least as reported in the research.

Relationship education programs. Relationship education programs provide education to a group of couples. They occur in class or workshop formats and focus on teaching skills. They are also called marital education or marital enrichment programs.

Checkups. Checkups include assessment and feedback sessions provided for one couple at a time, often led by therapists. Checkups are not therapy. Clinicians offer brief feedback and support.

Marriage Checkup (MC). The MC is a specific checkup designed to reach at-risk couples and help prevent decline. The MC has a format that uses motivational interviewing principles and strategies.

Relationship wellness checkup. The term checkup, relationship checkup, or relationship wellness checkup in this study is a version of the MC with minimal changes for the inclusion of sexual and gender minority couples. This checkup may change over time with further research.

Thematic Links for the Two Studies

The first and second manuscripts link thematically through intervention, methods, and LGBTQ issues. They differ in the population for the study. The first manuscript examines the checkup with lesbian couples; the second study examines the checkup with gay male couples. Together they aim to fill the gaps in relationship wellness research by including two additional populations that are currently underrepresented. Additional research may include transgender, genderqueer, polyamorous, and other identities that fall under the umbrella of sexual and gender minority couples.

Organization of the Dissertation

This dissertation is organized into four chapters. Chapter One presents an overview of the two studies and the literature related the goals of the study. Chapters Two and Three each stand alone as manuscripts for journal submission. Chapter Two includes its own review, methods, and results and focuses on lesbian couples. Chapter Three also includes a literature review, study methods, and results but focuses on gay male couples. Though the two studies use the same research, checkup, and methods, each article strives to provide pertinent information for the readers of that journal. The final chapter summarizes the combined results and concludes the dissertation.

Chapter 2: The Impact of Relationship Wellness Checkups with Lesbian Couples

The Impact of Relationship Wellness Checkups with Lesbian Couples

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The research contained in this manuscript was conducted under the approval of the Oregon State University Institutional Review Board (Study ID 7076). The manuscript was prepared as part of the first author's dissertation.

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Abstract

Relationship health impacts many facets of both physical and mental wellbeing, including depression, heart health, and even children's health. For a variety of reasons, distressed couples often delay entering therapy despite its value in supporting wellness and preventing distress. One early intervention program, the Marriage Checkup (MC), aims to keep healthy couples healthy with a brief supportive checkup. The MC is based on motivational interviewing principles and research on MC shows the program has a positive impact on relationship satisfaction, prevents decline, as well as improves health on other variables such as intimacy. However, past research on MCs has only focused on heterosexual couples. As such, this study explores the research question, "What is the impact of a relationship wellness check-up on lesbian couples' relationship satisfaction?" Using a single subject design, specifically concurrent multiple-baseline multiple-probe design, this study extends MC research to an underrepresented population. After conducting checkups over ten weeks with three lesbian couples, findings show the intervention had a medium effect on satisfaction (NAP = .66). These results indicate a relationship checkup can increase satisfaction for lesbian couples. The findings also suggest checkups with lesbian couples can have a comparable impact to their use with heterosexual couples. This study concludes by advocating that the checkup may help lesbian couples stay healthy, providing support for this marginalized group of couples in a time of prejudice.

Keywords: couples, lesbian, gay, same-sex, marriage checkup, relationship wellness checkup, motivational interviewing, prevention, brief intervention, marital health

The Impact of Relationship Wellness Checkups with Lesbian Couples

Upon reading the literature on early intervention for couples, it is easy to assume that either lesbian and gay couples do not exist or they enjoy uniform happiness. Neither assumption is accurate. Yet researchers seeking to improve relational wellness sideline gay and lesbian couples. Tracking couples of the same sex, or same gender, or couples on a gender-spectrum can change the face of couples research. To accomplish this process, researchers will need to be creative and have a willingness to examine new ideas. Until counseling research more accurately reflects this diversity, additional studies on these marginalized populations must fill the gaps. To fulfill this need, this study examines the impact of one wellness program, the Marriage Checkup (MC), with lesbian couples.

Robust evidence exists that relational health is a protective force in mental and physical wellbeing (Robles, Slatcher, Trombello, & McGinn, 2014). Yet many distressed couples delay seeking or do not seek therapy. Barriers to counseling include time, money, and the stigma of therapy (Cordova et al., 2001). Brief checkups reduce some of these barriers, and they help couples get support sooner (Cordova et al., 2001). One such brief program, the MC, consists of two sessions – assessment and feedback. The assessment session facilitates discussion of strengths and concerns. The feedback session reviews findings, supports existing strengths, and addresses challenges. The MC uses motivational interviewing principles whereby the therapist seeks to hear and understand the couple's viewpoint first and foremost. The process is collaborative, and couples explore their own concerns and ideas with the therapist's observations and support (Cordova, Warren, & Gee, 2001; Miller & Rollnick, 2013). The mechanism of change is the intimate conversation a couple has in the sessions (Cordova et al., 2014). Checkup studies with heterosexual couples show the program reaches couples that may not otherwise have

sought help. Checkups have benefits such as maintaining satisfaction, preventing decline, and for couples who need more help, promoting additional help-seeking (Cordova et al., 2014).

This study fills a gap in the research by exploring the MC with lesbian couples. A checkup may have unique benefits for lesbian couples that have yet to be understood. For example, past research suggests that lesbian and gay couples have higher rates of dissolution (Kurdek, 2004). Gay and lesbian couples report bias on the part of their therapists and often must resort to protecting themselves from it (Grove & Blasby, 2009). Some couples seek gay or lesbian therapists to avoid discrimination. Other couples withhold concerns about certain topics, such as sex, to avoid alienating their therapists (Grove & Blasby, 2009).

Despite these challenges, existing research suggests checkups may support lesbian couples in several ways. Checkups may (a) boost satisfaction, (b) prevent problems, or (c) shorten the time the couple takes to seek therapy – all benefits found with heterosexual couples (Cordova et al., 2014). Checkups may also (d) help lesbian couples find affirmative therapists if desired and (e) promote the couples' wellbeing in a climate of prejudice. To understand the potential effects of checkups on key relationship health outcomes, five topics will be reviewed: relationship satisfaction, lesbian relationship satisfaction, wellness programs, the MC, and the role of the MC in sexual and gender minority couples' wellness research.

Relationship satisfaction is defined as the subjective evaluation of the overall quality of the relationship (Graham, Diebels, & Barnow, 2011). Relationship satisfaction has been associated with longevity (Graham, Diebels, & Barnow, 2011), mental health, and physical health (Robles et al., 2014). In addition, its accurate measurement is relatively straightforward (Graham et al., 2011). The appeal of satisfaction as an outcome variable is its known correlation with health outcome, its ease of measurement, and its complexity. Many aspects of a relationship

impact the global concept of satisfaction. For example, research shows that conflict and support discussions impact satisfaction (Julien, Chartrand, Simard, Bouthillier & Begin, 2003; Mackey, Diemer, & O'Brien, 2004). Emotional and sexual intimacy also correlate with relationship satisfaction (Brown & Weigel, 2017; Yoo, Bartle-Haring, Day, & Gangamma, 2014). Humor, affection, and other signs of a supportive connection have also been associated with satisfaction (Gottman et al., 2003). The expectancy of a positive interaction, higher empathy, and perceived rewards relate to satisfaction (Gottman et al., 2003). Frequent expressions of contempt, disgust, and defensiveness result in lower satisfaction (Gottman et al., 2003). Other factors relating to low satisfaction include less time together and economic hardship (Anderson, Van Ryzin, & Doherty, 2010).

To add to the complexity, satisfaction is not simply the absence of dissatisfaction. A relationship can be both satisfying and dissatisfying at the same time. Also, an individual's perception of satisfaction fluctuates. Thus, several scores over time offer more useful information than a single score (Bradbury, Fincham, & Beach, 2000). Satisfaction over time has been studied, and four trajectories of satisfaction emerged for heterosexual couples (Anderson et al., 2010). Two-thirds of couples in the study had high satisfaction stable over time. The remaining one-third of the couples included: a steady low level of happiness, an initial low level of happiness followed by a decline, and a higher level of happiness followed by decline followed by recovery.

Satisfaction as an outcome variable has a rich history in couples' studies (Bradbury, Fincham, & Beach, 2000; Graham et al., 2011). However, as wellness and prevention programs have grown, emerging research suggests relationship satisfaction as an outcome measure may not be as ideal for these programs as it has been for therapy, survey, and observational research.

Therapy helps couples move from distressed to non-distressed levels of satisfaction. Therefore, a noticeable improvement on a more global measure like satisfaction is a reasonable expectation. Wellness programs have tended to yield more subtle gains – preventing decline, maintaining happiness, helping couples move from strong to stronger, and assisting at-risk couples to stay connected (Cordova 2013; Markman & Rhoades, 2012). As such, variables that are related to satisfaction but are more sensitive to subtle changes may be a better fit for wellness programs (Bradbury & Lavner, 2012). Examples of such variables include empathy, enjoyment, intimacy, and acceptance. Research continues to explore these avenues, and as emerging research pinpoints ideal variables and measurements, future checkup studies with the MC and lesbian couples will likely include them. Because satisfaction is still the most consistently used outcome in couples' wellness programs, its use in this study provides a means to compare the MC's impact with lesbian couples to existing research on heterosexual couples participating in both checkup programs and education programs.

Research on lesbian couples reveals more similarities than differences with heterosexual couples regarding relationship functioning and relationship satisfaction (Gottman et al., 2003; Julien et al., 2003; Mackey et al., 2004). However, some important differences emerged in research. One was, for heterosexual couples, higher physiological arousal correlated with lower satisfaction. For lesbian and gay couples, higher levels of arousal were beneficial (Gottman et al., 2003). Additionally, some studies compared gay and lesbian couples to each other. Affection was important to lesbian couples' satisfaction more so than gay male couples. Meanwhile, validation was more important for gay male couples' satisfaction compared to lesbian couples (Gottman et al., 2003).

The trajectory of satisfaction over time differed between heterosexual couples and gay and lesbian couples as well. For example, one study compared four groups: gay couples, lesbian couples, heterosexual couples – all with no children – and heterosexual couples with children. Results showed lesbian partners exhibited the highest levels of satisfaction over time. Gay and lesbian couples also showed the lowest changes over time. Heterosexual couples with no children had early decline then their trajectories stabilized. Heterosexual couples with children had early decline followed by a second phase of decline. Gay and lesbian couples with children were not included in the study. Decline predicted separation for all couples (Kurdek, 2008). Of note, even though lesbian couples showed the highest levels of satisfaction and the lowest change over time (Kurdek, 2008), they were more at risk of dissolution (Kurdek, 2004). These contradictions likely relate to social stigma rather than internal concerns within a couple.

Thus, another related topic of research includes how minority stress impacts gay and lesbian couples' satisfaction and health. The research shows that minority stress experiences for sexual and gender minority people includes discrimination by legal, governmental, social, and religious institutions. Minority stress also includes effects related to the promotion of negative stereotypes in the media and by individuals, a lack of role models, expressions of disgust and contempt, and lack of family support (Frost & Meyer, 2009; Meyer, 2003; Otis, Rotosky, Riggle, & Hamrin, 2006; Rostosky, Riggle, Gray, & Hatton, 2007). The concept of minority stress captures internal experiences too, such as anticipating rejection, increasing vigilance, deciding whether to hide one's relationship, and internalizing homophobic messages (Meyer, 2003; Rostosky et al., 2007).

Research on minority stress and relationship satisfaction examined how some of these forms of social prejudice impacted gay and lesbian relationship health. Internalized homophobia

correlated with lower relationship satisfaction (Frost & Meyer, 2009; Otis et al., 2006). An individual's score on internalized homophobia also impacted their partner's satisfaction score (Otis et al., 2006). Internalized homophobia increased depressive symptoms, which, in turn, negatively impacted satisfaction indirectly (Frost & Meyer, 2009). A strong connection to the LGBTQ community had a negative correlation with satisfaction in one study. Another study found a similar variable, friend support, correlated positively with relationship satisfaction (Graham & Barnow, 2013). Family support was not correlated with relationship satisfaction (Frost & Meyer, 2009). Being "out" as gay or lesbian also did not impact satisfaction (Frost & Meyer, 2009).

Minority stress had a positive impact on some relationships, showing some couples made handling discrimination an opportunity for stress-related growth. Some gay and lesbian partners reported facing discrimination together strengthened their relationship (Connelly, 2005; Frost, 2014; Rostosky et al., 2007). Lesbian couples noted developing unique qualities such as egalitarian relationships, flexibility, cohesion, social support, and finding affirming views helped them navigate prejudice together (Connelly, 2005; Rostosky et al., 2007).

Research on social policy suggests social programs and laws can impact relationship health. Hatzenbuehler (2010) discussed how anti-gay laws and policies negatively impact mental health for sexual minority individuals. These avenues included decreasing resources, intensifying minority stress, and increasing the psychological risk factors. Research has shown that mental health impacts relational health for sexual minority couples (Frost & Meyer, 2009; Otis et al., 2006). At the very least, Hatezenbueler's work indicated social policies also impact relationship health indirectly through mental health markers such as depression, internalized homophobia, and social support. In a related study, the mental health benefits of the civil union law for lesbian

and bisexual women included lower levels of perceived discrimination, lower sensitivity and awareness of and sensitivity to stigma, lower depression symptoms, and fewer adverse drinking consequences (Everett, Hatzenbueler, & Hughes, 2016). In light of the research on minority stress (Frost & Meyer, 2009; Otis et al., 2006), the impact of discrimination on relationship longevity (Kurdek, 2004), and these studies on social policy and mental health (Everett, Hatzenbueler, & Hughes, 2016; Hatzenbuehler, 2010), relationship health likely improves with affirmative laws and social policies and decreases with anti-gay laws and policies.

More research is required on how the aspects of minority stress impact sexual and gender minority couples' wellbeing. The strongest findings have been related to internalized homophobia, which has been the most frequently studied variable. Internalized homophobia consistently has a negative impact on satisfaction. Some findings on external factors, such as community and friend support, seem to contradict each other. Other external factors such as laws and social policies appear to impact lesbian relationships as well (Everett, et al., 2016; Hatzenbuehler, 2010). The potential for the MC to support lesbian couples through these different factors is significant. Taken together, these studies highlight the need to buffer the negative effects of prejudice on relationship health. Intervention research needs to progress, to help couples manage the risks associated with the known effects from discrimination. If the toll of discrimination manifests as increased dissatisfaction and early separation, wellness programs may act as one protective measure.

Research on relational wellness has led to the development of programs that effectively support maintaining healthy connections. Although improvements will continue to be made, existing programs increase satisfaction and prevent decline. Early intervention or wellness programs have included two broad categories. The first category is education programs (Halford,

2004; Markman & Rhoades, 2012). Education programs are usually offered in a classroom style setting, with multiple couples in attendance. The second category is checkups (Halford, 2004). Checkups are usually two private sessions with a couple and a therapist. The first session is assessment of the couple's functioning in different areas, and the second session is feedback for the couple on what is going well and what may help prevent or reduce concerns.

Findings on education programs show positive effects for couples. In a review of thirty studies, couples attending relationship education programs improved in communication and satisfaction (Markman & Rhoades, 2012). In a meta-analytic review, relationship education programs had a small effect size (d =. 30 to .36) (Hawkins, Blanchard, Baldwin, & Fawcett, 2008). Positive effects remained stable at three to six-month follow-ups. In discussing limitations, some researchers suggested that, to improve outcomes, education needed to be more tailored to couples' unique concerns (Bradbury & Lavner, 2012; Halford, 2004).

The value of customizing programs to couples' concerns also appears high for lesbian couples. Women in lesbian relationships tend to be more reluctant to attend education programs with their partners because of (1) skepticism about the program's relevance to their needs, (2) concerns about being comfortable and safe in the mixed group and (3) doubts about leaders' competence with lesbian couples (Scott & Rhoades, 2014). However, when interested, they desired programs addressing topics relevant to them such as discrimination, legal issues, relationship disclosures, finding support, relationship development, relationship roles, family planning, communication, and intimacy (Scott & Rhoades, 2014). In two related studies exploring the effect of an education program designed for gay male couples, couples who completed the program reported being pleased the facilitators used images and vignettes of gay couples. The couples also commented on how the program addressed their concerns. The pilot

program showed moderate effects in targeted areas such as problem solving, perceived stress, and negative communication (Buzzella, Whitton, & Tompson, 2012). In another study, a randomized control trial, the program's effect on satisfaction was small (d=.19). The program had stronger effects on other variables, such as observed negative and positive communication (d=.71 and d=.61 respectively) (Whitton, Weitbrecht, Kuryluk, & Hutsell, 2016).

The research on education programs shows the potential benefits of wellness programs for sexual and gender minority couples. Despite these findings, relationship education programs for these couples are not readily available. Relationship program leaders must recruit a certain number of couples to run them. Providers must also identify convenient times and meeting structures to appeal to busy couples and families, and couples must commit time to attend. Running regular programs for minority couples is not feasible for many communities.

Though no research exists on checkups, checkups do provide an alternative to education programs for wellness for sexual and gender minority couples. They offer similar benefits as education in terms of effect size in the research with heterosexual couples. The MC showed effect sizes of d = .29 for satisfaction and gains remained at one-year follow-up. Because a checkup intervention only takes one couple at a time, each checkup tailors topics to what the couple needs (Halford, 2004; Halford, Markman, Kline, & Stanley, 2003). This addresses the concern with some relationship education programs being too broad in scope. Checkups are complete in just two sessions, and by contrast an education program may run weekly for several weeks or a full day. Checkups require less time commitment than education programs and scheduling is more flexible, as the two sessions can fit into a couple’s schedule more easily than set group times. Although in an ideal world, couples would have access to both checkups and

education programs, checkups provide a means for lesbian couples to get support with similar effectiveness and potentially better accessibility.

Checkups are not problem-free. Two concerns emerged in the research. First, couples in one control group in an MC study reported a decrease in marital intimacy (Cordova et al., 2005). Cordova et al. discussed two potential reasons (1) decline occurred because the couples were already distressed and (2) couples had a negative reaction to identifying relationship concerns outside an active intervention. Thus, for this study, the choice of a single-subject design eliminated the need for a control group. Satisfaction was measured before and after the intervention. Pre- and post-intervention scores, as well as scores across couples across time provided the essential comparative data. This design choice eliminated the risks associated with being in a control group for couples.

Second, some checkups were structured without a therapist; these checkups did not have the same benefit as therapist-led checkups and led to more reported problems. One study found three to five percent of couples participating in assessment – with no feedback and no clinician – reported negative impacts, such as regret for rekindling old problems or anxiety completing the tasks (Bradbury, 1994). Programs that used assessment and feedback strategies but had no clinician also showed problems. In a study of the RELATE checkup program, the self-assessment group did not receive the same benefits as the clinician-led group (Larson et al., 2007). Checkups facilitated with a clinician appeared to reduce potential harm and increase the benefits (Larson et al., 2007; Worthington et al., 1995). The program for this study, the MC, had a clinician for both sessions. The clinician also used an established therapeutic technique, motivational interviewing. This combination – assessment, feedback, and therapist's presence

and use of a collaborative therapeutic model, has been an effective combination in research on the MC (Cordova et al., 2014).

Four relevant outcomes in MC research include this approach's effect on reaching more distressed couples, being more tolerable (appealing, reducing barriers), promoting more help-seeking behavior, and increasing satisfaction. First, the MC reached distressed couples and couples who had not sought help before. Couples in the MC had an average distress score between the scores found in the general population and in couples seeking therapy (Sollenberger et al., 2013). Sixty-three percent of the MC group had also never sought counseling before, and 32% reported it was their first use of any mental health service (Morrill et al., 2011).

