Available online at www.sciencedirect.com

ScienceDirect

Cognitive and Behavioral Practice xx (2016) xxx-xxx

Cognitive and Behavioral Practice

www.elsevier.com/locate/cabp

The Marriage Checkup: Adapting and Implementing a Brief Relationship Intervention for Military Couples

Jeffrey A. Cigrang, *Wright State University*
James V. Cordova and Tatiana D. Gray, *Clark University*
Elizabeth Najera, *Wilford Hall Ambulatory Services Center*
Matt Hawrilenko, *Clark University*
Crystal Pinkley, *United States Air Force School of Aerospace Medicine*
Matthew Nielsen, *Air Force Medical Operations Agency, Lackland Air Force Base, TX*
JoLyn Tatum and Kristen Redd, *Wright-Patterson Medical Center, Dayton, OH*

Given the significant negative impact of relationship distress on the health and well being of members of the military, preventative and accessible care is needed in order to provide crucial relationship support to service members and their families. This paper presents the rationale, key considerations, and feasibility for adapting the Marriage Checkup (MC), a brief intervention for enhancing marital resiliency, for use by internal behavioral health consultants (IBHCs) working in an integrated primary care clinic serving an active duty military population. We detail the adapted MC protocol, which was revised to contain military-centric content and fit into the fast-paced environment of primary care (e.g., streamlined to fit within three 30-minute appointments). IBHCs working in primary care were trained to offer the intervention at two air force bases. Twenty couples and 1 individual have completed the MC and a 1-month follow-up assessment. The MC intervention appeared to be well-received by both couples and IBHCs. In this paper, we provide specific guidance for clinicians and providers who are interested in integrating the Marriage Checkup into their practice.

Many of the most challenging community problems faced by senior military leaders are closely linked to the quality of marriage relationships. These include family violence, spouse maltreatment, and suicide. Half (51%) of the service members who either completed or attempted suicide from 2008 to 2010 had a history of a failed intimate relationship, and for nearly one-third (30%) this failure had occurred within 30 days of the self-harm event (Bush et al. 2013). Relationship distress not only affects marriages but is also associated with depression, substance abuse, work role impairment (Whisman & Uebelacker, 2006), and poorer children's health (Cummings, Goeke-Morey, & Papp, 2003). These problems, in turn, may negatively impact the service member's military readiness (Cigrang et al., 2014). Despite the potential high costs of chronic marital distress, very few couples seek therapy. In a recent Air Force study, only 6% of Airmen in distressed relationships reported making use of couple counseling after returning from deployment (Snyder, Balderrama-Durbin, Cigrang, Talcott, Slep, & Heyman, 2015). Indeed, distressed couples wait an average of 6 years before seeking help, at which point their relationship likely has deteriorated dramatically (Notarius & Buongiorno, 1992, as cited in Gottman & Gottman, 1999).

Thus, there is a substantial need in the military for early detection and preventative care for couples in deteriorating relationships before serious and irreversible relationship damage has occurred. There are currently no widely available means to fill this need. Mild-to-moderately distressed couples may view therapy as reserved for only the most severely distressed couples, and thus delay seeking treatment until its efficacy is seriously diminished by the chronicity and severity of the accumulated relationship dysfunction.

The Marriage Checkup (MC; Cordova, 2009; Cordova, 2013, Cordova et al., 2014; Cordova, Scott, Dorian, Mirgain, Yaeger & Groot, 2005; Morrill et al., 2011) addresses this issue by providing a less-threatening option for couples to seek early preventative care before they begin to identify as distressed. Intended to be the relationship health equivalent of the annual physical or dental checkup, the MC is a 4- to 5-hour assessment and feedback intervention (Cordova, Gee and Warren, 2005, Cordova, Scott, Dorian, Mirgain, Yaeger and Groot, 2005). Studies conducted with civilian samples have shown that couples

Keywords: Marriage Checkup; military personnel; marital relations; couples therapy

Please cite this article as: Cigrang et al., The Marriage Checkup: Adapting and Implementing a Brief Relationship Intervention for Military Couples, *Cognitive and Behavioral Practice* (2016), http://dx.doi.org/10.1016/j.cbpra.2016.01.002

receiving a Marriage Checkup demonstrate significant and lasting improvement across a range of marital health variables (Cordova et al., 2014; Cordova, Gee and Warren, 2005, Cordova, Scott, Dorian, Mirgain, Yaeger and Groot, 2005; Gee, Scott, Castellani, & Cordova, 2002; Morrill et al., 2011). In addition, the MC has been shown to attract couples across the distress continuum and be perceived by couples as more accessible than traditional therapy (Fleming & Cordova, 2012).

In recognition of the limited reach and potential stigma of tertiary mental health treatment, the military services and the Department of Veterans Affairs have implemented collaborative care models in primary care (Maguen et al., 2010; Seal et al., 2011). In a collaborative care model, mental health providers are embedded into the primary care setting and serve as Internal Behavioral Health Consultants (IBHCs) to the medical providers. The IBHC provides brief, focused assessments and interventions for patients referred by their primary care provider (Cigrang, Dobmeyer, Becknell, Roa-Navarrete, & Yerian, 2006; Goodie, Isler, Hunter, & Peterson, 2009; Wilson, 2003). Despite the prevalence of marital problems in the military, there has been no effort toward development of marital interventions suitable for primary care. Therefore, the current study was an investigation of the feasibility of using the MC with military couples in Air Force primary care clinics.

