Chapter 16
Marital Problems and Relationship Difficulties and Integrated Care Among Hispanic Populations

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Health disparities are vast for Hispanic families in the United States and access to behavioral health care may be particularly underutilized (U.S. Dept. of Health and Human Services, 2001). For example, several studies suggest that Hispanics, as compared to non-Hispanic Whites, are less likely to receive appropriate care for disorders related to depression or anxiety (Alegría, Jackson, Kessler, & Takeuchi, 2008; Young, Klap, Sherbourne, & Wells, 2001). Data are lacking, however, for other domains of mental health such as marital distress. Marital distress, despite its known links with poorer mental and physical health (Kiecolt-Glaser & Newton, 2001; Papp, Goeke-Morey, & Cummings, 2004), has received scant attention in the health disparities field of study.

Though limited in scope and quantity, research to date suggests that Hispanic couples experience marital distress at a similar rate to other couples, at least as compared to non-Hispanic white couples (Bulanda & Brown, 2007). In addition, as has been found with other couples, marital distress is both longitudinally and cross-sectionally related to depressive symptoms for Hispanic couples (Hollist, Miller, Falceto, & Fernandez, 2007; Treviño, Wooten, & Scott, 2007). Given that Hispanics now comprise the largest minority group in the United States and the proportion of married couples that are Hispanic doubled between 1980 and 2000 (Amato, Johnson, Booth, & Rogers, 2003), a research base on marital quality for Hispanics is long overdue. Some studies suggest that marital functioning for Hispanic couples more closely resembles non-Hispanic whites than Blacks (Bulanda & Brown, 2007), but very little is known about what factors might be uniquely important to Hispanic couples.

One movement that is actively gaining traction to try and reduce health care disparities is the integrated care model whereby medical and behavioral health

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professionals work side-by-side and in concert with one another. Numerous empirically supported programs and interventions exist to reduce and alleviate marital or couple distress, but given the separate silos medical and behavioral health professionals have historically worked in, it is likely the exception far more than the rule that distressed couples find their way to marital therapy or a marital educational group via their primary care physician. The goals of this chapter are to provide a brief review of marital distress and its impact on individual functioning, an overview of integrated behavioral health care and a stepped care model for addressing marital distress, including attention to cultural considerations and how they can be applied to interventions for marital distress to better serve Hispanic couples, and a review of the types of empirically supported marital interventions that are available.

Relationship Health

Social relationships affect mental health, health behavior, and physical health (Umberson & Montez, 2010) and perhaps no social relationship affects adult well-being as much as the marital relationship. Many couples will encounter difficulty at some point in their relationship and if these problems are not ameliorated, a whole host of potential negative consequences can occur for both the couple, and if there are children, their family. It is estimated that about one-third of couples experience distress or discord at any one point in time (Whisman, Beach, & Snyder, 2008). Marital satisfaction drops considerably over the first 10 years of marriage (Bradbury, Fincham, & Beach, 2000) and chronic relationship distress can sufficiently erode the positive elements of a relationship such that couples ultimately divorce. Divorce is common in the United States and it is estimated that nearly 50 % of marriages end within the first 20 years (Copen, Daniels, Vespa, & Mosher, 2012). Marital distress also is associated with an increased risk for a variety of psychiatric concerns including anxiety, mood, bipolar, and substance-abuse disorders (Whisman, 2007) as well as compromised endocrine and immune functioning (Kiecolt-Glaser & Newton, 2001).

The limited literature to date suggests that, overall, Hispanic couples are at similar risk for marital difficulties as non-Hispanic Whites. Confounding effects of ethnicity and economic stress, however, may place some Hispanic couples at higher risk. Negy and Snyder (2000) found inter-ethnic and non-Hispanic White couples to be similar in their levels of marital satisfaction; however, monoethnic Mexican-American couples experienced less satisfaction compared to inter-ethnic couples. Several studies suggest that external stressors impact marital satisfaction indirectly for non-Hispanic White couples and a couple of recent studies suggest that this is the case for Hispanic couples as well. In a study of 120 first-generation Mexican immigrant couples, Helms et al. (2014) found economic pressure and cultural adaptation stress to be linked with depressive symptoms, which in turn was associated with negativity in marital interaction and low marital satisfaction. Similarly,

Falconier, Nussbeck, and Bodenmann (2013) found how couples cope can mitigate the link between immigration stress and marital satisfaction for Hispanic couples, especially for wives.