Second, couples tend to be receptive of MC. In one pilot study, only one of 32 couples dropped out (Cordova et al., 2001). In a subsequent study with 74 couples, no couples dropped out (Cordova et al., 2005). In a third related study, which included follow-up surveys for two years, 27% dropped out. Cordova et al. (2014) noted the rate for the third study matched the 30% drop out rate commonly observed in longer studies. Combining the three studies, the MC showed accessibility and tolerability, making it an inviting option for couples in general as well as for those couples who may not have sought help otherwise.

The MC has also been shown to impact help-seeking behavior (Gee, Scott, Castellani, & Cordova, 2002). Help-seeking behaviors are an important target outcome because some couples attending the MC may need more help; part of the function of the checkup is to help couples get additional support if needed. For distressed couples, couple therapy is still the best option compared to education programs or checkup programs. Couple therapy provides the in-depth help these couples will need to recover. A recommendation for couple therapy is one potential outcome of a checkup (Markman & Rhoades, 2012). When given the suggestion for therapy,

women in heterosexual couples sought help at a rate of 60%. It is unknown whether lesbian couples exhibit similar levels of help-seeking behavior or if a checkup will boost their help-seeking efforts as it has in research on heterosexual women.

Research has also revealed that the MC can boost satisfaction for heterosexual couples. For example, distress scores remained lower one month after a checkup and were no longer significantly different than non-distressed couples (Cordova et al., 2001; Cordova et al., 2005). Results remained stable at one month and two-year follow-ups (Cordova et al., 2005; and Gee et al., 2002). In an MC study with 215 couples, the checkup had a small effect on satisfaction (Cohen's *d* post-intervention was $d = .29$). After a booster session at two years, satisfaction increased again, reaching close to a moderate effect ($d = .39$). Intimacy and acceptance also retained their gains at the two-year mark.

These scores indicate the MC has a small to moderate effect on satisfaction, similar to education programs. The similarity in outcomes of education programs and checkups confirm early intervention programs provide small satisfaction effects for couples. The full picture for checkups includes several gains. For healthy couples, checkups provide a small improvement in satisfaction and potentially prevent some problems. For mildly distressed couples, checkups catch problems earlier when they may need only a brief intervention. Finally, for seriously distressed couples, checkups increase their likelihood of entering therapy. These outcomes are significant given the importance of actively nurturing relational wellbeing, including benefits to both physical and mental health. These four outcomes are important in identifying a wellness intervention for lesbian couples, and research needs to be done to determine if the MC has a similar impact on lesbian couples as it does for heterosexual couples.

In addition to being tolerable, appealing, and supportive, the MC may be ideal for lesbian couples due to the methodology used by the clinician. As noted, the MC is based on motivational interviewing principles. This therapeutic process creates a collaborative working relationship. Giving lesbian couples the opportunity to express their own expertise may counter microaggressions and the anticipation of bias, and it may provide an antidote to lesbian couples' experience of being viewed through a particular lens (whether that lens being one that skews the viewpoint of the therapist positively or the negatively) due to their orientation alone (Grove & Blasby, 2009; Shelton & Delgado-Romero, 2013). The motivational interviewing process guides the clinician to treat the assessment as a process of the therapist coming to understand how the couple sees themselves – their strengths and challenges. The feedback session is not a review of a report as much as a continued conversation about change with information from research. Therapists encourage couples to share their perspective, following motivational interviewing principles of asking for the participant's perspective first, then offering additional information, then eliciting the couple's perspective on the new information (Cordova, Warren, & Gee, 2001; Miller & Rollnick, 2013). At the end of the feedback session the therapist offers advice in a manner consistent with motivational interviewing research on giving advice – the therapist reviews a menu of options and asks for the couples' opinion on which are appealing and includes the couples' own ideas of what may be most helpful. The couples' view of what to change, what motivates them to change, and how they might go about change are given priority (Cordova, Warren, & Gee, 2001; Miller & Rollnick, 2013). This process is particularly ideal when working with marginalized couples.

Sexual and gender minority couples have been absent in research on checkup interventions. To date, of the three studies in this area, all were conducted with heterosexual

couples (Cordova et al., 2005; Larson et al., 2007; Worthington et al., 1995). Several review articles for early intervention have also failed to consider lesbian or gay couples (Halford, 2004; Halford et al., 2003). As a hopeful contrast, three recent reviews reflected a shift. Each noted the absence of sexual and gender minority couples, citing it as concerning (Bradbury & Lavner, 2012; Markman & Rhoades, 2012; Hawkins et al., 2008). Although a recent study on the MC had six same-sex couples participate (Cordova et al., 2014), no data from the results was shared. Cordova et al. (2014) explained this decision by stating, "due to partner distinguishability on outcome variables, same-sex couples were excluded from the analysis" (p. 594).

A consistent theme across the literature has been the dearth of studies on brief interventions with sexual and gender minority couples. As such, the purpose of this study is to examine the impact of the MC with lesbian couples. The study fills a notable gap in the checkup research and simultaneously represents needed social advocacy by including lesbian couples in this body of research. The outcome of this study is one step toward the development of checkups that effectively support lesbian couples in maintaining their wellbeing. Specifically, this study focused on the question: What is the impact of a relationship wellness checkup upon relationship satisfaction for lesbian couples?

Method

Design

This study utilized a concurrent multiple baseline (Barlow, Nock, & Hersen, 2009) and multiple probe design (Gast, Lloyd, & Ledford, 2014). Three lesbian couples participated. Couples started the study at the same time. The checkup was staggered – offered at weeks four, six, and eight of the ten-week study. Researchers measured satisfaction at a minimum of three

points before the intervention for baseline, then the two weeks of the intervention and one week after for potential change.

This design helps assess for threats related to history, testing, and maturation (Barlow et al., 2009; Biglan, Ary, & Wagenaar, 2000; Christ, 2007). Another benefit of the design is not having a waitlist control group, which reduces the risk of harm found for waitlist couples (Cordova et al., 2005). The MC is an established program; thus, this study extends this existing program to a new population (Hawkins, Sanson-Fisher, Shakeshaft, D'Este, & Green, 2007). When it comes to using a wellness checkup with lesbian couples, however, this study constitutes a novel exploration of what may be most helpful to this population. The small sample size has benefits in this stage of early exploration. First, a concern in research with smaller or closer communities, such as this LGBTQ community, is diffusion into the community. Having too large of a sample can influence other people in the community at the early stages of development of an intervention. Small groups can help test the program, allow for adjustments, then be tested again in the same community on a larger scale (Biglan et al., 2000). The small size also lowers cost during this exploration process. Larger studies cost more and provide less nuanced information about what changes may need to be made to the program (Biglan et al., 2000).

Participants

Recruiting included flyers, print and online advertisement, local LGBTQ affirmative organizations, and word of mouth. Initial recruitment lasted approximately five months. Over this time only one couple enrolled. To boost interest a financial incentive was offered to participants. Over the next two months of recruitment, three additional couples enrolled. After conducting an information consultation regarding the study, three of the four couples chose to participate in the checkup.

The inclusion criteria for participation required couples to be cohabitating at the time of the study and together in a relationship for at least two years. Partners were over 18 years of age and not in, or currently seeking, couples therapy. Neither partner had been a client of the researcher's in the past. Couples considered for the study had to have an average CSI (4) score between 13.70 and 18.30.

Participant couple one (C1). Both partners were middle aged and Caucasian. They each work as white collar professionals. They had been together for over the required two years and were raising children. They heard about the checkup from a friend in a faith community group. They chose to participant in the checkup for two reasons: to get a sense of their relationship health and to help further research on lesbian couples. They took the checkup on weeks four and five.

Participant couple two (C2). Both partners were in early adulthood with one biracial and the other Caucasian. One partner was unemployed and the other was a blue collar worker in a service industry. They had been together for over the required two years in a committed relationship and were married. They did the checkup because the first partner's therapist encouraged her to do so. They also wanted to contribute to research on lesbian couples. They completed the checkup on weeks six and seven.

Participant couple three (C3). Both partners were middle aged. One partner had a Caucasian heritage and the other biracial. They each worked as white collar professionals. They had been in a relationship for over the required two years. They heard about the checkup from a friend of the researcher and they wanted to contribute to the research. They received the checkup on weeks eight and nine.

Measures

The Couples Satisfaction Inventory Four-Item (CSI (4)) is a four-item measure of relationship satisfaction. To create the CSI, Funk and Rogge (2007) surveyed 5,315 people using 280 questions from established measures. The questions with the most power and precision formed the CSI. The CSI had strong construct and convergent validity with the original measures. It also showed higher power and precision. Cronbach's alpha for the CSI (4) is .94, compared to common measures such as the Dyadic Adjustment Scale (DAS) (4) at .84, the Marital Adjustment Test (MAT) (15) at .88, and the Quality of Marriage Index (QMI) (6) at .96. The sample was largely female and Caucasian. Gay and lesbian individuals comprised 7% of the sample.

The CSI (4) distinguishes distressed from non-distressed couples. The scale for the CSI (4) ranged from possible scores of zero to 21. The distress cut-off score was 13.5. The mean for the CSI (4) was 16. Standard deviation was 4.6. One concern with the CSI was a drop in effectiveness in measuring change at higher scores, which can create a ceiling effect (Funk & Rogge, 2007). The scale was fully anchored. The first item had a seven-point scale from zero to six. Answers ranged from "extremely unhappy," to "perfect." The remaining three items fell on a six-point scale from zero to five. Answers ranged from "a little," to "completely." A sample question read, "I have a warm and comfortable relationship with my partner."

The CSI was ideal for this study. The increased power and precision was useful for a small sample size. The CSI was designed for use with couples from seriously dating to married (Graham et al., 2011). Lesbian couples' relationship status ranged from living together, domestic partnership, married, to in a long-term relationship by other definition. The language of the CSI

referred to "partner" rather than "spouse" and "relationship" rather than "marriage." Thus, no language changes needed to be made.

Qualtrics software (Qualtrics, February 2017) helped administer the inventory. As noted, the average CSI (4) score at screening had to be between 13.7 and 18.3. Couples scoring below this range would be more likely to benefit from couples' therapy rather than a checkup, and couples scoring above this range would present a ceiling effect, prohibiting a full understanding of the checkup's impact. All couples who completed the screening fell within the noted range. The three couples who enrolled had the following screening scores: C1's score was 14.50, C2's score was 17.00, and C3's score was 17.00.

Intervention

A week prior to their first interview, couples received surveys via an email link. The link included three surveys: Relationship Domains Assessment (Cordova, 2013), Areas of Concern (Cordova, 2013), and Areas of Strength (Cordova, 2013). Couples completed the surveys prior to the first meeting (Cordova, 2013). The therapist then used the three top-rated strengths and three top-rated challenges from these surveys during the checkup interview.

The assessment interview had five steps: (1) The consultant provided a structured opening. Couples briefly shared their reasons for seeking a relationship checkup, (2) the consultant listened to the couple's history (Buehlman, Gottman, & Katz, 1992), (3) couples discussed an area of conflict, (4) the couple shared their identified strengths and concerns, and (5) the consultant summarized the couple's strengths and concerns (Cordova, 2013).

In the feedback session, the consultant debriefed the couple on their report. Following the principles of motivational interviewing, on which the MC is based, the therapist intended to be collaborative and remained supportive of the couples' autonomy and their own reasons for any

behavior change (Cordova et al., 2001; Miller & Rollnick, 2013). The therapist (a) got the couples' perspective first, (b) supported the couples' expertise on their relationship, (c) provided advice and facilitated discussion, (d) elicited examples and thoughts from the couple, (e) reflected the couples' ideas about change, and (f) collaboratively formed a menu of options leading to a final plan (Cordova, 2013).

Therapist

The student investigator of this study was the clinician for the checkup. She has worked as a full-time clinician for over thirteen years. She is a Licensed Marriage and Family Therapist and Licensed Clinical Drug and Alcohol Counselor, as well as a national board-certified sex therapist with the American Association for Sex Educators, Counselors and Therapists. She has post-master's certificates in couple and family therapy, sex therapy, and LGBTQ couples and families. She is a MINT member (Motivational Interviewing Network of Trainers) and a MIA-STEP trainer (Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency). She specializes in working with couples, sexual health concerns, and LGBTQ health.

Procedure

In a study overview prior to participation, couples were told their results would be part of an Oregon State University study. The intervention was not treatment or therapy but rather information. The study would run ten weeks. The intervention would include two on-site appointments. As suggested by Bradbury (1994), informed consent included notifying participants that (1) some individuals find being observed and recorded stressful, (2) the checkup could lead to higher awareness of oneself and one's partner, and (3) participants did not need to reveal information they were uncomfortable revealing.

The study was conducted in two phases. During Phase A, the non-treatment baseline phase, couples completed the CSI (4) survey three or four times. They did the survey the first week of the study and for each of the three weeks before the date of their checkup (Gast et al., 2014; Hawkins et al., 2007; Scruggs & Mastropieri, 1998). The checkups occurred at weeks four, six, and eight. Couples were randomly assigned to one of these three spots. Random assignment was done via Random.org.

For Phase B, the intervention phase, couples completed the two-session intervention as described. They also took the CSI (4) survey the day after each of the sessions and one week later. Fidelity of the intervention was established using a shortened version of Cordova's fidelity assessment (Cordova, personal communication, October 1, 2014). One rater, a PhD student in counselor education, reviewed one-third of the sessions (Lombard, Snyder-Duch, & Bracken, 2004). The sessions were chosen randomly using the Stat Trek's random number generator (Stat Trek, 2016). The rater gave eight therapist behaviors a score between zero to five, from "not at all" present to "extensively" present. The maximum score was 40 (a score depicting when all eight behaviors occurred extensively). The rater gave the therapist a rating of 39 out of 40 for a 98% adherence rating. The only concern was that the therapist phrased one question differently from what the protocol indicated.

Data Analysis

Data analysis included visual analysis of the data and calculation of NAP (non-overlap of all pairs). For visual analysis three graphs, one for each couple, showed the CSI (4) scores session by session across all phases (Spriggs & Gast, 2010). Visual analysis included analysis of baseline stability, level change, and trend (Gast & Spriggs, 2010). Baseline data stability included the last three data points before the checkup (Gast & Spriggs, 2010). For stable

baseline, 80% of the data had to fall within 20% range of the median: 10% above and 10% below the middle score (Gast & Spriggs, 2010). For level change across phases, researchers compared the last point in baseline to the three data points in intervention phase. Although the first data comparison in single subject design is usually the only comparison made (Gast & Spriggs, 2010), the checkup is a two-step intervention, so data comparisons in this study included the second and third data points as well in order to see the impact of the full intervention. The three intervention points represented different stages of the intervention process: mid-checkup (after assessment session), post-checkup (after feedback session), and one week after completing the checkup. In addition the median from the last two data points from the baseline phase was compared to the median from the first two data points of intervention, as standard in visual analysis (Gast & Spriggs, 2010). Again to account for the full intervention occurring over two sessions, the median of the last two intervention data points was also compared. Trendlines between baseline and intervention phases were also compared. All data prior to the checkup determined baseline trend, and all data during and after the checkup determined intervention trend. Trend descriptions included improving (accelerating), declining (decelerating), or no change (zero celerating) (Gast & Springs, 2010).

Due to the small sample size, researchers used a non-parametric analysis of effect size for single subject design – nonoverlap of all pairs (NAP) (Parker & Vannest, 2009). NAP was calculated with Excel and an online calculator (Vannest, Parker, & Gonen, 2011). NAP scores have a range from .5 to 1.0. A NAP score of below .5 reflects decline. As a statistical measure, NAP has conceptual similarities to Cohen's d. Mathematically small, medium and large values of Cohen's *d* are set at .2, .5, .8 and align with NAP values of .56, .63, and .70, respectively. As Cohen's *d* does not apply to single subject design, such comparison is purely mathematical. In

review of over 200 sets of data, NAP values appear to correspond to the following effect sizes: NAP small 0–.65, medium .66–.92, and large .93–1.0 (Parker & Vannest, 2009). These values are used for analysis in this study.

Results

In total, four couples completed screening and all four met criteria for the study. No couples failed the screening process. By their choice, three of the four couples ultimately enrolled in the study. Charts (Figures 1 and 2) showed the satisfaction scores during baseline and intervention phases (Carr, 2005; Dixon et al., 2009). Visual analysis and NAP contributed to understanding the results.

Baseline data for C1's satisfaction was not stable. The median was 15.50, and the stability envelope was 13.95 to 17.05. Only 66% of the data fell in the stability envelope; the required amount for stability was 80%. Scores were 17.50, 15.50 and 15.00. The first data point, 17.50, fell out of range. Baseline trend was decelerating (using scores 17.50, 15.50, and 15.00).

Baseline data for C2's satisfaction was stable. The median was 17.50; stability envelope range was 15.75 to 19.25. Scores were 17.50, 17.50, and 18.00. One hundred percent of the data fell in the stability envelope. Baseline trend was decelerating (using all four data points which were 18.50, 17.50, 17.50, 18.00).

Baseline data for C3's satisfaction scores was stable. The median was 18.00, range was 16.20 to 19.80. Scores were 18.00, 18.00, and 16.50. One hundred percent of the data fell in the range. Baseline trend was accelerating using all four data points which were 13.00, 18.00, 18.00, and 16.50.

Visual Analysis Across Baseline and Intervention Phases

C1 had the following changes in level. Their last satisfaction score prior to checkup was 15.00. The score after the first session was 14.50, showing lower satisfaction after assessment. The score after the second session was 17.50, showing an increase in satisfaction after the full checkup was completed. One week after the intervention, satisfaction was still higher than the last baseline point at 16.50. With regard to medians values, the median from the last two data points in the baseline phase was 15.25. The median using the first two points of the intervention phase was 16.00 and, to account for the potential impact of completing two-part intervention, the median from the last two points of the intervention phase was 17.00. Thus comparison of the median values demonstrates a positive impact from the intervention, even more so after the full checkup was complete. Trend in the baseline phase showed declining (decelerating) satisfaction. Trend during and after the checkup showed improving (accelerating) satisfaction.

For C2, their last satisfaction score prior to checkup was 18.00. The score after the first session was 18.00, showing stable satisfaction after the assessment session. The score after the second session was 18.50 demonstrating an increase in satisfaction after the checkup. One week later, satisfaction remained steady at 18.50. The median from the last two data points in the baseline phase was 17.75. The median using the first two points of the intervention phase was 18.30 and the median from the last two points of the intervention phase was 18.50. The median value differences reflect a positive impact from the intervention. The trend shifted from declining (decelerating) prior to the checkup to increasing (accelerating) during and after the checkup.

C3’s last satisfaction score prior to checkup was 16.50. The score after the first session was 17.50, showing an increase in satisfaction after the assessment session. The score after the second session was 17.50 demonstrating consistent higher satisfaction after the full checkup. One

week later, satisfaction increased to 18.50. The median from the last two data points in the baseline phase was 17.25. The median using the first two points of the intervention phase was 17.50 and the median from the last two points of the intervention phase was 18.00. Thus median values show a positive impact from the checkup. Both baseline and intervention had accelerating trendlines. Comparing the slopes of the trendlines between baseline and intervention, the intervention trendline showed a slight increase. This shift indicated further improving satisfaction.

