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# Integrative behavioral couple therapy for intercultural couples: helping couples navigate cultural differences

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# INTEGRATIVE BEHAVIORAL COUPLE THERAPY FOR INTERCULTURAL COUPLES: HELPING COUPLES NAVIGATE CULTURAL DIFFERENCES

A clinical dissertation submitted in partial satisfaction

of the requirements for the degree of

Doctor of Psychology

by

Caroline Kalai, M.A.

October, 2016

Kathleen Eldridge, Ph.D. – Dissertation Chairperson

This clinical dissertation, written by

Caroline Kalai

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

Kathleen Eldridge, Ph.D., Chairperson

Barbara Ingram, Ph.D.

Mia Sevier, Ph.D.

TABLE OF CONTENTS

Page

Page

LIST OF TABLES

Page

# DEDICATION

In loving memory of my grandmother, Daika, who endlessly encouraged my pursuit of a doctoral degree.

ACKNOWLEDGEMENTS

It is with overwhelming gratitude and appreciation that I write my acknowledgements as I reflect upon the multiple contributors to my dissertation. The inspiration for my research sparked early in my graduate career during an academic course on couple and family therapy, taught by my dissertation chair, Dr. Kathleen Eldridge. I knew as an early clinician that my career would undoubtedly include working with couples. My journey through cultural exploration, maturation, and even challenging my family's expectations and obligations shaped my emerging multicultural identity. It generated my deep appreciation for the impact of cultures on identity formation, as well as the role of culture within interpersonal relationships. Integrating my fascination with culture and relationships into my research would not have been possible without the encouragement, motivation, and excitement of Dr. Eldridge. From the day we began brainstorming ideas, I absorbed her confidence and became fueled by her faith in me. My personal and professional interests were prioritized, and for that I am sincerely grateful. Her research experience, knowledge, guidance, approachability and continued support leaves me humbled. Thank you for reminding me to trust my skills while listening to my intuition throughout my doctoral program. Thank you for your authenticity, kindness, and candidness as I navigated the obstacle course that is graduate school. I am so proud to be under your wing.

I would also like to express my gratitude to my additional dissertation committee members, Drs. Barbara Ingram and Mia Sevier. Your combined research experiences and knowledge paved the direction of my study and contributed to its development. Thank you for your enthusiasm and investment in my dissertation.

My many mentors, teachers, supervisors, and role models who have shared and passed down a piece of their wisdom have shaped so much of who I have become. I cannot

separate who I am from what I do, which I have learned is a strength that makes me a better clinician. To Dr. Andrew Christensen, who provided me with my first exposure to research in couples therapy at UCLA by allowing me to assist his graduate student, Dr. Brian Baucom. Thank you for opening up your laboratory—your research home, comfort zone, and knowledge center. I would have never thought that 8 years later, I would be contributing to your incredible research achievements. To Dr. Aaron Aviera, who has served as a true representation of a clinically competent psychologist, and a genuinely peaceful soul—you have taught me how to become better attuned to my mind and body, you have strengthened my diagnostic and intuitive abilities, and you've provided all this while treating me like a colleague. To Dr. Shelly Harrell, thank you for modeling productivity, hard work, dedication and passion, all while maintaining an admirable positive attitude and cheerfulness. Your supervisory guidance through some of my most difficult cases have made me a more confident clinician. To Drs. Edward Shafranske and Robert de Mayo, it was a pleasure to sit with you during my clinical competency examination. I felt so lucky to pass my exam by two psychoanalytic/psychodynamic psychologists whom I aspire to emulate in my practice. I have confused and intrigued many family and friends by sharing my theoretical knowledge over friendly dinner conversation. To my internship mentor, Dr. Judd Christian, who highlighted my most valuable character strengths to guide my therapeutic work, I thank you for serving as my safe haven during this very difficult training year away from home. Whether accompanying you on hospital consults, decorating your office, sharing food from the hospital physician's lounge, helping me process personal struggles, or discussing clinical cases, I have never doubted myself in your presence. Thank you for reminding me that I am always good enough. And to one very special, patient, and adored mentor—Rabbi Yitz Jacobs, I thank you for rekindling my faith, shining a light on a large part of

my identity, supporting my spiritual path and allowing me to challenge your teachings in the spirit of learning, one class after the next.

Lastly, but certainly not least, I want to thank my family. They are the roots to my firmly grounded feet. I am extremely grateful and incredibly fortunate for my amazing siblings—Ronen and Karen. Thank you for your friendship, laughs, support, and motivation. I am humbled by our bidirectional relationships as both students and teachers to each other despite our age gaps. To my father ("Abbah"), I only wish to harbor half of your drive, curiosity, and commitment to the pursuit of a happy life. My eyes always well up in tears as I reflect on how grateful I am that my biggest hero is my own flesh and blood. You've overcome discrimination, beat all stereotypes, immigrated and started new in three different countries, and contributed to my education with unwavering support—from teaching me English after moving to the US, gluing popsicle sticks on my elementary school projects, balancing chemistry equations with me during high school, and debating about politics, religion and psychology as I emerged into adulthood—thank you from the bottom of my heart. To my mother ("Eema"), this dissertation and my doctoral degree are dedicated to you. You are the water that nourishes the roots of our family. Thank you for modeling to me the value of togetherness, loving kindness, patience and acceptance. Thank you for inspiring my interest to help couples and families feel the level of safety, happiness, and meaning that you bring to our lives.

# VITA

## EDUCATION

*Pepperdine University, Graduate School of Education and Psychology*, Los Angeles, CA
Doctor of Psychology in Clinical Psychology June 2016
Clinical Competency Exam: Passed June 2014
Dissertation Final Defense: Passed May 13, 2016
Title: *Integrative Behavioral Couple Therapy for Intercultural Couples: Helping Couples Navigate Cultural Differences*

*Pepperdine University, Graduate School of Education and Psychology*, Los Angeles, CA
Master of Arts in Clinical Psychology:
emphasis in Marriage and Family Therapy April 2011

*University of California, Los Angeles*, Los Angeles, CA
Bachelor of Arts in Psychology, Minor in Anthropology June 2008

## LANGUAGES

Beginning/Intermediate Spanish
-University of Belgrano in Buenos Aires, Argentina August-December 2007
Conversational Hebrew with intermediate reading skills
Conversational Farsi

## CLINICAL EXPERIENCE

Doctoral Intern July 2015-June 2016
*University of Miami-Jackson Memorial Hospital*, Miami, FL
*Adult Outpatient Center*
Supervisors: Victoria Bustamante-Avellaneda, Psy.D, Susan M. Williams, Ph.D., Judd S. Christian, Psy.D
-Conduct brief and long-term psychodynamic and cognitive behavioral therapy with a wide array of patients representing a spectrum of demographic and cultural backgrounds, clinical presentations and treatment needs. Common patient diagnoses include: affective disorders, anxiety disorders, PTSD, psychosis, personality disorders, and concurrent substance abuse complicated by medical illness and severe psychosocial stressors.
-Provide 15 to 20 hours of therapy a week. The modality of therapy includes individual, couples or family intervention.
-Complete a minimum of six integrated psychological assessments, with batteries including neuropsychological, cognitive and projective measures, including, WAIS-IV, MMPI-2, R-BANS, Rorschach Inkblot Test, and more. Develop appropriate recommendations and provide feedback to patients on testing results.
-Conduct weekly group therapy, including "Depression Group" (Behavior Activation), Cancer Group (CBT/Expressive Supportive Therapy), Dialectical Behavioral Therapy Group, and Co-Occurring Treatment Group (Guided Self-Change Group: Motivational Interviewing & CBT).

Each week, model therapy techniques and provide informal supervision to psychiatry residents, who attend group for observational learning.
-Receive a minimum of two hours of supervision per week. Supervision of psychotherapy is conducted according to numerous theoretical orientations including brief dynamic, cognitive, behavioral and psychodynamic.
-Attend monthly Morbidity and Mortality (M&M) Conferences coordinated by the Department of Psychiatry and Behavioral Sciences. These conferences are a peer review of mistakes occurring during the care of patients, typically highlighting recent cases and identify areas of improvement for clinicians involved in the case. The objectives of the M&M conference are to learn from complications and errors, to modify behavior and judgment based on previous experiences, and to prevent the repetition of errors that lead to complications. Conferences help in identifying systems issues (e.g., outdated policies, changes in patient identification procedures, etc.), which affect patient care.
-Attend weekly seminars, including: Introductory Seminars Series (skills and information needed for providing treatment to patients at JMH—risk management, suicide assessment, diversity), Clinical Psychopharmacology Seminar, Psychodiagnostic Seminar, Ethics, and Behavioral Pain Management.
-Attend weekly case conferences with internship class, led by Jackson Memorial Hospital's Chief of Psychology, Dr. Thomas Robertson. Present psychotherapy cases for discussion according to a formal psychiatric model. Provide a thorough review and discussion of 2 patients throughout the year, and discuss the specific techniques utilized in psychotherapeutic sessions. The focus of each presentation is on the integration between theory, clinical application, and utilization of the literature.
-Attend Psychiatry Case Conferences, led by Director of Adult Outpatient Clinic, Dr. Dante Durand, M.D., and present one psychotherapy case to residents and attending psychiatrists.
-Attend a minimum of 11 Behavioral Health Hospital Grand Rounds, presenting on a wide array of topics, including Intergenerational Transmission of Trauma, Drug Abuse and the Neurobiology of Addiction, Neurobiological Consequences of Childhood Trauma, Somatoform Disorders, ADHD, Autism, & Childhood bipolar disorder.

Doctoral Intern July 2015-October 2015
*University of Miami-Jackson Memorial Hospital*, Miami, FL
*Medical Psychology-Consultation and Liaison Services*
Supervisors: Efrain L. Gonzalez, Ph.D., Judd D. Christian, Psy.D.
-Provided psychological services to the surgical, emergency room, trauma, and medical units in Jackson Memorial Hospital. Psychological consultation may be requested based on pre-existing psychiatric issues, current distress, behavioral management issues, poor adherence to treatment, and capacity to provide informed consent.
- Learned the rapid assessment of medically compromised patients, and be able to render a diagnosis, provide treatment, and decide on disposition in medical areas that are intense and require rapid decision-making and follow up.
-Conducted clinical interviews and incorporate formal Mental Status Examinations to arrive at diagnostic impressions and treatment recommendations.
-Developed a good working knowledge of organic states and metabolic dysregulation that affect mental and emotional functioning and the relationship between mental disorders due to organic etiology and secondary psychological manifestations.

-Supervision involves seeing patients with Dr. Gonzalez, Dr. Christian, and other members of the Medical Psychology CL team as part of the "live" supervision that occurs in teaching hospitals affiliated with medical schools.

Extern August 2014-June 2015
*Harbor-UCLA Medical Center,* Los Angeles, CA
*Los Angeles Biomedical Research Institute*
*Collaborative Adolescent Research on Emotions and Suicide (CARES)*
Supervisors: Michele Berk, Ph.D., and Deborah Tate, LMFT
-Conducted supportive, client-centered therapy as part of a large, multisite NIMH grant funded study in collaboration with Dr. Marsha Linehan at the University of Washington. The study tests the effectiveness of Dialectical Behavior Therapy and Supportive Therapy for suicidal and self-injuring adolescents, ages 12-18. Adolescents were assigned to one of two treatment conditions and completed weekly questionnaires of their mood and behavior symptoms.
-Conducted individual and group psychotherapy for adolescents and young adults diagnosed with Borderline Personality Disorder. Sessions are video and audio recorded for supervision and training purposes, and for compliance to protocol.
-As a treating clinician and study participant, completed weekly questionnaires on therapy sessions.
-Conducted risk assessment and comply with research protocol and clinical supervisor about crisis intervention.
-Participated in weekly group and individual supervision.
-Completed documentation to comply with legal and ethical requirements.

Extern August 2014-June 2015
*Airport Marina Counseling Center,* Los Angeles, CA
Supervisor: Diana Hoffman, Ph.D. and Karen Schlaff, Ph.D.
-Conducted individual, couples, and family therapy and develop individualized treatment plans based on diagnosis, theoretical assessments, and cultural awareness to fit clients' needs.
-Concentration in psychodynamic and developmental theories with careful attention to family systems.
-Participation in a couple therapy track and on-going didactic training on a broad range of topics including risk assessment and crisis intervention.
-Completed intake interviews and documentation to comply with legal and ethical requirements.
-Wrote intake reports within a timely manner after conducting initial client interviews.
-Participated in weekly group and individual supervision to conceptualize relevant treatment plans.

Extern July 2013-June 2014
*Children's Hospital Los Angeles,* Los Angeles, CA
*Neuropsychology Program*
*Clinical Translational Sciences Institute*
Supervisor: Sharon O'Neil, Ph.D., M.H.A.
-Conducted neuropsychological evaluations with children, adolescents, and adults (e.g., childhood cancer survivors, adults with sickle cell disease) to determine functional status, including cognitive strengths and weaknesses, and to provide remedial recommendations and intervention.
-Patients assessed are from all medical divisions in the hospital and include those diagnosed with brain tumors, sickle cell disease, congenital heart disease, liver disease, optic nerve hypoplasia, prenatal and postnatal brain injuries, seizures, and focal brain lesions.
-Attended interdisciplinary neural tumors meetings with oncologists, nurses, pharmacist, radiation oncologist, social worker and neuropsychologist.
-Attended weekly neuropsychology didactics on topics including functional neuroanatomy, assessing patients with vision, physical or other impairments, brain tumors, sickle cell disease, seizure disorders and stroke.
-Attended didactic medical and psychology seminars, such as Pediatric Grand Rounds, Adolescent Medicine Grand Rounds, and Hematology-Oncology Grand Rounds.
-Attended brain cuttings with neurology interns and fellows.

Extern September 2012-June 2014
*Pepperdine University Psychological and Educational Clinic*, Los Angeles, CA
Supervisors: Aaron Aviera, Ph.D., Shelly Harrell, Ph.D.
-Conducted individual, couples, and family therapy and develop individualized treatment plans for clients with a variety of mood and personality disorders.
-Completed intake interviews with adolescent and adult clients.
-Wrote comprehensive intake reports within a timely manner after conducting initial client interviews.
-Prepared case presentations for clinical case conferences in order to facilitate diagnosis and treatment plan.
-Provided after-hours emergency pager coverage, assess for risk, and refer clients to appropriate resources to meet their needs.
-Participated in weekly dyadic, group, and peer supervision to conceptualize relevant treatment plans.
-Completed documentation to comply with legal and ethical requirements.

Extern September 2013-June 2014
*Wiseburn School District,* Hawthorne, CA
Supervisor: Keegan Tangeman, Psy.D.
-Facilitated group therapy and provide individual psychotherapy for children ages 5-10 years old.
-Utilized art, play therapy, and behavioral therapy to facilitate age-appropriate communication and behavior among children with social skills needs.
-Maintained contact with school officials, including teachers, staff and school psychologist in a collaborative effort to promote the well being and emotional development of children, and their response to treatment.

-Met with parents and maintain communication with family members in order to foster consistency of intervention by incorporating therapeutic techniques at home.
-Weekly supervision on case conceptualizations, treatment, technique, and assessment of matters related to the Department of Child and Family Services.

Marriage and Family Therapist Trainee October 2010-January 2012
*Open Paths Counseling Center,* Los Angeles, CA
Supervisor: Loretta Dubin, LMFT
-Conducted individual therapy for children and adolescents in a school-based traineeship.
-Utilized art therapy and play therapy to promote positive interaction and encourage students to work through emotional distresses that impact their academics.
-Maintained contact with parents and teachers to facilitate the student's emotional growth.
-Participated in weekly group supervision.
-Prepared presentations for group supervision in order to facilitate treatment approaches and discuss counter-transference experiences.
-Completed documentation to comply with legal and ethical requirements.