Although research is starting to grow with Hispanic couples, relatively few studies have focused on issues that may be specifically relevant to Hispanic couples. One of the issues that has been the subject of several studies, however, is that of acculturation or acculturative stress. Acculturation can be operationalized in different ways, but it commonly refers to the degree to which an individual endorses beliefs, attitudes, and behaviors of their culture of origin, the dominant culture in their new environment, or both (Negy & Snyder, 1997). A couple of studies suggest a link between acculturation and marital distress for Mexican Americans (Negy & Snyder, 2000; Vega, Kolody, & Valle, 1988), and Negy, Hammons, Reig-Ferrer, and Carper (2010) found acculturative stress to be associated with marital distress in a sample of Hispanic immigrant women. Acculturation differences between husbands and wives also have been linked to lower marital quality in Mexican-origin couples, with the relationship between acculturation (adoption of American cultural practices) and enculturation (maintenance or retention of culture of origin) implicated in understanding the complex role of acculturation and how it relates to relationship functioning (Cruz et al., 2014). Cruz and colleagues found cultural similarities between couples to generally be associated with positive marital quality, though interactive effects between acculturation and enculturation show the importance of assessing cultural orientation in a multi-dimensional manner. In addition, generation status, which is often considered a marker for acculturation, also has been linked to marital distress for Hispanic couples (e.g., Casas & Ortiz, 1985). Although findings are varied, studies tend to find greater marital distress for couples with higher levels of acculturation toward the dominant culture, especially when wives are more dominant-culture oriented than husbands. An assessment of acculturation would seem to be a potentially important component when conducting a culturally sensitive marital intervention.

Integrated Care and Hispanic Families

Hispanic families are the largest ethnic minority in the United States. Estimates project that by 2050, Hispanic families will make up nearly 30 % of the U.S. population (Ennis, Rios-Vargas, & Albert, 2011; Gutierrez, Barden, & Tobey, 2014; Passel & Cohn, 2008). In recent decades, the United States has made significant efforts to improve the quality of health care and access to health care and reduce disparities, but ongoing economic, social, and racial/ethnic disparities continue to exist. In fact, with regard to Hispanics specifically, according to the 2012 report of the Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities, health disparities between Hispanics and other populations have minimally improved over the last decade. Underutilization of mental health care in particular is an area of growing concern (Gutierrez et al., 2014). Even when differences in the prevalence

of mental health difficulties are controlled for, Hispanics are less likely to access mental health services than non-Hispanic Whites (Cabassa, Zayas, & Hansen, 2006).

Numerous economic factors are cited as contributing to the disparity in health care access including financial limitations and geographical concerns (Gutierrez et al., 2014). The socioeconomic status of Hispanic couples in the United States is difficult to summarize globally as they occupy all rungs of the socioeconomic ladder. Given the diverse cultural, political, and economic circumstances in their heritages that lead them or their forebearers to immigrate to this country, even the terms "Hispanic" and "Latino" are so broad and encompassing that many of the differences within this large group are lost. Nonetheless, on average and a collective group, Hispanics are more likely to experience economic distress than non-Hispanic whites and overall, they have lower levels of educational achievement than non-Hispanic whites (Casper & Bianchi, 2002; Fronczek, 2005). Hispanics also have substantially higher uninsured rates than non-Hispanic whites (CDC, 2011). All of these socioeconomic factors may inhibit access to care. In addition, economic instability is stressful for couples and may negatively affect the quality and stability of marriages (Conger, Conger, & Martin, 2010). Thus, economic struggles may not only be associated with marital stress but also may present a barrier to accessing interventions that might provide some relief.