When comparing intervention scores to the last baseline score, visual analysis showed a consistent increase in satisfaction by the end of the two checkup sessions. Visual analysis of trend indicated an improvement in the trend of satisfaction after the checkup – each couple either moved from declining to improving satisfaction or had an increase in an already improving direction for satisfaction.

Effect Size and NAP

C1 had a NAP score of .50. Thus, the effect size of the checkup with C1 was not significant. C2's NAP score was .79, reflecting a medium effect size. C3's NAP score was .66, also a medium effect size. For the full series, all three couples, NAP was .66; thus, the intervention overall had a medium effect size.

Discussion

This study sought to answer the research question: "What is the impact of a relationship wellness checkup upon relationship satisfaction for lesbian couples?" Using NAP, the wellness checkup had a medium effect size on relationship satisfaction for these lesbian couples. Visual analysis supported this outcome with improvements in trajectory and in level across phases.

One explanation for the moderate effect size originates from research on the MC with heterosexual couples. Lesbian couples and heterosexual couples have more similarities than differences (Gottman et al., 2003; Julien et al., 2003; Mackey et al., 2004). Therefore, how the MC affects heterosexual couples likely applies to lesbian couples. For heterosexual couples the mechanism of change for the MC partly involved how the MC created opportunities for couples to express their vulnerabilities (Cordova et al., 2005). In addition, the MC reminded partners of the positive qualities of their relationship, fostered acceptance and patience, and helped couples activate resources to improve their connection (Cordova et al., 2014). For these lesbian couples, the effect size for their checkup may be explainable via these same mechanisms.

Another potential reason for these results may lie in how a wellness programs challenges discrimination and prejudice. Being offered a relationship checkup designed for couples in a *normative functioning range* partially countertacts any social marginization experienced by the couple. A wellness checkup assumes, by design, couples are healthy, do not need therapy, and are following a normative developmental process with typical ups and downs. Disgust, lack of awareness or interest, lack of acknowledgement, being exoticized, or even having well-meaning others depict their relationships as problematic are overt and covert forms of discrimination. These processes occur within families, social and work environments, faith communities, and in therapists' offices. For lesbian partners, having the opportunity to talk about their relationships from the perspective of a being a healthy couple could be a relief or perhaps – just as important – give them a chance to be seen for their strengths. As such, the mere experience of being treated, a priori, as a normal couple may in itself be beneficial to a couple's sense of satisfaction.

A third explanation for the obtained results pertains to the level of specification to lesbian couples. The MC intervention used in this study was adjusted to meet lesbian-specific couple

issues. Changes to the structure of the intervention were small and included shifting language from “marriage” to “relationship.” In addition, during the two sessions the clinician’s responses reflected awareness of lesbian couples’ concerns in at least two ways. First, the clinician provided information from research on lesbian couples’ health in the session and in the feedback report. One mechanism in social discrimination that impacts lesbian well-being is a lack of research about staying healthy. Similarly, lesbian couples often have low access to the existing knowledge on unique concerns for lesbian couples’ health (Hatzenbuehler, 2010). Therefore, the therapist sharing research findings related to lesbian couples represented another way checkups support wellbeing. Second, the clinician listened for and validated experiences of heterosexism and homophobia. The therapist’s intention to bear witness to the pain caused by prejudice may have countered harmful effects related to homophobia, internalized homophobia, concealment, and isolation.

A fourth explanation is that the three previous explanations for the obtained results combined to yield the findings. The MC had a small effect size with heterosexual couples (Cordova et al., 2014), and the effect size for these three lesbian couples was moderate. Therefore, a combination of factors may have driven an effect size greater than typically encountered in MC research. These factors may include the interpersonal benefits found in MC research with heterosexual couples alongside social benefits that serve as antidotes to prejudice for lesbian couples. The MC research consistently produces solid results with heterosexual couples, and lesbian couples are not so notably different that a checkup would have a significantly different result. The social benefits of offering a wellness program to these marginalized couples cannot be ignored given the preponderance of research on how prejudice impacts wellbeing. Lesbian couples not only have less access to culturally competent wellness

programs, they must weather the costs of being ignored, excluded, and pathologized (Hatzenbuehler, 2010). The checkup may counter these social concerns.

The structure of this multiple baseline design study presents some strengths and limitations related to internal validity. Concurrent multiple baseline design allowed for assessment of history, maturation, and testing. For threats related to history, each couple participated in the study over the same ten weeks. They received the checkup at randomly assigned times within those ten weeks. For maturation, baseline data was taken over at least three weeks to determine trajectory prior to the checkup. Overall, the short duration of the study also aimed to minimize maturation effects. The multiple-probe design decreased the risks related to testing as testing was done as infrequently as possible. Balance was struck between measuring frequently enough to establish trend – thus, capturing the movement of each couples' satisfaction – and using the minimum number of probes possible to reduce effects related to testing. Though the design provided means to assess the effects related to history, maturation, and testing, and they did not appear to impact the results, they are not eliminated completely.

Another potential limitation is the possible presence of a ceiling effect of using the CSI (4) with couples already functioning in the normal range. The couples in this study were non-distressed in their scores on the CSI, and the CSI does not capture changes effectively when couples score in the higher range (Funk & Rogge, 2007). The medium effect size may reflect a point at which the measure no longer captures changes or differences. Regardless of whether the score is impacted by a ceiling effect, for a prevention program, scores reflecting the couple is staying on track or averting decline may be a reasonable outcome. The couples are not moving from distressed to healthy but from healthy to healthier, and a moderate effect size is important in this context. In addition, the small effect sizes found for heterosexual couples lasted one to

two years, a finding that suggested these gains were enduring (Cordova et al., 2014). Future checkup studies will show how lesbian couples sustain gains.

Procedural validity was assessed with a review by an independent rater. However, therapist-related effects, such as skill-level and rapport, could not be compared. Therapists who are more or less sensitive (than the therapist for this study) to lesbian couples' concerns, aware of current research on lesbian couples, or prone to bias may have had different results.

In terms of generalizing the results, for single subject design, replication studies support external validity. Using the MC with lesbian couples adds to existing robust research on the MC – taking the already well-researched program to a new population. From the perspective of creating a checkup with maximum benefits for lesbian couples, this study represents a start. Additional studies using the MC with lesbian couples, perhaps with some modifications, will strengthen the validity of these results and potentially further improve checkups for this population. In particular, using the intervention with couples in other locations with different therapists will strengthen the external validity of these results.

These findings led to five implications for future research in this area. First, emerging research recommends the dependent variables in wellness intervention research should include other outcomes beyond satisfaction (Bradbury & Lavner, 2012). Other variables may be more responsive than satisfaction for wellness programs like the checkup and education. Satisfaction shows mild to moderate effects for couples for wellness programs (Cordova et al., 2014; Hawkins, Blanchard, Baldwin, & Fawcett, 2008) while other variables show more variance in and thus, may be a better measure of the effect of a wellness program. More research is needed to determine the predictive value of these other emerging variables for longevity and satisfaction. One measure, the Intimate Safety Questionnaire (ISQ), appears to be a potential candidate

(Cordova, Gee, & Warren, 2001; Cordova & Blair, n.d.). The ISQ may be sensitive enough to capture changes from wellness programs, showing a difference between treatment and control groups (Cordova et al., 2014) in an MC study. The scale is 28 questions, and a shorter version would be ideal for single subject design studies due to the frequency of measurement. Other alternative variables include enjoyment, empathy, compassion, commitment and time spent together, and felt acceptance (Bradbury & Lavner, 2012; Cordova et al., 2005; Cordova et al., 2014; Hawrilenko, Gray, & Cordova, 2016). By reviewing the range of variables and current potential measures, future studies can help determine how to best capture success in helping lesbian couples maintain their well-being.

Second, this study matched the MC intervention closely. Creating programs to fit concerns of gay and lesbian couples specifically may have added benefits (Buzzella et al., 2012; Scott & Rhoades, 2014; Whitton et al., 2016). Future research may compare the MC with a checkup catered to lesbian couples' concerns. A revised checkup could include direct discussion of coping with discrimination, garnering social support, defining roles in the relationship, and handling relationship disclosures (Buzzella et al., 2012; Scott & Rhoades, 2014).

Third, couples generally still need support to come to checkups (Markman & Rhoads, 2012). For sexual and gender minority couples, the barriers to attending wellness programs are even stronger (Meyer & Wilson, 2009). Intersecting concerns such as financial hardship, age, disability, race, religion, nationality, gender identity, and socioeconomic status also increase the challenge for some couples (Lavner & Bradbury, 2017; Pregulman et al., 2011). Internalized homophobia may make attending a checkup difficult, particularly if couples are concerned that therapists may be looking for faults in their relationship or if either individual in the couple feels shame about their relationship and hesitates to seek support as a result. Increasing the

attractiveness of checkups continues to be a goal. Incentives helped achieve this goal for this study. Also, when researchers provided education about checkups to community groups and referrals, they emphasized the concept of relationship wellness. The message reflected the aim of checkups to keep couples healthy. Framing the checkup as a "Relational Wellness Checkup" instead of a "Relationship Checkup" in promotional materials may attract more couples by inoculating any stigma attached to the latter as being therapy or a process that looks for pathology.

Fourth, as part of a public health initiative, increasing exposure and providing access to checkups at certain moments in a couples' life may increase awareness for couples to be protective of relational health. For example, giving checkups at physical rehabilitation facilities, at mental health and substance use program sites, and at re-check doctor appointments for serious physical health concerns could help couples through challenging life changes and potentially improve recovery. Providing a checkup as part of an unemployment and vocational rehabilitation program could help couples navigate stressful events such as disability, job loss, unemployment, and underemployment. Similarly, checkups could be offered during times of developmental life changes for couples. For example, a checkup could be offered at retirement, financial, and wedding planning seminars and conventions, at fertility clinics and adoption agencies, and concurrent with well-child visits to the doctor. Same-day interventions could be offered at community events such as Pride, fundraisers, or health fairs to increase accessibility. Online checkups with a therapist could increase appeal as well. Offering checkups at these times and places could increase awareness of the importance of being proactive in maintaining relationship health.

Fifth, many of these suggestions generalize to all couples. Additional steps may help lesbian and other sexual and gender minority couples to combat the impact of discrimination. New research suggests that targeting external stressors for some groups, such as poor couples, may increase their well-being (Lavner & Bradbury, 2017; Trail & Karney, 2012). Existing programs provide financial assistance, child care, parenting classes, and resources for employment. The focus on external factors alleviates the belief that all problems are a result of personal or interpersonal deficits. Studies suggest intervening in these systemic ways has a positive impact on relational health (Lavner & Bradbury, 2017). Along this line, interventions that directly help sexual and gender minority couples and families manage prejudice may have a positive impact. No research has been done with sexual and gender minority relationship health and programs focused on managing external discrimination. A study of the impact of helping couples and families combat prejudice is overdue. Given lesbian and gay relationships are more prone to dissolution than heterosexual couples, and this risk is associated with social stigma, a program focused on handling prejudice may have an even greater impact on relationship health than a checkup. A combination program that address both interpersonal concerns, such as a checkup, as well as external stressors, such as handling social prejudice or unemployment, may be more helpful than any of these programs alone.

In addition, the small sample size allows for some initial exploration of how variables such as race and class impacted the results of this study. Given that the women in this study represented a variety of heritages, observations based on race are considerably difficult. Socioeconomic status may have been a variable: for example the couple with the lowest socioeconomic status had the highest NAP score. Exploring class and race as factors in the checkup with lesbian couples is worthwhile.

As the primary implication for practice, these three couples showed how a relationship wellness checkup may benefit lesbian couples in similar ways as the MC benefits married heterosexual couples by improving satisfaction. Lesbian couple wellness is both ordinary and extraordinary – ordinary in that relationships of all varieties can be healthy and extraordinary in that, despite the lack of social awareness, support, and value, many lesbian relationships are thriving. Research comparing heterosexual and lesbian couples indicates couples have more similarities than differences, and using a checkup with lesbian couples was certainly not without indirect support. However, important differences for marginalized couples have been documented. This study builds on existing support for checkups as a reasonable wellness intervention for lesbian couples as a specific and important population.

Other implications for practice relate to the potential social benefits of checkups. First, the explicit inclusion of lesbian couples – i.e. inviting them to attend checkups and ensuring they know they are welcome – creates awareness that these couples exist in a social context where gender and sexual minority couples are often ignored or invisible. Second, offering the MC, which has been available to married heterosexual couples for over 16 years, to lesbian couples makes this public health intervention increasingly accessible to all couples. Third, opening relationship wellness programs to overtly include lesbian couples and, in the future, other sexual and gender minority couples, sends the message that these couples are normative in development, face the same life concerns as all couples do, and benefit from the same services. Clear and unwavering inclusivity acknowledges the importance of lesbian relationship health and supports that their health is worth maintaining in social support programs.

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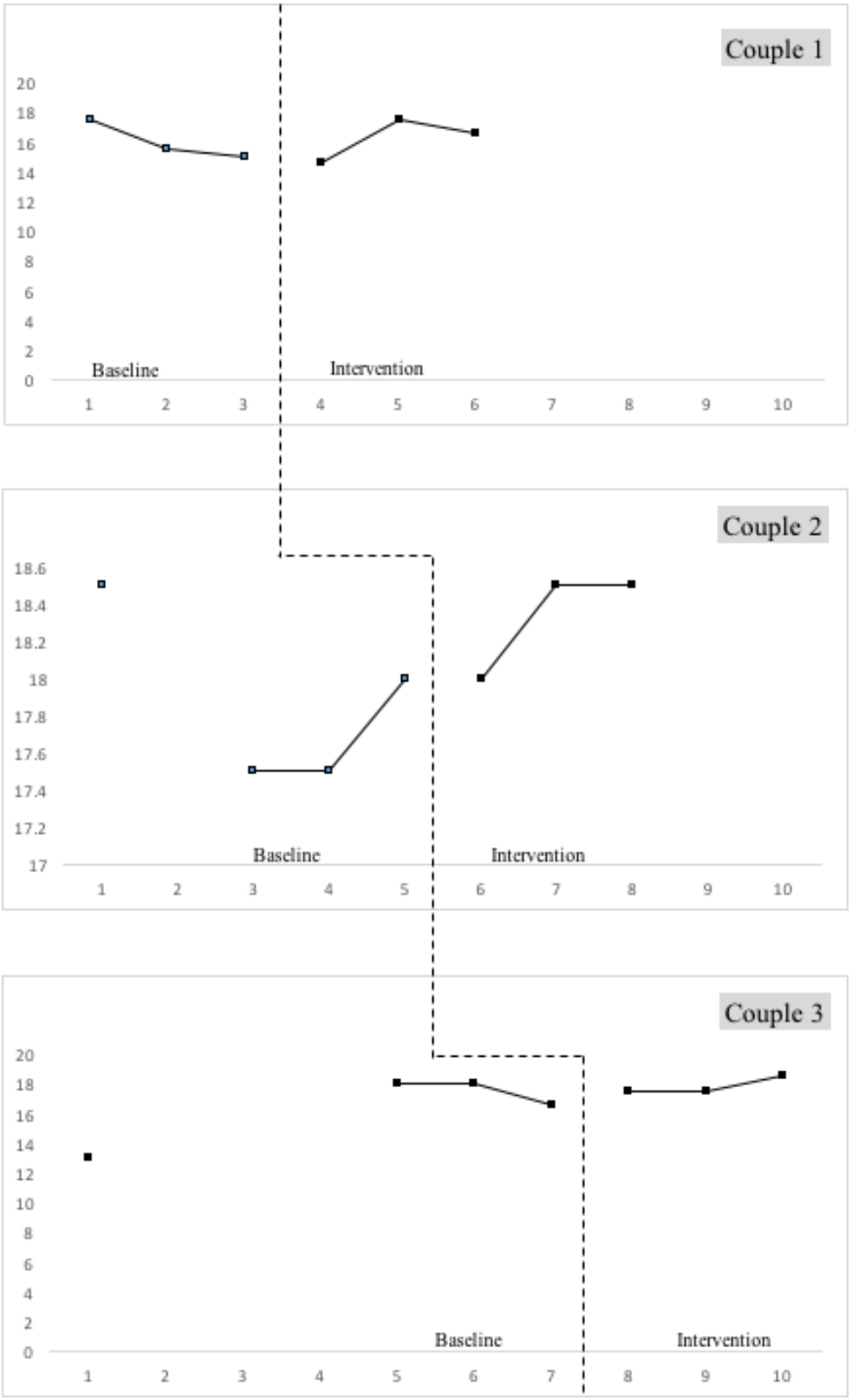

Figure 1. Relationship satisfaction for lesbian couples across phases. This figure how lesbian couples' satisfaction changed across phases of the study.

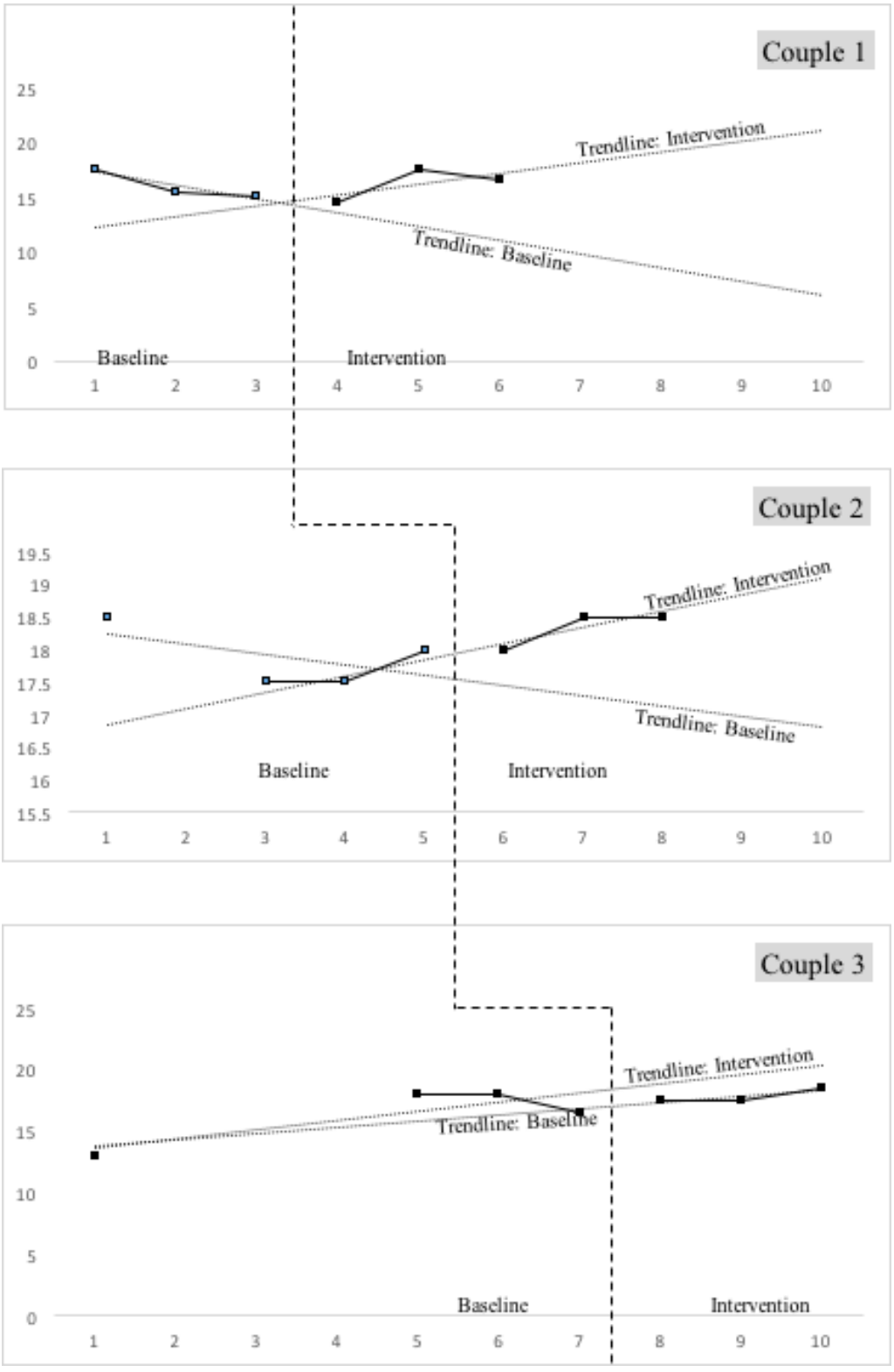

Figure 2. Relationship satisfaction for lesbian couples with baseline and intervention trendline. This figure shows the trendline for satisfaction for baseline and intervention phases for each couple.