Marriage and Family Therapist Trainee October 2010-April 2011
*Monte Nido Treatment Facility*, Malibu, CA
Supervisors: Anna Kowalski, LMFT, Keesha Broome, LMFT
-Prepared meals and ate with clients struggling with eating and exercise disorders as a therapeutic objective of modeling and encouraging appropriate eating behaviors.
-Spent time with clients during outings and group therapy sessions.
-Co-facilitated evidence-based cognitive-behavioral psychotherapy groups.
-Observed process groups such as "Body and Soul," "Mindfulness," and "Nutrition and Exercise."
-Completed process notes for individual clients following group sessions.
-Attended weekly group supervision to discuss client cases.
-Met with a team of professionals including a nutritionist, dietitian, nurse, and fitness instructor on a weekly basis to follow up on client progress.

Marriage and Family Therapist Trainee January 2010-June 2010
*Parkhill School*, West Hills, CA
Supervisor: Gil Freitag, Ph.D.
-Co-facilitated Social Skills, Interpersonal Skills, and Substance Abuse groups with adolescents struggling with behavioral and learning disabilities.
-Developed curriculum and met with supervisor weekly to collaborate/discuss clients and group strategies.
-Utilized cognitive behavioral techniques, psychoeducation, and literature by Irvin D. Yalom on group psychotherapy to promote self-awareness, group cohesion, and interpersonal growth.

Behavioral Interventionist/Floortime Therapist August 2008-November 2008
*Intercare Therapy, Inc.,* Los Angeles, CA
Supervisor: Naomi Heller, M.A.
-Worked with children with Autism and children showing early autistic tendencies.
-Therapy was conducted in settings such as their homes, schools, and agency.
-Applied play-based therapeutic technique based on Stanley Greenspan's Floortime model; techniques involved sitting with the child and taking his/her lead in activities.
-Collaborated with supervisor, teacher, and parents to help further the child's emotional growth and facilitate a consistent, nurturing environment for the child, both at school and in the home.
-Utilized evidence-based behavioral techniques and maintained daily log of behavioral goals and progress of each child.

ASSESSMENT TRAINING & EXPERIENCE

*Cognitive Assessment*
-Test administration and report writing on WISC-IV, WAIS-IV, VMI-6, Bender, CTONI-II, and WRAT
*Personality/Projective Assessment*
-Test administration and report writing on MMPI-2, MCMI, Rorschach, HTP, Rotter Incomplete Sentences Blank (RISB), and TAT
*Additional Assessment Exposure*
-As part of a Master's level course, conducted the Family Assessment Measure-III on a volunteer participant and learned administration techniques pertaining to Kinetic Family Drawing (KFD), DAP:SPED, TEMAS, and MSI-R.
Neuropsychological Assessment Experience
-Test administration, report writing and interpretation of: RBANS, MoCA, Color Trails, Bayley-III, Battelle-II, BOT-II, CANTAB, CELF-IV, CBCL, CMS, COWAT, CVLT-II/CVLT-C, D-KEFS, EOWPVT/ROWPVT, Grooved Pegboard, JOL, NEPSY, NEPSY-II, Rey-O, TEACH, VMI, WAIS-IV, WASI-II, WIAT-II, WISC-IV, WJ-III, WMS-III, WMS-IV, WPPSI-IV, WRAML-II and parent/self-report measures including ABAS-II, BASC-II, BRIEF, BDI-II, BAI, and PEDS-QL.
-Training also included in vivo supervision with Sharon O'Neil, Ph.D. and Children's Hospital Los Angeles.

LEADERSHIP EXPERIENCE

Chief Intern July 2015-June 2016
*University of Miami-Jackson Memorial Hospital*, Miami, FL
Supervisor: Dr. Susan Chalfin, Ph.D. and Dr. Melisa Oliva, Psy.D., Directors of Clinical Training
-Hand-selected as a co-chief to serve as a liaison between faculty and interns and to represent the interns in various institutional process.
-Assist Director of Clinical Training and Psychology Coordinator in the design and implementation of internship application process, including the orientation sessions and tours during the interview dates.
-Assist Director of Clinical Training and Psychology Coordinator with special projects needed to ensure the smooth operation of the internship program and compliance with APA and APPIC regulations.

-Designate tasks as needed to the interns
-Present aggregate data regarding evaluation of various components of the training program twice during the year.
-Assist with oversight and compliance of Intern Responsibilities, including collection of supervision logs, testing logs, writing samples, and evaluations of seminars for each intern.
-Monitor attendance of interns at each required didactics seminar and Grand Rounds.
-Responsible for maintaining the intern files and keeping them updated on a consistent basis.

SUPERVISORY/TEACHING EXPERIENCE

Peer Supervisor September 2014-June 2015
*Pepperdine University Psychological and Educational Clinic,* Los Angeles, CA
Supervisor: Aaron Aviera, Ph.D.
-As an advanced student in the program, provided one hour of face-to-face clinical supervision to first and second year doctoral students under the supervision of the clinic director.
-Attended first-year doctoral students' case conferences and learn to facilitate the group supervision.
-Attended weekly supervision of peer-supervision with primary supervisor.
-Among the areas of focus during peer supervision was the initial intake evaluation process, which encompasses intake interview technique and process, differential diagnosis, treatment recommendations, and providing feedback on the initial drafts of the written intake reports.
-Available for after-hours consultation.
-Provided reviews and feedback on all current clients seen, and review sessions that are video or audio taped.
-Additional tasks included mentoring, and providing support to the clinic director in the ongoing tasks associated with overseeing a training clinic.
-Participated in clinic outreach and networking activities, clinic program development projects, and quality assurance (chart reviews).

Teaching Assistant September 2010-December 2010
*Pepperdine University*, Malibu, CA
Supervisor: Steven Rouse, Ph.D.
-Provided assistance for undergraduate course "Educational Tutoring: Camp David Gonzales"
-Supervised undergraduate students as they tutored minors (generally ages 16 and 17) in a detention facility operated by the L. A. County Department of Probations
-Oversaw the dyadic tutoring occurring in the facility's cafeteria, observing the behavior of both the tutor and the minor to ensure participants abided by the standards of behavior appropriate for a tutoring relationship
-Supported and mentored undergraduate students and ensured attendance and participation
-Reported student progress to professor.

Teaching Assistant January 2006-June 2006
*Calvary Christian School*, Pacific Palisades, CA
-Facilitated play and interaction between pre-school aged children
-Assisted head instructor with daily classroom chores and routines, yard-watch, and instruction
-Co-facilitated structured classroom activities
-Led small group activities within the classroom including artwork and reading

RESEARCH EXPERIENCE

Doctoral Dissertation June 2013-June 2016
*Applied Scholarship Community, Pepperdine University,* Los Angeles, CA
Dissertation Chair: Kathleen Eldridge, Ph.D.
-Dissertation Defense: Passed June 2016.
-Topic: Integrative Behavioral Couple Therapy (IBCT) and its effectiveness with intercultural couples.
-Qualitative, multiple-case study on IBCT therapists' experiences utilizing IBCT with a specific intercultural couple, recommendations for utilizing IBCT with intercultural couples, and general recommendations for working with intercultural couples.

Doctoral Research Assistant January 2013-October 2013
*Multicultural Training and Research Lab Pepperdine University,* Los Angeles, CA
Supervisor: Shelly Harrell, Ph.D.
-Collaborated with Dr. Shifra Teitelbaum and fellow doctoral student researchers on evaluating a youth empowerment program, "youTHink," on its impact and effectiveness in instilling motivation and leadership in at-risk youth. YouTHink is aimed at empowering adolescents and young adults through active dialogue about relevant social justice issues, teaching communication and teamwork, and promoting community outreach.
-Attended youTHink community events with the youth, coded video-recorded process groups to provide feedback to researcher on observations, helped create an IRB proposal, and partook in the development and presentation of a poster at the 2013 Society for Community Research and Action Conference in Miami, Florida.
-Findings of the study aimed to contribute to the field's current shift towards examining the optimal conditions whereby the arts and education enable youth to find their voice and contribute to positive social change.

Research Coordinator and Laboratory Manager May 2011-June 2012
*University of California, Los Angeles, Department of Psychology*, Los Angeles, CA
*UCLA Baby Lab*
Supervisor: Scott P. Johnson, Ph.D.
-Responsible for creating IRB and CPHS addendums, continuing reviews, and modifications.
-Recruited, scheduled and ran subjects in the lab, wrote quarterly newsletters, and helped with data analysis.
-Coordinated and ran lab meetings with graduate students and undergraduate student research assistants.
-Responsible for management of lab expenses- purchases, reimbursements- and assisted Dr. Johnson with budget and grant writing.
-Learned to administer research studies using Electroencephalography (EEG).
-Research incorporated eye-tracking paradigms to learn the ways in which infants learn words, perceive familiar and unfamiliar stimuli, recall objects, and their preferences in facial features. Studies on sequence learning, visual perception, facial perception, and perceptual completion were created by doctoral level students and by Dr. Johnson.
-Results were measured by looking times, target locations on eye-tracking monitors, and habituation times.

Graduate Student Research Assistant June 2010-May 2011
*Pepperdine University- Boone Center for the Family,* Malibu, CA
Supervisor: Hannah Parmelee, M.S.
-Trained by the Boone Center for the Family's Relationship IQ Project
-Conducted literature reviews, preparation for IRB proposal applications, participated in research design, instrument creation, data collection, data analysis, and result reporting

Undergraduate Student Research Assistant June 2007-August 2007
*University of California, Los Angeles, Department of Psychology,* Los Angeles, CA
*Language and Cognitive Development Laboratory*
Supervisor: Catherine Sandhofer, Ph.D.
-Conducted research on children's abilities to learn new words and concepts by comparing and contrasting new shapes and figures
-Responsible for recruitment of subjects and collaboration with pre-schools
-Traveled to various schools and conducted the research with children between the ages of 3-5
-Gathered results and discussed them in weekly lab meetings

Undergraduate Student Research Assistant January 2007-June 2007
*University of California, Los Angeles, Department of Psychology,* Los Angeles, CA
*Couple's Therapy Laboratory*
Supervisor: Andrew Christensen, Ph.D.
-Worked with a study of couples' physiological behavior during marital therapy sessions
-Gathered and collected data, including the frequency of specific physiological behaviors while one partner was the "target" and again while that same partner was the "attacker" during conflict/heated discussion
-Provided data entry and analysis of voice and pitch of both male and female patients

POSTER PRESENTATIONS
*Society for Community Research and Action*
June 2013
YouTHink: Engaging Students in Contemporary Issues and Civic Action Through Art
Marta Orozco, M.A., Caroline Kalai, M.A., Claudia V. Peña, M.A., Hank Skulstad, M.A., Blaire Thomas, M.A. and Shelly P. Harrell, Ph.D.

*Los Angeles County Psychological Association*
October 2013 A Culturally-Syntonic Perspective on Psychosocial Development: Implications for Intervention
Caroline Kalai, M.A., Hoda Abou-Ziab, M.A., Kimberly Clark, M.A., Shelly P. Harrell, Ph.D.

PROFESSIONAL ASSOCIATIONS
American Psychological Association (APA) 2010-Present
Psi Chi-The International Honor Society in Psychology 2010-Present
Los Angeles County Psychological Association 2013-Present

ABSTRACT

Integrative Behavioral Couple Therapy (IBCT), an empirically supported and evidence-based third-wave behavioral approach for treatment of couples, is examined in this multiple case study. Specifically, the qualitative experiences of therapists using IBCT in their work with intercultural couples are examined through each therapist's typed responses to open-ended questions. Each participating therapist in this study contributes by describing one case in which IBCT was used to help the couple navigate cultural differences as part of treatment. This study describes the various stressors faced by intercultural couples, therapists' formulations of cultural differences, change processes and change mechanisms during treatment, and similarities and differences across therapists' reports. The study concludes with participating therapists' recommendations for treatment of intercultural couples in general, and recommendations for utilizing IBCT with intercultural couples. Lastly, implications for future research are provided.

## Chapter I: Introduction

Within the last half of the century, the United States has seen a notable increase in interracial and intercultural marriages (Frame, 2004). According to the 2010 United States Census Bureau, there has been a 28% increase in *interracial or interethnic*, opposite-sex married couples in the last 10 years (Lofquist, Lugaila, O'Connell, & Feliz, 2012). Given that the rate of immigrants to the United States is over 1.2 million per year, it is not surprising that *intermarriage* is occurring in at least half of US couples and likely to continue increasing in prevalence (Camarota, 2001; McGoldrick, Giordano, & Garcia-Preto, 2005). There is significant research on intercultural relationships indicating that partners in such relationships face an increased number of stressors, such as misunderstanding in communication; differences in values, beliefs or customs; as well as negative societal and familial reactions (Bustamante, Nelson, Henriksen, & Monakes, 2011; Falicov, 1995; Waldman & Rubalcava, 2005). Not surprisingly, research also suggests that they are more susceptible to relationship discord and at higher risk of divorce (Bustamante et al., 2011). In view of these challenges, ongoing research in treatment for intercultural couples is needed.

There is substantial empirical support for the benefits of treatment of couples in general, suggesting that it is effective for about 50-70% of couples (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Lebow, Chambers, Christensen, & Johnson, 2012; Shadish & Baldwin, 2003). Evidence-based and empirically-supported approaches to couple therapy have been identified, such as Cognitive Behavioral Therapy for Couples (Epstein & Baucom, 2002), Integrative Behavioral Couple Therapy (IBCT; Jacobson & Christensen, 1998), and Emotionally-Focused Couple Therapy (EFCT; S. Johnson, 2004). However, limited research has focused on treatment recommendations specifically for intercultural couples. While empirical studies have primarily

focused on treatment outcomes and mechanisms of change in couple therapy, the literature has not focused on the specific use of these treatments with intercultural couples.

To contribute to our understanding of treatment of intercultural couples, it is important to qualitatively explore how therapists help couples navigate culturally rooted issues in therapy. Specifically, this study qualitatively examined the application of Integrative Behavioral Couple Therapy (IBCT; Jacobson & Christensen, 1996; Jacobson, Christensen, Prince, Cordova, & Eldridge, 2000) with intercultural couples in order to: (a) provide detailed descriptions of the couples' culture-specific differences and how therapists have used IBCT interventions with intercultural couples (e.g., examples of specific interventions they used), (b) provide detailed descriptions of how intercultural couples changed in IBCT (e.g., client change processes; mechanisms of acceptance and behavior change; breakthrough and turning points in treatment), (c) understand therapists' impressions of using IBCT with intercultural couples struggling to navigate through their differences, compared to their experiences using this approach with other couples, and (d) offer recommendations (i.e., dos and don'ts) for using IBCT interventions with intercultural couples, and general recommendations for working with intercultural couples. As such, this study offers useful information to clinicians regarding IBCT-specific and general guidance for working with intercultural couples.

**Background**

Because a central focus of this study is how therapists help couples navigate cultural differences between partners, the examination of existing literature will begin with definitions of terms such as culture, race, bi-cultural and inter-cultural. Following these definitions, the literature review will address stressors experienced specifically by intercultural couples, buffers and coping mechanisms utilized, and other unique factors in working with intercultural couples

in therapy. Lastly, this study includes an overview of IBCT conducted with couples in general (not specific to intercultural couples), and a discussion of treatment techniques, mechanisms of change, and research outcomes.

## Definitions

**Culture and race.** It is essential to delineate *culture* and *race* in the context of this study. It is often the case that culture and race are used interchangeably and that culture is equated to race and ethnicity; however, Hays (2001) explains that the inclusivity and general use of the term culture excludes the historical implications of racism and biological links that encompass the concept of race, emphasizing that race is a socially constructed concept. As a socially constructed concept, it sheds light on one of the oppressive elements of culture. For instance, mezzo-systemic and macro-systemic processes illustrate the way in which racism is experienced between individuals and institutionalized across mainstream culture, respectively. Micro-systemic, or internalized racism, occurs in a racist system when racial groups that experience racism on a macro-level support the power of the dominant group. Racism is internalized when an oppressed group maintains the attitudes, beliefs, behaviors, and social structures of the group holding power and privilege, and then inadvertently limit their own advantages (Bivens, 2005).