The Current Study

The purpose of this study was to test the feasibility of adapting a brief marital intervention for military couples in a primary care setting based on the existing Marriage Checkup program. This brief intervention includes assessment of the couple's relationship history, strengths, and concerns and provides individualized feedback to the couple with a list of options addressing the couple's primary concerns. A positive aspect of using the Marriage Checkup model is that it has been shown to attract couples with a wide range of relationship functioning from very distressed to very satisfied (Morrill et al., 2011). Therefore the "check-up" model may prove to reduce treatment-seeking barriers for service men and women. Since relationship distress is a primary concern for military couples, it is necessary to create an intervention specifically addressing the needs of military couples.

The Marriage Checkup

The goal of the MC is to provide the theory, structure, and tools for clinicians to provide regular checkups for couple's relationship health with the twin goals of prevention and early intervention. The MC is designed to lower the barriers to seeking marital health care by being easily accessible, brief, and advertised for all couples interested in maintaining their health with a regular checkup. The objectives of the MC are (a) early identification of relationship health deterioration, (b) prevention and early intervention, (c) motivating appropriate help seeking, and (d) fostering long-term marital health and preventing divorce.

The MC consists of two phases: a therapeutic assessment phase and a motivational feedback phase. In order to fit into the structure of integrated behavioral health care, the assessment phase was conducted in two separate half-hour appointments and the feedback phase in the third and final half-hour appointment. Within this broad structure, the MC has three components: a relationship history interview, the therapeutic assessment of relationship strengths and concerns, and motivational feedback.

The therapeutic goal of the MC is to reorient partners toward intimacy as the foundation of long-term relationship health. Active-duty couples are often under considerable strain, including repeated deployments, which can exacerbate problematic relationship patterns, damaging long-term relationship health by interfering with the intimate connection between partners. Diminished relationship health in turn affects all other health systems, including increased risk of suicide (Bush et al., 2013). At the heart of the MC is a process designed to reignite the vibrant intimate connection between partners, based on a behavioral theory of intimacy (Cordova & Scott, 2001). The presumption is that the complexity of the day-to-day life of making a living and raising a family, combined with our natural tendency to turn away from each other in response to the mounting emotional complexity of a long-term intimate relationship, undermines the intimacy process by decreasing our willingness to remain emotionally open and vulnerable with each other. Further, this complexity diminishes our availability to respond to each other's vulnerability with compassion, understanding, and empathy. The stressors and demands of active-duty military service may uniquely affect these processes by adding in factors such as frequent deployments (including the unique stressors associated with transitioning out of and then reintegrating back into the family household), unpredictable schedules, frequent moves to new bases, the complexities of communicating long-distance between home base and theater, and interrupted social support networks.

The Adapted MC Protocol

Several adaptations were made to the original MC in order to tailor the protocol for military couples. The researchers at Clark University worked with the members of the Air Force research team to develop military-specific content for the assessment tools used in the MC. In addition, the team developed and piloted a protocol to use when only one member of the couple is available to come in

Please cite this article as: Cigrang et al., The Marriage Checkup: Adapting and Implementing a Brief Relationship Intervention for Military Couples, *Cognitive and Behavioral Practice* (2016), http://dx.doi.org/10.1016/j.cbpra.2016.01.002

for an MC, given the likelihood that some partners seeking an MC may have a partner who is currently deployed or otherwise unable/unwilling to participate in an in-person checkup. Finally, the MC was streamlined to fit within a primary care setting. More specifically, it was reformatted into three 30-minute appointments. Appointment 1 consisted of assessment of the couple's relationship history and each partner's top nominated relationship strength, Appointment 2 focused on assessment of each partner's primary relationship concern, and Appointment 3 was dedicated to providing motivational feedback to the couple. While the MC was modified from two 90-minute sessions to three 30-minute sessions, it is important to note that no portion of the original MC was omitted for the military adaptation; rather, we streamlined the protocol and reduced the time allotted for each section. Therefore, the broad format and spirit of the original intervention remains the same, the IBHCs simply had to move through the streamlined protocol quickly. In practice, this manifested as a more strictly controlled pacing of each session, minimizing chatting and tangents, and delving straight into the heart of each section.

Session One

In the first half-hour appointment of the current primary care version of the MC, the IBHC conducts a relationship history interview and a therapeutic assessment of the couple's strengths. The IBHC spends the first 5 minutes of the session building rapport by welcoming and orienting the couple to the task at hand. Then, using the script below, the IBHC conducts a brief relationship history (approximately 10 minutes, 5 minutes for each partner). These questions are asked in batches, which is intended to elicit the most salient aspects of the couples' origin story. These questions are addressed to both partners in turn, allowing each person to provide their unique perspective on the development of their relationship.

1. *"Why don't we start from the beginning… Tell me how the two of you met and got together… What were your first impressions of each other? What initially attracted you to each other?"*
2. *"Tell me about how you decided to get married… Of all the people in the world, what led you to decide that this was the person you wanted to marry?"*

The relationship history interview is designed to both establish a positive rapport building emotional tone to the MC and to reorient the couple to the qualities that originally attracted them to each other.