Sociocultural factors also are cited as potential barriers to Hispanics receiving comparable mental health services as their non-Hispanic White counterparts. English language proficiency, for example, is a notable predictor of health care usage (Fiscella, Franks, Doescher, & Saver, 2002). A lack of Spanish-speaking providers likely limits mental health care utilization for many individuals. Some Hispanic individuals also may also fear questions about citizenship or risk of deportation (Shattell, Hamilton, Starr, Jenkins, & Hinderliter, 2008). Concerns about the cultural sensitivity of interventions is another concern for Hispanics seeking mental health services and culturally relevant services that are grounded in empirical science are in insufficient supply to keep up with demand (Flores, Olson, & Tomany-Korman, 2005). Even once services are accessed, less than optimal outcomes may result for Hispanics due to premature termination (Kouyoumdjian, Zamboanga, & Hansenmn, 2003). Some of the reasons for leaving therapy early are likely culturally related, including possible unintentional biases on the part of service providers (Bridges et al., 2014) and Vasquez (2007) found that ethnic minority clients may not establish as strong a therapeutic alliance with the service provider as majority culture White clients, especially when the care provider is White. For all of the above reasons, Hispanics have less access to and receive fewer mental health services than do non-Hispanic whites even though studies suggest that rates of mental health concerns are comparable across the two groups (U.S. Dept. of Health and Human Services, 2001).

One potential means to overcoming utilization disparities is through integrated health care. Integrated health care is an approach to health care that is characterized by a high degree of collaboration and communication among health professionals. In the broadest use of the term, "integrated behavioral health care" (IBHC) describes

health care settings where behavioral health and medical providers work together. Integrated care can occur along a continuum of collaboration, however, from minimally to fully integrated. As articulated by Blount (1998), in the fully integrated model, there is close collaboration between behavioral health and medical professionals and they share the same sites, vision, and systems. All providers are "on the same team" and have developed an in-depth understanding of each other's roles and areas of expertise. In this scenario, facilities are shared and collaborative routines are regular and smooth. All providers chart in the same patient medical record and may even see clients together when this is appropriate. Informal consultation between health and mental health care workers occurs regularly.

Initial presentation in an integrated care clinic. Integrating mental health care into primary care services may be one way to reduce barriers to accessing services for Hispanic couples (Bridges et al., 2014). Some studies suggest that Hispanics are more likely to seek mental health care services from their primary care setting as compared to any other resources, including specialty mental health care (Bridges et al., 2014; Vega, Kolody, Aguilar-Gaxiola, & Catalano, 1999). Although primary care physicians often have limited training in the assessment, diagnosis, and treatment of mental health problems (Mitchell, Vaze, & Rao, 2009), this issue can be more easily overcome in an IBHC setting as compared to a traditional care setting.

There are several ways in which an individual with significant marital distress may initially present at an integrated care clinic with a concern other than marital problems. Mental health concerns often co-occur with medical conditions or can mimic medical conditions. For example, an individual might present with symptoms related to anxiety/depression, either with or without a co-occurring with a medical condition, or mood symptoms may be attributed to a medical condition (e.g., heart problem) that does not exist. Maritally distressed individuals also are overrepresented in those seeking help for psychological difficulties, regardless of whether or not marital distress is reported as one of their primary concerns (Lin, Goering, Offord, Campbell, & Boyle, 1996). Thus, for a variety of reasons, individuals may seek services from their primary care physician for needs that go beyond physical conditions and ailments, and may well include mental health issues.

Numerous studies indicate a bidirectional relationship between marital or couple functioning and mental health. In contrast to happily married persons, maritally distressed individuals are three time more likely to have a mood disorder (e.g., Whisman, 2001, 2007). Although depression may be the most common type of psychological disorder to be reciprocally related to marital distress, individuals in distressed or conflictual relationships are also more vulnerable to anxiety disorders and substance-use problems (Proulx, Helms, & Buehler, 2007; Whisman, 2007). Links between marital quality and risk for a psychological disorder have been replicated across numerous racial and ethnic groups, including several groups of Hispanic heritage (McShall & Johnson, 2015).

Couple distress also is associated with poor physical health (Umberson, Williams, Powers, Liu, & Needham, 2006). Marital conflict, in particular, has been shown to

have direct adverse effects on cardiovascular, endocrine, immune, neurosensory, and other physiological systems that, in turn, can contribute to physical health problems (Kiecolt-Glaser & Newton, 2001). Whisman and Uebelacker (2012) found poor marital adjustment and divorce to be associated with risk for metabolic syndrome in women, and marital loss is associated with increased risk for cardiovascular disease (Zhang & Hayward, 2006).

Screening measures for marital distress. Given known links between emotional distress and marital difficulties, as part of the screening process to determine etiology of a presenting problem, one logical step for physicians is to utilize screening measures to detect for possible marital distress. Simple and short screening measures exist for marital distress and if these were given routinely by primary care physicians, with individuals with higher scores to be scheduled for a follow-up consult with a mental health specialist, many more couples may be referred to appropriate support and intervention.