As such, it is important to acknowledge the danger in presenting race as simply a biological fact or using the term as equivocal to an individual's culture. Therefore, in this study, race alone is *not* synonymous with culture.

As suggested by Betancourt and Lopez (1993), we must go beyond ethnicity and race and examine specific processes involved within group dynamics to improve our understanding and definition of culture. Consistent with this broader view and definition of culture, Sevier and Yi (2008) described culture with the inclusion of values. Examples of values endorsed by particular

cultures include personal control, collectivism, spiritual beliefs, social norms such as gender roles, and communication patterns. They described emotional styles as well as beliefs and attitudes to be helpful in understanding particular cultures (Sevier & Yi, 2008).

In addition, other studies use culture to refer to "shared meanings, beliefs, and traditions that arise as a group shares common history and experiences that 'give particular interpretations to the world'" (Seshadri & Knudson-Martin, 2013, p. 44). A broader interpretation of culture is provided by Mabry (2010) who described culture as "the configuration of learned behavior and as the result of behavior whose components and elements are shared and transmitted by the members of a particular society" —[a representation of the] "ethos of a people as well as a way of life" (p. 416).

Therefore, culture can go beyond demographic categories and socially constructed concepts, such as race, and be defined as differentiating experiences. Hence, culture in this sense does not refer to ethnicity or race, but a wider construct of characteristics that identify and differentiate individuals.

In sum, it is important to emphasize that race and culture are not synonymous. It should not be assumed that individuals from different racial groups (e.g., a Caucasian female and an African American female) are *culturally* different from one another, especially if they were raised in similar neighborhoods, religious communities, received the same education, and maintain similar interests. Nevertheless, while race alone is not used to define a culture, the varying histories, beliefs, and/or experiences of racial groups can be taken into consideration in understanding cultures that develop *between* races. This study aimed to incorporate all distinguishable group experiences, including the cultural experiences of particular races, under

the umbrella of culture. Ultimately, the definition of culture within this study emerged qualitatively based on how participating therapists and their clients conceptualized the term.

**Bi-cultural versus Intercultural couples.** The terms *bi-cultural* and *inter-cultural* have been used interchangeably to differentiate individuals or couples coming from two distinct cultural backgrounds. Based on Berry's (1997) model of acculturation, however, bi-culturalism was defined as experiencing an independent feeling about your own (or your family's) culture of origin *and* a second culture, simultaneously within one's self. Meanwhile, Silva, Campbell and Wright (2012) define an intercultural couple as the union between two people of different nationalities. This may or may not include differences in race, ethnicity, religion or language. Therefore, the term bi-cultural is used to describe the existence of two cultures *within* an entity, such as an individual. In other words, it is the co-existence of two cultures in describing one individual's cultural identity (Benet-Martinez, Leu, Lee, & Morris, 2002), whereas the term intercultural generally implies differences *between* two entities (e.g. between two individuals). Given these definitions, intercultural couples can consist of bicultural individuals.

Intercultural is often used interchangeably with *cross-cultural*, which emphasizes a comparative tendency (Trimmer & Warnock, 1992). However, in this study, the term intercultural is used instead of cross-cultural, to define couples that identify as culturally different from one another on multiple levels of diversity with no pre-specified number of differences between partners. Gender as a dimension of culture is not considered a differentiating variable between partners in this study (i.e., if a heterosexual couple is the same across all dimensions of culture, then gender did not define the couple as intercultural); however, gender role differences as a result of opposing cultural views is considered a differentiating factor of an

intercultural couple. Ultimately, what defines an individual's culture is the individual and the group with which he/she identifies.

As defined by Crippen and Brew (2013), individuals in intercultural couples *self-identify* with a cultural background that is different from their partner. This study, therefore, examined therapists who have experience working with couples in therapy in which partners have identified themselves as culturally different from one another. Because not all couples seek treatment specifically due to their cultural differences (i.e., they are not aware that their marital discord might be rooted in cultural differences), therapists were asked to reflect on couples in therapy who were trying to navigate problems that were at some point identified as being caused at least in part by cultural differences.

**Stressors of Intercultural Couples**

A great deal of empirical research and literature suggests that cultural differences give way to marital dissatisfaction as heterogeneity leads to couples facing higher levels of stress, conflict, and internal strain (Bustamante et al., 2011). According to Hsu (2001), the fact that partners from *similar* cultures experience conflict as a result of diverse values, beliefs, attitudes and habits makes intercultural couples more vulnerable to encountering problems because intercultural couples enter the relationship with greater differences. Consequently, intercultural couples enter romantic relationships at higher risk than their culturally homogeneous counterparts because intercultural couples have a higher potential for misunderstanding. This becomes increasingly likely if they have different worldviews, languages, communication styles, familial dynamics and views on relationships, or experience disapproving societal reactions (Bustamante et al., 2011).

Characterological attributions made to one's partner as a result of misunderstanding culturally influenced behavior are another mechanism of instilling stress in these couples. As described by Silva et al. (2012), partners who reject or ignore the presence of cultural variation in their relationships and, instead, ascribe differences to their partner's personal characteristics are contributing to the stress and harm placed on the relationship. Furthermore, Silva and colleagues add the potential risk faced by partners whose family members live abroad, suggesting that these intercultural couples may face less familial support in areas of child rearing or acceptance of the relationship. These pressures, with the addition of language barriers, may also contribute to less acquaintance and increased prejudice between the intercultural couple and extended family members. On a chronosystemic level (i.e. how time affects the various systems influencing an individual's development), Silva et al. (2012) suggest that over time, an individual's socialized and internalized beliefs, values, and ideas about the world can also negatively impact the functioning of an intercultural relationship. Differences stemming from their families of origin and developed over time can cause distress if partners do not negotiate and merge "desired elements from each person's existing cultural and familial identities" (p. 864).

These couples, referred to as *unresolved* couples by Seshadri and Knudson-Martin (2013), do not know how to manage the risks and stressors, or how to merge their differing backgrounds and developmental histories. As a result, they often ignore unaddressed conflicts and tension, which inevitably leads to decreased relationship satisfaction.

**Buffers and Coping Strategies**

Scholars have sought to learn the ways in which intercultural couples navigate through culturally rooted stressors to promote relationship longevity, intimacy and satisfaction. Bustamante et al. (2011) summarize some of the literature pertaining to coping strategies

employed by intercultural couples that are either *balanced* or *unbalanced*. In their qualitative, interview-based study on coping mechanisms employed by intercultural couples, Bustamante et al. (2011) found that gender role flexibility, humor about differences, deference to culture-related preferences of their partner, recognition of their similarities, redefining their relational ability (i.e., reframing their relationship dynamic), and a general appreciation for other cultures are important buffers against marital dissatisfaction for balanced couples. Falicov (1995) proposed that the difference between balanced and unbalanced intercultural couples lies in the couples' views of their cultural similarities and differences. Specifically, she described that unbalanced couples in distress maintain impoverished, distorted and disintegrated views of their fundamental differences. Meanwhile, balanced intercultural couples do not deny their differences, but integrate them into their relationships. In fact, the appropriate use of humor, giving your partner time and space, expressions of affection, and interest or enthusiasm have the power to eliminate negative affect that often leads to unfavorable outcomes (M. Johnson et al., 2005; Seshadri & Knudson-Martin, 2013).

In the context of intercultural relationship satisfaction, Seshadri and Knudson-Martin (2013) discuss the buffers of intercultural/interracial stress and emphasize partners' *awareness* of needs and *curiosity* about differences as a means to enhancing intimacy; therefore, a lack of curiosity and acceptance of partners' unique cultural experiences also presents a risk and potential stressor for the relationship. It is essential, therefore, that couples acknowledge difficulties in meeting their partner's needs, acknowledge their relationship distress as a result of conflicting ways of organizing experiences (Waldman & Rubalcava, 2005), and practice some of the key aforementioned buffers to stress.

**Working with Intercultural Couples in Therapy**

Because couple therapy may not be readily accessible or culturally accepted in some cultures, it is important for therapists to recognize sensitivities and tailor their therapeutic approach accordingly. Several treatment methods have addressed cultural considerations in couple therapy, including Emotionally Focused Couples Therapy (S. Johnson, Hunsley, Greenberg, & Schindler, 1999), Systems Theory (Bhugra & De Silva, 2000), and IBCT (Sevier & Yi, 2008). In general, these methods approach the couple through various avenues (e.g., a focus on each partner's attachment style in relation to emotional needs in the relationship; a focus on the role that each partner plays in their marriage; a focus on behavior change via insight, empathy and acceptance). However, no obvious literature pertaining to how these approaches have specifically addressed working with intercultural couples exists. One exception is a recent case study that describes the use of specific IBCT interventions, therapy and couple change processes, and change mechanisms with a couple navigating a communication difference based on their unique cultural backgrounds (Mahgerefteh, 2015).

No one therapeutic approach has been shown to be superior to another in regards to its applicability to intercultural couples. Therefore, consideration of the couple's needs, culture-specific stressors, interpersonal dynamics, and their views on therapy should be taken into consideration in working with intercultural couples from any theoretical framework and treatment approach. The following are specific recommendations based on existing literature for therapists who work with intercultural couples in therapy.

As discussed, it is important when working with intercultural couples in therapy to identify culturally rooted stressors and appreciate the cumulative impact of these stressors on a couple (Sullivan & Cottone, 2006). This aims to prevent trivializing the couple's experience and

requires therapists to pay special attention to how the combination of all their differences produces a wider array of potential stressors. For example, Sullivan and Cottone (2006) describe an intercultural couple (Russian and Italian) with individual differences beyond simply language, ethnicity, and religion. They explain that the culmination of these differences contribute to a host of cultural differences associated with emotion, conflict expression and management, and the role of the family of origin in raising children. Therapists are encouraged to remain attentive to these intricate forces in the relationship that are not as obvious as, for instance, differences in religious beliefs or language.

Upon identification of stressors, several important considerations and treatment recommendations are encouraged. Bustamante et al. (2011) suggest that encouraging couples to take a stance of curiosity is key. For example, helping couples ask their partner questions about their culture in an effort to learn more about the meanings of certain customs and behaviors is a way to encourage curiosity in the relationship. Couples can also be encouraged to explore with curiosity the similarities and differences in their values and beliefs. Additionally, therapists can encourage cultural reframing, in which couples create a reality that accommodates each partner's culture. For example, an intercultural couple (e.g., Middle Eastern Jew and European Christian) may create one environment by merging shared values, beliefs, customs, behaviors and traditions. As such, they might eat Sabbath meals every week, celebrate Christmas, decorate their home with Middle Eastern fabrics, and speak to their children in multiple languages, thereby creating a culture of their own that incorporates what is meaningful to each of them. As one couple described it, "We take the best from both cultures and cultures we have lived in, and make it something else that works for us" (Bustamante, et al., p. 161). These couples essentially

merge two individual cultural identities into one unique *couple identity,* or third culture (Bustamante et al., 2011; Kim, Prouty & Roberson, 2012).

With the help of clinical insight and interpretation by a professional therapist, couples can learn how their subjective experiences, internalizations, and socialized constructs play a role in their diverging relationship expectations (Hsu, 2001; Sullivan & Cottone, 2006; Waldman & Rubalcava, 2005). In addition, Bustamante et al. (2011) recommend that psychotherapists hold equal standards of increasing their own psychological and cultural awareness while identifying their own worldview and potential biases. Becoming aware of their own biases can help professionals develop cultural competence, mindfulness of their reactions and expectations of the couple, and appreciation for the influence and importance of culture without minimizing it's relevance in the couples they treat (Bustamante et al., 2011). Therapy with intercultural couples requires empathy, curiosity, and nonjudgmental attitudes towards each individual's cultural experience. By modeling these behaviors, the therapist creates an atmosphere conducive to positive change.

**Overview of Integrative Behavioral Couple Therapy (IBCT)**

Helping couples identify, understand, and accept differences is an important element in working with intercultural couples (Waldman & Rubalcava, 2005) and is an essential, foundational component of IBCT. Developed by Andrew Christensen and Neil Jacobson, IBCT is a third-wave behavioral therapy for couples. IBCT places a primary emphasis on acceptance, which paradoxically leads to change. This newfound perspective of acceptance was inspired by exposure to meditation, acceptance, religion, and philosophy of Eastern cultures, which is in direct contrast to Western notions of "changing the things that upset you" (Jacobson & Christensen, 1996, pp. xiii). A secondary focus is on behavior change, as indicated by the

empirically supported treatment model of Traditional Behavioral Couple Therapy (TBCT). Change-focused methods directly promote positive behaviors and decrease negative behaviors through behavior exchange, and by teaching problem solving and communication skills (Doss, Thum, Sevier, Atkins & Christensen, 2005). Combined with these effective strategies for achieving rapid behavioral change early in treatment in TBCT, the integrative model enhances these methods by simultaneously promoting emotional acceptance. Specifically, attention is given to emotional reactions and experiences that individuals encounter in response to their differences, as opposed to solely finding solutions to changing them. Due to the fact that some cultural factors are stagnant and insoluble, IBCT could be especially helpful with intercultural couples that face stress related to cultural differences (Christensen, Atkins, Berns, Wheeler, Baucom, & Simpson, 2004). It is important to note that these differences are not ignored or merely tolerated with resignation, but used to foster greater understanding, intimacy, and emotional connectedness through interventions such as unified detachment and empathic joining (Jacobson et al., 2000).

One of the ways to foster greater understanding in IBCT is through the DEEP formulation of the problem. In this approach, therapists describe a couple's relationship distress as a combination of four factors that contribute to and exacerbate relationship distress. DEEP is an acronym that describes these factors, which include Differences, Emotional Sensitivities, External Stressors, and Patterns of Interaction (Christensen, Doss, & Jacobson, 2014). Differences or incompatibilities between partners may include their needs for social interaction, sexual interests, beliefs, desires for closeness, or parenting styles that result from individuals' genes, histories, social learning, cultures, or socio-economic statuses. Emotional sensitivities of individuals, particularly in regards to the differences between partners, may result from prior

situations/experiences (e.g., trauma), or strong emotions (e.g., fears) based in cultural views or social learning. External stressors or circumstances describe stressors outside of the couple that impact the relationship and may include children, finances, medical conditions, extended family members and/or social groups. Lastly, Patterns of problematic interactions describe the communication style of the couple that is dysfunctional and often include moving away and/or against one another. For instance, partners who move away from one another might withdraw, escape, avoid, or shut down while partners who communicate against one another might criticize, blame, demand, exaggerate or escalate arguments. This formulation, which is provided to the couple in a joint feedback session following initial assessment (i.e., one joint session, two individual sessions) is useful in facilitating acceptance by helping couples understand how their differences are normal and that their incompatibilities are mutually created. Furthermore, it highlights how partners' problematic interactions are attempts to resolve their differences and can lead to traps that become *irreconcilable* (Christensen, et al., 2014).

Following formulation of the problem, IBCT interventions are implemented. To facilitate empathic joining, a core strategy used in this model, IBCT therapists draw on each partner's expressed vulnerable feelings underlying the problem, and then seek to help the couple elaborate on those emotions by modeling empathy for having valid and understandable reactions. Utilizing this with *both* partners, the objective is to encourage empathy between them in order to facilitate joining in place of blame (Christensen et al., 2004). A second important strategy used to promote emotional acceptance is to elicit a unified detachment from the problem—that is, both partners step away from the problem and use dialogue to *describe* the problem rather than evaluating it and using judgment. Through this perspective, the therapist aims to help the couple detach from emotionally escalating talk and view the problem objectively with insight into specific triggers

and variations of their behaviors. Lastly, tolerance-building strategies are used as a stepping-stone towards acceptance. Christensen et al. (2004) describe tolerance as the engagement of the couple in discovering some of the positive functions of their differences. One tolerance intervention, for example, can include identification of positive features of aversive behaviors. These are often behaviors or characteristics that initially attracted partners to one another, but later served negative functions (e.g., a female partner may have initially been attracted to her husband's drive, motivation, and work ethic, but later resents all the time he spends working). Other tolerance building interventions include exposure techniques, such as role-playing negative behaviors, and teaching partners self-care strategies. Thereafter, couples can discover the ways in which those differences can serve a positive function. This strategy encourages insight and problem solving by the couple in order to facilitate more emotional detachment from the problem. In this way, couples don't take their partner's behavioral patterns personally, an attitude that ultimately elicits fewer expectations for change (Christensen et al., 2004).