The IBHC then spends the remainder of the session (15 minutes) conducting the therapeutic assessment of strengths. The strengths interview utilizes a questionnaire of 33 potential relationship strengths. The strengths questionnaire includes items such as, "We're good friends," "We laugh and smile together," "We're a good team when it comes to parenting," and "We both cope well with the demands of military life." Prior to the session, each partner is asked to choose his/her top 3 relationship strengths from the list provided. During the strengths assessment portion of the session, the therapist reads the first partner's top 3 strengths and asks her to identify her primary relationship strength. The interview continues by asking her to describe the chosen strength in detail and discuss how it benefits the health and happiness of their relationship. Next, the IBHC asks the other partner to reflect on the first partner's top nominated strength. The IBHC then switches to the other partner, identifies his primary relationship strength, and proceeds with the same questions for him and his partner. The therapeutic goal is to immerse partners in what is best about their relationship and to establish a positive strengths–based platform from which to enter into a discussion of their relationship concerns.

Session Two

Session Two is dedicated to discussion of the couple's primary relationship concerns. Prior to the session, a questionnaire is used to help partners identify their primary relationship concerns from a list of 48 common relationship issues. Items include, "We do not regularly spend quality time together," "We do not express our emotions in healthy ways," "We are not physically affectionate with each other on a daily basis," and "Coping with deployment can be hard for us." The IBHC begins the session by welcoming the couple and then quickly orienting them to the task of Session Two.

> *"Now that we have developed a broad sense of the strengths in your relationship, I'd like to talk with you about those areas of your relationship that you have identified as areas of concern."*

During the session the IBHC chooses a partner to begin and reads his top 3 concerns and asks him to identify his primary relationship concern. After he chooses, the therapist prompts a discussion of the concern by saying:

> *"Okay, so you would say [e.g., money] is the biggest area of concern for you in your marriage. Tell me a little bit about that issue. How would you describe what the issue is?"*

The therapist then paraphrases, validates, and uses one of the techniques described below. The IBHC then turns to the other partner and briefly elicits her perspective of her partner's concern (e.g., money). Approximately 12 minutes are dedicated to the first concern. Then IBHC then repeats the process with the second partner,

Please cite this article as: Cigrang et al., The Marriage Checkup: Adapting and Implementing a Brief Relationship Intervention for Military Couples, *Cognitive and Behavioral Practice* (2016), http://dx.doi.org/10.1016/j.cbpra.2016.01.002

eliciting her greatest relationship concern (e.g., time together), and proceeding with the therapeutic interview regarding that concern (12 minutes). During Session Two the therapist works to use the partners' concerns as a basis for creating a moment of intimate connection between the partners by helping them to develop a greater sense of compassion and deep understanding of each other.

The therapeutic techniques, described in more detail in the following section, include (a) uncovering the softer emotions underlying expressions of hard emotions, (b) uncovering understandable reasons for each partner's role in their mutual trap, and (c) helping partners to see the naturally occurring patterns and themes that contribute to the mutual trap (Jacobson & Christensen, 1996). The therapist uses his or her empathic imagination to help partners understand each other more compassionately and to develop a greater experience of empathy and acceptance for each other. Empathic imagination refers to the IBHC's reflection on their own empathic experience to make educated guesses about the partners' softer, most intimacy-conducive emotional experiencing. The goal is to create moments during the appointment that are experienced as genuine and intimate between partners with the expectation that those intimate moments rooted in greater compassionate understanding will be self-perpetuating beyond the appointment itself.

Session Three

Prior to the feedback session, the IBHC uses a computer program to create a feedback report for the couple. The report consolidates information from the first two MC sessions and provides the couple with a menu of options for addressing their relationship concerns. While the IBHC uses the report as a map to guide the session, the intention is to maintain an open, collaborative dialogue with the couple, and consequently they are not given a copy of the report until the end of the session. The aim of the feedback session is to reintroduce the most positive aspects of the couple's relationship, selected from their relationship history and strengths interviews, in the service of solidifying their appreciation and gratitude for their strengths. Then the newly developed understanding of their relationship concerns, with an emphasis on a deeper mutual compassionate understanding, is reviewed and discussed. Finally, the IBHC works with the couple to develop an action plan for how they can continue to actively nurture their relationship. Each of these therapeutic processes is in the service of facilitating real experiences of genuine intimacy between partners that are likely to reactivate the intimacy process in the relationship.

MC Therapeutic Techniques

The MC is designed to reestablish, strengthen, and maintain a couple's intimate connection by reorienting them towards what is best about them as a couple and by using their long-standing perpetual issues (Gottman, 1994) as the context for building intimacy bridges (IBCT; Jacobson & Christensen, 1996). The following techniques are adapted from Jacobson and Christensen (1996) and integrated throughout the concerns section of the Marriage Checkup. Given the fast-paced nature of the MC, IBHCs do not have time to thoroughly explore each therapeutic technique; rather, they are encouraged to use their clinical judgment to implement the technique that is most salient for each partner's relationship concern.

Uncovering Soft Emotions

When couples disagree, they often lead with what we call "hard emotions." These are emotions such as anger, frustration, contempt, and resentment that function as a shield in relationships: keeping your partner at arm's length and protecting your more vulnerable feelings. Yet even if what we need in the moment is comfort or reassurance from our partner, expressions of anger almost always elicit further expressions of anger. We theorize that anger is never a simple experience, but is nearly always complicated by "softer" emotions, which allows us to access more compassion eliciting content. Soft emotions are those expressions of emotional experiences such as sadness, loneliness, worry, fear, love, and missing that in turn naturally elicit a gentler and more empathic response from partners. In order to uncover soft emotions within the MC, therapists are taught to listen beneath the content of what each partner says for the softer emotional themes and then reflect that emotional experience back to the partner. For example:

> WIFE: He just works all the time. He never makes time for the kid's activities. He always prioritizes the job over our family and I'm just sick of it.
>
> THERAPIST: So it sounds like you have been spending a lot of time missing him, wishing you could spend more time together, and wanting him to be there for all the sweet moments with your family.