Fortunately, several empirically supported screening measures for marital distress exist. One of the shortest questionnaires, containing just four items, is the Couple Satisfaction Index (CSI; Funk & Rogge, 2007). To develop the CSI, 176 potential items were culled from eight well-validated self-report measures of marital satisfaction. Using principal components analysis and item response theory, 32 items were selected for the CSI and then shorter versions of this measure were created by identifying the items that provided the largest amount information for the assessment of relationship satisfaction. The CSI items assess global satisfaction with the relationship and are rated on Likert-scales ranging from 0 to 6 or 0 to 5, with total scores ranging from 0 to 21. The cut-off score for marital distress is 13.5. The 4-item version of the CSI has demonstrated good convergent and construct validity and higher precision measurement of marital satisfaction than longer measures such as the Marital Adjustment Test (MAT; Locke & Wallace, 1959) and the Dyadic Adjustment Scale (DAS; Spanier, 1976).

Another recently developed questionnaire to assess for marital distress that is brief is the Marital Satisfaction Inventory-Brief form (MSI-B; Balderrama-Durbin, Snyder, & Balsis, 2015). The MSI-B is a shorter version of the Marital Satisfaction Inventory-Revised (Whisman et al., 2008). The MSI-B contains 10 items and total scores range from 0 to 10, with higher scores indicating greater distress. The MSI-B shows excellent discriminant validity in being able to distinguish community from clinical samples and scores ≥ 4 are classified as significantly distressed. Although the original MSI-R has been successfully translated and validated for use in Spanish (Negy & Snyder, 2000), and thus translation of the ten items of the MSI-B are available in Spanish, the MSI-B itself has yet to be formally assessed for reliability and validity in Spanish. Nonetheless, the impressive empirical care that has gone into translating the MSI-R items is a significant advantage of the MSI-B for cross-cultural samples.

Sabourin, Valois, and Lussier (2005) created the DAS(4) by using nonparametric IRT (Hambleton, Swaminathan, & Rogers, 1991) on the 32 items of the DAS to select the four items that consistently provided the most information at the distress threshold. Scores <13 are classified as distressed. The DAS-4 is as effective in

predicting couple dissolution as the DAS-32 and is less affected by socially desirable responding. The DAS-4 also shows good stability over time.

The Quality of Marriage Index (QMI; Norton, 1983) is a 6-item measure of global relationship satisfaction. Five items are rated on Likert-scales which range from 1 to 7 (e.g., "We have a good relationship") and one item, regarding overall level of happiness in the marriage is rated on a scale that ranges from 1 to 10. Total scores range is from 6 to 45, with higher scores indicating greater satisfaction with the marriage. The QMI is well validated and has been shown to have good reliability (e.g., Funk & Rogge, 2007).

A stepped-care approach. Once marital distress is identified as a potentially contributing factor to an individual's distress, a behavioral health professional can intervene and in coordination with integrated care, a stepped-care model within ICBH can be applied. A stepped-care approach within an integrated care setting could include the following three sequentially organized steps.

As a first step, especially if marital distress is mild, information on relationship success could be provided to the individual in the form of handouts, bibliotherapy references, or e-health options. One of the more popular books written for couples to educate and assist them in improving their relationship quality is, The Seven Principles for Making Marriage Work, written by John M. Gottman, Ph.D., and Nan Silver. This book is also available in Spanish, Los Siete Pricipios para Hacer que el Matrimonio Funcione. On line, several websites are available to educate and assist couples about relationship health, including www.healthymarriageinfo.org, which also has most of its materials available in Spanish.

In addition to providing individuals with sources of information and education about marriage, another Step 1 intervention might be for behavioral health professionals to help clients engage in prevention programs. Several marriage and relationship education programs have been designed as preventative options for couples and for individuals with low or mild distress, these might be a good option. In a recent and inclusive meta-analysis of relationship education programs, Hawkins and colleagues (Hawkins, Blanchard, Baldwin, & Fawcett, 2008) found that relationship education programs result in increases in communication skills and relationship quality (small to medium effect sizes). Similarly, Stanley, Amato, Johnson, and Markman (2006) found that premarital education was associated with a lower divorce rate and was effective at enhancing satisfaction and commitment and lowering levels of conflict for couples of various races and income levels. In this study, Latinos participated in marital education programs at a rate similar to that of non-Hispanic Whites (and more so than Black couples) and also benefited similarly. This study is important as it among the few that have targeted a diverse and/or disadvantaged sample.