Preliminary data on IBCT by Jacobson et al. (2000) was collected on 21 couples requesting therapy for marital distress. Each couple was randomly assigned to either TBCT or IBCT and all received between 13 and 26 sessions. The results of the study indicated that both husbands and wives experienced greater improvements in their satisfaction following IBCT than they did following TBCT. While they found that IBCT produced as much, if not more, change than TBCT, the preliminary research indicated the need to determine long-term effects of the treatment.

Since the preliminary IBCT research results of the 21 couples, Christensen et al. (2004) expanded their study to include over 100 married couples that were seriously and chronically distressed. Their levels of distress were indicated on three measures of marital satisfaction

completed at different points prior to random assignment and treatment. To be included in the study, participants had to be legally married, living together, fluent in English, and both spouses had to be between 18 and 65 years old. Additionally, couples were required to meet criteria for scores on measures of distress. Exclusion criteria determined by the researchers included disorders of substance abuse/dependence and severe mental illnesses such as schizophrenia and bipolar disorder, as well as disorders of borderline, schizotypal, or antisocial personality, as assessed in diagnostic interviews. Additionally, couples were required not to be in psychotherapy during marital treatment to avoid confounding therapy results. Results of the study found that IBCT produced steady improvement throughout therapy, whereas TBCT produced rapid improvement followed by plateau or decline of satisfaction (Christensen et al., 2004).

In a later study comparing the mechanisms of change early in treatment and later in treatment between couples engaged in TBCT or IBCT, researchers found that emotional acceptance of behaviors might be crucial to improvements in relationship satisfaction (Doss et al., 2005). Even when undesirable behaviors relapsed in the second half of treatment for couples in the IBCT condition, IBCT promoted acceptance that was significantly related to relationship satisfaction later in treatment (Doss et al., 2005).

**Critique and Need for Further Study: Implications for IBCT with Intercultural Couples**

It is possible that IBCT is particularly well suited for working with intercultural couples (Sevier & Yi, 2008). Because it is modified to make each couple's experience meaningful by way of thorough assessment and collaboration, it relies on the expectation that each couple is unique. This third-wave, behavioral approach is based on understanding and acceptance. As a foundation, acceptance involves appreciation of unique cultural experiences between and within couples. For intercultural couples seeking therapy due to their cultural differences, IBCT seeks to

use those differences as a catalyst in cultivating acceptance and change (Sevier & Yi, 2008). Because IBCT was established on acceptance and embraces a broad range of differences, it should be effective with couples navigating different cultural backgrounds (Sevier & Yi, 2008). Consequently, for couples who struggle with differences in their cultural values or behaviors related to cultural factors, acceptance might foster enduring, long-term relationship satisfaction whereas the sole use of behavioral change mechanisms might develop immediate, yet temporary positive interactions.

Although there is strong evidence for the effectiveness of IBCT, it would be helpful to know how it works specifically with intercultural couples. Although there are case descriptions of IBCT in the literature (Christensen, Wheeler, & Jacobson, 2008; Eldridge, Christensen, & Jacobson, 1999; Schachter, 2015), they do not address cultural differences between partners. One recent case study (Mahgerefteh, 2015) does provide detailed examples of how a therapist used specific IBCT interventions, such as unified detachment and empathic joining, to help a couple navigate a cultural difference between them. In that study, one partner self-identified as culturally Jewish while the other did not, and their communication differences were based, in part, on this cultural difference. Aside from the descriptions of how that therapist worked with that specific couple, it is unclear how therapists can effectively use IBCT to help intercultural couples navigate their cultural differences.

**Focus and Scope of Study**

The purpose of this research is to contribute to the literature on Integrative Behavioral Couple Therapy and the literature on intercultural couples by providing rich case-based descriptions of how therapists use IBCT with intercultural couples, and to provide recommendations for treatment of intercultural couples. This objective is achieved through an

explorative and qualitative approach. Given the diversity in cultural differences that could become problematic for couples, this study did not have a priori categories of intercultural couples. Rather, couple therapists were allowed to describe couples who met their own criteria of "intercultural" and provide detailed descriptions of how specific IBCT interventions were used to bring about change and acceptance in those problematic areas. Lastly, participating therapists' perspectives on the utility of specific IBCT techniques with intercultural conflicts were gathered. Four research objectives in this study guided the information gathered from participant therapists: (a) the culture specific differences of the selected intercultural couples they treated and how they used IBCT interventions in treatment, (b) how their selected couple changed in IBCT, (c) their impressions using IBCT with intercultural couples, and (d) recommendations for using IBCT with intercultural couples, and working with intercultural couples in general. Taken as a whole, this study represents an attempt to discover and describe specific therapy factors that contribute to relationship satisfaction with intercultural couples through the lens of IBCT practitioners, and will conclude with relevant clinical recommendations.

## Chapter II: Methodology

### General Project Approach and Methods

To qualitatively examine therapists' experiences using IBCT with intercultural couples, a multiple case study design (Baxter & Jack, 2008) was utilized to gather data on the experiences of therapists who have been trained in Integrative Behavioral Couple Therapy.

Case studies are the preferred research design when *how* and *why* questions are posed (Yin, 2014), which is in line with the purpose of this study describing how therapists use IBCT with intercultural couples. Because this research project sought thick descriptions of multiple cases in order to draw cross-case conclusions, a multiple case study design was chosen (Yin, 2014). In a multiple case study design, the research aims not only to provide rich descriptions as conducted in an individual case study design (e.g., exploratory, explanatory, or descriptive), but also to explore differences and similarities between carefully selected cases for the purpose of developing findings across contexts. Of significance to multiple case studies is that they allow researchers to make predictions about the impact of context, which differs between cases (Baxter & Jack, 2008). In this study, contextual differences included treatment settings, therapists, number of treatment sessions, and intercultural variations of the couples between cases. The constant and specific phenomenon of this study is the use of IBCT with intercultural couples. Also, because this study may have limited transferability as it aimed to understand *unique situations* (i.e., intercultural couples that represent a unique population), then this particular study presents an *intrinsic* interest across multiple cases (Stake, 1995).

Following methodological recommendations for conducting multiple case studies (Baxter & Jack, 2008; Stake, 1995; Yin, 2004), the current study aimed to develop rich descriptions of how therapists use IBCT with intercultural couples. In addition, this multiple case study design

closely examines participant responses about specific cases to uncover similarities and differences across therapists in the use of IBCT with intercultural couples. This particular study also summarizes therapists' recommendations for working with intercultural couples.

**Participants**

Criteria used in recruitment of therapists required therapists to (a) be licensed clinical psychologists, (b) have been practicing IBCT for at least 5 years, and (c) have experience utilizing IBCT with an intercultural couple(s). Demographics of each participating therapist was gathered, including type of licensure, years in practice, couple therapy practice setting, and preferred psychotherapy orientation. Participants for the proposed study were recruited from the Integrative Behavioral Couple Therapy website provided by the University of California, Los Angeles ("Therapists," n.d.). The website provides a list of therapists who have been trained in IBCT through didactic instruction and supervision by an IBCT trained supervisor. These supervisors observed their work in couple therapy via video or audio recording, and provided regular feedback. Many of the therapists have been trained directly under the supervision of Dr. Andrew Christensen, either as graduate students, as therapists on the clinical trial comparing IBCT and TBCT, or in a Veterans Affairs setting as IBCT is being disseminated throughout that system. Therefore, a convenience sample of therapists nationwide who are listed on the website was used for recruitment.

In this qualitative study, the goal was to obtain an in-depth understanding of therapists' experience using IBCT with intercultural couples. As such, this study was discovery-oriented, as its aims were to learn more about IBCT and to answer questions that can provide recommendations for treatment (Mahrer & Boulet, 1999). Research on qualitative methodology suggests that the question of *how many* participants is more suitable to quantitative purposes

(Englander, 2012). However, Giorgi (2009) recommends at least three and anywhere between five to twenty participants, while keeping in mind that research based on depth of the content should not be confused with quantitative research that is based on sampling strategies.

Specifically for multiple case study design, researchers indicate that there is no simple answer to the question of how many cases are specifically recommended; some indicate that *no* minimum number is recommended (Rowley, 2002; Stake, 1995; Tellis, 1997). While the single case study may focus on or employ a single unit of analysis, or multiple units of analysis within a single case, a multiple case study focuses on comparisons between selected cases and often follows a "replication logic" (Yin, 2014, p. 174; Zucker, 2009). While the number of cases is not emphasized, "cases need to be carefully selected so that they either produce similar results (literal replication), or produce contrasting results but for predictable reasons (theoretical replication)" (Rowley, 2002, pp. 21-22). Typically, Rowley (2002) indicates that six to ten cases might be used to achieve replications that predict strong evidence for the initial set of propositions (i.e., research speculations/hypotheses).

However, because this study does not indicate propositions, replication of participant therapists' responses is not required. Instead, this study answers research questions from a discovery-oriented and exploratory perspective without any preconceived notions or interest in the development/support of a theory. Because the study sought to achieve cross-case conclusions, this researcher focused on the conclusions presented within each case rather than on obtaining saturation. In sum, the number of cases depends on the nature of the research. Because multiple case studies do not *require* propositions, and because this study does not incorporate the use of propositions that typically use 6-10 cases, fewer cases were anticipated based on the discovery-oriented and exploratory nature of this study.

To provide the rich descriptions of cultural differences, IBCT interventions, and perspectives on IBCT's utility with intercultural couples, the use of three participants was anticipated in advance. A total of three participants were deemed sufficient given the recommendations in the qualitative methodology literature, the general scope and guidelines of this project, and practical considerations. Despite a large pool, the selection criteria eliminated many therapists and it was anticipated that many would decline or not call back at all. Additionally, the eligible participants were asked to complete a lengthy and detailed set of questions, which took considerable time to complete thoughtfully. Out of 79 therapists contacted, 6 therapists responded, met inclusion criteria, and agreed to participate. Of these, 4 returned their responses to the researcher within a time frame of 3 to 16 weeks, depending on the participant. Three of these 4 participants contributed usable data for this project that met the required criteria.

These 3 therapists were licensed clinical psychologists, one of whom was a former graduate student of Andrew Christensen and as part of graduate work was trained in Integrative Behavioral Couple Therapy, and two of whom were trained in Integrative Behavioral Couple Therapy but also served as consultants through the VA training program, helping to train VA therapists in IBCT. Part of the demographic data collection also asked the therapist participants to identify their own cultural background in order to acknowledge cultural differences between participating therapists and the couples they treated. The first participant (Case Study 1) was trained in IBCT, and also served as a consultant through the VA training program, helping to train VA therapists in IBCT. He identifies as a 40 year-old, Caucasian, Catholic male who was born and raised in the United States and is of Greek/Slovakian heritage. He reported primarily speaking English in his home growing up, but identified the most salient aspect of his cultural identity as Greek with a strong value in family connection and interdependence. The second

participant (Case Study 2) was also trained in IBCT and served as a consultant through the VA training program, helping to train VA therapists in IBCT. She identifies as a 40 year-old, Caucasian female who was born and raised in the United States and primarily spoke English in her home. She reported being raised in a collectivistic family in rural, southern United States and that a salient aspect of her cultural identity was the emphasis on family and collectivism. Specifically, that the needs and goals of her family were equally important to her own needs. Lastly, the third participant (Case Study 3) was trained in IBCT and provides home-based primary care through the VA. She also uses IBCT with couples in her private practice. She identifies as a 43-year old Caucasian female who was born and raised in the United States and that a salient aspect of her cultural identity is growing up in a bicultural family. She indicated that she is influenced by Midwestern, American culture, Unitarian Universalist beliefs, as well as being a mother and wife to her Central American husband and children. Table 1 presents the professional and demographic information of the selected therapist participants.

**Procedures and Measures**

Prior to participation, the researcher called therapists at the numbers provided on the IBCT website to introduce herself and the study (Appendix A). Therapists who did not answer the call received a voice message. Therapists who showed interest in participation were asked for their email addresses in order to send information packets. The information packets included an information sheet (Appendix B) and a screening measure to determine qualification and achievement of inclusion criteria (Appendix C). Upon receiving completed screening measures, the researcher emailed each therapist to indicate whether his/her participation was requested (Appendix D) and if qualified to participate, the researcher provided a questionnaire document (Appendix E).

Table 1

*Therapist Participant Demographics*

| Therapist | Age | Gender | National Origin, Ethnicity, Primary Language | Religion | Salient Cultural Identity | License Type, Years in Practice | Preferred Orientation and Couple Therapy Practice Setting |
|---|---|---|---|---|---|---|---|
| 1 | 40-45 | Male | USA, Greek-Slovak, Caucasian, American English | Catholic | Greek, family connection, and inter-dependence | 5-10 years, Ph.D. | Behavioral Systems<br>Couple therapy practiced in VA medical center and private practice |
| 2 | 40-45 | Female | Southern USA, Caucasian, American English | Protestant | Collectivistic, needs of the family prioritized over needs of the individual | 5-10 years, Ph.D. | CBT with integration of other theoretical frameworks for individual. Integration of family systems with families.<br>Couple therapy practiced in VA medical center, outpatient clinic |
| 3 | 40-45 | Female | USA, Caucasian/ Anglo, English and Spanish | Unitarian Universalist | Midwestern, White female and mother; being part of a bicultural family | 5-10 years, Ph.D. | Cognitive Behavioral Therapy<br>Home Based Primary Care through VA and private practice |

To qualitatively examine therapists' experiences utilizing IBCT with intercultural couples, data were gathered through a questionnaire administered to selected participants. The questionnaire asks therapists to consider one specific case working with an intercultural couple. Questions are open-ended and pertain to specific cultural differences that caused stressors in the relationship, asking how the therapist formulated the couple's conflicts as culturally rooted, and how the therapist used IBCT interventions with the couple. Additionally, participants were asked

for their IBCT conceptualizations of their intercultural couples through the DEEP formulation approach (e.g., Differences, Emotional Sensitivities, External Stressors, Patterns of Interaction). Therapists were also asked to reflect on what they could have done differently that could inform recommendations for conducting therapy with intercultural couples, and describe their impressions about using this approach with intercultural couples. When participants did not electronically return the questionnaire after 2 weeks, the researcher contacted them via email to see if they had any questions or needed clarification of any items (Appendix F). On a few occasions, the researcher contacted participants for clarification of responses after they completed the questionnaire (Appendix F).

Data analysis began following the second submission and continued through the last submission. Rather than coding procedures indicated by traditional qualitative methods, analysis of this data involved a cross-case synthesis for similarities and differences between responses to research questions. This required aggregating findings across individual cases and maintaining process notes. These notes included procedural information such as the date of each submission, and notes taken by the researcher (e.g., reactions, thoughts, feelings, questions for clarification, observations of similarities and differences across cases, potential quotes and summary ideas for use in presenting results). These notes not only aided in the qualitative analysis, but also allowed for accuracy of therapists' intended statements and impressions. Within each research objective, summaries of therapists' responses to questionnaire items (pertaining to that research objective) are reported and followed by specific quotations that demonstrate main ideas, and particularly poignant or useful information. Finally, similarities and differences across the cases are summarized, again through an examination of participants' responses, and highlight conclusions and general findings.