Chapter 3: The Impact of Relationship Wellness Checkups with Gay Male Couples

The Impact of Relationship Wellness Checkups with Gay Male Couples

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The research contained in this manuscript was conducted under the approval of the Oregon State University Institutional Review Board (Study ID 7076). The manuscript was prepared as part of the first author's dissertation.

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Abstract

Relationship health affects the physical and mental health of partners, children, and other family members. Distressed couples encounter a range of barriers to seeking help, despite the value of therapy and other programs that support relationship health. One wellness program, the Marriage Checkup (MC), aims to reduce these barriers and get couples help sooner. The MC is based on motivational interviewing principles and research shows the program improves relationship satisfaction, prevents decline, and has a positive impact on other variables such as intimacy. Gay male couples face relationship challenges that the MC is meant to remedy and have additional concerns to finding professional support for these challenges due to social prejudice. As such, checkups may provide support to gay male couples the same way they provide support to heterosexual couples alongside potentially helping gay couples combat some of the negative effects of discrimination. However, as early intervention programs such as the MC show a positive impact, research on maintaining wellness for gay male couples lags. To date, no studies on relationship checkups with gay male couples exist. Hence, the main question for this study is: What is the impact of a relationship check-up on gay male couples' relationship satisfaction? A non-concurrent, multiple-probe, multiple-baseline design was used to examine the MC with three gay male couples from this marginalized population. The findings show that the MC had a medium effect on relationship satisfaction (NAP .73). These results suggest the MC may increase satisfaction for gay male couples and may have a similar or larger effect for gay male couples as for heterosexual couples. The implications of these findings for practice and further research are discussed.

Keywords: couples, gay, same-sex, marriage checkup, relationship wellness checkup, motivational interviewing, prevention, brief intervention, marital health

The Impact of Relationship Wellness Checkups with Gay Male Couples

Relational health relates to many aspects of physical and emotional health and well-being. Relational health impacts depression, heart health, adherence to health behavior changes, children's health, and more (Goeke-Morey, Cummings, & Papp, 2007; Rappaport, 2013; Robles et al., 2014; Whisman & Uebelacker, 2006). Given the range of benefits that stem from relational health, programs aimed at relationship wellness are becoming increasingly valuable as public health initiatives (Cordova, 2014). However, relationship wellness research has a history of overlooking issues pertaining to marginalized and vulnerable populations. To establish the efficacy of wellness programs, much more attention needs to be granted to understudied segments of the population, including gay couples.

In general, reaching out for help or support is a difficult decision for most couples. Despite the growing evidence of the benefits of relational health, many couples do not seek therapy until they are highly distressed, if at all. Barriers to getting help include lack of time, lack of money, worry about being distressed enough to need therapy, and fears about the therapy process (Eubanks-Fleming & Cordova, 2012). To counter these barriers and prevent decline, government initiatives such as Healthy Marriages (U.S. Department of Health & Human Services, n.d.) aimed to make relational wellness programs accessible (Cowan & Cowan, 2014). One wellness program, the Marriage Checkup (MC), has been successful in reducing barriers. The effects of MC include increased relationship satisfaction, prevention of decline, and enhanced intimacy (Cordova et al., 2014; Gee, Scott, Castellani, & Cordova, 2002; Morrill et al., 2011; Sollenberger et al., 2013).

Sexual and gender minority couples have the same barriers to overcome in getting help as heterosexual couples. However, they also face unique additional barriers. When considering

therapy, gay couples report fears about prejudice (Grove & Blasby, 2009). Shelton and Delgado-Romero (2013) found that gay and lesbian individuals experience microaggressions (responses that, often unintentionally, demonstrate social prejudice) during the therapy process. These microaggressions include therapists' behaving as if sex and sexual orientation are taboo topics, being over-familiar and assuming they understand gay couples' experience, treating sexual orientation as the crux of all problems, or avoiding sexual orientation as a concern altogether (Shelton & Delgado-Romero, 2013). The anticipation and experience of discrimination create additional barriers to getting help and put gay male couples at further risk of dissolution.

Adapting current practices in research to include gay couples will require innovation in design, methods, and analysis. While inclusion of sexual and gender minority couples remains elusive in larger clinical trials in relationship wellness research, small studies fill in the gaps. The following study achieves this objective by examining the impact of the MC with gay male couples. Literature pertinent to this study covers five areas: (1) wellness programs, including the MC, (2) wellness programs for gay male couples, (3) relationship satisfaction, (4) relationship satisfaction for gay male couples, and (5) help-seeking processes, barriers, and motivation.

Prevention interventions typically fall into two broad categories. The first category includes education programs which are usually run as classes with multiple couples. These programs focus on teaching relationship skills (Halford, 2004; Markman & Rhoades, 2012). The second category consists of checkups which are done with two sessions with one couple at a time. These programs provide assessment and feedback and offer take-home solutions to promote continued wellbeing (Halford, 2004; Cordova et al., 2001). Research with heterosexual couples has shown these two forms of wellness support are similar in effectiveness but vary in appeal to different couples.

Relationship education programs include marital education classes, marital enrichment workshops, premarital counseling groups, and other programs that offer skills to groups of couples. Relationship education programs tend to enhance relationship satisfaction. Most programs have a small effect size (Cohen's *d* = .30 to .36). These positive results appeared to remain stable at short-term follow up, three to six months (Hawkins, Blanchard, Baldwin, & Fawcett, 2008; Markman & Rhoades, 2012). Programs are often offered through faith communities and via federal, state, and local initiatives. One appealing quality of education programs is that they are less expensive and hold less stigma than therapy. Government-funding makes education programs even more accessible (Cowan & Cowan, 2014). Education programs, particularly pre-martial programs, are attractive to many couples. In one survey 44% of married couples married since 1990 received premarital relationship education, typically through a faith community (Stanley, Amato, Johnson, & Markman, 2006).

Relationship education programs however do not fit all couples. First, education programs follow a general program that aims to meet the needs of most couples. Catering programs to specific topics may be more beneficial (Bradbury & Lavner, 2012; Halford, 2004). More education programs are attempting to use the program to address specific concerns, such as having a child. However, the programs still must maintain some general appeal within these more specific topics. Also, although more couples attend education programs than seek therapy, high-risk couples are still underrepresented in relationship education programs (Bradbury & Lavner, 2012; Halford, O'Donnell, Lizzio, & Wilson, 2006).

The second category of wellness programs for relationship health are checkups. They are offered to one couple at a time and usually consist of two sessions with a clinician. Checkups impact relationship satisfaction positively, with similar outcomes to education programs (d = .29

for the MC). (Cordova et al., 2014; Larson, Vatter, Galbraith, Holman, & Stahmann, 2007; Worthington et al., 1995). Checkups are offered through similar venues including federal, state, and local initiatives, and like education programs they also have less stigma than therapy (Cordova 2013; Cowan & Cowan, 2014). Amid these similarities, there are important differences. Checkups are briefer in nature and more customized to each couple than relationship education (Cordova et al., 2014). Moreover, checkups appear to attract healthy couples as well as couples who are somewhat distressed, signifying a broad appeal (Sollenberger et al., 2013). Thus, checkups provide encouragement to couples who are doing well, and they provide resources to couples who need more help. Checkups have the benefit of leaving a positive impact on the relationship, holding strong appeal to couples, and having a low-cost low-time format.

Although a body of research on checkups exists, no studies on checkups with gay couples have been performed. Meanwhile, only a few small studies exist on relationship education programs with gay male couples. This study aims to start research on checkups with gay couples to bolster this very small foundation. In addition to beginning this research on checkups, four outcomes led to choosing the MC as the checkup intervention for this study. The MC has been effective (1) reaching distressed couples, (2) being tolerable to couples (appealing, reducing barriers), (3) promoting help-seeking, and (4) positively impacting couple satisfaction.

First, the MC reached distressed couples. As noted, couples participating in the MC had higher distress levels than couples in the general community and lower levels than couples seeking counseling (Sollenberger et al., 2013). Sixty-three percent of the couples in one MC study had never sought counseling before. Thirty-two percent said it was their first use of any mental health service (Morrill et al., 2011). Thus, many couples who would not have sought help otherwise attended the checkup.

The MC appeared tolerable and accessible. In the pilot study only one of the 32 couples dropped out (Cordova et al., 2001). In a second study, none of the 74 couples dropped out (Cordova et al., 2005). In a third study, the longest study of the three with a two-year follow-up, 57 of the 215 couples (27%) dropped out. Cordova et al. (2014) noted the higher rate for the third study matched the 30% drop out rate for longer studies in general. The outcomes of the three studies together revealed tolerability and accessibility for couples.

The MC positively impacted help-seeking behaviors (Gee, et al., 2002). Brief interventions, both checkup and education, do not replace therapy because for highly distressed couples therapy still provides the best results (Markman & Rhoades, 2012). Thus, increasing a couples' help-seeking behaviors to enter therapy, when needed, is a critical outcome. When given the recommendation for couple therapy as part of the checkup, 60% of the women in the heterosexual couples sought therapy (Gee et al., 2002).

The MC had a positive impact on relationship satisfaction. Three MC studies showed an increase in satisfaction for couples (Cordova et al., 2001; Cordova et al., 2005; Cordova et al., 2014). In their longest study, Cordova et al. (2014) showed small effect sizes (d = .29) after the checkup. Effects dropped during the first year but improved again after a one-year booster session with a small, but increased, effect size (d = .39). These gains reflected improvement across a wide range of couples – distressed to not distressed. Overall, the MC consistently enhanced couples' satisfaction.

Whether the MC is attractive, tolerable, and helpful, and improves satisfaction for gay male couples remains to be determined with research. Certainly appeal, tolerability, and helpfulness are an ideal combination for reaching and supporting these marginalized couples. In addition to these four research outcomes, the MC was chosen for this study because the methods

are based in motivational interviewing principles. As gay couples report bias in therapy (Shelton & Delgado-Romero, 2013), motivational interviewing provides a potentially ideal method for working with these minority couples. Clinicians following motivational interviewing principles listen to and prioritize how clients see a situation or concern and aim to form a collaborative working relationship rather than a relationship that prizes the therapist's expertise (Cordova et al., 2001; Miller & Rollnick, 2013). The MC model, because of the base in motivational interviewing, gives gay male partners a chance to convey their own experience and knowledge about their relationship and have their viewpoint prized in the sessions. This model provides a critical component for gay male couples given the potential for homophobia and heterosexism in therapy (Grove & Blasby, 2009; Shelton & Delgado-Romero, 2013).

Checkup studies in general were not free of negative outcomes. Cordova et al. (2005) noted some couples in the control group had a decrease in satisfaction. Cordova et al. cited two potential reasons for this finding: (1) continuing decline occurred as it would have even without being in a control group or (2) the couples in the control group had a negative reaction to identifying relationship concerns without support. To alleviate these potential concerns with decline, this study did not have a control group. By using a single subject design, each couple in the study became their own control. The series of pretests and posttests, as well as examining the impact of a checkup on different couples at different times, contributed to the potential validity of the results.

Also, some checkups used clinicians to guide the process and some checkups included the option for couples to complete the checkup on their own. The latter approach yielded two concerns. First, a small percentage (3%–5%) of couples who completed assessments with no clinician reported a negative impact including anxiety completing the tasks and regret for

rekindling old problems (Bradbury, 1994; Worthington et al., 1995). Second, in a study comparing clinician-led checkups to self-led checkups, clinician led checkups had more benefits (Larson et al., 2007). Thus, clinician-led programs showed less harm or more improvement. The MC made an ideal choice for a checkup intervention because of the clinician's involvement throughout the process.

As noted, research on wellness programs is marked by the absence of gay male couples. Even in critical reviews of wellness programs, the lack of gay couples has only achieved notoriety relatively recently. For example, review articles from thirteen years ago failed to identify the absence of gay couples in wellness program research (e.g., Halford, 2004). As a hopeful sign, two recent reviews note the need to include gay and lesbian couples in future research (Hawkins et al., 2008; Markman & Rhoades, 2012). These reviews show the growing awareness of the need to foster inclusion of sexual and gender minority couples in relationship wellness programs.

Only a few studies using relationship education programs for gay male couples exist. Rather than making only surface changes to an existing program, the education program for the studies was crafted to help gay couples specifically (Buzzella, Whitton, & Tompson, 2012; Whitton & Buzzella, 2012; Whitton, Weitbrecht, Kuryluk, & Hutsell, 2016). The new topics for the program included managing discrimination, demonstrating commitment, finding social support, and fostering sexual health. Facilitators used vignettes and videos of gay men throughout the program. Couples reported they found the program beneficial, and they believed they were safer in a group with gay male couples rather than a mixed group (Buzzella et al., 2012). Researchers found the program had a small effect on satisfaction (d = .19) (Whitton, Weitbrecht, Kuryluk, & Hutsell, 2016). A notable factor, couples reported time spent with other

gay male couples in the group as particularly valuable. Few programs currently offer the opportunity to sit with other sexual and gender minority couples and share experiences. Thus, for gay couples, both checkups and education programs would ideally exist in their communities, giving couples choice between the briefer and more private format of a checkups, as well as the option for education programs which allow for connection to other couples in the community.

As noted, research with gay and lesbian couples is missing for checkup interventions. Three different checkup studies examined only heterosexual couples (i.e., Cordova et al., 2005; Larson et al., 2007; Worthington et al., 1995). In a recent study on the MC, six same-gender couples participated (Cordova et al., 2014). Though the couples participated, the researchers excluded the data in the analyses. Cordova et al. (2014) provided the rationale, "Due to partner distinguishability on outcome variables, same-sex couples were excluded from the analysis" (p. 594). Thus, although gay and lesbian couples have had checkups, the impact of the checkups on gay and lesbian couples' wellbeing is still unknown.

Relationship satisfaction is the subjective experience of the quality of a relationship (Graham, Diebels, & Barnow, 2011) and it correlates with mental health, physical health (Robles et al., 2014), and relationship longevity (Graham, Diebels, & Barnow, 2011). The concept of relationship satisfaction connects with many aspects of a relationship. Negative behaviors in conflict relate to lower satisfaction, and stronger friendship correlates with higher satisfaction (Julien, Chartrand, Simard, Bouthillier & Begin, 2003; Mackey, Diemer, & O'Brien, 2004). Strong emotional and sexual intimacy relate to higher satisfaction (Brown & Weigel, 2017; Yoo, Bartle-Haring, Day & Gangamma, 2014). Positive interactions, high empathy, humor, affection, and other perceived positive aspects of the relationship are associated with higher satisfaction. Meanwhile, frequency of contempt, disgust, and defensiveness correlate with lower satisfaction.

To complicate the factors, satisfaction is not simply the absence of dissatisfaction, a relationship can be both satisfying and dissatisfying at the same time (Whisman et al., 2008; Bradbury et al., 2000). Thus, satisfaction captures many aspects of a relationship and represents a complex construct.

Relationship satisfaction continues to be a useful outcome variable because of its complexity, its established connection to health outcomes, as well as the ease in measurement. In terms of measurement, even short self-report surveys have provided a reliable assessment of a couples' overall health. Many measures effectively discern distressed couples (at risk couples) from non-distressed (Graham, Diebels, & Barnow, 2011).

Trends in satisfaction have been examined, and studies have revealed typical patterns of satisfaction over time. For example, in one study with heterosexual couples, four patterns emerged. Two-thirds of the couples had high degrees of happiness that were stable over time. The remaining couples fit into one of three categories: (1) a steady low level of happiness, (2) an initial low level of happiness then further decline, and (3) a higher level of happiness followed by decline then a recovery (Anderson, Van Ryzin, & Doherty, 2010). This research indicates many couples have steady satisfaction over time.

Satisfaction as a variable has limits. The finding that many couples have stable satisfaction over time does not mean they are guaranteed long-term wellbeing. Couples who have stable satisfaction are not immune to divorce (Bradbury & Lavner, 2012). As satisfaction correlates with many factors, it provides a useful summary of a couples' current level of distress. However, wellness programs that aim to prevent distress may require variables that are more sensitive to early intervention during times when satisfaction is stable. For example, in one MC study, the effect size of change for intimacy for heterosexual couples was moderate ($d = .37$)

compared to satisfaction which had a small effect size (d = .23) (Cordova et al., 2014). In relationship education programs with gay men, observed negative communication (d = .71), observed positive communication (d = .67) and perceived stress had (d = .41) had stronger outcomes compared to satisfaction (d = .19) (Whitton et al., 2016). The objective in finding variables appropriate for wellness programs is not to chase the variable that shows the highest impact, but rather to tease out constructs that are relevant to ongoing wellness and sensitive to early intervention.

Despite the drawbacks of satisfaction, it is routinely used and it provides a reasonable starting point for this study. Satisfaction scores are common outcomes in both checkup studies and relationship education. Satisfaction provides a common factor which allows for comparison between these existing studies and this current study. Because the emerging research is still inconclusive about the best fit for outcome variables to replace satisfaction and because comparison is important in exploring how this existing intervention works with gay male couples, satisfaction fits for this study. As emerging research identifies variables to accurately measure smaller changes in couples' wellbeing during periods of stable satisfaction, those variables should be included in future checkup studies with gay male couples.

Factors that contribute to global satisfaction are similar between gay couples and heterosexual couples (Julien et al., 2003; Mackey et al., 2004). However, some differences exist. For example, one study found low physiological arousal has been associated with higher satisfaction in heterosexual couples while high levels of physiological arousal related to higher satisfaction for gay couples (Gottman et al., 2003). The researchers hypothesized intense arousal may signal higher emotional engagement for gay couples. This signal may be important in staying together when social support is less available. In research comparing gay male couples

and lesbian couples, affection was more important to lesbian couples' satisfaction; by contrast, validation was more important in gay male couples' satisfaction (Gottman et al., 2003).

The trajectory of change for gay male couples may also be different for heterosexual or lesbian couples. One study compared four groups: gay male couples, lesbian couples, heterosexual couples with no children, and heterosexual couples with children. In comparing couples without children, heterosexual couples and lesbian couples both reported higher steady satisfaction rates than gay male couples. Gay and lesbian couples also had relatively low change over time compared to heterosexual couples. All couples showed decline before separation (Kurdek, 2008). As previously noted, a later study on trajectories identified the most common path as stable satisfaction (Anderson et al., 2010). Unfortunately, this more recent study included only heterosexual couples. More research will need to be done to reconcile the mixed findings, however these results indicate gay male couples could benefit from wellness programs due to the potentially lower levels of satisfaction for gay male couples.