One of the more popular evidence-based programs aimed at preventing marital distress is the Prevention and Relationship Education Program (PREP; Markman, Renick, Floyd, Stanley, & Clements, 1993), which teaches couples communication and conflict resolution skills that are associated with marital success. The program utilizes features of behavioral and cognitive therapy, while placing particular

emphasis on the problem-solving skills component. At a 5-year follow-up, PREP demonstrated effectiveness with couples in the program having higher levels of positive communication skills, lower levels of negative communication, and lower levels of marital violence compared to controls (Markman et al., 1993). A recent RCT of PREP used by couples through religious organizations, however, suggested that there were no overall differences in the divorce rate for couples using PREP versus naturally occurring services (i.e. premarital education provided by religious organizations; Markman, Rhoades, Stanley, & Peterson, 2013). PREP is one of the few programs that has begun to be empirically tested with underserved ethnic minority groups. Daire et al. (2012) conducted focus groups with Hispanic individuals who had completed 20 h of marital relationship education using a PREP-based curriculum. Participants reported learning and acquiring new communication skills and they also reported an increase in peace and calm at home.

There is some evidence that it may not be necessary to have intensive preventative education programs in order to achieve some measure of success. Rogge and colleagues (Rogge, Cobb, Lawrence, Johnson, & Bradbury, 2013) compared two time intensive relationship education programs, PREP and CARE, the latter being designed specifically for the trial, with a one session relationship awareness (RA) program. The RA program did not focus on building relationship skills but instead focused on increasing partners' awareness of the relationship through looking at current behaviors and deciding if these behaviors were constructive or destructive. There were no differences in relationship dissolution or satisfaction between couples receiving the time intensive skills training (PREP and CARE) and those in the RA session, suggesting that more intensive preventative education programs may be unnecessary, at least for some couples. The long-term effectiveness the RA session is not clear, however.

If Step 1 options are insufficient, Step 2 options that could be considered by the behavioral health professional might include brief or web-based interventions. One evidence-based brief intervention option for distressed couples is the Marriage-Checkup (MC; Cordova et al., 2014). The MC was designed to fill the gap between preventative relationship education and tertiary treatment by serving as a brief intervention for couples who are at risk for marital deterioration, but who are not otherwise seeking treatment for their marriage. The MC is a two-session assessment and feedback intervention which is designed for early problem detection and early intervention. In an RCT of the MC, Cordova et al. (2014) found that when compared to a control condition, the MC results in improvements in relationship satisfaction, intimacy, and acceptance. The effect sizes for MC were similar to other marital education programs and gains in intimacy and acceptance were maintained at the 2-year follow-up, when comparisons were made with the control group. The authors suggest that similarly to a yearly doctor visit, the MC should be provided annually to couples.

Web-based marital interventions have started to become popular in recent years and they address both preventative goals as well as provide interventions for distressed couples. Marital programs accessed via the internet address many obstacles couples commonly cite as interfering with treatment-seeking, such as financial limi-

tations, geographical concerns, and the shame an individual or couple may feel by attending therapy (Hoge et al., 2004). Several web-based interventions have been developed to target relationship distress and these programs are often adaptations of previously proven in-person relationship education programs and couple therapies. ePREP, an online version of the PREP relationship program, was found to be effective at improving mental health and relationship relevant outcomes at a 10-month follow up as compared to a control condition (Braithwaite & Fincham, 2009). Another online relationship education program is "Power of Two Online". After completing the 2-month online program, participants reported improved marital satisfaction and conflict management compared to participants in a control condition (Kalinka, Fincham, & Hirsch, 2012). OurRelationship.com is a new web-based couple intervention program aimed at reducing couple distress (Doss, Benson, Georgia, & Christensen, 2013). An adaptation of IBCT, couples are taken through a three-step program aimed at increasing their awareness of a "core issue" in the couple's relationship, promoting acceptance of their partner's feelings and opinions around this issue, and learning skills that can help them talk about and work through their core issue. Web-based programs would seem to have a lot to offer Hispanic couples as the delivery of culturally responsive content could be individualized for couples. Increasing awareness of lower cost interventions such as on-line programs may be an important step for increasing access to marital interventions and this could easily be implemented in an integrated care setting, especially if primary care physicians were educated about these options.