Discovering Understandable Reasons

All people come from a unique background and bring a complex history into their romantic relationships. These histories often shape the way we interact and respond to being hurt. Within the MC, the therapist's role is to be curious about why the main area of concern (e.g., money) is a deep concern for that person. In order to discover understandable reasons, the therapist explores the partner's history in relation to his or her concern. The therapist

Please cite this article as: Cigrang et al., The Marriage Checkup: Adapting and Implementing a Brief Relationship Intervention for Military Couples, *Cognitive and Behavioral Practice* (2016), http://dx.doi.org/10.1016/j.cbpra.2016.01.002

first searches for a clearly understandable reason why this person has this concern, and then works to reflect the concern in a way that elicits understanding and compassion from the partner.

For example:

HUSBAND: I just can't stand it when she goes over the budget every month. She just spends and spends and spends and it drives me crazy.

THERAPIST: So you worry about staying on budget. Can I ask what money was like for you and your family when you were growing up?

HUSBAND: We never had much money. My mom worked several jobs but my dad drank and spent most of it on alcohol. I just watched what was coming in get blown on booze and then we were the ones to suffer. He was so reckless.

THERAPIST: So you come from a background where money was really scarce, and you just had to sit back and helplessly watch anything that did come in go to waste, right before your eyes?

HUSBAND: Exactly.

Identifying Patterns and Themes

All couples fall into certain habits or patterns with one another, both in times of joy and conflict. One of the primary IBCT techniques utilized in the MC is to help partners identify the themes and patterns that play out in their relationship. Many couples are so deeply entrenched in their patterns, that they are unable to see them clearly for themselves. Therefore, the therapist's role is to help the couple identify, name, and describe their interactional pattern. In order to identify themes the therapist first listens to the patterned nature of how the couple describes conflict. She may even ask the couple to describe a recent argument around the primary concern. Once the therapist has a decent understanding of the pattern, she renarrates the difference between the two partners in a compassionate way, describes the pattern in detail, emphasizes the cyclical nature of it, and giving the pattern a name.

For example:

WIFE: We just never agree on what to do anymore. I never feel up for going out and he seems resentful when we stay in.

THERAPIST: So it seems like you each have different ways of re-charging after a long week. You like to stay home, curl up on the couch, and completely relax. Whereas your husband prefers to get ready, go out, socialize and do something different. Has this type of pattern always been true for the two of you?

WIFE: Well, I guess it has. I've always been more of a home-body and he's always been more outgoing. That's actually one of the things I love about him. Though lately, I feel like we can never agree or compromise. Neither one of us is happy about it.

THERAPIST: This sounds like a very normal natural difference between the two of you, and in fact something that you both actually appreciate about one another. Though over time, it seems as if you have polarized around this difference. The more you push to stay home and relax, the more your partner feels stifled and wants to go out and let off steam. And when you feel him pulling for new experiences and socialization, you feel even more like staying in the cozy comfort of your own home. You can see that neither one of you are at fault here, you are simply different, and the way that you are naturally moved to behave actually pulls you further away from compromise. We tend to call this the introvert/extrovert pattern. It is something that many couples face and the first step is to simply notice when you are falling into that pattern.

Effectively utilizing these therapeutic techniques within the tight timeframe of a half-hour behavioral health session required that IBHCs manage the session very efficiently. IBHCs had to be especially skilled in selecting the right strategy for a particular couple given they would not get a second chance in the allotted time. The therapeutic mantra for MC sessions was "go deep, fast."

Following are two clinical vignettes provided by the active duty clinicians who served on the project.

Clinical Vignette 1

Philip and Susan (pseudonyms) provided a prime example of how the MC is a benefit to the military population. The partners were initially hesitant about participation based on fears about a negative impact on the active-duty member's career (Philip). A strong consideration for active-duty military members is the stigma associated with seeking help, particularly through the mental health avenue. Many service members are concerned that initiating care through mental health, even for marital or couples therapy, could negatively impact his/her career. This long-standing perception serves as a strong

Please cite this article as: Cigrang et al., The Marriage Checkup: Adapting and Implementing a Brief Relationship Intervention for Military Couples, *Cognitive and Behavioral Practice* (2016), http://dx.doi.org/10.1016/j.cbpra.2016.01.002

barrier for many to seek support or treatment. Philip and Susan expressed their gratitude that the MC was preventative in nature and was offered through the Primary Care Clinic, which reduced the stigma of participation. Prevention and maintenance are core concepts of the military and the MC translates these concepts into an easily understood and appreciated language. The couple likened the MC experience to conducting a SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis on the job of work–related situations. Once this connection was made, any fear either partner had about career implications vanished.

Philip and Susan were a young couple who embarked on their active-duty career shortly after getting married 5 years ago. They had only been at this duty station a few months and were coming from a very intense first assignment that took them from one coast of the United States, where both were raised, across the country to the opposite coast. This move involved distance from family for the first time in both of their lives and a complete shift in culture, landscape, and life tempo. They both laughed and grimaced as they retold stories and discussed elements of this move and life change. Philip and Susan agreed that their shared sense of optimism and making the most of any situation was what they clung to during the significantly challenging times of their first 3 years of marriage. The questionnaires the couple completed highlighted many strengths and protective factors for their relationship. Our first meeting highlighted these strengths and the couple appeared to revel in the reinforcement of their burgeoning foundation of relationship assets. Susan expressed her gratitude directly, verbalizing a sense of relief to have an unbiased party extol the health of their marriage.