Some researchers have looked at the unique concerns for sexual and gender minority couples and their satisfaction. In one study, researchers examined how internalized homophobia, out-ness, community connectedness, and depressive symptoms related to relationship satisfaction. Internalized homophobia and community connectedness impacted satisfaction negatively. Internalized homophobia increased depression, which also reduced relationship satisfaction. Out-ness did not have an impact on relationship satisfaction (Frost & Meyer, 2009). A second study found family support as unrelated to relationship quality, but friend support was a positive factor (Graham & Barnow, 2013). One qualitative study found some couples viewed discrimination as a shared challenge that strengthened their relationships and improved their connection (Frost, 2014). In another qualitative study, research found long-term gay male

couples (over 10 years) said the important factors in staying happy were sexual compatibility, commitment, having common interests, sharing the same values, being able to compromise, sharing complimentary personalities, having family and community support, and being able to resolve conflict (Grey, 2006). Some of these concerns are part of the MC protocol, including maintaining a healthy sex life, sharing common interests, and fostering compromise and conflict skills. Additional potential areas to add to future checkups for gay male couples include reducing internalized homophobia, coping with prejudice, and finding supportive friendships.

Existing wellness programs – education and checkups – appear to work well. Current research continues to examine how to improve these programs. Program attendance remains a ubiquitous challenge. Accordingly, all couples' barriers to getting help must be considered. Also, couples' reported motivations to attend wellness programs must be explored in order to understand what helps some couples overcome the barriers.

To start, research with heterosexual couples shows most couples fall in one of two categories: (1) believing they do not need therapy or (2) believing their problems are too severe for therapy (Morrill et al., 2011). These two camps both inhibit help-seeking. On one hand, couples may believe they will naturally remain healthy which may make them prone to taking their health for granted. On the other hand, couples in distress who believe help will not be helpful are vulnerable to simply tolerating their struggle or separating without getting help. In addition to these two categories, heterosexual couples reported the following specific concerns when asked about getting help: (a) difficulty finding the time for sessions, (b) the belief that couples therapy was dangerous, (c) the concern that admitting a problem could end the relationship, (d) worry therapists would blame them, and (e) not wanting to bring up old issues (Eubanks-Fleming & Cordova, 2012). For wellness education programs, heterosexual couples

noted barriers of meeting cost, finding time, and anticipating being embarrassed discussing their concerns with others (Burr et al., 2014). These reasons reflected both internal and external barriers to getting help for heterosexual couples.

Although no parallel research exists, gay couples may likely struggle with the same concerns as heterosexual couples do. In addition, gay couples face additional concerns related to potential and real prejudice in the help-seeking process. Gay and lesbian couples reported they were aware of bias when they sought help (Grove & Blasby, 2009). Some couples did not seek therapy because of the anticipated bias. Other couples sought gay therapists to avoid prejudice. And for couples who did receive help from heterosexual therapists, they reported they withheld topics in therapy, such as sexual problems, because they were afraid of alienating their therapist (Grove & Blasby, 2009). In terms of education programs, lesbian couples reported being afraid that (a) they would not be comfortable or safe in the mixed group setting, (b) the leader would not be competent in working with gay or lesbian clients, and (c) the material would not meet their needs (Scott & Rhoades, 2014). These realistic concerns about prejudice from therapists, content of education programs, and safety from judgment in a group increased gay and lesbian couples' hesitation in getting help.

No studies have examined the barriers for checkups for heterosexual or gay couples, although likely the concerns discussed apply to some degree as they reflect heterosexual and gay couples' concerns about getting help in general. Gay couples likely will still have concerns about therapist bias, therapist competence, and whether the program content will meet their needs. Offering an MC directly to gay couples may reduce some of these barriers if the program effectively addresses these concerns. In one MC study clinicians asked couples "What prompted you to complete the Marriage Checkup?" Five respondents voluntarily indicated they did the

checkup because the program “included gay couples” (Morrill et al., 2011, p. 476). Thus, simply allowing participation in checkups appeared to spur motivation for gay couples to attend.

Just as understanding factors that create barriers can help improve attendance, understanding the factors that motivate couples to seek help will inform outreach strategies. Research exploring what led couples to decide to seek help found heterosexual partners went through several steps in the process, including recognizing they had a problem, deciding therapy might help, and finally seeking therapy (Doss, Atkins, & Christensen, 2003). Individuals moved through these steps on their own. They also influenced their partner's process. On a hopeful note, at times even low levels of distress were enough for some couples to seek help (Eubanks-Fleming & Cordova, 2012). Help-seeking shares similarities with other change processes. The process starts with thinking about change, then progresses to influencing one’s partner, and then finally making the decision to enroll in a program. Thus, raising awareness and providing education about maintaining wellness may spur contemplation about the value of wellness programs, which ultimately may lead to increased attendance.

Couples entering educational programs did so for a variety of reasons. Education programs attracted couples looking to enrich their relationships (Doss, Rhoades, Stanley, & Markman, 2009), and couples attended education primarily to gain skills (Burr et al., 2014). Couples listed several skills as important: communication and conflict management skills, tools to deal with future problems, and support for managing finances. Some couples also said they wanted to share with other couples. Some wanted to get the perspective of the group leader on their relationship (Burr et al., 2014). Research on education groups indicates that customization enhances their effectiveness (Bradbury & Lavner, 2012) and research on couples’ motivation shows that couples may also be more likely to attend if the program aligns with their current

concerns. For example, some education programs are geared toward premarital education and other groups help couples getting ready to have their first child (Bradbury & Lavner, 2012). Relationship education programs serve a need – skills, group sharing, low cost, low stigma, attractiveness to couples who want to improve their relationships, and specific topics for specific concerns. This finding is mirrored for gay couples as dedicating a program to their needs was beneficial. Groups specific to gay couples had appeal as they addressed unique concerns related to managing discrimination and other relevant content (Buzzella et al., 2012).

For checkups, couples gave an even wider range of reasons for attending. First some couples had subtle help-seeking motives. For example, they said they hoped a checkup would give them a chance to talk. Second, some couples were openly worried about their relationship health and they participated to get help to address a specific problem. Third, couples were motivated by curiosity. They gave reasons such as wanting to learn about their relationship, doing something interesting or fun, having time together, or keeping a strong relationship strong (Morrill et al., 2011). This broad appeal leads checkups to be an important component in a relationship wellness program. The MC was designed to appeal to these different motivations and values, and the research reflects it does so (Morrill et al., 2011). Checkups tap into a range of motivations, reach some distressed couples, offer privacy for those who do not want to be in groups, provide a low-cost option, lower stigma, and give support tailored to each couple.

Overall, checkups may reduce barriers more consistently and effectively than either relationship education or therapy. As inferred from related research, the MC process could be made more attractive to gay couples by having, and promoting, MC clinicians knowledgeable about gay couples. Further, for effective MC delivery, clinicians should understand the unique struggles with prejudice, relationship disclosures, internalized homophobia, and other topics.

Finally, strategic outreach and advertising programs could make MC programs appear even more welcoming.

A consistent theme in the research on prevention and wellness has been the near absence of gay male couples. Studies that fill this gap, such as Buzzella et al.'s (2012) education program for gay male couples, provide valuable evidence for how programs can support these marginalized couples. The present study focused on a checkup with gay male couples with the research question: What is the impact of a relationship wellness checkup on relationship satisfaction for gay male couples?

Method

Design

This study used non-concurrent multiple baseline and multiple probe design, and the independent variable was a checkup. The dependent variable was couple satisfaction. Three gay male couples completed study.

The multiple baseline and multiple probe design helped assess threats related to history, testing, maturation, and statistical regression (Barlow, Nock, & Hersen, 2009; Biglan, Ary, & Wagenaar, 2000; Christ, 2007). Couples received the checkup on randomly assigned weeks within a ten-week framework. Using an existing checkup, the MC, added to the rigor of the study (Hawkins, Sanson-Fisher, Shakeshaft, D'Este, & Green, 2007) as the MC is well-established with heterosexual couples. The couples generated their own comparison data, and scores were collected before and after the checkup. As noted previously, this design avoided the risks associated with couples being in a waitlist control group.

Participants

Recruitment included flyers, print and online advertisement, local LGBTQ affirmative organizations, and word of mouth. The criteria for eligibility included the following: (a) couples considered themselves in committed partnerships, (b) couples were cohabiting, (c) couples were not in or currently seeking couples therapy, (d) couples had been together at least one year, and (e) each member of the couple was over 18 years of age. Couples considered for the study had to have an average CSI (4) score between 13.70 and 18.30. Three gay male couples participated, and they are described in more detail below.

Participant couple one (C1). Both partners were young adults and college educated professionals. One partner was Latino and the other Caucasian. They had been together over the required year in a committed relationship. Their initial CSI (4) average score was 16.00. They heard about the checkup from a university professor. They believed the checkup would be a good way see how their relationship was doing and hoped the checkup would parallel a physical health checkup for their relationship. They also wanted to contribute to research. They took the relationship checkup intervention on weeks four and five.

Participant couple two (C2). Both partners were middle aged adults and college educated professionals. They were both Caucasians. They had been together over the required year and were married. They found out about the checkup from an ad in a local newspaper. They wanted to do the checkup to contribute to research that would benefit others and to take an opportunity to improve their relationship. Their initial CSI (4) average score was 16.00, and they completed the checkup on weeks six and seven.

Participant couple three (C3). Both partners were young adults who worked in

moderate-paying positions. One was Caucasian and the other biracial. They had been in a relationship for over the required year and they married when marriage became legal in their state of residence. They heard about the checkup form a mutual friend of the researcher. They attended the checkup to contribute to research and to get another perspective on their relationship wellbeing. Their initial CSI (4) average score was 17.50. They received the intervention on weeks eight and nine.

Measures

Couples Satisfaction Inventory Four-Item (CSI 4). The CSI (4) measured couple satisfaction with four questions. The scale was developed using item response theory. Effective questions were culled from a survey of 280 questions from existing measures. The most precise and useful questions from the analysis formed the CSI. The sample population was over five thousand individuals. Gay and lesbian individuals comprised of 7% of the sample (Funk & Rogge, 2007).

The CSI (4) demonstrates strong internal consistency. It has convergent validity with other standard measures such as the Quality of Marriage Index and the Kansas Marital Satisfaction Scale (Funk & Rogge, 2007). Cronbach's alpha for the CSI (4) is .94. The CSI (4) has a range of zero to 21 for scoring. The distress cut-off score is 13.5 or lower. The mean for the CSI (4) is 16, and standard deviation is 4.6. One concern with the CSI is its drop in effectiveness in measuring change at higher scores. This ceiling effect is not unusual for a couple satisfaction measure (Funk & Rogge, 2007). The scale is fully anchored. The first item is a seven-point scale running from zero to six, with answer descriptions ranging from "extremely unhappy," to "perfect." The remaining three items fall on a six-point scale from zero to five. Answers range

from “a little,” to “completely.” A sample question reads, “How rewarding is your relationship with your partner?”

The CSI uses language for a wide range of couples from seriously dating to cohabitating to married (Graham et al., 2011). Given gay couples’ relationship status can be described as cohabitating, domestic partnership, married, or a long-term committed relationship by other definition, the CSI (4) provides ideal flexibility. Words such “partner,” rather than “spouse,” and “relationship” instead of “marriage” do not require changes for use with gay couples.

Intervention

Phase B of the study was a two-session intervention. The first session was an interview to assess strengths and challenges. The second session was a review of results and a discussion of ways to maintain relationship health.

Before the assessment, couples received surveys via email. Qualtrics software (Qualtrics, February 2017) served as the email survey system. Partners completed the surveys separately prior to the meeting. The surveys included: Relationship Domains Assessment (Cordova, 2013), Areas of Concern (Cordova, 2013), and Areas of Strength (Cordova, 2013). The therapist asked partners about their top-rated strengths and top-rated challenges from these surveys during the checkup process.

The clinician followed motivational interviewing principles in assessing the couple and providing information (Cordova et al., 2001; Miller & Rollnick, 2013). The first session, the assessment interview, followed the steps outlined in the MC protocol. First, couples briefly shared their reasons for seeking a relationship checkup. Second, couples answered questions about their relationship history (Buehlman, Gottman, & Katz, 1992). Third, couples had a

conversation about an area of conflict. Finally, fourth, the couple and clinician reviewed the strengths and areas of concerns from their surveys (Cordova, 2013).

The second session was for feedback, and again a motivational interviewing style was used. First, the clinician asked permission and shared feedback on a specific area. Second, the clinician elicited thoughts and examples from the couple, focusing on their expertise of their relationship. Third, the clinician attended to changes the couple wanted to make. Fourth, for the final take-home plan, a menu of options was considered, and clinician focused on the couple's preferences and motivations. The final summary focused on self-efficacy, strengths, and changes the couple wanted. The couple received two copies of the written report and any take-home suggestions they wanted to try.

Therapist

The facilitator for the checkups worked full-time for over thirteen years in clinical settings, specializing in couple therapy. She is a Licensed Marriage and Family Therapist and Licensed Clinical Drug and Alcohol Counselor. She is a MINT member (Motivational Interviewing Network of Trainers) and a MIA-STEP trainer (Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency). Her training as a sex therapist includes national board certification by the American Association for Sex Educators, Counselors and Therapists (AASECT). She has three post-master's certificates: couple and family therapy, LGBTQ couples and families, and sex therapy.

Procedure

Potential participants had the following information about the study. Their results would be part of a study through Oregon State University. The checkup was not treatment or therapy, but rather information about their relationship. The study would run for ten weeks, and during

two weeks of the study they would attend on-site appointments. Informed consent included, as suggested by Bradbury (1994) three elements. First, it included a statement that being observed and recorded could be stressful. Second, it informed participants that the study could lead to increased awareness of oneself and one's partner. Finally, participants were informed that neither partner needed to reveal information they were uncomfortable revealing. Initial recruitment lasted six months and one couple enrolled. A financial honorarium was added within three months two more couples enrolled.

Phase A was the non-treatment baseline, and Phase B was the intervention. The starting point for Phase B for each couple was randomly assigned at week four, six, or eight. Random.org was used for the assignment of the intervention week. For Phase A couples took the CSI (4) three times to establish baseline (Hawkins et al., 2007; Scruggs & Mastropieri, 1998). The schedule follows recommended times for multiple probe designs – the first week of the study and the three weeks before the intervention (Gast, Lloyd, & Ledford, 2014). During Phase B, couples completed the two-session intervention as described previously. They completed the CSI (4) after each session and one week later.

Cordova's fidelity assessment for the MC (Cordova, personal communication, October 1, 2014) guided the fidelity check. One rater, a PhD student in counselor education, reviewed one of the three sessions. This accounted for the recommended thirty percent of the sessions for review (Lombard, Snyder-Duch, & Bracken, 2004). The sessions for review were picked by random selection with the Stat Trek's random number generator (http://stattrek.com/statistics/random-number-generator.aspx). The fidelity reviewer used a short version of Cordova's fidelity instrument and found clinician was 100% faithful to the model with a score of 40 out of 40.

Data Analysis

The impact of the intervention is determined by visual analysis of the CSI data across phases (Gast & Spriggs, 2010) including baseline stability, trend at baseline, and trend during and after the intervention. A graph displays the CSI (4) scores by session across both phases (Spriggs & Gast, 2010). Nonoverlap of all pairs (NAP) is the statistical measure for assessing the impact of the intervention (Parker & Vannest, 2009; Vannest, Parker, & Gonen, 2011). Single subject design benefits research with unique participants in real-world settings. Because of the small sample size, aspects of each participants' individual circumstances are more accessible than in studies using larger samples. Thus, analysis includes visual analysis, NAP, as well as consideration of some of the unique factors for the couples that influence results.

NAP was calculated in Microsoft Excel and with an online calculator. A NAP value of below .5 is considered declining. Small, medium and large effect size are between .5 and 1. Mathematically, Cohen's *d* and NAP compare with small, medium and large values of Cohen's *d* .2, .5, .8. respectively and corresponding NAP values .56, .63, and .70 respectively. However, Cohen's *d* does not apply to single subject design. After analysis of 200 studies, NAP was adjusted to the following effect sizes: NAP small 0–.65, medium .66–.92, and large .93–1.0. (Parker & Vannest, 2009).

Results

Four couples completed screening before their participation in the initial enrollment period. Three met the criteria. The fourth couple had a CSI (4) score of 19.00, which was above the 18.30 maximum score for set for the study, so they could not participate. In week eight of the study, the third couple left the study. Recruitment resumed and the initial concurrent design was changed to a non-concurrent design. One additional couple completed screening and entered the study. This couple followed the same baseline time frame as the original third couple, but nine

weeks later. Figures 3 and 4 showed the satisfaction scores across the baseline and intervention phases (Carr, 2005; Dixon et al., 2009). Visual analysis of the phases and trendline as well as NAP scores contributed to understanding the results.

Visual Analysis within Baseline Phase

Baseline data for C1's satisfaction was not stable. The median was 14.50, and the stability envelope was 13.05 to 15.95. Two of the three scores fell in the stability envelope; only 66% of the data fell in the range and the required amount for stability was 80%. Scores were 16.50, 14.50, and 13.50. The first data point, 16.50, was out of range which led to the determination of lack of stability. The baseline trend was decelerating (using scores 16.50, 14.50, and 13.50).

Baseline data for C2's satisfaction was stable. The median was 18.50; the stability envelope range was 16.65 to 20.35. Scores were 17.50, 19.50, and 18.50. All three scores before the intervention fell in the stability envelope. Baseline trend was accelerating (using scores 17.00, 17.50, 19.50, and 18.50).

Baseline data for C3's satisfaction scores was stable. The median was 16.50, the stability envelope range was 14.85 to 18.15. The three scores prior to intervention fell in the stability envelope (15.50, 16.50, 18.00). Baseline trend was flat, zero-celerating, using all four data points which were 17.50, 15.50, 16.50, and.18.00.

Visual Analysis Across Baseline and Intervention Phases

C1's last satisfaction score prior to checkup was 13.50. The score after the first session was 15.50, showing an increase in satisfaction after assessment. In order to explore the impact of the full intervention (the first session is only half of the intervention), comparisons were done with the second and third data points as well for all couples. The score after the second session

was 15.50, showing a continued increase in satisfaction from the last baseline point. One week after the intervention, satisfaction was up from the last baseline point, with a score of 17.00. Comparison of median values demonstrated a positive impact as well. As standard in single subject design, the last two data points in the baseline phase were compared to the first two data points in the intervention phase (Gast & Spriggs, 2010). In addition, to examine the impact of the full two-week intervention, the same baseline median was also compared to the median taken from the last two data points of the intervention phase. The median from the last two points in the baseline phase was 14.00. The median from the first two data points of intervention phase was 15.50. And the median from the last two data points of the intervention phase was 16.25. Thus comparing median values shows a positive impact, even more so after the full checkup was complete. Trend in the baseline phase showed declining (decelerating) satisfaction, while trend during and after the checkup showed improving (accelerating) satisfaction.

For C2, their last satisfaction score prior to checkup was 18.50. The score after the first session was 17.50, showing a drop in satisfaction after the assessment session. The score after the second session was 18.00 demonstrating again a lower satisfaction rating after the feedback session than the week before the checkup (18.50). One week later, satisfaction was again at 18.00 and still lower than the score before the checkup (18.50). Median values also show a decline. The median from the last two points of baseline was 19.00, the median from the first two intervention phase points went down to 17.80, and the median using the last two points in the intervention was still down from baseline at 18.00. Trend shifted from improving (accelerating) prior to the checkup to still accelerating but slightly less positive in slope during and after the checkup. In other words, after the checkup the trajectory was less positive, although still in an improving direction.