For more severely distressed couples, or for couples for him Step 1 and Step 2 options were not effective or were not sufficient, several empirically supported, in-person treatment options exist. In a meta-analytic review of marital interventions for distressed couples, Shadish and Baldwin (2003) found a large effect size for marriage therapy. Specifically, the effect size for marriage therapy was $d=0.84$, suggesting that couples receiving marital therapy have more favorable outcomes than more than 80 % of couples who do not receive treatment. A more recent study found couple therapy to positively impact 70 % of couples receiving treatment (Lebow, Chambers, Christensen, & Johnson, 2012). Although these findings are very promising, it is important to note that most intervention studies for couples are based on samples where the majority of couples are White and middle class (and generally well educated). Limited data exist on how effective these interventions are with more diverse samples, but one of the purposes of this chapter is to consider how to apply these interventions to Hispanic couples.

There are a variety of evidence-based treatments that couples can choose from, with behavioral marital/couple therapy (BMT or BCT) being one of the most commonly studied approaches. BCT typically consists of some combination of communication training, problem-solving training, contingency contracting, behavior exchange, cognitive restructuring, and emotional expressiveness training. BCT has been evaluated in multiple randomized controlled trials, and Shadish and Baldwin (2005) conducted a meta-analysis to evaluate the overall effectiveness of BCT. The authors found an average effect size of $d=0.59$, which suggests that couples receiving BCT were better off than 72 % of couples who did not receive treatment.

However, the authors concluded that BCT did not necessarily result in better outcomes when compared to other forms of couple therapy. The outcomes generally assessed in studies of BCT include a variety of factors such as relationship satisfaction, improvement in desired areas of change for partners, and being indistinguishable from normative nondistressed couples (Halford, Sanders, & Behrens, 1993; Jacobson & Follette, 1985). More specifically, BCT can produce positive changes in the amount of direct expression, acceptance, and positive nonverbal behavior while decreasing the amount of critique, refusal, and negative nonverbal behavior (Hahlweg, Revenstorf, & Schindler, 1984).

Another couple intervention that has been evaluated in multiple trials is emotionally focused couple therapy (EFCT). This therapy focuses on relationships from an attachment perspective and emphasizes the formation of emotional responses that prime bonding events to then create new patterned, constructive cycles of caring within couples (Johnson, Hunsley, Greenberg, & Schindler, 1999). The therapy consists of nine steps as outlined in a meta-analytic review of EFCT conducted by Johnson et al. (1999). EFCT significantly reduces relationship distress (as measured by dyadic adjustment) compared to both wait-list controls and pretreatment scores. Additionally, in most of the studies in the Johnson et al. (1999) meta-analysis, over half of the couples enrolled in EFCT no longer met criteria for being maritally distressed post-therapy. When examining the four randomized clinical trials (RCTs) of EFCT in this meta-analysis, a very large effect size of $d = 1.31$ was attained, suggesting that a treated couple performed better than 90 % of untreated couples. However, this effect size should be interpreted with caution given that it is based on only four RCTs.

There are three other commonly used couple therapies that have received significant empirical support. Integrative behavioral couple therapy (IBCT) is the most recently studied couples therapy and is built upon traditional BCT techniques, with an additional focus on emotional acceptance (Christensen et al., 2004). IBCT integrates traditional BCT's behavior change approach with an increased focus on empathy, intimacy, and emotional acceptance. This is achieved through detachment, in which relationship problems are understood as impartially as possible by the couple, and empathic joining, in which couples are taught to express emotions and feelings, leading to both individuals accepting the other's perspective and ultimately feeling closer to each other.

In a randomized clinical trial of 134 distressed couples, IBCT performed similarly to BCT, with 71 % of IBCT couples and 59 % of BCT couples demonstrating reliable improvement on relationship satisfaction (Christensen et al., 2004). IBCT and BCT also were found to have continued benefits over time and, at a 5-year follow up, 50 % of IBCT and 46 % of BCT couples maintained their gains with continued clinically significant improvement (i.e., reliable improvement or recovery; Christensen, Atkins, Baucom, & Yi, 2010).