Although this research also searched for themes (i.e., differences and similarities within and between cases) to develop recommendations for future clinicians, re-occurring processes (i.e., replication) in the responses were not broken down into discrete ideas as implicated in open coding strategies of other qualitative methodologies, such as content analysis (Strauss & Corbin, 1998). Rather, the goal of this multiple case study design was to explore and describe each individual case (similar to individual case studies), and to understand similarities and differences between cases in order to provide a thick description of therapists' experiences (Baxter & Jack, 2008).

## Chapter III: Results

Participating therapists provided demographic information on their selected couple, followed by an IBCT conceptualization of the couple according to the DEEP formulation approach (e.g., Differences, Emotional Sensitivities, External Stressors, Patterns of Interaction). Table 2 illustrates demographic information of each therapist participant's selected couple, and Table 3 illustrates each therapist participant's IBCT conceptualization of their selected couple.

Table 2

*Selected Couples' Demographics*

| Case | Partner | Age<br>Gender | Education<br>Occupation | Ethnicity<br>Religion | National origin (country of birth or ancestors)/ Where raised (country, region, urban/rural) | Language(s) spoken in home currently/ Language(s) spoken in home growing up | Cultural self-identification and other cultural details |
|---|---|---|---|---|---|---|---|
| 1 | 1 | 50s<br>Male | BA<br>On disability | Caucasian;<br>Christian (non-denominational) | USA;<br>Rural | English;<br>English | White |
| | 2 | 50s<br>Female | BA<br>Sales Rep | African American;<br>Christian (non-denominational) | USA;<br>Rural | English;<br>English | Raised in rural, predominantly white town, experienced overt racism frequently |
| 2 | 1 | 20s<br>Male | BA<br>Healthcare clinician | Caucasian;<br>Agnostic | Unknown to therapist;<br>Urban | English;<br>English | White |
| | 2 | 20s<br>Female | BA<br>Nurse | Hispanic; Catholic | USA, Puerto Rico; Urban | English;<br>English and Spanish | First generation American; Hispanic-American |
| 3 | 1 | 60s<br>Male | 2 years college;<br>Veteran with disabilities | Latino;<br>Fundamentalist Christian | USA, parents Mexican;<br>Northwest USA | English;<br>English and Spanish | Considers himself Latino, felt very separate from Anglos growing up. |

(continued)

| Case | Partner | Age<br>Gender | Education<br>Occupation | Ethnicity<br>Religion | National origin (country of birth or ancestors)/ Where raised (country, region, urban/rural) | Language(s) spoken in home currently/ Language(s) spoken in home growing up | Cultural self-identification and other cultural details |
|---|---|---|---|---|---|---|---|
| | 2 | 60s<br>Female | High School;<br>Caregiver | Caucasian;<br>Fundamentalist Christian | USA;<br>Rural, Southern USA | English;<br>English | White; her identity as a Christian is very important to her, especially as it relates to her role as a wife. |

*Note*. Length and Status of Relationship at the time of therapy:
Case 1: Married 3 years; 2nd marriage for both; both partners have adult children from previous relationships.
Case 2: Together 3 years. Dating when presented for therapy. Engaged and then broke off engagement while taking a break from therapy. Returned to therapy when reunited and were married while involved in therapy for the second time. No children.
Case 3: Married for 5 years; adult children from previous marriages who no longer live in the home.

Table 3

*DEEP Formulations*

| Case | Differences | Emotional Sensitivities | External Stressors | Pattern of Interaction |
|---|---|---|---|---|
| 1 | Female partner has a stronger need for closeness than male partner; Each partner endorsed a different experience with racism. | Male partner was in construction and strongly identified with being productive; since becoming unemployed, he is more reactive to anything that triggers his sense that he is "useless."<br><br>Female partner felt lonely growing up in a large family and although she wanted to feel "special," she didn't have much of an opportunity. Now she is more reactive to triggers that give her the message that she isn't special and feels resentful and lonely. | Male partner is unemployed and on disability for an injury; some of their family does not support their relationship. | Mutual withdrawal. |

(continued)

| Case | Differences | Emotional Sensitivities | External Stressors | Pattern of Interaction |
|---|---|---|---|---|
| 2 | Male independent since adolescence; he highly values independence and believes it makes him more mature.<br><br>Female comes from a highly involved family with a collective cultural background. She values family interaction and her mother and siblings are involved in many of her bigger life decisions. | Male struggles with PTSD post combat; he lost close friends in battle. He copes by avoiding emotions and following a strict set of rules. He exhibits angry outbursts that are difficult to predict. Maintaining control is more important than close relationships.<br><br>Female has a history of being put down and devalued by people close to her and has an anxious coping style. She feels most comfortable when she is able to organize, plan or control situations she is in. | Male is engaged in treatment for PTSD.<br><br>Female's siblings are vocal in their lack of support for their relationship. | When Male is triggered or otherwise unable to suppress emotional arousal (feeling out of control), or when female attempts to initiate plans (make decisions) he compensates by engaging in loud verbal authoritative lectures. They both engage initially, then Female disengages and Male feels worse as his need to resolve the issue (maintain control of situation) is unmet. |
| 3 | Three specific differences were identified and reported by partners over the course of therapy. Therapist indicated that jealousy and insecurity between partners was salient. Secondly, partners reported differences regarding their religious practices and beliefs. Lastly, partners presented with differences in financial management. | Religion was a sensitive topic for the male veteran due to his belief that his previous wife divorced him because he was not religious enough.<br><br>Financial insecurity was a sensitive issue for the female partner because her previous relationship involved financial abuse. It also presented as a sensitive issue for the male partner who, as a consequence of a mental illness, was unable to manage finances. | Male struggled with a medical condition, which became problematic in the marriage as it contributed to differences, such that his wife had to drive him and manage finances (led to feelings of jealousy and insecurity). This couple also experienced conflict around their children from previous marriages (e.g., "his kids/her kids problems"). | High risk for physical violence. When differences surfaced, each party would become defensive and the situation would escalate to yelling, abusive language, and sometimes shoving. |

## Case Study 1

**Objective 1: Culture-specific differences between selected intercultural couple, and IBCT interventions utilized.** This first intercultural couple initially sought therapy due to "emotional distance, feeling disconnected from one another, as well as low emotional and sexual intimacy." Some of the most central and problematic cultural differences experienced by the couple (e.g., culture-related stressors) described by the participating therapist included racism

endorsed by the female partner. Specifically, as an African American sales representative, the female partner often made visits to businesses in predominately poor, white, rural counties where she encountered racism. Meanwhile, her spouse, who identifies as White, argued that she often "misinterpreted communication" with others, which made her "too sensitive." While her partner viewed her as sensitive in general, she argued that her experience with racism might have sensitized her to noticing it more. As a result, the female partner felt misunderstood and "hurt." Furthermore, because the male partner felt helpless and guilty about his unemployment, this prompted him to try to help "solve" the problems *she* experienced at work around race; however, because he believed that her problems at work stem from her own perception (i.e., internalized, micro-level racism), rather than actual, institutionalized, macro-level racism, he followed with the assumption that they are solvable by her. From the female partner's perspective, her experiences at work were not due to her perception and are not solvable by her; rather, she wanted him to understand her, especially because he has not experienced racism himself. Discussion in therapy, therefore, often related to her experiences with racism and the couple's attempt to navigate around this central issue. As a consequence of not understanding one another's cultural differences, which include their unique experiences of others and their environment, this couple experienced marital discord.

Thus, this couple did not initially present to therapy having already identified a key cultural difference as a source of conflict, but reported "feeling disconnected from one another." The participating therapist formulated their conflicts as culturally rooted as this understanding emerged over the course of therapy and as the therapist identified the female partner's emotional reaction to racism as opportunities for this emotionally distant couple to develop intimacy.

Therapist 1 reported that upon identifying this culturally rooted stressor, he began to talk about culture directly as influencing their interactions around this issue. Specific IBCT interventions utilized included empathic joining and unified detachment, with a greater emphasis on empathic joining. The therapist indicated that identifying moments when the female partner notices her need for understanding, but does not express this need, has been especially successful for the couple. As a result, the male partner has remarked that he feels angry about how she is treated at work as well as helpless. Her understanding of how difficult helplessness is for him has allowed her to be more open about asking for what she needs, which is just for her partner to express empathy. The participating therapist indicated, "he is continuing to learn how to do this and they are becoming closer." Regarding unified detachment, the therapist stated:

> We have developed a metaphor for their mutual avoidance … "building a wall" … and how each interaction they have in which they decide to not talk, or avoid a significant issue, is another "brick." This has allowed them to identify a wide range of behaviors that are "bricks." They have both acknowledged how their avoidance maintains their problem and deepens the divide.

Acknowledging their avoidance behaviors that resulted from cultural misunderstanding as a major problem, the couple was able to unify and detach from this problem together and work toward a mutual therapeutic goal.

**Objective 2: How the selected intercultural couple changed in IBCT.** Regarding change processes observed in the couple, such as shifts that occurred in their interaction patterns during therapy, this therapist observed the female partner "soften" as she began to understand her partner's behavior as prompted by helplessness rather than not caring. This has allowed her to be

more open about the vulnerable feelings she experiences, which has allowed him to move toward her more and create a better connection. As stated in one questionnaire item by the participant: "She became tearful in session last week and he responded by moving his chair toward her and telling her how much he loves her, which he hasn't said in over a year."

The therapist identified this particular session as a major breakthrough and turning point in treatment. The male partner was able to identify and express helplessness and the female partner was able to express her fear for the first time. Specifically, she expressed fear that she was going to lose him, as well as her fear that he really didn't care about her.

Other shifts that occurred in therapy pertaining to acceptance and behavior change included the male partner recognizing that her discussions about work are bids to connect rather than requesting solutions. Also, the male partner recognized that avoiding his spouse served a function of avoiding the experience of helplessness. As a result, he is identifying and expressing soft emotions more directly with her and is also asking her about her day more. The female partner has learned to recognize, through acceptance, that her partner's behavior was prompted by helplessness rather than not caring about her. As a result, she became more aware of what she needs from him and began talking more about her workday without fear.

**Objective 3: Therapist's impressions using IBCT with the selected intercultural couple versus other couples.** Using IBCT with other couples who may not present with culturally-rooted discord, this therapist reported having a similar degree of curiosity in their past experiences, which inform IBCT interventions and other techniques. *Specific* ways in which cultural differences informed interventions and techniques were not reported. With this selected couple in mind, however, Therapist 1 highlighted one *general* difference in his approach to IBCT, which pertained to cultural considerations in therapy. He stated:

> I see another couple… both partners are Caucasian, and race and cultural experiences are not a primary issue; however, the pattern of interaction is the same as the couple above. I'm not sure there are many differences in the application of IBCT, other than for me to express more curiosity of her experiences with racism and be mindful as a Caucasian male therapist that I, like her husband, haven't had experiences with racism, which I openly acknowledged with her. I think that helped me avoid a split alliance.

To avoid the split alliance, the therapist engaged the couple in an open dialogue regarding the cultural differences between them as a couple and the participant as a clinician. Overall, he reported that IBCT is "an outstanding intervention" and is "perfect for intercultural couples" because of the way in which acceptance interventions are applied. He highlighted that in his clinical experience, he has not yet heard of another couple therapy modality that directly addresses culturally rooted differences in the same way as IBCT.

**Objective 4: Therapist's recommendations.** This therapist indicated that he would not have done anything differently in treating the selected couple because engaging in conversation regarding cultural differences during the couple's feedback session was beneficial for treatment. As such, particular recommendations pertained to the techniques that this clinician finds most productive in treating an intercultural couple. Regarding intercultural differences and the potential contributions to marital discord:

> Make sure that it's at least discussed with the couple during the feedback session even if you don't think it's contributing to their presenting pattern of interaction. This, I think, will make interventions around cultural factors more effective down the line… Related to this, I wouldn't automatically assume that cultural differences are contributing to their presenting pattern… it may not always be the case.

Furthermore, the participating therapist indicated that empathic joining and unified detachment are particular IBCT interventions best suited for intercultural couples. He explained that because the purpose of these interventions is to change the meaning of partner behavior, understanding their partner behavior from a cultural lens could help build more flexibility in their reactions to one another. In general, for clinicians who are interested in using IBCT with intercultural couples, Therapist 1 recommended that clinicians always ask partners about their cultural experiences, beliefs, and identification as these can be "powerful components of the conceptualization." In addition, it is recommended that the clinician be aware of his/her own cultural beliefs regarding family structure and functioning as this might also impact conceptualization of the intercultural couple, whether using IBCT or any other couple therapy modality.

**Case Study 2**

**Objective 1: Culture-specific differences between selected intercultural couple, and IBCT interventions utilized.** The second intercultural couple sought therapy because "they were experiencing significant discord and did not have the tools to navigate their difficulties successfully." They were somewhat inexperienced, as described by Therapist 2. Specifically, they did not use effective communication skills and as this therapist stated, "they had not fully committed to their identity as a couple (in addition to their identities as individuals)."

Some of the most central and problematic differences were in regards to involvement of their families. The female frequently consulted with her family members when making personal decisions. Additionally, she valued spending time with her family, even though time spent with her family wasn't always a positive experience for her. Therapist 2 described the male partner as more independent, as he moved out of his home as a teen, but continued to have regular contact

with his parents. As a result of his early autonomy, he became frustrated with his partner because he wanted her to be more individuated from her family members like he was. He also wanted her to speak out against family members who he felt were treating her poorly.

Although this couple did not present to therapy reporting conflict that was rooted in their cultural differences, Therapist 2 reported that the couple tended to talk about their background in terms of how they were raised. Without prompting from their therapist, the couple also spoke about how their histories with their families influenced how they think and feel, which pointed to cultural differences. Furthermore, Therapist 2 indicated that it was often clear when the female's cultural values, such as spending time with family or including family in decision-making, were primary or secondary factors.

> Occasionally, when culture was particularly salient, the couple and I discussed ways the female's family beliefs, values, and behaviors are consistent with their culture and how that differs from the male's values… and sometimes how the cultural values differed from the female's personal values and how she dealt with that conflict.

Therapist 2 utilized all IBCT interventions over the course of treatment, including behavior change, such as communication skills training. This therapist reported that it was important for the couple to gain these skills in order to progress in treatment because they were unable to move forward otherwise. Therapist 2 helped the partners explain their perspectives and accomplished active listening by encouraging them to reflect what they heard their partner say before uncovering underlying emotions. Thereafter, empathic joining focused on helping the partners utilize active listening to reflect softer underlying feelings expressed by one another. Through unified detachment, Therapist 2 engaged the couple in a discussion of recent problematic interactions in a play-by-play manner. She had each partner speak for him/herself

when describing his/her own behaviors, thoughts, and feelings rather than having each partner speak about the other partner's problematic behaviors. In this regard, unified detachment from the problem arose as each person shifted from speaking about the problem they see in their partner to their own individual experiences. As such, the problem became how to manage and tolerate behaviors, thoughts and/ feelings. Lastly, tolerance-building interventions were implemented, such that Therapist 2 assigned each partner during sessions to "rehearse" the behaviors that were unwanted by their partner. The goal of "role-playing negative behaviors" as an IBCT tolerance-building technique was to see the impact that each person's behaviors had on their partner. In other words, this therapist had the couple purposely engage in unwanted behaviors during moments when they were not naturally inclined to actually behave that way (e.g., no particular triggering situation; they simply "pretended" during the session), with the intent of more objectively observing how the unwanted behavior affects the other.

"This exercise had an immediate impact on the male in this relationship who could see how the female reacted even when she knew he was just pretending to be upset. This exercise also resulted in the female reducing some of her behaviors that were bothersome to the male."

**Objective 2: How the selected intercultural couple changed in IBCT.** Change processes that occurred in the couple's interaction patterns over the course of treatment included changes in the forms and patterns of dialogue and communication between the partners. Therapist 2 reported that the most salient changes occurred very gradually across the course of therapy.

> At the beginning of therapy, this couple was 100% talk and 0% listen. Emotionally laden communication that was very loud was the norm in and out of session. To address this, I

had to frequently interrupt the male to allow for opportunities to process what had been said.