Our next meeting focused on the challenges and concerns of the relationship. The couple, still riding the wave of positivity instilled during the first appointment, was primed and ready for the therapeutic interview of areas they could improve upon in their relationship. The deliberate order of the MC process provides confidence for couples to be more forthcoming and honest about concerns and challenges in the relationship. Susan and Philip were able to identify and discuss areas for improvement and recognize that they are tackling problems in the prevention phase rather than dragging in a broken and inert relationship. The couple required minor prodding and encouragement to expound on some of the topics and concerns raised, such as differences in libido, finding more opportunities for quality time together, and balancing their respective challenging careers. They left the appointment with a more compassionate understanding of their concerns and their partner's perspective.

The final appointment provided the couple with verbal and written feedback, which was was well-received and appreciated. The couple again verbalized the benefit to them of having the strengths of their relationship highlighted. They responded to the specific and tangible feedback provided to them through the print-out as if they received a personalized gift, wrapped up with a monogrammed bow. During the feedback session Philip and Susan were fortified with methods to knock down barriers and collaboratively developed concrete steps to address their concerns. At the conclusion of the meeting and the MC, the couple shared their hope that this opportunity will be available to them in the future and that participating becomes a standard practice for the prevention and maintenance of their marriage.

Susan and Philip represent military families across the board who bear the brunt of extraordinary threats and challenges to their relationships. Deployments, moves across the country and the globe, distance from family and natural supports, geographic separations, and the toll of work demands are only some of the more recognized sacrifices and expectations. The MC can be an invaluable tool to stabilize, fortify, and shield military marriages with an outcome of mission success.

Clinical Vignette 2

The in-visit event that seemed to capture the heart of the MC best happened with Jonathan and Veronica (pseudonyms). It was clear that Veronica and Jonathan had been arguing when they arrived for their second appointment. They seemed tense and upset with each other and when they sat down in the clinic room, their body language was clearly agitated and they were physically as turned away from each other as the chairs in the room would allow. They sat silently, staring daggers at each other. Their first words of the appointment continued the intense negativity of their recent argument.

During the first 10 to 15 minutes of the appointment Veronica and Jonathan discussed each of their most significant relationship concerns. What became most apparent was that their relationship conflicts were primarily characterized by a classic pursue-withdraw pattern. Identifying relationship patterns is one of the primary therapeutic tools of the MC. In this particular case, the topic of conflict seemed to be primarily beside the point, because as any disagreement started to intensify, Jonathan would physically and emotionally withdraw, leading Veronica to intensify her pursuit, at which point Jonathan would say very hurtful things in an attempt to get Veronica to stop, but which would only continue to intensify the conflict. The conflict would continue to intensify until both partners felt emotionally exhausted and simply ran out of the steam required to continue.

The clinician noted the possible presence of this pursue-withdraw pattern, noting that it is a very common relationship pattern, and asking about the understandable

Please cite this article as: Cigrang et al., The Marriage Checkup: Adapting and Implementing a Brief Relationship Intervention for Military Couples, *Cognitive and Behavioral Practice* (2016), http://dx.doi.org/10.1016/j.cbpra.2016.01.002

reasons for each partner's role in the pattern. Uncovering understandable reasons is another primary intervention in the MC. In this case, the clinician asked each partner about what conflict looked like in their family of origin. Veronica noted that she came from a very emotionally expressive family in which family members were very open about disagreeing with each other. She described her family as very passionate both in terms of love, warmth, and affection, and in terms of open and often loud expressions of disagreement. She noted that arguing in her family was not threatening or hurtful, but just another way of staying vividly engaged with each other. Veronica noted that it was foreign for her to be in a relationship with someone who withdrew during conflict and it made her feel rejected and "cast out."

Jonathan, on the other hand, shared that he grew up avoiding any emotional expression of his own and avoiding any emotional expression of others in his family. Intense expressions of emotion were both frightening and overwhelming to him, and not knowing what else to do, he reactively sought to escape what felt dangerous and uncontrollable.

The IBHC noted that the pattern emerged organically between them because of natural differences in their early family experiences. When friction arose between them, Veronica would move toward Jonathan in an effort to vividly engage him in a kind of intimate dance — one in which she felt comfortable and connected. Jonathan, on the other hand, perceived Veronica's approach as an overwhelming emotional confrontation that felt scary and punitive, so he did what he had always done: escaped. However, his attempt to self-regulate by escaping, made Veronica feel abandoned, so she would intensify her pursuit, which only made Jonathan feel more attacked and elicited a counterattack, escalating the conflict.

Highlighting the emergent nature of a relationship conflict pattern theoretically shifts the blame from within the partners, and places it instead on the more compassionately understandable pattern between them. In the case of Jonathan and Veronica, what made them stand out as an example of the MC process, was how dramatically the emotional tone in the room shifted during the appointment from intensely negative to warm, compassionate, and loving. As each person's understandable family history was revealed, the partners palpably softened toward each other, physically relaxing and turning back toward one another. Even the physical distance between them diminished and they became perceptibly closer. Veronica said that she understood Jonathan's story and it really resonated with her. As she paused to reflect on the story, she realized she was not to blame; rather, it was the environment of Jonathan's upbringing that predisposed him to withdraw, and she began to demonstrate real empathy for him. Both partners started to acknowledge that different upbringings could later be the source of unintended conflict.