The goal of insight-oriented couple therapy (IOCT) is to have couples resolve underlying conflictual emotional through addressing developmental issues, collusive interactions, irrational role assignments, and maladaptive relationship patterns (Snyder & Wills, 1989). IOCT was compared to BCT in a randomized clinical trial

of 79 distressed couples. Both treatments performed similarly well with both demonstrating statistically and clinically significant improvement in marital satisfaction (Snyder & Wills, 1989). At a 4 year follow-up, a significantly higher proportion of BCT couples had experienced divorce compared to IOMT couples (38 % for BCT, 3 % for IOMT; Snyder, Wills, & Grady-Fletcher, 1991). These data are supported by only one study, however, and should be interpreted with this caution in mind.

Finally, in a randomized clinical trial of 42 couples, Goldman and Greenberg (1992) compared integrated systemic marital/couple therapy (ISMT/ISCT) with EFCT. The primary aim of ISCT is to reverse fight cycles by changing the meanings attributed to these negative cycles. The authors describe seven steps in the therapy, including restructuring and reframing the problem, encouraging the couple to take proceed slowly, and prescribing a relapse. In the trial, ISCT and EFCT were equally effective in lessening relationship distress. However, at a 4-month follow-up, ISCT couples showed a greater maintenance of gains than EFCT couples. These findings should be interpreted with caution, however, given that they are based on only one trial and the small sample size was relatively small.

The Step 3 therapies discussed thus far are well-established, evidence-supported options for treating couple/marital distress. There are no data to suggest, however, that any one approach is superior in its effectiveness than any other. In addition, it should be noted that a minority of couples (25–30 %) show no improvements from any of these therapies. Additionally, some treated couples fail to maintain their gains over time and up to 45 % will show significant deterioration when assessed 2 years or longer post-termination (Snyder & Halford, 2012). There are a few issues that still need to be addressed in future research and developing a better understanding of who the interventions best for and how to improve their effectiveness more broadly are two needed areas of research. One of the more obvious areas that needs be addressed is studying marital distress and its treatment in diverse cultures and ethnic groups. The therapies reviewed thus far have been examined in samples that are predominantly middle-class, heterosexual, and non-Hispanic White, and research to establish treatment validity among people of different socioeconomic statuses, sexualities, and ethnicities is very much needed.

Cultural Considerations for Evidence-Based Interventions

In order for marital interventions to be effective with Hispanic couples, some modifications are likely to be needed to make them fully applicable to diverse populations. Most marital intervention research to date has been done with white, middle-class, generally well-educated couples (Dion, 2005; Ooms & Wilson, 2004). Although there is some evidence that marital interventions can be effective among diverse populations (Daire et al., 2012; Hawkins & Fackrell, 2010; Owen, Quirk, Bergen, Inch, & France, 2012), cultural diversity factors are rarely directly incorporated into marital programs or interventions (Perez, Brown, Whiting, & Harris, 2013).

Acculturation and the migratory experience are two factors that may contribute to marital distress in Hispanic couples and are rarely directly addressed in marital interventions. In addition, many aspects of marital interaction and marital functioning likely differ according to cultural and ethnic factors, including communication skills, conflict management strategies, problem-solving approaches, and child rearing, and existing intervention approaches could widen their cultural appeal if they could accommodate some of these factors. Hispanics represent many different cultural traditions related to marriage, and while it is impractical to think that any intervention will accommodate each specific branch of Hispanic heritage, unless marital therapists can understand these differences and adapt interventions and materials in relevant ways, they are likely to struggle and to fail to meet the needs of Hispanic couples (Hawkins, Carroll, Doherty, & Willoughby, 2004).