And although productive and reciprocal dialogue began to develop as therapy progressed, Therapist 2 highlighted that it required frequent interruption, direction, and redirection to reflect what one partner said before prompting the other partner to speak. She reported that it felt much like being a "conductor," stopping and then starting communication. Emitting empathy and demonstrating listening helped the couple soften and build more trust mid-therapy. By the end of therapy, Therapist 2 indicated that the couple shifted from better understanding themselves, to understanding their partner. Specifically, each partner learned the other's sensitivities and behaviors. They also were better able to express vulnerable emotions once they became aware of them. Most notably, "they listened as much as they spoke."

While these gradual changes were observed over the course of treatment, major breakthroughs in treatment occurred as well. For instance, Therapist 2 reported that breaking off their engagement early in therapy set the relationship back; however, reuniting afterward served as a turning point for them.

> Up to this point they had been acting as individuals who like the idea of being in a relationship and were thrown into the party-planning aspects of marriage more than the coming-together aspects. When they reunited a few months after they broke off the engagement, they were committed to finding out what was important to them as a couple (vs. individuals or what their family or society valued).

Thereafter, Therapist 2 noticed shifts in change mechanisms. Specifically, each partner was observed to have made behavior changes upon moving toward acceptance. When the female partner developed better listening skills and reduced the frequency of dismissive behavior when

she was upset with her partner (behavior change), she became more comfortable with some aspects of her partner's emotional responses (acceptance), such as understanding the underlying sensitivities behind some of his behaviors. When the male partner began to demonstrate better listening over time, improved his coping skills with PTSD, and reduced the intensity and frequency of emotional verbal expressions (behavior change), he became more sensitive to his partner's needs and showed more empathy and less judgment when she did not do things the same way he would (acceptance).

**Objective 3: Therapist's impressions using IBCT with the selected intercultural couples versus other couples.** In comparing the utility of IBCT with couples who struggle to navigate through culturally rooted stressors and other couples, who do not present with culturally rooted relationship discord, Therapist 2 reported some similarities and differences. Regarding application of IBCT interventions, similar techniques were employed with intercultural couples and other couples. However, Therapist 2 noted that the only difference unique to intercultural couples is the inclusion of cultural factors in the conceptualization of sensitivities. External factors related to cultural differences are also observed to contribute to discord in these couples. She noted that sometimes the differences, however, could be a catalyst to relationship success. Therapist 2 reported that, overall, IBCT is effective in treating intercultural couples who are struggling with culturally rooted differences that cause or exacerbate relationship dissatisfaction because "IBCT is a very flexible approach in which cultural factors can easily be considered. IBCT methods allow couples to develop a better understanding of the positive and negative impact of cultural background on relationship functioning."

**Objective 4: Therapist's recommendations.** This therapist indicated that she would not have done anything differently in treating the selected couple. As a result of successful treatment,

she provided recommendations for using IBCT with intercultural couples in general. In regards to the use of the IBCT formulation, Therapist 2 recommended that therapists consider the impact of cultural factors as variables that could be differences, emotional sensitivities or external stressors that impact relationship functioning. In other words, the differences between partners may be cultural in nature, emotional sensitivities may be guided by cultural views of emotional expression, and external stressors may be related to cultural variables like time with family and other obligations. Additionally, Therapist 2 suggested that therapists pay attention to how cultures contribute to partners' specific behaviors (e.g., how particular cultures might promote or normalize specific behaviors) and then consider the roles that those culturally adaptive behaviors play within the couple's pattern of interaction. No IBCT intervention seems more or less suited for intercultural couples, according to this therapist's experience. Rather, cultural considerations in general are encouraged. "Every couple you see will have cultural differences. Some just aren't as obvious. Even couples who look similar and come from similar backgrounds may have been raised with cultural differences that impact their relationship."

Overall, in working with intercultural couples from *any* theoretical approach, Therapist 2 cautioned clinicians against over or under pathologizing cultural factors, stating, "They are neither good, nor bad. They just are." Lastly, it is recommended that clinicians follow the couple's lead when considering cultural factors and that this could be facilitated by using their language when discussing culture.

**Case Study 3**

**Objective 1: Culture-specific differences between selected intercultural couple, and IBCT interventions utilized.** The third intercultural couple presented to therapy with jealousy and insecurity issues that led to domestic violence. Therapist 3 conducted a risk assessment at the

onset of treatment, and both partners were able to contract for safety in order to begin therapy. Specific differences between partners were related to religious beliefs and practices, money management, and social interaction. Although they attended the same church, the male partner felt that his wife was too dogmatic about her religion. Therapist 3 also identified gender role expectations as a culture specific difference. Specifically, financial management expectations reflected the cultural value that the husband should manage the money; however, because he was diagnosed with a mental illness (bipolar disorder), he did not always make good financial decisions. When the wife contradicted his poor financial decisions or asked for something she needed to purchase, her husband would become offended and insecure. The social interaction issue stemmed from a discussion around the male partner's jealousy of his wife speaking to other people, including men, after church services and then inviting them to the home. This jealousy was partly due to the fact that he was socially anxious, and in part due to his disability. These perceptions stemmed from his internalized experiences of ableism, both on a micro and macro level, which highlighted another culture-specific difference. Therapist 3 also explained how differences in social interaction were also culturally informed:

> If he saw her speak to another man, he would misconstrue the situation as being threatening, he would storm out or yell, and she would be embarrassed and confused. They finally realized that this difference was that the wife was more comfortable in social situations…. They also had a cultural difference in that she was raised in a Southern white family where socializing was a very important expectation and in his Mexican-American family, women mostly socialized with family members and it was not acceptable to talk with men other than your husband.

These were the most central and problematic differences. Although not reported by the couple to their therapist as a cultural difference, the understanding that their problems were rooted in cultural differences emerged as part of Therapist 3's formulation of their problems.

Upon discussion with the couple in therapy, they agreed that their differences were culturally rooted. As such, the concept of culture was used directly with this couple. The extent to which the issue was presented in therapy as being representative of each partner's cultural background surfaced as the couple spoke about their life experiences, as well as negative experiences in their previous marriages. For instance, as the male partner blamed religious differences for his previous divorce, he became aware that the problem was culturally rooted since it presented itself again in his current marriage.

Therapist 3 utilized all IBCT interventions over the course of treatment, including empathic joining, unified detachment, and tolerance building. She described techniques used for each intervention as follows: Empathic joining was accomplished by having each partner understand and then describe their partner's perspective on the problem. This was done by each partner reflecting exactly what they heard their partner share (e.g., thoughts and feelings). Then, this therapist encouraged partners to reflect on how they believed their partner might think or feel given their new understanding of their partner's description of the problem.

> I asked the veteran and wife to accurately reflect the other's perspective on the difference being addressed. I also asked each to use empathy to discuss how the other's sensitivities are affecting the present situation by asking questions like, "And why is this hard for (the other) to talk about / work on?"

Techniques that Therapist 3 used to target unified detachment from the problem incorporated the partners' involvement in formulating and continuously reflecting on the

problems as related to each of their individual differences. Therapist 3 regularly reminded each partner about the DEEP formulation as it related to each specific difference and asked them to relate each problem to the DEEP formulation, as well as their usual patterns. In that regard, the couple began to view the problem as a combination of differences, emotional sensitivities, external stressors, and patterns of interaction (some of which are rooted in cultural differences) rather than viewing the problem as a direct consequence of their partner.

To help the couple build tolerance to negative behaviors, Therapist 3 employed techniques such as encouraging self-care strategies. This included "time apart" for cooling down when their interactions became heated. This was essential given their hostile interaction style and history of physical violence (e.g., pushing, shoving). Self-care for this couple also entailed spending more time doing the things that they enjoyed as individuals as well as a couple. The goal was not to separate them through self-care activities, but to incorporate behaviors that they previously enjoyed together as a method to increase pleasure and increase their ability to withstand negative experiences without conflict. These activities were identified as both related and unrelated to their conflicts, such as going to church and enjoying leisure activities and hobbies.

**Objective 2: How the selected intercultural couple changed in IBCT.** Because this couple presented to therapy with hostility and difficulty with communication, the most salient shift that occurred in the couple's interaction patterns during therapy sessions was when they became more able to communicate to each other directly and less often through their therapist. Therapist 3 indicated that this change was especially meaningful because they began to use therapy more productively. They used therapy as a time to communicate their needs and their feelings rather than a time to criticize one another. As a result, change mechanisms (i.e., behavior

change and acceptance) were observed in each partner. While the male partner decreased aggression toward his wife, overspending, and threats to leave the relationship as a way to get his needs met (behavior change), his wife also decreased her aggression and overspending, while meeting her social interaction needs through other self-care activities. As a result, the male partner recognized and understood the process whereby his behavior, a shift in gender roles in the marriage, and his disability led to his feelings of insecurity, and how it impacted the relationship (acceptance). His wife also recognized how some problems (e.g., male's decreasing responsibilities and social anxiety) resulted from her husband's reaction to and difficulty coping with his disability as well as his expectations of gender roles due to his cultural upbringing (acceptance).

**Objective 3: Therapist's impressions using IBCT with the selected intercultural couples versus other couples.** Therapist 3 reported that her experience utilizing IBCT with this couple has been both similar to and different from her experience utilizing it with couples whose differences seem less related to cultural differences. Because discussions of how past relationships and childhood experiences affect reactions, beliefs, and behaviors in partners within all relationships, the use of all IBCT components (i.e., formulations of the problem, interventions and techniques) can be used similarly with all couples. Therapist 3 discussed that the ease in using IBCT with intercultural couples depends on partners' levels of comfort speaking about their cultures. She indicated that, in her experience, making the discussion around culture explicit is something that many mixed couples are not accustomed to doing. She also reported that using IBCT with intercultural couples could often be easier, especially if the differences are part of cultural aspects that partners were initially drawn to in each other. "Differences in culture are an

easy and fun way to demonstrate how differences can feel positive and negative, but in the end, are just differences and are parts of our identities that we can't change and wouldn't want to."

Therapist 3 also provided overall impressions. In her experience, IBCT is very effective in treating intercultural couples who are struggling with culturally rooted differences that cause (or exacerbate) relationship dissatisfaction. She highlighted that addressing the presence of cultural issues or problems rooted in cultural differences might add complexity to discussions with the couple; however, she further indicated that these discussions contribute to the richness of dialogue that elicits interest toward one another. Regarding cultural differences, Therapist 3 stated: "They are generally differences that were quite obvious at the onset of the relationship and then became more difficult to ignore/cope with/avoid, and have not yet been addressed outside of therapy." This made IBCT with the selected couple especially engaging as they began to address how cultural differences influenced their religious practices, gender role preferences (money management responsibilities), and desired social interaction.

**Objective 4: Therapist's recommendations.** In considering recommendations for future clinicians, Therapist 3 reflected on things she would have done differently with the couple she treated. Due to the fact that this couple had a significant break in treatment (six sessions followed by a six month break and then another seven sessions), Therapist 3 recommended a smoother treatment schedule and that this could have been beneficial to this particular couple. Therapist 3 also indicated that she would have liked to spend more time exploring the cultural background of the female partner, though the female partner was quite unaware of cultural influences on her behavior and that was less acute than dealing with patterns that might lead to physical aggression. In retrospect, more time in treatment upon overcoming their tendency to use physical

aggression would have allowed deeper understanding of their culturally rooted discord. No particular changes to the IBCT interventions she employed with this couple were suggested.

Therapist 3 also provided recommendations for using specific IBCT interventions with intercultural couples (unrelated to the selected couple) that are based on effective strategies she has used in her practice. She recommended teaching partners how to formulate the problems in their marriage by initially introducing innocuous differences:

> I like to find a culturally-relevant difference that is not identified as a "problem" to the couple, then do a DEEP formulation around that difference as an example of how to do a DEEP formulation and how some differences are both easily navigated and welcomed by the couple. This can be something like differences in food preferences, religious background, clothing styles, anything that the couple actually enjoys about their cultural differences. Then, to foster tolerance in other areas, I try to find a culturally relevant difference that is more tolerated than enjoyed, such as attending different religious ceremonies or doing holiday traditions both ways instead of combining them. Then we do a DEEP formulation about this difference and talk about skills they use for tolerance.

Therapist 3 also recommended a specific strategy aimed to unify partners by having each partner talk about the ways in which they enjoy being married to someone of a different culture, what attracted them to their spouse, and in what ways life would be less rich for them if they did not have the cultural differences in the home. This is particularly useful for intercultural couples; however, Therapist 3 believes that all IBCT strategies are well suited for intercultural couples. No particular IBCT intervention is preferred over another. She highlighted: "They work best when the couple is able to note some differences that are enjoyable or neutral and when the couple is not engaging in overt racism toward each other or their families."

Beyond recommendations for using specific IBCT interventions, Therapist 3 generally recommended that when using IBCT with intercultural couples, therapists should identify and address any of their own discomfort in discussing cultural issues. It is also important that clinicians be comfortable discussing their own cultural backgrounds in order to serve as a model for the couples they treat. Through self-disclosure, the therapist not only normalizes the process by which culture influences and/or motivates behaviors, but aligns with partners by demonstrating how their cultural backgrounds impact their behavior and relationships. Also, Therapist 3 suggested that clinicians explore their own levels of comfort outside of their cultural element. For instance: "If you, the therapist, are Anglo, then put yourself regularly in situations where you are a cultural minority. Be uncomfortable. Notice your reactions and learn more about yourself and how your cultural background shapes your reactions and worldviews." In this way, clinicians can understand some of the discomfort experienced by the couples they treat.

Lastly, in working with intercultural couples in general through any treatment approach, Therapist 3 suggested overtly expressing to partners the therapist's interest and enjoyment of learning about cultural differences, especially as this might encourage partners to be more curious and explore their own cultural backgrounds. As clinicians understand their own cultural biases, clinicians will gain more sensitivity to the biases of couples: "Don't become shocked upset when you identify racist beliefs or behaviors; consider these as you consider other dynamics within the couple or other differences that involve a discrepancy between behavior and values." Most importantly, maintaining dialogue about cultural differences is essential. Even if the topic is uncomfortable for the couple, therapists are recommended to refrain from avoidance of the topic simply to avoid discomforting the couple.

**Summary and Cross-Case Analysis**

Prior to describing the results of the cross-case analysis, this section will provide a review of the data collected and some summary observations. The previous case studies examined three intercultural couples whose problems in therapy emerged as culturally rooted and facilitated culturally relevant discourse over the course of therapy. Participating therapists reported on the salient problems experienced by the intercultural couples they treated and reported formulating the couples' problems through a cultural understanding of their differences. In general, specific IBCT interventions utilized in treatment were not altered for individuals due to their cultural differences; rather, culture was incorporated in the formulation of the problem, which facilitated many interventions and therapeutic techniques. Particular shifts and change mechanisms over the course of treatment were discussed, including acceptance and behavioral change processes, much of which uniquely focused on acceptance of particular behaviors as a result of greater understanding that behaviors and/or beliefs are culturally rooted. Also, therapist's impressions of using IBCT with intercultural couples in comparison to couples whose problems are not rooted in cultural differences were reported favorably, such that IBCT is particularly well suited for intercultural couples. Lastly, recommendations for utilizing IBCT with intercultural couples, and general recommendations for working with intercultural couples were provided and universally focused on the importance of maintaining open dialogue around the cultural contributions to partners' differences. Table 4 illustrates IBCT interventions utilized by each participating therapist over the course of treatment with their selected couple.