This appointment was the first time Veronica and Jonathan had discussed their conflict as a pattern or really discussed it at all, partly because of their pattern itself and partly because they were not able to see their own blind spots. Although this interaction appears to unfold at a leisurely pace, the IBHC limited the analysis of the problem to 15 minutes and provided a concise summary of the identified problem within the 30-minute visit. At the start of the appointment the provider set clear expectations for the visit, including the duration, which resulted in the patients responding positively to staying focused and redirecting to the identified problem.

Methods

Participants

Twenty couples and 1 individual ($N = 41$) enrolled in the MC Study. Three couples were unable to finish the protocol, leaving 17 couples and 1 individual who completed all three appointments of the MC ($N = 35$). Thirty participants were successfully contacted for the 1 to 2 month follow-up calls, resulting in an attrition of 9 participants throughout the study. All of the participants identified as heterosexual. The average age of the sample was 35.4 years ($SD = 8.5$). Participants had an average of 17.2 years of education ($SD = 2.5$) and an average relationship length of 11.1 years ($SD = 8.2$). There were 5 dual active-duty couples in the study ($N = 10$), 76% of the active-duty participants in the sample were officers with a military rank O2-O6 and 24% of the active duty participants were enlisted with a military rank of E5-E9.

In terms of race, 59% identified as Caucasian, 14% as African American, 11% as Asian, 5% as Multi-Racial, and 12% declined to report their race. Seventeen percent of the sample identified as Hispanic, Latino, or Spanish.

Procedures

Each couple was seen for three 30-minute appointments in an outpatient primary care clinic by an IBHC (active-duty military clinical psychologist or licensed clinical social worker). Prior to the initial appointment, couples completed a series of questionnaires asking about the quality of their relationship, including their relationship history, satisfaction, intimacy, strengths, and concerns. Non-active-duty partners were compensated $50 for participation in the study. If both partners were active-duty military they were informed that they would not be able to receive financial compensation and they provided written acknowledgement of this prior to the study. This study was approved by the Air Force Research Laboratory Institutional Review Board.

Please cite this article as: Cigrang et al., The Marriage Checkup: Adapting and Implementing a Brief Relationship Intervention for Military Couples, *Cognitive and Behavioral Practice* (2016), http://dx.doi.org/10.1016/j.cbpra.2016.01.002

Table 1
Descriptive Statistics for Participant Evaluation of the Marriage Checkup

Item	Feedback Mean (SD)	1-Month Mean (SD)
How satisfied were you with the MC?	4.80 (0.41)	4.50 (0.73)
How much did the MC help you learn strategies to improve your relationship health?	4.63 (0.81)	4.17 (1.05)
How much do you feel the MC helped you better understand your strengths as a couple?	4.74 (0.51)	4.37 (0.85)
How much do you feel the MC helped you better understand your concerns as a couple?	4.66 (0.64)	4.47 (0.82)
How much do you feel the MC helped you better understand your relationship overall?	4.66 (0.48)	4.13 (0.90)
How much would you recommend the MC to other couples?	4.80 (0.41)	4.60 (0.72)
How much do you feel your MC was helpful?	4.77 (0.43)	4.53 (0.78)
	n = 35	*n* = 30

Note. All items were scored on a range of 1 (not at all) to 5 (very much).

Measures

Marriage Checkup Evaluation – Couple (MC Eval; Cordova et al., 2012). The MC Eval is an 8-item measure assessing the couple's satisfaction with their MC. Sample items on the MC Eval include: Do you feel your Marriage Checkup was helpful? Do you feel the Marriage Checkup captured your relationship overall? and Would you recommend the Marriage Checkup to other couples? Scores range from 1 (*not at all*) to 5 (*very much*), with higher scores indicating greater satisfaction with the MC. This measure has been used in previous studies of the MC.

Marriage Checkup Evaluation – Therapist (MC Eval-T; Cordova et al., 2012)

The MC Eval-T is a 10-item measure assessing the therapist's satisfaction with the MC model. Sample items on the MC Eval-T include: How satisfied are you with the Marriage Checkup model? Do you think the Marriage checkup was helpful to the couple? and Do you think that the Marriage Checkup was effectively administered in the allotted time? Scores range from 1 (*not at all*) to 5 (*very much*), with higher scores indicating greater satisfaction with the MC model. This measure was adapted for use with behavioral health consultants in primary care.

Results

Couples completed a questionnaire measuring their level of satisfaction with the MC intervention itself. The scale ranged from 1 (*not at all*) to 5 (*very much*), and across the questions the average response was 4.72 immediately postcheckup and 4.40 at the 1-month follow-up, indicating that couples were satisfied with their MC experience. Results are presented in Table 1.

In addition, the study IBHCs completed a questionnaire measuring their level of satisfaction with administering the MC Intervention. The scale ranged from 1 (*not at all*) to 5 (*very much*). The overall average response was 4.35, indicating that the IBHCs were generally satisfied with the MC protocol. Results are presented in Table 2.