For this couple, C2, although the results could indicate the couple had a negative response to the checkup, the 2 weeks prior – which was their peak score of 19.50 – was the week they were on their vacation after their wedding. Two weeks previously, during a non-probe phase, they were married. The impact of the checkup on their overall well-being is difficult to determine, as a wellness checkup would not likely have the same impact on satisfaction as their wedding and honeymoon. Their marriage came after seven years together and after marriage become legal in their state less than two years prior. Their ceremony was an important event for many reasons, and both partners noted in the checkup how their decision to marry was deeply meaningful in their life and for their community of friends. Few wellness programs may have the same level of positive impact as a such a socially and personally pivotal ceremony. However, checkups offered to engaged or newlywed partners may still be beneficial, even though the immediate scores here don't show a benefit in comparison to the benefit of the wedding process itself.

For this checkup couple, their earliest scores (17.00 and 17.50) were lower than their scores during the honeymoon (19.50) and lower than their scores after the checkup (18.00). The wedding and honeymoon likely boosted their score higher than might be their typical baseline satisfaction. However, the post-checkup score was higher than their initial two satisfaction scores during the study and their screening score. Thus, the checkup may have had benefit, just not the same benefit as the marriage and honeymoon. In addition, a study with relationship education with newlywed and engaged gay male couples also showed no change in relationship satisfaction after the program, though changes occurred on other variables and couples reported high satisfaction with the program (Buzzella et al., 2012). Thus, the checkup could also have a positive impact for newlywed couples on variables more sensitive to wellness programs.

C3's last satisfaction score prior to checkup was 18.00. The score after the first session was 18.00, showing stable satisfaction after the assessment session. The score after the second session was 19.00 demonstrating higher satisfaction after the full checkup compared to the last baseline point. One week later, satisfaction went up to 19.50, an increase from the last score before the checkup as well. The median from the last two points in the baseline phase was 17.25. The median from the first two data points of intervention phase was 18.50, showing improvement. The median from the last two data points of the intervention phase was 19.25 showing further improvement after the full two-week checkup. Comparing the trendlines between baseline and intervention, the intervention trendline showed an accelerating or positive slope, a change from a stable or zero-celerating trendline. This shift indicated improving satisfaction as well.

When comparing intervention scores to the last baseline score, visual analysis indicated for C1 and C3 an increase in satisfaction after the checkup. C2 showed a decrease in satisfaction. Visual analysis of trend indicated improvement in satisfaction for C1 and C3 after the checkup, and a slightly less positive slope of improvement C2 after the checkup. The result of two couples showing a positive impact and one showing a negative impact may result in a conclusion that the MC had no impact (Kratochwill et al., 2013). However, the NAP result for the study group and the mitigating factors related to C2 indicate the intervention may have had a positive impact.

Effect Size and NAP

C1 had a NAP score of .78. Thus, the effect size of the checkup with couple one was moderate. C2's NAP score was .45 a decline in satisfaction, again noted here in the context of comparison with their recent nuptials and honeymoon. C3's NAP score was .96, a large effect

size. For the full series, all three couples, NAP was .73; therefore, the intervention had a medium effect size.

Discussion

This study sought to answer the research question: What is the impact of a relationship wellness checkup upon relationship satisfaction for gay male couples? The statistical analysis using NAP indicates the intervention had a moderate effect size. Visual analysis supported this result with two of the three couples.

These results are more robust than those from studies on other wellness programs. The MC with heterosexual couples had a small effect size on satisfaction (Cordova et al., 2014). A relationship education program with gay male couples also had a small effect size on satisfaction (Whitton, et al., 2016). As the effect size here was larger than similar programs, a combination of factors likely contributed to the results.

First, across sexual orientation differences, couples tend to be more similar than different (Gottman et al., 2003; Julien et al., 2003; Mackey et al., 2004). Therefore, the mechanism of change for the MC with heterosexual couples likely contributed to the results here to some degree. In research with heterosexual couples the mechanism of change was the time spent fostering intimate conversations (Cordova et al., 2005). Additional factors included reminding partners of the positive qualities of their relationship, building acceptance, and helping couples activate resources to support their own wellbeing (Cordova et al., 2014). These gay male couples likely had the same interpersonal benefits from the checkup.

Another set of considerations for the moderate effect size is how the checkup may counter the impact of social prejudice for gay couples. Emerging research points to three ways discrimination contributes to more concerns with mental health issues for sexual minority

individuals. Given the connection between social stigma, mental health, and relationship satisfaction, these three factors are likely related to relationship health as well. The MC may offer a remedy in each of these areas.

The first social factor for couples is how discrimination leads to less access to resources (Hatzenbuehler, 2010). This concern includes issues such as gay couples having fewer options for relationship wellness programs compared to the accessibility of these programs for heterosexual couples. Also, the lack of funding for research with gay couples, and the resultant lack of studies, has yielded a lack of knowledge about how to best support these couples' wellbeing. In addition, dissemination of the existing research is compromised: Gay couples' health is rarely discussed in media or other common venues. The MC may counter these avenues of discrimination. First offering the MC explicitly to gay male couples signals they are welcome, countering fears about whether the program is appropriate and improving access. Second, running a wellness checkup for gay couples shows an interest in gay male couples' well-being and an investment by funding research directly focused on their relationship health. Finally, the checkup provides an opportunity to disseminate knowledge about gay male couples' wellbeing to these couples directly so they may benefit from existing research. The clinician in this study included research specific to gay male couples in the sessions and in the feedback reports.

The second mechanism by which social prejudice impacts sexual and gender minority people is via the increase in exposure to minority stressors (Hatzenbuehler, 2010). This factor includes lack of social support, acts of prejudice, increased burden due to concealment, perceived discrimination, anticipated rejection (Hatzenbuehler, 2010), and the negative impact of internalized homophobia on relationship health (Frost & Meyer, 2009; Otis et al., 2006). The checkup potentially countered these concerns. Offering a wellness program, a program designed

for couples who are already functioning in a healthy range to gay male couples offers social recognition and support. Changes in the program language and the therapist's attentiveness to homophobia, heterosexism, concealment, and perceived discrimination may have reduced the burden and resulting distress from managing these variables. The emphasis in the checkup on affirming the couples' strengths and healthy connection may have countered internalized homophobia.

The third mechanism is the resulting elevation in psychological risk factors from these stressors. These psychological risk factors include isolation, rumination, as well as increased pessimism and hopelessness (Hatzenbuehler, 2010). The checkup may serve as a protective intervention that buffers against these risk factors through affirming and reinforcing couples' intimate emotional connection. Close and intimate relationships provide emotional support which increases resilience (Barrett, 2017). Improving relationship health likely improves coping with discrimination, thus reducing psychological risk factors.

As noted, the results of this study are best conceptualized as a product of both the typical gains from interpersonal support for couples found in MC research with heterosexual couples and as the benefits related to how a checkup may counter the known impact of prejudice for gay couples. Taken together, potential factors for the results include improving interpersonal processes and countering social prejudice. This combination may explain the moderate results of the checkup with these couples.

In regard to the variables of race and class, no clear connections can be made in terms of how these factors impacted the checkup. The couple who had the lowest NAP was the only couple of the three comprised of two Caucasian men, however their low score is more likely related to their marriage and honeymoon than their race. In terms of class differences, each

couple was relatively middle class in status, so no anecdotal information about class differences can be determined from this sample. Certainly, an exploration of intersecting status variables is worthwhile as additional studies are done with gay male couples.

All study designs exhibit strengths and limitations. The multiple baseline design used here provides a means to assess several threats to internal validity, including maturation, history, and testing. The baseline data taken prior to the intervention and the relatively short time of the study reduced threats related to maturation. The assessment for threats related to history was done with the non-concurrent design. Each couple had different baseline lengths – three, five, or seven weeks. A multiple-probe assessment decreased the threat of testing as testing occurred less frequently with this design addition. Procedural validity was assessed via fidelity checks with an independent rater.

Selection is a threat to validity in this study. Couples responded to an advertisement and volunteered their time. They were not randomly selected from a population of gay male couples. Therapist-related effects, such as skill-level, could not be assessed. Of note, a therapist who is more aware of gay male couples' concerns or more prone to bias compared to the therapist for this study may have different results. Replication studies strengthen external validity in single subject design, so additional checkup studies with gay male couples are important to fortify the integrity of the findings. In particular studies using the same intervention but in different geographical areas and with different therapists will strengthen the generalizability of the results.

A cautionary note must be made regarding the ceiling effect with the CSI (4). The couples in this study had a normative functioning score on the CSI, and satisfaction measures such as the CSI have a ceiling effect with couples in this range (Funk & Rogge, 2007). The MC's medium effect here may have occurred because couples are not significantly distressed to start.

Movement did not occur from a problematic stage to healthy stage but rather from a relatively healthy state to improved health and averted decline. Regardless of a potential ceiling effect, moderate benefits are not to be discounted. The myriad benefits of relationship health—including physical and emotional wellbeing—indicate prevention of distress and continued relationship health are worthwhile goals. Research on the MC indicates that the small effect sizes found for heterosexual couples lasted as long as one to two years (Cordova et al., 2014). Follow-up studies for future checkups will show how gains will maintain for gay male couples.

There are three primary implications for future studies. First measuring satisfaction alone is not enough to understand the impact of the checkup on couples. Many couples have stable satisfaction and are still at risk. In addition, satisfaction correlates with other variables – sometimes being a useful outcome variable and sometimes being an important predictor variable (Brown & Weigel, 2017). Other variables that may be more useful in wellness research include felt acceptance, intimacy, empathy, commitment, time spent together, and others (Bradbury & Lavner, 2012; Cordova et al., 2014; Cordova et al., 2005; Hawrilenko, Gray, & Cordova, 2016). In one MC study, intimacy for heterosexual men was more responsive, showing more sensitivity to change, than satisfaction (Cordova et al., 2014). This finding may or may not be similar for gay men. In relationship education studies with gay men, the variables of observed communication, self-reported communication, and perceived stress had greater changes than satisfaction in response to the program (Whitton et al., 2016). As an example, one alternate measure is the Intimate Safety Questionnaire (ISQ) (Cordova, Gee, & Warren, 2001; Cordova & Blair, n.d.). A large randomized control trial found this questionnaire was a reliable measure of change for heterosexual couples. Researchers reported intimacy via the ISQ showed a useful difference across time between treatment and control groups (Cordova et al., 2014). Emerging

research with the ISQ and other variables will determine which are most salient to relationship health and longevity for gay male couple.

Second, the MC is designed for heterosexual couples. This study maintained the MC's original form for three reasons. First, this study replicated an existing checkup with a new population. The intent was not to create a new intervention but rather establish initial effect size for an existing program before modifications are considered or made. Second, accessibility to checkups for gay male couples is important as strong barriers to care exist. An existing intervention provides accessibility – the MC is currently offered in various states. A new intervention would not be as widespread. Third, gay male couples show more similarities than differences with heterosexual couples. Using an existing program was likely to be relatively effective. However, as noted, research on education programs for gay couples indicates creating programs that address unique concerns might have additional benefits for gay couples. That is, creating a checkup that addresses gay male couples' concerns may increase interest, affirm daily struggles, and further counter heterosexist bias (Buzzella et al., 2012; Scott & Rhoades, 2014). Although the clinician made natural interventions during the course of the sessions, additional studies can make modifications to the actual structure and form of the MC and compare results to the results found here.

The third implication for future research includes exploring the challenge of increasing attendance in wellness programs (Markman & Rhoades, 2012). Difficulties increase when couples experience hardship, including homophobia and heterosexism (Meyer & Wilson, 2009; Pregulman et al., 2011). Internalized homophobia may also impact couples' attendance as partners struggling with internalized homophobia may feel more shame about their relationships. Future research should identify the most effective means to increase engagement. In this study,

framing the intervention as a wellness program and offering financial incentives helped in recruiting couples. Renaming the program, the "Relationship Wellness Checkup" and promoting the idea of "keeping healthy couples healthy" may have fostered trust in the program's intent to support well-being (rather than look for pathology) and thus, attracted these couples. Giving wellness checkups at clinics, doctor's offices, and community events may improve accessibility. A same-day checkup could be offered at health fairs. Online checkups with a therapist may be more convenient for busy couples and families. Educating couples about the benefits of relationship health for physical and mental health and increasing their awareness of available programs could garner more interest. Encouraging word-of-mouth within the community with incentives and other recruiting strategies may also increase interest (Meyer & Wilson, 2009).

Implications for practice include how offering a checkup supports relationship wellbeing before problems set in or start and thus serves to help gay couples stay healthy and connected. Relationship health contributes to healthy individuals—both physically and mentally—as well as family health. In addition, there are the social benefits of offering a checkup to gay couples as a checkup may counter the negative impact of social marginalization These social benefits again have relational, mental, physical, and family health benefits. For counselors interested in client wellness, social change, sexual minority health, the checkup appears to have important results for a relatively brief intervention.

In addition, practice implications for the checkup include social advocacy benefits. Offering a checkup program to gay couples may provide a venue to shape or challenge public perception. Recruitment for this study included spending time in various community groups providing information about healthy gay couples. This outreach counters invisibility as well as challenges views that gay male couples are unhealthy. Increasing awareness of wellness

programs for gay male couples reminds the public that gay male couples' well-being exists and is worth nurturing.

This study demonstrates the potential efficacy of checkups for gay male couples. Using the MC with gay male couples was unlikely to do harm, given that gay male couples are more similar than different to heterosexual couples. In fact, other MC studies have included small numbers of gay couples. However, a study with targeted analysis on how a checkup impacts gay couples has been overdue. This small study offers initial confirmation that, for these three gay male couples, an MC checkup was beneficial. This study marks a beginning for developing sensitive checkup programs that deploy methods that enhance gay male couples' health and longevity.

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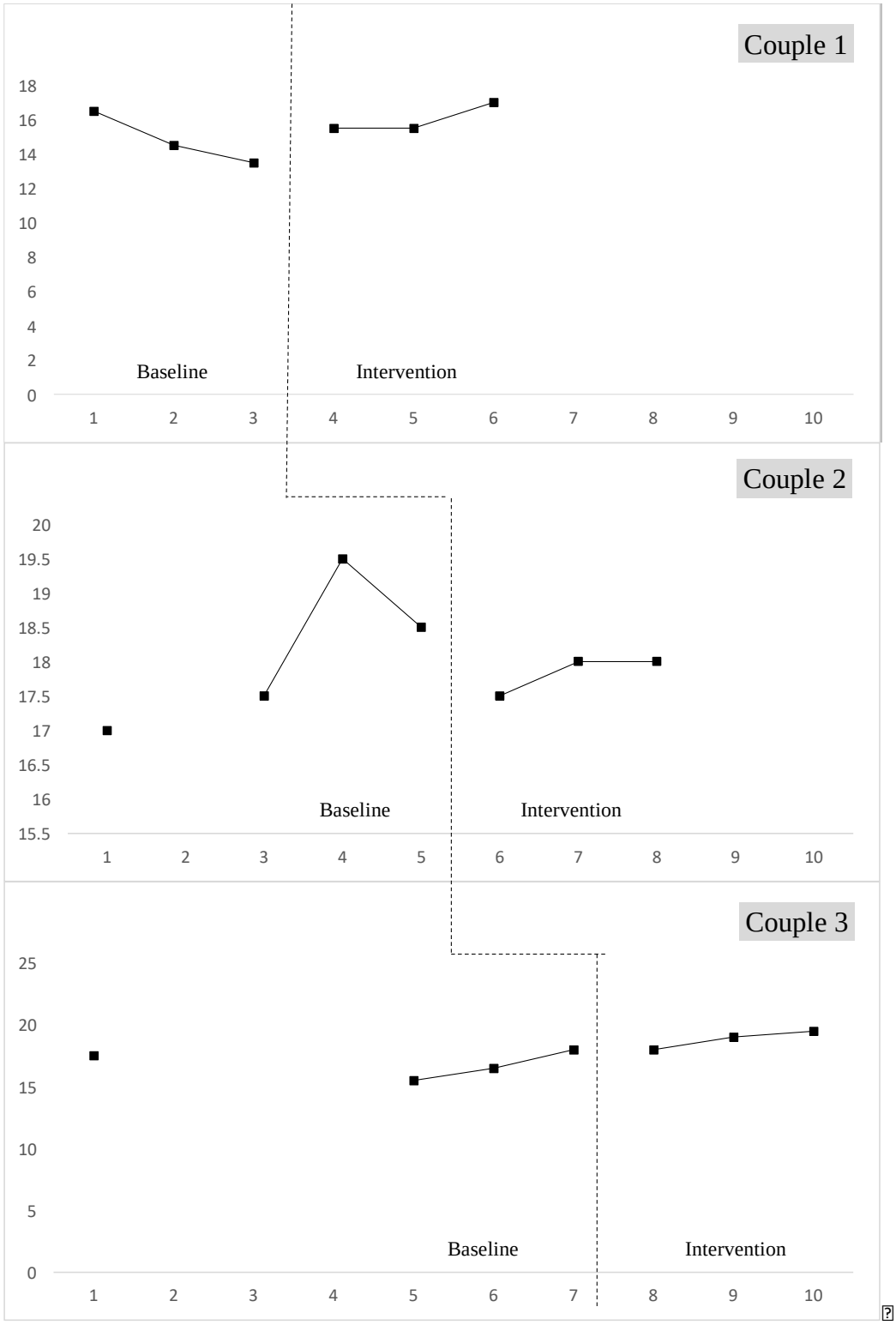

Figure 3. Relationship satisfaction for gay male couples across phases. This figure shows how gay male couples' satisfaction changed across phases of the study.