Table 4

*IBCT Interventions*

| Therapist | Empathic Joining Interventions | Unified Detachment Interventions | Tolerance Building Interventions |
|---|---|---|---|
| 1 | Communication skills training: Identifying and describing each partner's own experience rather than describing what their partner did or what they think their partner thinks or feels. Then reflecting what they heard their partner say. | Identifying problem within their interaction (avoidance) rather than individual behaviors, and creating a metaphor for their problem to be used throughout therapy | None |
| 2 | Communication skills training: Identifying and describing each partner's own experience rather than describing what their partner did or what they think their partner thinks or feels. Then reflecting what they heard their partner say.<br><br>Active Listening to reflect softer underlying emotions | Engaged couple in discussion of recent problematic interactions in a play-by-play manner having each speak for themselves to describe their own behaviors, thoughts, and feelings. | Role-play negative behaviors |
| 3 | Communication skills training: Identifying and describing each partner's own experience rather than describing what their partner did or what they think their partner thinks or feels. Then reflecting what they heard their partner say.<br><br>Active Listening to reflect underlying soft emotions. | Reminded the couple of the DEEP formulation as it related to each difference. Asked them to relate the current problem to the DEEP formulation and their usual patterns. | Time apart for cooling down during hostile arguments.<br><br>Self-care strategies, including activities they enjoy and used to enjoy doing together |

## Conclusions

The findings of this study reveal several conclusions regarding the utility of IBCT with intercultural couples. The predominant elements in therapists' responses were synthesized using the method of cross-case analysis in which individual cases were compared for similarities and differences (Yin, 2014; Zucker, 2009). Findings were organized around the research objectives of this study to formulate conclusions.

**Inviting culture into the IBCT case formulation.** The findings of this study suggest that culture took a front row seat in the IBCT formulations of intercultural couples' presenting problems. Across cases, therapists indicated that couples did not tend to present their problems as

cultural differences or as inherently rooted in cultural differences. In all cases discussed, couples initiated therapy due to commonly reported problems by all couples, such as a lack of intimacy, involvement of extended family members, insecurities, communication problems, financial issues, feelings of mistrust and jealousy, and complaints about their partners' behaviors and decisions. And in all cases, findings demonstrated that each reported problem was rooted in a cultural difference between partners, such that each partner's behaviors, views, values, and beliefs were moderated by his/her upbringing and cultural background. Each participating therapist reported a need to initiate dialogue around culture with the selected couple. Then, each therapist suggested the impact of the couples' cultural backgrounds in understanding the differences that developed into problems over time. Therefore, each participating therapist took initiative by inviting culture into the IBCT formulation and conceptualization of the problem, and presenting it during the feedback session.

Regarding how culture was integrated into the DEEP aspects of the formulation, across cases, cultural influences were most prominent in the formulation of differences. For instance, Therapist 1 overtly highlighted how each partner's varied experience with racism caused considerable distress and communication withdrawal. Therapist 2 reported the couple's differences in terms of "values," such as individualism and collectivism, which pointed to differences in cultural upbringings. Finally, Therapist 3 indicated that feelings of jealousy and insecurity arose following shifts in gender role expectations, as well as desired levels of religiosity and social interaction, all of which were shaped by each partner's cultural background.

Following identification of cultural differences, examining emotional sensitivities and external stressors as an outcome of cultural disparities between partners appeared to be a

common process among all participating therapists. However, therapists did not consistently report sensitivities and stressors as explicitly culturally rooted in the same manner they reported the differences. For instance, in describing emotional sensitivities, Therapist 2 did not identify the male's experience of losing a sense of control as an incongruent cultural value (i.e. losing control goes against his value of being independent and self-sufficient); rather, it is understood as a culturally rooted dilemma for him simply in comparison to his wife's value of family involvement and reliance on the collective. And in regards to the external stressors in Case 3, culture did not directly cause the stressors (e.g., disability); rather, stressors were exacerbated due to the male's cultural values because they tapped into insecurities and sensitivities rooted in his gender role expectations (e.g., money management, driving, social interaction). Nevertheless, the cultural implications remain present within each of these formulation elements.

One area of the formulation where no participant incorporated the impact of culture was in reporting partners' interaction patterns. It is unknown to what extent partners' communication styles are normative within their cultures/upbringings or whether each partner's interaction style is unique to them. Overall, these findings suggest that partners' understanding of their relationship dynamics as a combination of individually learned cultural processes might depend on the degree to which the clinician (a) draws on his/her knowledge of ways in which culture influences behavior, (b) believes that differences, sensitivities, stressors and interaction patterns might be culturally rooted, (c) initiates dialogue about how their problems might be culturally rooted, and (d) presents each element of the formulation with cultural considerations during feedback and therapy.

**Secondary role of culture in the utility of interventions.** Across cases, the degree to which cultural considerations were incorporated in IBCT interventions varied. This is likely due

to variations in the prominence of culturally rooted problems; however, it appears that the inherent usefulness of the interventions themselves yielded positive outcomes, as demonstrated in early preliminary and follow-up outcome research (Christensen et al., 2004; Jacobson et al., 2000), regardless of any need for cultural modifications, interpretations, or the likelihood that partners bring up culture during dialogue. As such, the extent to which interventions were tailored to incorporate cultural differences was at the discretion of the therapist. For the most part, Therapists 1 and 2 gave culture secondary attention when utilizing techniques for empathic joining. However, Therapist 3 chose to employ cultural differences within empathic joining techniques, such that partners were encouraged to empathically reflect how the other's cultural sensitivities affect situations. Nonetheless, all therapists employed empathic joining techniques without changing the process of the interventions, only varying the extent to which the content of the interventions focused on culture.

Unified detachment techniques across cases also remained theoretically grounded, with variations in cultural considerations between therapists. Once again, Therapist 3 utilized the cultural formulation as a unified detachment technique, which reminded the couple that their problems were rooted in their cultural differences (something they can agree and unite upon) rather than their partner's behaviors.

As tolerance building techniques, Therapist 3 also found culturally relevant differences that her selected couple already tolerated more than enjoyed, such as attending different religious ceremonies, and then encouraged partners to reflect on skills they used to tolerate those experiences with their partner. Therapist 3 also incorporated partners' cultural differences into tolerance building by asking partners to reflect on the reasons they were initially attracted to their partner due to their cultural differences, and how their lives might appear less rich had the

differences not been present. Responses from Therapists 1 and 2 do not point to the inclusion of cultural differences in tailoring these interventions.

These findings demonstrate that Therapist 3 utilized cultural differences across all interventions when developing techniques. In contrast, Therapists 1 and 2 employed techniques that did not purposefully elicit dialogue around those culturally formulated differences. This finding presents an interesting perspective about whether a couple's cultural differences should be used as a catalyst for intervention strategies. It also points to the question of whether techniques are just as effective with intercultural couples even without making continuous connections to culture throughout treatment. All in all, mechanisms that promoted behavior change and acceptance across all cases were largely and primarily achieved through the utility of IBCT interventions, whereas a cultural formulation and ongoing consideration of cultural influences throughout treatment were secondary, but also important, in promoting acceptance.

**IBCT as fundamentally suited for intercultural couples.** Progress achieved during the course of therapy for all couples appeared to have been enhanced by the conceptual and methodological foundations of IBCT, which were particularly well suited for these couples as suggested earlier in this paper (Sevier & Yi, 2008). As highlighted in Case 1, the female partner understood her husband's underlying soft emotions (e.g., helplessness) following exploration of his cultural identity and experiences with racism. In comparing their experiences of racism, both partners began to feel more understood. Because the root of their problem was uncovered as a difference in cultural experiences, they were better able to move into a place of empathy and detachment from what they previously viewed as the problem in their partner or relationship. They were then better able to progress through IBCT interventions toward acceptance. IBCT

appeared to be effective in addressing this cultural difference early in therapy, as seen in the other cases presented as well.

In this study, IBCT succeeded in respecting and reframing differences as unique *and* problematic in the context of conflicting views, beliefs, upbringings and behaviors. Therefore, it is fundamentally well suited for intercultural couples because it views cultural differences as both positive and negative, making it a flexible approach with this population. As stated by Sevier and Yi (2008), "The openness of the IBCT perspective to a wide range of differences is a strength in application to diverse populations—as diversity is, in its essence, all about differences" (p. 198). In this study, therapists did not indicate any need to change interventions, further supporting IBCT's methodological strengths with intercultural couples.

**Promoting discussion around cultural influences.** Across cases, it appeared that emitting more curiosity and interest in cultural differences might be the differentiating factor between utilizing IBCT, or any other therapeutic modality, with intercultural and homogeneous couples. However, it is also emphasized that cultural differences can be found in most couples, even when they do not present their problems as rooted in cultural differences. Sullivan and Cottone's (2006) research on culturally based couple therapy and intercultural relationships further highlighted that the range of cultural differences extends far beyond the limited categories we have created (e.g., racial differences) and it is often through examining couples' problems (e.g., communication, mood expressions, mismatched marital expectations, differing coping styles) that culturally rooted differences are identified. As is the case in the selected couple by Therapist 2, both partners were born and raised in the same urban location; however, each uncovered differences in their expectations of family involvement that was rooted in cultural differences. Therefore, couples who look similar and come from similar backgrounds

may have been raised with cultural differences that impact their relationship. As discussed earlier in this paper, therapists' curiosity is key in uncovering these differences in order to address them in therapy and facilitate greater understanding between partners (Bustamante et al., 2011). In contrast, Therapist 1's view that cultural differences may *not* always be the key factor contributing to marital distress is also important to take into consideration in order to avoid incorrectly formulating problems around issues that are not central to the couple. Therefore, promoting dialogue around cultural differences remains important as it not only uncovers culturally rooted problems, but also serves to expose false assumptions that problems are rooted in cultural differences.

**Diversity within the therapy room.** It must be acknowledged that for each couple presented in the previous case studies, cultural differences between partners were expected as part of inclusion criteria; however, cultural differences between the couple and their therapist added richness to these findings. Although not one of the primary research objectives, the similarities and differences between therapists and their clients are important to take into consideration. Given the fact that partners often struggle to understand one another's needs with enough cultural sensitivity and acuity, it could be presumed that information might also be lost in translation to therapists, who are not without shortcomings.

At a superficial glance, each participating therapist in this study differed from partners in level of education, age, languages, religious identification, and ethnicity; however, each of these categories also suggest differences in privileges, experiences, beliefs, customs, traditions, values, emotional expression, family expectations, gender roles and many more complexities that create barriers between therapists and couples. As Waldman and Rubalcava (2005) suggest, these

differences could impact intersubjective experiences and the therapeutic alliance. In describing intersubjectivity between partners, they stated,

> One of the difficulties in working with intercultural couples, particularly those who are not psychologically aware, is that each partner views the other through his or her own cultural organizing principles, without being aware that the perceptions, and the feelings that arise from them, are individual, subjective and culturally influenced. (p. 236)

Likewise, therapists are also susceptible to making sense of couples' affective expressions and behaviors in terms of their own unconscious cultural organizing principles (Waldman & Rubalcava, 2005). Therefore, just as individual therapists are encouraged to evaluate their own cultural identifications, biases, assumptions, and differences between themselves and their individual therapy clients, couple therapists are held to the same self-reflective standards (Bustamante et al., 2011). Participating therapists' responses in this study revealed appreciation for this phenomenon and indicated the importance of cultural self-reflection by all members in the therapy room.

## Chapter IV: Discussion

Analysis of three participant therapists' responses to open-ended questionnaires about their experiences using IBCT with a selected intercultural couple yielded several similarities and differences. It was found that all therapists incorporated partners' specific cultural differences in the formulation of the problem despite the fact that no couple presented to therapy actually reporting that their problems are rooted in culture-specific differences. It also appears that incorporating a couple's cultural differences into treatment techniques (not changing the IBCT interventions) was only employed by one therapist, but the interventions were reportedly effective in eliciting behavior change and acceptance across cases, nonetheless. As such, employing cultural differences in tailoring IBCT techniques may be a secondary advantage following the fundamental effectiveness of IBCT interventions alone. Therefore, findings indicated that IBCT is fundamentally well-suited for intercultural couples. It views cultural differences as unique—neither positive, nor negative—which makes it flexible and likely to promote flexible, non-blaming discussion around cultural differences. Lastly, results uncovered cultural variations between couples and their therapists that warrant self-reflection and special attention to intersubjective experiences and potential biases between therapists and couples.

This study contains several strengths. Therapist participants' responses are a contribution to the literature on IBCT through further description of how this treatment approach has been utilized with a specific population. It provides rich and detailed information about some ways in which couples report differences and explains how understanding these differences as culturally rooted emerges in therapy. Of particular contribution are the useful methods in which participating therapists reported formulating each case with careful cultural considerations, as

well as the recommendations provided to IBCT clinicians who work with intercultural couples or will inevitably encounter them in their practice.

There are also several methodological strengths of this study. For example, participants' responses were prepared and submitted directly, preventing any inaccuracies that can occur with transcriptions of face-to-face or telephone interviews. Furthermore, the screening measure ensured well-trained and actively engaged IBCT practitioners as participants. The participants in this study were recruited from a database of clinicians on the IBCT website, with all three participants trained by Dr. Andrew Christensen either directly or through the VA, where two participants also served as consultants. Additionally, the researcher gathered demographic information of both participating therapists and their clients to add to the quality of comparisons across cases.

**Conceptual and Methodological Limitations**

There are several potential limitations to this project to consider. Because this project called for a multiple case study methodology where the focus was on developing rich descriptions of a particular phenomenon in multiple contexts (Braxton & Jack, 2008), replication of responses across cases was not required, although could have been useful in finding more similarities. Because a small sample size yielded minimal replication, this limited the variations between cases and provided limited perspectives. As such, participating therapists and the couples presented by them cannot represent the full range of diversity and conflict seen between and within couples.

The definition of intercultural couples is also broadly defined in this study. As a result, the cases are not representative of all intercultural couples and may undervalue or overlook uniqueness and differences *within* specific cultures. In regards to methodology, it is also

important to take into consideration the limitation of not speaking directly to participant therapist in an interview format, which would have otherwise allowed for spontaneous questions, elaboration, and clarification of responses.

Another observation was made in the therapists' responses to IBCT interventions used with their selected couple that warrants the need for clarification of questionnaire items. For instance, all therapists reported utilizing what is traditionally considered a change-based intervention, communication skills training, when asked about empathic joining interventions, which are typically considered acceptance-based. These responses highlight the inter-related nature of change and acceptance, by indicating the utility of traditional behavioral change methods to provide a safe structure for facilitating soft disclosures, which in turn fosters acceptance. However; it is unknown the extent to which therapists used the IBCT empathic joining intervention of a non-blaming reformulation of the problem, or other less structured means of fostering soft disclosures, as it was not explicitly named/mentioned. More specific responses may have been provided if questions asked therapists to report separately on traditional behavior change and acceptance-based methods used, to distinguish them from one another, although as mentioned they are closely inter-related and both important in IBCT.

Information that may have been interesting to collect includes the parental cultural identification of both therapists and couples (e.g., did parents identify as bicultural, or were parents an intercultural couple?) to determine partners' and therapists' levels of exposure to intercultural relationships. Additionally, while participating therapists responded to demographic questions about their own cultural identifications, the potential clinical implications of differences between the therapists and their selected couples were not addressed in the research objectives and might be a point of interest in future studies. Lastly, differences between couples

and their therapists might point to potential biases, such as split therapeutic bonds and working therapeutic alliances, that may have had a positive or negative impact on treatment outcomes (Jurek, Janusz, Chwal, & de Barbaro, 2014).