Discussion

The results of the current study provide preliminary evidence suggesting that the MC can be effectively adapted to a military population and successfully used by IBHCs working in an integrated primary care clinic. The study successfully recruited 20 couples with at least 1

Table 2
Descriptive Statistics for Therapist Evaluation of the Marriage Checkup

Item	Mean (SD)
How satisfied are you with the Marriage Checkup model?	4.50 (0.57)
Did the Marriage Checkup seem to help the couples that you saw learn strategies to improve their marital health?	4.00 (0.00)
Do you think the Marriage Checkup was helpful to the couples that you saw?	4.50 (0.57)
Do you think the Marriage Checkup effectively captured the strengths of the couples that you saw?	4.25 (0.50)
Do you think the Marriage Checkup effectively captured the concerns of the couples that you saw?	4.25 (0.95)
Do you think the Marriage Checkup effectively captured each couple's overall relationship?	4.00 (0.00)
Would you recommend the Marriage Checkup to other mental health professionals?	4.75 (0.50)
Do you think that the Marriage Checkup was effectively administered in the allotted time?	4.00 (0.00)
Do you think that the Marriage Checkup fit well within a primary care setting?	4.50 (0.57)
Did you enjoy administering the Marriage Checkup?	4.75 (0.50)

Please cite this article as: Cigrang et al., The Marriage Checkup: Adapting and Implementing a Brief Relationship Intervention for Military Couples, *Cognitive and Behavioral Practice* (2016), http://dx.doi.org/10.1016/j.cbpra.2016.01.002

active-duty partner and 1 individual participating without her partner.

Given that poor relationship health is a significant concern within military populations (as well as civilian populations), and that it has proven difficult to successfully reach the vast majority of military couples who may be experiencing poor relationship health, the current results are promising in that they suggest we may be able to successfully reach a potentially much higher percentage of at-risk couples with a brief, integrated, low-demand relationship health intervention like the Marriage Checkup. In addition, the adapted protocol was easily adopted by IBHCs and appeared to fit smoothly into the rapid pace of an integrated primary care setting.

Limitations

While this study addresses a significant need and employs a novel approach to helping the relationships of military members, it does have several limitations. First, it is important to note that the majority of the active-duty participants in this feasibility study were officers, so more attention needs to be paid to recruiting enlisted members of the military, as they tend to be at higher risk for relationship distress. In addition, we want to acknowledge that the primary premise and goal of the MC (e.g., to reorient partners towards intimacy as the foundation for relationship health) is a culturally driven assumption. While not all cultures may hold intimacy as the principle basis for relationship success, we purport that igniting or reigniting the intimacy process has potential benefits for all couples, regardless of cultural, racial, ethnic, or socioeconomic background. In addition, the brevity of the Marriage Checkup required the skillful management of time during each session. While challenging, the protocol was successfully implemented into the BHOP paradigm and the therapists were able to stay within the time limits of the sessions. Lastly, this study only recruited a small sample and the current report does not focus on treatment outcomes. Further work remains to be done to understand the efficacy of the MC with military couples in an integrated care setting with a randomized clinical trial. The authors have recently received funding to complete this work and recruitment will begin in 2016.

Conclusions

The results of the current study provide good preliminary evidence that the MC protocol can be successfully adapted for use within an integrated primary care setting and effectively delivered by trained internal behavioral health consultants. Further, military couples appeared to be attracted to participate in the MC and satisfied with their experience of the checkup. IBHCs, in addition, were also satisfied with the experience of delivering the protocol.

Recommendations

The current results are very encouraging and suggest strong support for continuing this line of research into a full-scale randomized clinical trial to establish the clinical efficacy of the military-adapted version of the MC protocol. If a further clinical trial provides evidence for the efficacy of the MC, then widespread dissemination throughout the primary care system could result in substantial improvement in overall marital health throughout the military (since IBHCs are positioned throughout the Department of Defense), with positive implications for overall mental, physical and child health and outcomes.

References

Bush, N. E., Regar, M. A., Luxton, D. D., Skopp, N. A., Kinn, J., Smolenski, D., & Gahm, G. A (2013). Suicide and Suicide Attempts in the U.S. military, 2008-2010. *Suicide and Life-threatening Behavior, 43*, 262–273. http://dx.doi.org/10.1111/sltb.12012

Cigrang, J. A., Dobmeyer, A. C., Becknell, M. E., Roa-Navarrete, R. A., & Yerian, S. R. (2006). Evaluation of a collaborative mental health program in primary care: Effects on patient distress and health care utilization. *Journal of Community and Primary Care Psychiatry, 11*, 121–127. http://dx.doi.org/10.1185/135525706X121192

Cigrang, J., Talcott, G. W., Tatum, J., Baker, M., Cassidy, D., Sonnek, S., Snyder, D. K., Balderrama -Durbin, C., Heyman, R., & Slep, A. (2014). Intimate partner communication from the war zone: A prospective study of relationship functioning, communication frequency, and combat effectiveness. *Journal of Marital & Family Therapy, 40*, 332–343. http://dx.doi.org/10.1111/jmft.12043

Cordova, J. V. (2009). *The Marriage Checkup: A scientific program for sustaining and strengthening marital health*. New York: Jason Aronson.

Cordova, J. V. (2013). *The Marriage Checkup practitioner's guide: Promoting lifelong relationship health*. Washington, DC: American Psychological Association.