Three of the specific factors have been proposed to be included in marital intervention programs to make them more culturally inclusive of issues important to Hispanic couples are respeto, familismo, and machismo/marianismo (Gutierrez et al., 2014; Perez et al., 2013). Respeto is a Hispanic family value that affects relationship health and it refers to the traditional perception of hierarchal authority in a family (Garza & Watts, 2010; Gutierrez et al., 2014). Gutierrez et al. (2014) advise marital educators and therapists to be well versed in this construct so that cultural norms are not unknowingly violated. In a qualitative study of Latino men and women who had participated in a marriage and relationship education program, Perez and colleagues (2013) found that their focus groups found attention to issues of familismo and machismo/marianismo to be valuable. Familismo has been described as the Latino culture's identification and loyalty to the nuclear and extended family (Lugo Steidel & Contreras, 2003). This construct emphasizes interdependence and connectedness among family members through their obligation to protect, honor, respect, and support the family and it prioritizes the family responsibilities over the individuals' needs (Falconier et al., 2013). The couples in the Perez et al. (2013) study indicated a keen awareness of how struggles in their marriage affected their children and extended family members, especially conflict that took place in front of their children. The couples in this study also reported it helpful for the marital program to address gender-typed differences in the roles men and women were expected to play in a marriage. No research to date has yet examined how acculturation issues are related to respeto, familismo, machismo/marianismo, or how interactions between these variations affect marital quality, but these are important directions for future studies.

Existing marital interventions and scientifically tested programs were developed in a particular linguistic and cultural context and it is a fair question to ask to what extent they are relevant for other ethnocultural groups that do not share the same language or cultural values (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009). As Bernal and colleagues (2009) articulately point out, an over emphasis on the systematization of interventions, potentially resulting in a "one size fits all" type of approach, may undermine the very goal of the scientific approach (competent delivery of services). Clearly, a balance between the selection of appropriate and scientifically sound interventions and culturally competent practice is needed. Some

cultural factors may be easier to address and incorporate than others. For example, issues regarding how marital conflict can impact children and larger family system relationships and how expectations regarding gender roles can impact couple communication and couple behavior are already incorporated into many marital interventions and it therefore seems that with further culturally responsive adjustments, existing programs could better meet the needs of Hispanic families without compromising integrity or fidelity of the interventions themselves.

Making modifications to well-established empirically supported interventions to accommodate the needs of minority groups without compromising fidelity of interventions is not a simple process, though models have been proposed as to the optimal ways of accomplishing this goal. The Ecological Validity Model (EVM; Bernal, Bonilla, & Bellido, 1995; Bernal et al., 2009) provides a systematic framework for adapting the content and methods of existing interventions to make them more culturally sensitive to specific minority groups. This model was originally specifically written with Latino populations in mind, and it addresses eight dimensions of interventions: language, persons, metaphors, content, concepts, goals, methods, and context. For example, using this model, Rosselló and Bernal (1999; Rosselló, Bernal, & Rivera-Medina, 2008) modified content from EBT therapies to incorporate cultural values of familismo and respeto in treating depressed adolescents. The model was later expanded to a more general cultural adaptation process model that consists of three general phases and ten specific target areas. As outlined by Domenech Rodríguez and Wieling (2004), the first phase is a collaborative effort between the change agent (researcher) and a community leader with the goal being to find a balance between community needs and scientific integrity. In the second phase, evaluation measures are selected and adaptations are made in line with adaptations made to the intervention. The third phase consists of integrating information learned and data collected in phase two into a newly packaged intervention.

In addition to the need for culturally informed and culturally competent marital interventions, there also is a need for culturally competent trainers to teach them. It will be important that those doing the training in culturally informed marital interventions have an understanding and appreciation for different values, customs, and ways of communicating. In particular, there is a significant need for more Spanish speaking interventionists so that Hispanic couples are able to speak in their language of choice. The importance of this issue cannot be overstated. It is not sufficient for existing intervention programs and materials to be merely translated into Spanish, they need to be appropriately adapted and interventions need to be led by people who are capable of conducting interventions in Spanish as needed. This is critical because many thoughts or ways of conveying emotion do not translate easily or well into English (Perez et al., 2013). In many cases, it is probably preferable to have the interventionist also be a person of Hispanic heritage to optimize cultural sensitivity. Although not yet studied in the context of marital therapy or marital education programs, there is some suggestion in the literature that more favorable therapeutic outcomes are obtained when there is an ethnic and linguistic match between the client and the therapist (Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Vasquez, 2007).

In conclusion, given the high rate of marital distress and its associations with mental and physical health concerns, continuing to better understand these interconnections and how to intervene, is vitally important, especially for underserved and understudied minority groups such as Hispanic couples. Helping medical professionals be better tuned into marital stress and how it presents has the potential to promote better utilization of interventions that can reduce marital distress and perhaps even promote greater physical well-being for these couples.

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