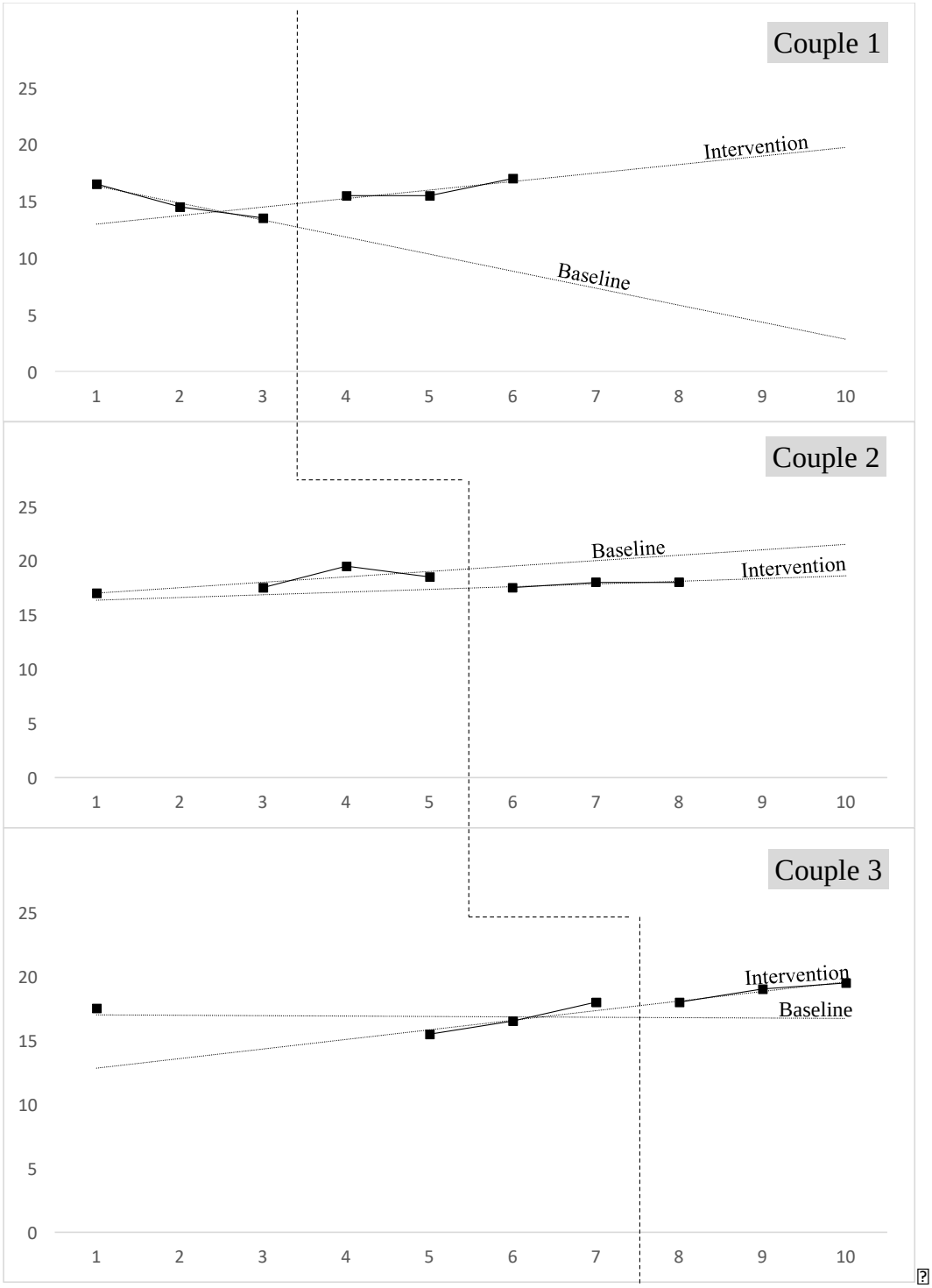

Figure 4. Relationship satisfaction for gay male couples with baseline and intervention trendline. This figure shows the trendline for satisfaction for baseline and intervention phases for each couple.

Chapter 4: Conclusion

Supporting relationship health is increasingly important in public health, and relationship checkups are one effective way to provide such support (Cordova, 2013). However, checkup studies have not included outcomes on sexual and gender minority couples. Gay and lesbian couples share many similarities with heterosexual couples, and a checkup may offer these couples the same benefits that heterosexual couples receive. In addition, gay and lesbian couples potentially benefit from additional wellness support due to the impact of social prejudice on their relationship wellbeing, as social prejudice creates a higher risk for dissolution for these couples (Kurdek, 2004). Finally, social change can potentially be fostered by offering checkups to gay and lesbian couples: clearly welcoming their participation supports social recognition of these commonly marginalized couples. Therefore, the purpose of this research was to examine the impact of an established checkup, the Marriage Checkup (MC), on this overlooked segment of the population.

This chapter will first summarize each of the two studies, situating the findings amongst relevant research. It will then review each study's limitations. Finally, recommendations for further research and practice will be proposed.

Summary of Findings

The two presented studies fulfill a need for more research on the impact of checkups on gay and lesbian couples' wellness. The first study, entitled "The Impact of Relationship Wellness Checkups with Lesbian Couples," demonstrated that a relationship wellness checkup had a medium effect size with three lesbian couples. Visual analysis supported this statistical finding. These results are consistent with research using the MC with heterosexual couples which found a small effect size for satisfaction (Cordova et al., 2014; Whitton, Weitbrecht, Kuryluk, & Hutsell,

2016). The positive results are encouraging given the current climate of social prejudice and may be part of the antidote to discrimination which takes a toll on lesbian relationships and leads to more frequent dissolution.

The second study, entitled "The Impact of Relationship Wellness Checkups with Gay Male Couples," showed a medium effect size with three gay male couples. Visual analysis showed an increase in satisfaction for two of the three couples. Analysis of trend also indicated improvement in the trajectory of satisfaction for these two couples. The third couple had a small drop in satisfaction and a slightly less positive trajectory in satisfaction after the checkup. However, the third couple had their marriage ceremony and honeymoon during their baseline phase, which may have been a mitigating factor for the results. This couple did have a continued positive slope in satisfaction, albeit slightly less positive than during their baseline phase. The medium effect size overall is consistent with research on wellness programs including using the MC with heterosexual couples and using a relationship education program with gay male couples, both having a small effect size on satisfaction (Cordova et al., 2014; Whitton, Weitbrecht, Kuryluk, & Hutsell, 2016). The results here may also reflect the benefits of running a wellness program for gay couples in a climate of prejudice. A program specifically designed for gay couple's wellbeing may counter some of the negative effects of social stigma on these couples.

Discussion

Synthesis of Findings

These two studies explored relationship wellness interventions for sexual and gender minority couples. As noted, public health initiatives have already emphasized the importance of relationship health for heterosexual couples. While being sidelined in this research, sexual and

gender minority couples have suffered under the impact of social stigma and prejudice. In turn, these two studies represent the start of a new strand of research with these marginalized couples.

The research question that guided both studies was: What is the impact of a relationship wellness checkup upon relationship satisfaction for lesbian and gay male couples? Together, through NAP analysis, these studies indicate that a relationship wellness checkup had a positive impact overall. As a result, these studies lay the groundwork for improving the MC for sexual and gender minority couples. Finally, this research helps demarginalize this segment of the population in a field that has, until now, paid little attention to understanding best practice for their support.

An additional, albeit anecdotal, finding from this study is insight gained into these couples' motivations to attend a checkup. Understanding motivation to attend is key to strategizing how to effectively encourage sexual and gender minority couples to utilize such resources while facing prejudice. The reported attendance motives of these six couples included wanting to contribute to the research, wanting to stay healthy or improve their relationship health, wanting another perspective on their relationship, and following a recommendation of a trusted friend or advisor. These motivations align with research with heterosexual couples. Both groups cite a desire to improve the relationship, to get another perspective on their wellbeing, to keep a healthy relationship healthy, and to contribute to research as reasons (Morrill et al., 2011).

Despite the small sample size, it is noteworthy how the most frequent reason reported by these six couples was the desire to contribute to research for their community. In fact, all six couples cited this reason as at least one of their primary reasons for participating. The social meaningfulness of this reason may be a significant enough for gay and lesbian couples to risk getting help and subsequently help therapists enhance best-practices, so other couples get

culturally competent care. In one MC study with primarily heterosexual couples, 38 out of 198 individuals reported wanting to do the checkup to contribute to research (Morrill et al., 2011).

In addition, encouragement from trusted others appeared as a motivation for these gay and lesbian couples. This motivation did not appear in research with the MC with heterosexual couples. Four of the six couples in this study noted the influence of friends or trusted others in attending. Individual therapists, faith community leaders, and friends in common with the clinician appeared to be influential in these couples' decision to participate in the checkup. The influence of others may also be important in helping gay and lesbian couples get wellness support. Providers of checkup programs may find establishing trust and cultivating relationships with medical, spiritual, therapeutic, community, and social support networks for sexual and gender minority people may be as important as aiming advertisements to appeal to couples' themselves.

In terms of gender differences, exploring how the checkup impacts lesbian couples compared to gay male couples is worth further study. In this initial small group, comparing NAP scores indicates the intervention may have had a slightly larger impact on the gay male couples. The top two scores for the gay males couples were moderate and large (.78 and .96). The top two NAP scores for the lesbian couples were both moderate (.79 and .66). In addition, the total NAP for the gay male couples (.73) was larger than for the lesbian couples (.66). This higher NAP for the gay male couples occurred even with the couple who had a negative score in the gay male couple group. Future studies will determine if this difference is consistent and significant, and if so what may be the factors for the potentially stronger effect for gay male couples. In addition, research on the MC with heterosexual couples indicates men in heterosexual relationships have a stronger boost in acceptance from the checkup compared to women in heterosexual relationships

and both men and women have a boost in satisfaction and intimacy (Cordova et al., 2014). Exploring the checkup with outcome variables of acceptance and intimacy alongside satisfaction may further highlight gender differences between gay male couples and lesbian couples with cisgender partners. Research with transgender and genderqueer couples is consistently missing, and research including transgender and genderqueer individuals will help support relationship health across the gender spectrum.

Limitations

One set of limitations of these two studies pertains to additional concerns with internal and external validity. Regarding internal validity, testing was relatively frequent – the Couple Satisfaction Four-Item (CSI (4)) was administered six or seven times over ten weeks. Two aspects of the study were designed to reduce the threat of testing as much as possible. First, a multiple-probe test design was used to collect data before the intervention was introduced. Couples took the CSI (4) no more than four times during the baseline condition, rather than each week for the three to seven weeks of their baseline. Second, the CSI (4) was selected for its combination of effectiveness and brevity. The CSI (4) had a Cronbach's alpha at .94. Other common measures, which are longer, had similar scores: the DAS (4) at .84, MAT (15) at .88, and the Quality of Marriage Index (6) at .96. With only four questions, testing time was short.

Selection was a threat to external validity. Couples responded to an advertisement or flyer and therefore were not randomly selected. The sample may be biased for couples who have altruistic motives to further research, strong help-seeking motives, or the time and means (transportation, access) to participate. Unsurprisingly, finding couples for the study was a significant challenge; the recruitment of six couples exceeded eight months. Sexual and gender minority couples have many reasons to be protective of their relationships. For gay and lesbian

couples, the target of prejudice is their romantic and sexual relationships. Furthermore, internalized homophobia may be a barrier to attending a checkup if individuals feel shame about their relationship and are hesitant to seek support as a result. The relatively recent passing of federal laws allowing for gay marriage and the marked absence of gay and lesbian couples in relationship wellness research, with a few notable exceptions, underscores the social struggle. Additional work needs to be done to engage more couples and improve appeal and accessibility.

Along this thread of legalization of marriage, recruiting for this study started in 2016. Marriage became legal in the participants' state in 2014, just as the criteria for participation in the study was being set, and marriage became legal on the federal level in 2015, just as the study was in IRB review. By the time the study had full enrollment, marriage had been federally legal for about a year. Some couples in the study had married, some couples had plans to marry, and some remained in committed relationships with no immediate plans to marry. The timing of the study, in the midst of such a significant social change, potentially contributed to the results of the study. One strong factor in social discrimination was the ban of lesbian and gay couples from legal marriage (Hatzenbuehler, 2010). The benefits of marriage were just becoming available to these couples during this study, and these benefits were unlikely fully realized. However, the legal changes signaled increasing social acceptance. Hatzenbuehler's research would suggest these couples' satisfaction scores may have been overall slightly higher as a result of lowered social stigma. Given the arc of gaining access to legal marriage has occurred over decades, the relative impact of the intervention may have remained the same even with potentially higher initial scores. However, couples may have been more optimistic as a result of obtaining legal marriage at the time of the study. Given the potential for increased optimism, the checkup may

have had a larger impact on these couples' wellbeing than it would have had of the study occurred even two or three years earlier.

The therapist was the same for each couple. Using the same therapist was a useful aspect of this study in that it provided consistency and some experimental control of one other variable for this small sample. Skill was assessed with the fidelity check. However, other therapist-related effects, such as rapport, could not be evaluated and differences between other therapists could not be evaluated. The therapist for this study had extensive training in working with LGBTQIAP couples and referenced research on gay and lesbian couples in the sessions and the feedback reports. Therapists who are more or less sensitive to gay and lesbian couples' concerns, aware of current research on gay and lesbian couples, or prone to bias may have different results.

A final limitation of this research pertains to generalizability. This limitation is common with single subject designs. In working with a smaller sample, more nuanced observations provide important details in adapting a program like the MC to gay and lesbian couples. The cost is lower external validity. Still, this study can add validity to using the well-validated MC program with gay and lesbian couples as a new population. In effect, this study signifies the beginning of a customized form of a check program for sexual and gender minority couples.

Despite the aforementioned validity concerns, other assessments of validity showed the study provided a reasonable structure to assess for maturation, history, and procedural validity. In terms of maturation, gathering baseline data before the intervention, having different baseline lengths, and the relatively short period of the study allowed for assessment of this threat for these six couples. The outcome indicates the changes in these ten weeks are likely related to the intervention rather than how the couples' would have progressed without the intervention.

In terms of history, the concurrent design for the first study provided assessment for this threat. Each couple received the intervention at different times within the ten weeks – having a baseline length of three, five, or seven weeks. The non-concurrent design allows for assessment related to history as the different baseline lengths were maintained and each couple received the checkup at different times within their ten weeks. Thus, the results could be reasonably assessed for the influence of outside events on the outcomes. In this vein, one event appeared to influence the intervention with the second gay male couple. They were married and had their honeymoon in the middle of the baseline phase. This event appeared to have increased their satisfaction and thus in comparison the checkup appeared to have a negative impact on satisfaction. Most likely, the couple benefited from all three – their wedding, their honeymoon, and the checkup. The checkups' impact was understandably less than the other two events.

Threats related to procedural fidelity were assessed using a modification of Cordova's fidelity assessment for the Marriage Checkup (Cordova, personal communication, October 1, 2014). Two of the six sessions were reviewed for a total of 30% of the checkups (Lombard, Snyder-Duch, & Bracken, 2004). The rater determined the therapist was 100% adherent to the protocol for gay male couples and 98% adherent to the protocol for lesbian couples.

Overall, with the challenges and strengths in regard to validity, these two studies showed the checkup had a moderate effect on satisfaction for these couples. The study being situated in previous research on the MC increases its external validity to some degree, although more research with gay and lesbian couples will help. Other threats were minimized or were assessed with some clarity. A reasonable conclusion for these couples is the MC was beneficial.

Recommendations for Future Research

The next steps in research can be summarized under two broad categories: modifications and accessibility. There are several aspects to each and the details follow. In addition, future research should include transgender, genderqueer, polyamorous, and other sexual and gender minority relationships that have been excluded in research with relationship wellness programs.

The following specific steps may extend research on how to effectively modify the MC to suit sexual and gender minority couples better. First, research may explore whether integrating questions on surveys and in assessment sessions specific to sexual and gender minority couples' concerns improves effectiveness. Research should explore relevant topics such as coping with prejudice, getting social support, managing roles, handling relationship disclosures, and family planning (Buzzella et al., 2012; Scott & Rhoades, 2014).

Second, research needs to be conducted to determine variables beyond satisfaction that are effective in measuring maintenance of wellbeing. A start could be using the Intimate Safety Questionnaire (ISQ) (Cordova & Blair, n.d.) or identifying a similar, yet shorter measure. Other outcome measures related to acceptance, empathy, commitment, time spent together, observed and self-reported communication, and perceived stress may also be useful dependent variables.

Third, research has found that providing resources for couples struggling with poverty, unemployment, or underemployment – such as job training, income supplements, childcare and healthcare subsidies – has benefits. In some studies support for managing these external stressors had more benefit that targeting interpersonal processes – the latter being the focus of most relationship wellness programs (Lavner & Bradbury, 2017). These services can be integrated into the MC in the feedback session as well community referrals from the MC clinician. The MC's flexible format provides room to include support for facing these external stressors.

Fourth, research needs to be done to determine whether helping sexual and gender minority couples directly with their unique external stressors has an impact on wellbeing and relationship longevity. This research could explore education and training for couples to manage acts of discrimination, perceived discrimination, the anticipation of discrimination, and internalized homophobia in ways that strengthen their bond. As research evolves, these additional components could be added to the MC. As with all components of the MC, these resources for managing external stressors – low income and prejudice – would be provided to couples who need them. The adaptive format of the MC allows practitioners to give support to the couples who could benefit and to avoid providing unnecessary information to couples who are well-versed and skilled in these areas or who do not need these forms of support.

The next area for further research relates to improving accessibility and appeal. First, recruiting remains a challenge to this research. One task is to find more effective ways to promote relationship health in general. Research on marketing and promotional materials can help determine what appeals to sexual and gender minority couples in particular for education and awareness about relationship wellbeing. In addition, couples' motivations provide information about what may create interest; in this study helping their community and being encouraged by trusted others emerged as themes worth further exploration. Research can confirm and extend these findings on motivation.

The next step is getting the material to couples. Outreach efforts at Pride, community health fairs, and other events for sexual and gender minority people may help. The efficacy of shorter screenings, online programs, and programs in accessible locations (clinics, community centers, unemployment offices), as well as suggestions for checkups at specific junctures (marriage, having children, retiring), may also be examined in research. Cultivating connections

with a wide range of community leaders and organizations and building relationships within the community over time may continue to be beneficial as well.

Regarding appeal, the use of incentives has been explored in both studies on relationship wellness interventions and with sexual and gender minority individuals (Cordova et al., 2014; Devaney & Dion, 2010; Meyer & Patrick, 2009). Participation in this study may have been related to the addition of the incentive. The initial recruitment from July to November only yielded two couples. The incentive was announced in January. Within two months, three lesbian couples, four gay male couples, and one transgender couple had completed the screening process.

Research can illuminate how incentives are viewed by sexual and gender minority couples and how to best structure financial components. Couples in this study did not mention the incentive as a reason for attending the checkup, whereas in MC research with primarily heterosexual couples, some couples did indicate the incentive was one reason they attended (Mock, 2014; Morrill et al., 2011). Incentives have been used with wellness programs for couples (see Cordova et al., 2014 and Devaney & Dion, 2010), and with sexual and gender minority individuals (Meyer & Patrick, 2009). Reviewers of sexual and gender minority studies determined that, rather than a single ideal process, incentives should be determined for each unique study and group (Meyer & Patrick, 2009). The use of incentives requires careful examination for efficacy, ethical dilemmas, and fit for the setting and population (Klein, 2014; Meyer & Patrick, 2009). The amount, form, and delivery are areas to explore in future research.

One incentive option is the format used for this study – $50 on a general card given after the 10-week mark of the study. This incentive was framed as a small honorarium and a thank you to individuals for their time and contribution to the research. However, other options are worth

evaluating to determine if they are more cost-effective and possibly more helpful. Structuring incentives to support the couples' wellbeing directly warrants exploration, like how one relationship education program offered financial incentives for a task like budgeting (Devaney & Dion, 2010). Creative incentives may tie directly to variables that appear to relate to maintaining relationship health such as increasing intimacy, acceptance, time spent together; reducing stress; and improving communication. For example, an incentive may encourage spending time together – dinner or a movie for two or a raffle for a larger gift such as an overnight stay at a hotel with dinner and breakfast. A basket of tools, books, and gifts for relationship wellbeing (e.g., massage candles, card games for talking about sex, or a book on cheap and easy dates) may be a playful and romantic incentive that encourages intimacy. These ideas may also tap into common motivations for attending a checkup such as improving relationship health and keeping a healthy relationship healthy.

Another area for future study is gay and lesbian couples who have been together for a longer period of time, such as 20 years or more. Couples in this study ranged from 17 months to seven years. How a checkup may appeal to and impact couples who have been together longer is worth future exploration. Long-term couples may have personal and relational factors that contribute to sustaining relationships in spite of social prejudice. They may also have different kinds of support in their communities. Understanding the different needs of long-term gay and lesbian couples and how a checkup may be structured to appeal to and benefit them is an important area for study, particularly as no couples of such length enrolled in the program.