Cordova, J. V., Fleming, C. J., Morrill, M. I., Hawrilenko, M., Sollenberger, J. W., Harp . . . Wachs, K. (2014). The Marriage Checkup: A randomized controlled trial of annual relationship health checkups. *Journal of Consulting and Clinical Psychology, 82*(4), 592–604. http://dx.doi.org/10.1037/a0037097

Cordova, J. V., Gee, C. G., & Warren, L. Z. 2015. Emotional Skillfulness in Marriage: Intimacy as a Mediator of the Relationship Between Emotional Skillfulness and Marital Satisfaction. *Journal of Social and Clinical Psychology, 24*, 218–235. http://dx.doi.org/10.1521/jscp.24.2.218.62270

Cordova, J. V., & Scott, R. (2001). Intimacy: A behavioral interpretation. *The Behavior Analyst, 24*, 75–86.

Cordova, J. V., Scott, R. L., Dorian, M., Mirgain, S., Yaeger, D., & Groot, A. 2015. The marriage checkup: An indicated preventive intervention for treatment-avoidant couples at risk for marital deterioration. *Behavior Therapy, 36*, 301–309. http://dx.doi.org/10.1016/S0005-7894(05)80112–1

Cummings, E. M., Goeke-Morey, M. C., & Papp, L. M. (2003). Children's responses to everyday marital conflict tactics in the home. *Child Development, 74*(6). http://dx.doi.org/10.1046/j.1467–8624.2003.00646.x

Fleming, C. E., & Cordova, J. V. (2012). Predicting relationship help seeking prior to a Marriage Checkup. *Family Relations, 61*, 90–100. http://dx.doi.org/10.1111/j.1741–3729.2011.00686.x

Gee, C. B., Scott, R. L., Castellani, A. M., & Cordova, J. V. (2002). Predicting 2-year marital satisfaction from partners' reaction to a marriage checkup. *Journal of Marital and Family Therapy, 28*, 399–408. http://dx.doi.org/10.1111/j.1752-0606.2002.tb00365.x

Goodie, J. L., Isler, W. C., Hunter, C., & Peterson, A. L. (2009). Using behavioral health consultants to treat insomnia in primary care:

Please cite this article as: Cigrang et al., The Marriage Checkup: Adapting and Implementing a Brief Relationship Intervention for Military Couples, *Cognitive and Behavioral Practice* (2016), http://dx.doi.org/10.1016/j.cbpra.2016.01.002

A clinical case series. *Journal of Clinical Psychology, 65*, 294–304. http://dx.doi.org/10.1002/jclp.20548

Gottman, J. M. (1994). *What predicts divorce? The relationship between marital processes and marital outcomes.* Hillsdale, NJ: Lawrence Erlbaum Associates.

Gottman, J. M., & Gottman, J. S. (1999). The marriage survival kit. In R. Berger & M.T. Hanna (Eds). *Preventative approaches in couples therapy* (pp. 304–330). Philadelphia, PA: Brunner/Mazel.

Jacobson, N. S., & Christensen, A. (1996). *Acceptance and change in couple therapy: A therapist's guide to transforming relationships.* New York: Norton.

Maguen, S., Cohen, G., Cohen, B. E., Lawhon, G. D., Marmar, C. R., & Seal, K. H. (2010). The role of psychologists in the care of Iraq and Afghanistan veterans in primary care settings. *Professional Psychology: Research and Practice, 41*, 135–142. http://dx.doi.org/10.1037/a0018835

Morrill, M. I., Eubanks-Fleming, C. J., Harp, A. G., Sollenberger, J. W., Darling, E. V., & Cordova, J. V. (2011). The Marriage Checkup: Increasing access to marital health care. *Family Process, 50*, 471–485. http://dx.doi.org/10.1111/j.1545–5300.2011.01372.x

Seal, K. H., Cohen, G., Bertenthal, D., Cohen, B. E., Maguen, S., & Daley, A. (2011). Reducing barriers to mental health and social services for Iraq and Afghanistan veterans: Outcomes of an integrated primary care clinic. *Journal of General Internal Medicine, 26*, 1160–1167. http://dx.doi.org/10.1007/s11606–011-1746-1

Snyder, D. K., Balderrama-Durbin, C., Cigrang, J., Talcott, G. W., Slep, A., & Heyman, R. (2015, August). Help-seeking among Airmen in distressed relationships: Implications for alternative delivery systems. In J. C. Flanagan & M. L. Kelley (Co-chairs), *Mental health, alcohol use, and relationship satisfaction among military members and veterans.* Symposium presented at the meeting of the American Psychological Association, Toronto, Canada.

Whisman, M. A., & Uebelacker, L. A. (2006). Impairment and distress associated with relationship discord in a national sample of married or cohabiting adults. *Journal of Family Psychology, 20*, 369–377. http://dx.doi.org/10.1037/0893-3200.20.3.369

Wilson, P. G. (2003). The Air Force experience: Integrating behavioral health providers into primary care. In R. G. Frank, S. H. McDaniel, J. H. Bray, & M. Heldring (Eds.), *Primary care psychology* Washington DC: American Psychological Association.

Support for this project was provided by a grant (FA8650-12-D-6280) from the Department of Defense to the first author and second author. This is the first publication of the study data.

The views expressed in this article are those of the authors and do not necessarily reflect the official policy or position of the Department of the Air Force, Department of Defense, or the U.S. Government.

Address correspondence to Jeffrey A. Cigrang, Ph.D., Wright State University, School of Professional Psychology, 9 N. Edwin C. Moses Boulevard, Dayton, OH 45402-8470; e-mail: jeffrey.cigrang@wright.edu.

Received: April 5, 2015
Accepted: January 11, 2016
Available online xxxx