Qualitative research can contribute to understanding the checkup intervention as well. A grounded theory study could help clinicians understand the process couples go through in getting a checkup. A grounded theory study could examine a checkup from the start – exploring couples'

process of deciding to attend – to the end – what changed and what did not change after the checkup. Interpersonal and intrapersonal processes could both be explored. Phenomenological methods could explore specific moments, for example the process of deciding to enter a checkup or the experience of the checkup intervention itself. Findings from these studies could be used to improve the intervention itself as well as increase its appeal to couples.

Recommendations for Practice

Implications for clinical practice include the relational and social benefits of offering wellness checkups to gay and lesbian couples. First, this study confirms a checkup program like the MC can have benefits for gay and lesbian couples, such as improving satisfaction. Heterosexual, gay, and lesbian couples have more similarities than differences and using a checkup with gay and lesbian couples was likely a reasonable choice before this research. However, important differences exist, and research including gay and lesbian couples was overdue. These results indicate offering a checkup to lesbian and gay couples may provide benefits found in previous MC research such as increased intimacy, acceptance, positive perspective, and activation to stay connected (Cordova et al., 2014).

Second, additional implications for practice include the potential for a checkup to serve as a form of advocacy to counter social prejudice. Federally recognized marriage has an immediate benefit on the legal and financial lives of many gay and lesbian couples and provides social recognition (Hatzenbuehler, 2010). Legal recognition also has mental health benefits (Everett, Hatzenbuehle, & Hughes, 2016). However, actual social acceptance, not simply legal recognition, may lag in some places. Access to services previously available only to married heterosexual couples will take time: programs may be under a legal obligation to allow gay and lesbian couples participation, but being truly welcomed and offered culturally competent care

will be another step. An affirming checkup is one way to help gay and lesbian couples navigate the legal, financial, and social changes (or lack of social changes) in their lives. In this area, offering a checkup directly to gay and lesbian couples may provide 1) welcoming access to this wellness program, 2) a signal of counselors' investment in sexual minority relationships, 3) opportunities for dissemination of knowledge, 4) social recognition, 5) support to counter the effects of homophobia and heterosexism, 6) affirmation of the couples' healthy and resiliency, and 7) assistance maintaining a healthy emotional connection (Hatzenbuehler, 2010).

Third, offering a checkup openly and directly to gay and lesbian couples has broader implications for promoting awareness. Clear, visible support counters prejudice that leads to avoiding, dismissing, or ignoring these couples. A program designed to prevent problems offered to gay and lesbian couples makes a public statement that not only do gay and lesbian couples exist, healthy gay and lesbian couples exist and they warrant community recognition and support.

Given gay male couples in relationship education programs expressed enjoying connecting with other gay couples (Buzzella et al., 2012), and the research with gay and lesbian couples indicates that support from friends improves relationship satisfaction (Buzzella, Whitton, & Tompson, 2012; Graham & Barnow, 2013; Grey, 2006), inclusion of couples sharing in a group setting offers important benefits. Therefore, checkups and relationship education together offer important options for the sexual minority couples and can potentially complement each other. Clinicians offering checkups may want to consider referring couples to appropriate relationship education programs – if such programs exist in their community. Couples attending relationship education programs may benefit from a referral to a welcoming checkup program if

they want individual support on a key concern. Combined, these early intervention and wellness programs can foster natural resilience and continued health.

If no relationship education programs exist, checkup program clinicians may consider integrating a group component. One successful model, in Oklahoma, attempted to provide a sense of community by providing follow-up support and celebrations in groups (Devaney & Dion, 2010). Using this model, checkup boosters for sexual and gender minority couples may include an option to attend a group session with other couples, perhaps sharing a meal, learning new tips and research, and having an opportunity to share experiences. This form of follow-up may benefit sexual and gender minority couples in unique ways given the relative social invisibility of healthy gay and lesbian couples and the benefits of additional community support.

One point of caution in offering programs to gay and lesbian couples relates to therapist bias. Gay and lesbian couples reported that they have learned to protect their relationships from providers who may hold prejudice, as well as from unintentional bias and ignorance from well-meaning therapists. These couples report that they can be resilient, yet clinicians should aim to do no harm first and foremost in these programs.

Implications for practice in the context of the literature reviewed here include the need for programs to intentionally train the clinicians leading checkups to understand gay and lesbian couples experience in therapy. Therapists should also be willing to take resposibility for unintentional missteps as research indicates these missteps are inevitable (Shelton & Delgado-Romero, 2013). Finally, therapists should demonstrate an ability to weave in research and feedback into a checkup that is accurate and sensitive to the differences between gay, lesbian, and heterosexual couples.

This study has application for counselor educators training future counselors. First, the study may provide an example of single subject design methods for research classes. The choice of methodolgy for this study can be used to initiate class discussion of when single subject design is an ideal design fit. Single subject design has strong application for counselors working in research areas that include certain forms of social advocacy where funding is sparce, when looking to understand the nuances of an intervention before a larger trial, work in small communities where diffusion into a community is a risk, and more. Additionally, the study may be useful in assessment courses: the checkup provides a unique perspective on assessment as reliable and valid measures, such as the CSI, are used side-by-side with clinical observations, such as looking for markers of longevity and decline (fondness, admiration, contempt, defensivenss, and more). Also, using the checkup with a marginalized population demonstrates how clinical observations need to account for the impact of social discrimination. For example, a gay or lesbian couple showing signs of strong physiological arousal signals health and predicts longevity whereas in a heterosexual couple the same clinical observation would signal a problematic interaction and potential decline. For similar reasons, the study may be useful in multicultural classes to consider culturally competent care for lesbian and gay individuals and couples. And perhaps most obvious, the study is worth presenting in couple and family classes to understand diversity in interaction, the impact of social prejudice, and the importance of advocacy, prevention, and wellness interventions which are particularly unique to the field of counseling.

Conclusion

Relationship decline is not easy to predict. Couples who are doing well by standard satisfaction measures can still be at risk for separation. Gay and lesbian couples are even more at

risk for dissolution (Kurdek, 2004). Prevention of relationship distress is likely an individualized and nuanced process, one that cannot be accomplished by a universal approach (Bradbury & Lavner, 2012), and so these personalized short checkups are an important tool in fostering relationship wellness.

Checkups use motivational interviewing to understand and connect to each couple, with their unique story, and the strengths and challenges of their relationship. They can readily be adapted to the topics important to each couple, which can include getting support in areas the couple identifies as difficult, handling prejudice and other external stressors, hearing information based on research about gay and lesbian couples, and more. Checkups are appealing to a wide range of motivations for couples to attend – from something fun to contributing to the research.

In general, the findings from this study support the outcomes from larger studies with heterosexual couples with the MC with potential additional benefits to these gay and lesbian couples. The results reinforce that culturally sensitive clinicians can safely offer a checkup that follows the MC protocol to gay and lesbian couples. Offering checkups to gay and lesbian couples, even as the checkup itself continues to be improved for this population, visibly supports gay and lesbian relationships in a culture of continued prejudice. Checkup programs for gay and lesbian couples are worthwhile for the health of individuals and families, for social justice, and for support for sexual minority families and couples in every community.

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APPENDICES

Appendix A: Advertisements for Couples

Relationship Wellness Checkups for Lesbian, Gay, Transgender, and Genderqueer Couples

You could get $50-$60 for participating in this research study.

We are seeking volunteers in Northern Nevada for a research study. The purpose of the study is to examine the relationship between a wellness checkup and couple satisfaction.

A relationship wellness checkup is for couples that would like to know about the health of their relationship. The service is not therapy. It is a check-up process. Couples will get feedback about their relationship strengths and, if the couple raises any concerns, tailored take-home suggestions for them too. Each partner will receive a copy of a written report highlighting strengths and offering ideas for any challenges.

To find out more about this study, please contact:

Mary Minten

775 329 4582 ext 8

mintenm@oregonstate.edu

Do not reply to public forums, groups, or listserves – please contact Mary directly at the number or email above.

Study information:

To participate in this research you must: be over 18 and English speaking, not past or current clients of the researchers, be able to give sufficient time to the study, have access the internet and email. As a couple you must be in a committed partnership, live together, and not currently be in or seeking couples therapy. The study seeks couples in three groups – couples who self-identify as 1) lesbian, 2) gay, and 3) transgender/genderqueer.

Participation in this study involves completing online questions and attending two in-person appointments. The questions include screening questions and relationship questions. They also include four questions asked five to seven times during the study, and six-month follow-up questions.. The sessions are about 60- 90 minutes each. In total, the study will take four hours over the course of the study.

Couples who have both partners meet screening criteria and complete the 10-week study –including two onsite appointments and questionnaires, will receive a Visa/MC gift card for $50. Couples who have both partners complete the six-month follow-up questionnaire will get an additional $10 Visa/MC gift card. Note: The principle investigator for this study is Cass Dykeman.

OSU Oregon State University

Relationship Checku
775 329 4582
mintenm@oregon
state.edu

Relationship Checku
775 329 4582
mintenm@oregon
state.edu
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Relationship Checku
775 329 4582
mintenm@oregon
state.edu

Advertisements for Couples

Appendix B: Research Study Announcement for Professional Network

Dear Fellow Professionals,

My name is Mary Minten and I am a Ph.D. candidate at Oregon State University conducting a study entitled "A Relationship Checkup for Lesbian, Gay, Transgender and Genderqueer Couples" to meet requirements for the completion of my dissertation. The purpose of quantitative study is to examine the effectiveness of a checkup intervention (a prevention and early intervention to help couples early in the distress process, before they are seeking counseling) with self-identified lesbian, gay, transgender and genderqueer couples. A limited amount of research that has been done on relationship checkups with lesbian, gay, transgender and genderqueer couples and there is a strong need for additional research. I am asking for your support in identifying participants who may qualify. Participation in this research project is strictly voluntary. Participants will receive the relationship checkup intervention at no charge, but there is no financial remuneration.

If you know couples who may qualify and be interested in participating, please forward the study announcement to them and have them contact me directly at directly via email mintenm@onid.oregonstate.edu or by calling me at: 775-329-4582 ext 8. *Please do not use your professional or personal power to pressure any persons to participate in this research.*

The principal researcher is Dr. Cass Dykeman. This study has been approved by the Human Subjects Board of Oregon State University and is study 7076. Participants in this study will have a two-session intervention, the first session including an assessment of their relationship and the second session including feedback and support based on the assessment. Participants will take part in two sessions, which last two-three hours each. They will also

complete an online initial screening, online assessments related to their relationship prior to their first session, and over the course of ten weeks they will take an online survey of four questions. They may be asked to complete a short six-month follow-up questionnaire as well. The total time commitment should not exceed ten hours.

To be eligible for this study:

- The participants must be over 18 and English speaking
- The participants must not be past or current clients of Mary Minten
- The participants have the capacity and willingness to be in this study
- The participants can give sufficient time to the study
- The participants have access the internet and email
- Couples are in committed partnerships
- Couples have been together at least two years *(Note: these criteria were later changed to one year, which impacted the gay male couple study.)*
- Couples live together
- Couples are not currently in, or seeking, couples therapy
- Couples self-identify as lesbian, gay, or transgender/genderqueer couples
- Couples have an average Couple Satisfaction Index score that fits for the study (this score will be completed during the online screening)

As stated previously, participation is this study strictly voluntary and if you know someone that may be interested, please share the attached request for participants. Interested couples should not reply to the group listserv or in public forums. They must contact me directly via email mintenm@onid.oregonstate.edu or by calling me at: 775-329-4582 ext. 8.

Appendix C: Changes to Marriage Checkup

The Marriage Checkup domains questionnaire title originally read: “Marriage Checkup Questionnaire: Relationship Domains Assessment.” For this study the title was changed to read: “Relationship Checkup Questionnaire: Relationship Domains Assessment.

All assessments – “Relationship Domains Assessment,” “Relationship Checkup Questionnaire: Areas of Strengths” and “Relationship Checkup Questionnaire: Areas of Concerns” had minor changes in language. All references to “marriage” were changed to “relationship.” References to parenting were changed to include parenting and caregiving. One reference to having a baby was changed to having a baby, adopting a child, or other similar increase in caregiving responsibility. Question 40 on the Areas of Concern questionnaire originally read: “40. Our relationship is suffering the effects or aftereffects of an affair.” For this study, the question read: “40. Our relationship is suffering the effects or aftereffects of a breach in our sexual or intimacy agreement, such as an affair.”

Appendix D: Participant Handout

Local LGBTIQAP-affirmative therapists for couples counseling and other concerns

Jennifer Dustin, MFT-S, LCADC
(775) 825-2503

Megan Keller, MA, MFT, LCADC, NCC
(775) 525-1586

Jacquelyn Kleinedler, MA, MFT, LADC, NCC
(775) 329-4582

Steve Nicholas, EdD, MFT
(775) 825-2503

Meri L. Shadley, PhD, MFT-S, LCADC
(775) 329-4582 x3

Marcy Swiateck, MFT
(775) 329-4582 x6

For low-cost services, the Downing Clinic at the University of Nevada Reno (UNR) offers counseling with Master's level counseling student interns, supervised by UNR faculty. Their phone number is (775) 682-5516.

Local LGBTIQAP-affirmative therapists for Drug and Alcohol Recovery

J.J. Lee, MEd, LADC-S
(775) 335-5625

Jennifer Dustin, MFT-S, LCADC
(775) 825-2503

Jacquelyn Kleinedler, MA, MFT, LADC, NCC
(775) 329-4582

Megan Keller, MA, MFT, LCADC, NCC
(775) 525-1586

Meri L. Shadley, PhD, MFT-S, LCADC
(775) 329-4582 x3

NRAP Nevada's Recovery & Prevention Community

1664 N. Virginia Street
Mail Stop 279 -- University of Nevada, Reno
775 784-6265

Community Groups

Spectrum of Northern Nevada has social groups and events for the LGBTIQ community
http://spectrumnv.org
info@spectrumnv.org
TINN (Trans in Northern Nevada)
(contact through Spectrum)

Our Center
http://www.ourcenterreno.org
https://www.facebook.com/OurCenterReno/
1745 South Wells Ave
Reno Nevada 89502
775 624 3720

Three Degrees is a local LGBTIQ networking group
https://www.facebook.com/groups/3DegreesReno/

PFLAG (Parents families, and friends of lesbians and gays)
Reno NV
info@pflagrenosparks.org
https://www.facebook.com/pflagrenosparks
(775) 358-4874

PFLAG (Parents families, and friends of lesbians and gays)
Carson City NV
http://community.pflag.org/cr
(775) 220 4151

University of Nevada-Reno: Center for Student Cultural Diversity
http://www.unr.edu/cultural-diversity
(775) 784-4936

University of Nevada Reno: Queer Student Union
http://www.facebook.com/unrqsu
https://orgsync.com/16610/chapter
unrqsu@gmail.com

Reno Gay Pride
http://www.renogaypride.com
Info@RenoGayPride.com

1-877-344-RENO
Nevada Gay and Lesbian Visitors & Convention Bureau
https://www.facebook.com/NevadaGayTourism

Stonewall Democrats of Northern Nevada
http://www.washoedems.org/affiliates/stonewall_democrats
1465 Terminal Way Suite 1
Reno, NV. 89502-3209
775 323 8683

Transgender Allies Group (TAG)
http://www.transgenderalliesgroup.org

Northern Nevada Transgender resource guide 2016:
https://issuu.com/nnhopes/docs/transgender_resource_guide_2016
(We update the guide regularly, so if in doubt that this one is the most recent, put "Northern Nevada Transgender Resource Guide" in your search engine and look for the most recent version!)

Spiritual Resources

Shalom, Fellowship/Bible Study Group
Sparks First Christian Church
560 Queen Way . Sparks, NV 89431
Contact Jacci Turner at jacci@
renoshalom.com

Trinity Episcopal Church
200 Island Avenue Reno, NV 89501
(775) 329-4279

Reno First United Methodist Church
209 West First Street Reno NV 89501-1202
www.renofirstmethodist.org
(775) 322-4564

Unitarian Universalist Fellowship of Northern Nevada
780 Del Monte Ln, Reno, NV 89511(775) 851-7100
http://www.uufnn.org/

Lord of Mercy Lutheran Church
3400 Pyramid Way Sparks, NV 89431
(775) 358-7863

Holy Cross Lutheran Church in Reno
4895 S. McCarran Blvd, Reno, NV 89502
775-827-4822

Lutheran Church of the Good Shepard
357 Clay Street Reno, NV 89501

(775) 329-0696

First Congregational Church of Reno
627 Sunnyside Drive, Reno, NV 89503
(775) 747-1414

Additional Mental Health Services

Reno Crisis Call Center
(775) 784-8090
http://www.crisiscallcenter.org

National Suicide Prevention Lifeline
(800) 273-TALK
(800) 273-8255

The GLBT National Hotline
help@GLBThotline.org
http://www.glbthotline.org – website offers instant messaging/chat
1-888-843-4564 general hotline
1-800-246-7743 youth hotline

Legal Services

The American Civil Liberties Union, Nevada Office
1325 Airmotive Way, Suite 202 Reno, Nevada 89502
(775) 786-6757
http://www.aclunv.org/lgbt

Transgender Law Center (Though they are not local to Reno – they are in Oakland and San Francisco - they are an excellent resource for legal concerns including school, employment, other legal concerns)
(415)865-0176
Collect line for inmates & detainees: (510)380-8229
Legal Assistance: Danny Kirchoff, Client Advocate, (415)865-0176 x306 or visit our Get Legal Help page.

Washoe Legal Services
299 South Arlington Avenue
Reno *Nevada* 89501
(775) 329-2727

Domestic Violence Services

Committee to Aid Abused Women
1735 Vassar St Reno, NV 89502

https://caaw.org
info@caaw.org
24-hour Hotline (775) 329-4150

Safe Embrace
http://www.safeembrace.org
24 Hour Crisis Hotline: (775) 322-3466
Toll free: (877) 781-0565
info@safeembrace.org

General Job Training and Resources in the Reno area

These are LGBTQIAP specific or necessarily all staff know to be friendly, but they are accessible if employment resources are needed. Unemployment and underemployment present challenges to many couples when one or both partners are dealing with these concerns.

Reno Nevada Employment Resource Center
580 Reactor Way Ste 3
Reno, NV
https://www.ldsjobs.org/ers/ct/center/68633?lang=eng
Phone: 775-856-2623
Fax:775-856-2625

Nevada Department of Employment, Training & Rehabilitation's (DETR) Bureau of Vocational Rehabilitation
http://detr.state.nv.us/Rehab%20Pages/voc%20rehab.htm
Northern Nevada
Phone: (775) 687-6860 TTY: (775) 684-8400
Reno Rehabilitation office - 1325 Corporate Boulevard (775) 823-8100
Also see Nevada JobConnect sites below.

Nevada Job Connect
http://nevadajobconnect.com/jobs/
Reno Town Mall
4001 South Virginia Street
Reno, NV 89502
P: 775.284.9600
F: 775.284.9663

2281 Pyramid Way
Sparks, NV 89431-2119
P: 775.284.9520
F: 775.284.9511

121 Industrial Way

Fallon, NV 89406
P: 775.423.5115
F: 775.423.6116

Job Corps (for younger adults)
http://www.jobcorps.gov/home.aspx

Also check out Three Degrees (noted above) which is a local LGBTIQ business networking group.
https://www.facebook.com/groups/3DegreesReno/