**Implications for Future Research**

Recognizing that this study is the first known multiple case study to examine the utility of IBCT specifically with intercultural couples, further study is needed. Assuming that no additional findings could develop given the sample size of 3 case studies would be incorrect given the limitations discussed. Of interest will be learning how these findings compare to replication studies or determining how direct contact with couples (i.e., interviews with partners) might yield different findings. Comparison to larger sample sizes that include additional variations in intercultural differences and culturally rooted distress might also be valuable. Follow-up studies and longitudinal qualitative analyses might be useful in learning about these couples' marital satisfaction over time, and how cultural considerations in treatment did or did not contribute to long-term outcomes. For instance, taking a closer look at specific change mechanisms in a follow-up study might inform the degree to which behavioral change and acceptance were maintained around their cultural differences and whether the degree to which their therapist utilized a culturally-informed formulation or incorporated cultural differences into interventions contributed to the maintenance of these changes. In fact, tailoring open-ended questionnaires or conducting qualitative interviews with intercultural couples who engaged in IBCT could shed light on short-term and long-term gains, change mechanisms and their continuance overtime, as well as differences between the therapists' and couples' perception of progress over the course of treatment and follow-up. If the progress exhibited by couples in these cases is fundamentally attributed to IBCT and *enhanced* by formulating differences as culturally

rooted, then it could be hypothesized that a large scale quantitative study, such as the randomized clinical trial and follow up study that examined over 100 marital couples in distress (Christensen et al., 2004, 2008), would yield similar findings, if not better, with a large sample of intercultural couples. Of significant interest would be the development of a comparative study to determine how intercultural couples rate marital satisfaction following treatment in one of several conditions, such as (a) receiving IBCT without any cultural considerations or implementation into treatment formulation and interventions, (b) receiving IBCT with cultural considerations within formulations of the problem (as done by Therapists 1 and 2), and (c) receiving IBCT with employment of partners' cultural differences in the development of treatment techniques across all interventions (as done by Therapist 3).

Research by Perel (2000), and a study by Heller and Wood (2000) about the development of a *third-reality* or *third-culture building*, indicated that couples who use cultural reframing as a coping mechanism (i.e., developing a *third-culture* or *transcultural reality* that guides behavior within a relationship and creates an environment that ameliorates conflict) are more likely to report marital satisfaction. As such, they encourage therapists to apply these techniques in treatment interventions with intercultural couples. It would be interesting to know how effective IBCT would be in facilitating this process. For example, it might be used in tailoring IBCT interventions, such that, following unified detachment from the problem, change mechanisms might include collaboration between partners to develop an environment where aspects of both cultures are invited. Through tolerance building techniques, acceptance might emerge in the presence of a newly formed, agreed upon, and mutually developed third culture.

Lastly, a study focusing on cultural differences between clinicians and their couples, level of self-disclosures, and therapeutic alliance would also generate further information about the

possible positive or negative effects of diversity within the therapy room among all members. Taken together, future investigations pertaining to the study of intercultural relationships and IBCT remain numerous and would vastly contribute to the growing literatures in the treatment of couples, diversity, and IBCT.

**Conclusions**

The results of this study may serve as a preliminary step for those who are interested in examining the utility of IBCT with intercultural couples. A major strength of this study is that a qualitative examination of this treatment approach with intercultural couples specifically had not yet been conducted. This study gives consumers a glimpse into the therapy room of an IBCT therapist through discussion of theoretical formulations of culturally rooted discord, examination of change mechanisms, and useful recommendations. Perhaps the greatest contribution of this study is its specific recommendations for IBCT clinicians working with intercultural couples. It is recommended that clinicians incorporate dialogue around culture early in treatment as an aid to their IBCT formulations and then share their conceptualizations, including thoughts about the cultural roots of partners' differences, during initial feedback sessions. Secondly, clinicians are recommended to ask and reflect on partners' cultural identifications, experiences, beliefs, and values just as they would reflect on their own. Third, therapists are recommended to avoid over/under pathologizing cultural differences (i.e., "they are neither good nor bad," they are just different), pathologizing particular cultural views that contribute to relationship distress, or attributing too much of the couples' discord to cultural differences. Lastly, clinicians should be careful in expecting couples to speak comfortably about culture; therefore, therapists are recommended to model through clinically appropriate self-disclosures about ways their own cultural identifications shape or influence their relationships and behaviors.

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# APPENDIX A

## Literature Review Table

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
|---|---|---|---|---|---|---|---|
| American Psychological Association (2014). Five principals for research ethics. | Professional Association | N/A | N/A | N/A | N/A | N/A | Ethical guidelines for conducting psychological research |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
|---|---|---|---|---|---|---|---|
| American Psychological Association (2003) Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. | Professional Association | N/A | N/A | N/A | N/A | N/A | Rationale and needs for addressing multiculturalism and diversity in education, training, research, practice, and organizational change; basic information, relevant terminology, current empirical research from psychology and related disciplines. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
|---|---|---|---|---|---|---|---|
| Atkins, D.C., Berns, S.B., George, W.H., Doss, B.D., Gattis, K., & Christensen, A. (2005). Prediction of response to treatment in randomized clinical trial of | Journal Article | Purpose: To address limitations in the literature by examining pretreatment measures that predict change in marital satisfaction within IBCT and TBCT. Three sets of predictors included: demographics (age, education, income, years married, and whether they had children), intrapersonal | 134 "seriously and stably distressed" couples that, on average, were married 10 years, had at least one child, were in their early 40s, had a college education, and majority were Caucasian. Couples | Criterion Variable: Dyadic Adjustment Scale Predictor Variables: Through a demographics questionnaire: age, years of education, monthly pretax income, years married, presence of children, and wife employment status; intrapersonal variables | Correlational | Better communication and greater desired closeness are associated with less initial marital distress, whereas greater initial distress is associated with poorer affective communication and more steps taken towards separation or | Interpersonal variables explain the most variance while demographic and intrapersonal predictors are more modest in explaining variability in change components. In sum, little predicts successful or unsuccessful outcome. Because many couples do not show improvement following couple therapy, predictors are important clinically. Of importance is the |

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| marital therapy. | | (overall mental health and personality characteristics) and interpersonal (communication, commitment, intimacy) variables. | where one partner had a psychological disorder (met criteria for Axis I or Axis II disorder), or was taking psychotropic medication were excluded from the sample. | measured by: NEO Five Factor Inventory, Compass Outpatient Treatment Assessment System, and structured clinical interviews for DSM IV for Axis I and II, and Family History of Distress Scale; interpersonal variable measured by: Communication Patterns Questionnaire, Closeness and Independence Inventory, Affective Communication Scale from MSI-R, and Marital Status Inventory. | | divorce. The strongest improvement in therapy occurred in couples married over 18 years. | finding that interpersonal variables are not the strongest predictors, but have traditionally been the targets of most interventions. This further justifies the need to improve our ability to predict who will benefit from therapy. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
|---|---|---|---|---|---|---|---|
| Baker, S.E. & Edwards, R. (2012). How many qualitative interviews is enough | Discussion paper | Purpose<br>To gather and review responses to the question "How many qualitative interviews is enough?" | 14 renowned social scientists and 5 early career researchers | N/A | N/A | N/A | Answer to the question is "it depends" on the nature and purpose of the research. Practical considerations include level of degree, time available and institutional review requirements. It also depends on whether the research has "'saturated' the possible epistemological, methodological and pragmatic responses" |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
|---|---|---|---|---|---|---|---|
| Baucom, D. H., Shoham, V., Mueser, K.T., Daiuto, A. D., & Stickle, T. R. (1998). Empirically supported couple and family interventions for marital distress and adult mental health problems. | Journal Article | Purpose: To evaluate the efficacy, effectiveness, and clinical significance of empirically supported couple and family interventions for treating marital distress and individual adult disorders, including anxiety disorders, depression, sexual dysfunctions, alcoholism and problem drinking, and schizophrenia. Questions- Is one form of marital therapy more efficacious than the others overall? How should a clinician select from the interventions the one that is most appropriate for a given couple? | N/A | N/A | Meta-Analysis | BMT (Behavioral Marital Therapy) and EFT (Emotionally Focused Therapy) can be viewed as efficacious for treating marital distress; BMT is efficacious and specific, and EFT is efficacious and possibly specific. IOMT, cognitive-behavioral marital therapy, CT for couples, and couples' systemic therapy all meet criteria for possibly efficacious treatments. ; when couples are randomly assigned to treatment, a sizable portion of the couples remain distressed at the end of treatment and at follow-up, regardless of the form of intervention that they have received. BMT is superior to no treatment in alleviating depression; partner-assisted format of SST for female primary (lifelong) orgasmic disorder is | By far, the most widely evaluated approach to couples therapy is BMT, and findings to date indicate that it is an efficacious intervention for treating relationship distress. Other approaches (e.g., emotion focused, insight oriented, and cognitive) to marital therapy also appear to benefit distressed couples, although much less research has been conducted to evaluate them thus far; general marital therapy may be most appropriate for treating individual psychopathology when there is co-occurring relationship distress that can be linked in some way to the nature of the presenting symptoms. |

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| | | | | | | feasible and may be beneficial to both partners; exposure interventions for agoraphobia may show enhanced benefit from involvement of the partner in some capacity. | |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
|---|---|---|---|---|---|---|---|
| Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. | Journal Article | Purpose: To guide the novice researcher in identifying the key elements for designing and implementing qualitative case study research projects | N/A | N/A | Literature Review | N/A | Determining the type of case study after developing research question(s) will be guided by the overall research purpose. Definitions of case study types and multiple case study design is included. Author recommends the use of Computer Aided Qualitative Data Analysis Software (CAQDAS) to help researchers organize and store data. Recommendations for analysis vary depending on type of case study. Overall goal of case study is to describe the study in such a comprehensive manner as to enable the reader to feel as if they had been an active participant in the research and can determine whether or not the study findings could be applied to their own situation. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
|---|---|---|---|---|---|---|---|
| Benet-Martinez, V., Leu, J., Lee, F., Lee, & Morris, M.W. | Journal Article | Hypothesis: Cultural frame shifting—shifting between two culturally based interpretative | STUDY 1: 65 first-generation or immigrant Chinese American | STUDY 1: IV: American or Chinese priming condition; Bicultural type-High vs. | Experimental | STUDY 1: Bicultural type significantly moderated the effects of cultural | Across three experiments, researchers demonstrated that Chinese American biculturals possess separate American |

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| (2002). "Negotiating biculturalism: Cultural frame switching in biculturals with oppositional versus compatible cultural identities." | | lenses in response to cultural cues—is moderated by perceived compatibility (vs. opposition) between the two cultural orientations, or bicultural identity integration (BII). 1) an interaction between bicultural type (high vs. low BII) and cultural primes (American cues vs. Chinese cues) on the social attributions of Chinese American biculturals; 2) Chinese American biculturals with high BII will behave in a prime-consistent manner, making stronger internal attributions (a characteristically Western behavior) for American primes than for Chinese primes; 3) Chinese American biculturals with low BII, on the other hand, will behave in a relatively more prime resistant manner, making stronger internal attributions for Chinese primes than for American primes. | undergraduates (26 men, 39 women; mean age = 20.3, SD = 3.4). All participants were born in a Chinese country. (People's Republic of China, Taiwan, Hong Kong, Macao, or Singapore), lived at least 5 years in a Chinese country (M = 12.4, SD = 5.6), and lived at least 5 years in the United States (M = 8.4, SD = 3.3).<br><br>STUDY 2: 176 first-generation Chinese American individuals (73 males, 103 females; mean age = 15.96, SD = 1.55). All participants were born in a Chinese country (People's Republic of China, Taiwan, Hong Kong, Macao, or Singapore) and had lived at least 5 years in a Chinese country (M = 8.75,SD = 3.55) and the United | Low.<br>DV: participants' attributional rating of the fish display measured by 9-point Likert Scale.<br><br>STUDY 2:<br>IV: American or Chinese priming condition; Bicultural type-High vs. Low.<br>DV: participants' intern al and external attributions of the fish displays, which were measured using both open-ended and close-ended formats. Measured using 7-point Likert scale.<br><br>STUDY 3:<br>IV: Landscape primes; Bicultural type-High vs. Low.<br>DV: participants' internal and external attributions of the fish displays, which were measured using close-ended formats<br><br>MEASURE:<br>BII was assessed using a short vignette, developed for the purposes of the study, which were called the Bicultural Identity Integration Scale–Pilot Version (BIIS-P). | | priming on attributions. When shown American primes, biculturals with high BII made stronger internal attributions, a characteristically Western attribution style, than when they were shown Chinese primes. Biculturals with low levels of BII, on the other hand, exhibited the reverse pattern.<br>STUDY 2: Biculturals high on BII behaved in a prime-consistent manner: Chinese primes elicited more external attributions, and American primes elicited more internal attributions. Biculturals with low BII, on the other hand, behaved in a prime-resistant manner by making more internal attributions in the Chinese priming condition and more external attributions in the American priming condition.<br>STUDY 3: Confirmed | and Chinese cultural schemas that guide their behavior and that each schema can be activated by situational cues. |

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| | | | States (M = 8.31,SD = 3.70).<br><br><u>STUDY 3:</u> 35 first-generation Chinese American individuals (15 men, 20 women; mean age = 20.37, SD = 1.40). All participants were born in a Chinese country and had lived at least 5 years in a Chinese country (M = 10.5, SD = 4.7) and in the United States (M = 9.2, SD = 4.7). | | | prediction that differences in BII would not moderate biculturals' attributions after being exposed to noncultural cues. | |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
|---|---|---|---|---|---|---|---|
| Berry, J. W. (1997). Immigration, acculturation, and adaptation. | Journal Article | <u>Purpose:</u> To outline a conceptual framework within which acculturation and adaptation can be investigated, and then present some general findings and conclusions based on a sample of empirical studies. | N/A | N/A | Literature Review | N/A | Psychological acculturation is influenced by numerous group-level factors in the society of origin and in the society of settlement, national immigration and acculturation policies, ideologies and attitudes in the dominant society, and social support. Psychological acculturation is also influenced by individual-level factors. The bi-cultural acculturation strategy appears to be a consistent predictor of more positive outcomes than assimilation, separation, or marginalization. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
|---|---|---|---|---|---|---|---|
| Betancourt, H. & Lopez, S. R. (1993). The study of culture, ethnicity, and race in American psychology. | Journal Article | Purpose: It is proposed that by including theory, conceptualizing, and measuring cultural and related variables, mainstream, cross-cultural, and ethnic research can advance the understanding of culture in psychology as well as the generality of principles and the cultural sensitivity of applications. | N/A | N/A | Literature Review | N/A | Authors addressed and tried to clarify confusion in the understanding and use of the concepts of culture, race, ethnicity, and social variables. These terms are often used as general explanatory factors for intergroup variations in psychological phenomena. Authors also suggested ways in which to infuse the study of culture in mainstream research and theory as well as ways to enhance experimentation and the use of theory in cross-cultural research. Finally, they illustrated ways in which to study sociocultural variables and to consider theory in ethnic minority research. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Bhugra, D., & De Silva, P. (2000). Couple therapy across cultures. | Journal Article | Purpose: To develop a model for assessing and working with couples who are culturally different from their therapist. To provide useful information for therapists who are treat couples when cultural difference play an important role. | N/A | N/A | Model Development | N/A | Assessment and management of the couple in therapy includes recommendations that the therapist be aware of roles/expectations within the therapeutic relationship (between therapist and couple), be open and prepared to change treatment strategies (e.g., techniques), and assessment questions must be culturally sensitive. Interventions must appropriately fit cultural background of couple. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
|---|---|---|---|---|---|---|---|
| Bivens, D.K. (2005). What is internalized racism? In *Flipping the script: white privilege and community building*. | Book Chapter | Purpose: To understand and address internalized racism and the ways that internalized racism manifests in society. | N/A | N/A | N/A | N/A | Internalized racism manifests on an inner, interpersonal, cultural and institutional level. As people of color are victimized by racism, we internalize it. Individuals, institutions and communities of color are often unconsciously and habitually rewarded for supporting white privilege and power. Race is a social and political construct. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
|---|---|---|---|---|---|---|---|
| Bustamante, R. M., Nelson, J. A., Henriksen, R. R., & Monakes, S. (2011). Intercultural couples: Coping with culture-related stressors | Journal Article | Purpose: To examine experiences of participating intercultural couples in order to identify and understand potential culture-related stressors in their marriages and the coping strategies that these intercultural couples employed. | Five intercultural couples who had been married and cohabitating for 5 or more years, self-identified as intercultural, had children, and resided in the large urban area of a city in a southwestern state. | Questionnaires: Interview questions and background/demographic questionnaire | Qualitative, phenomenological | Differences that can cause stress include: childrearing practices, time orientation, family connections, and gender role expectations. In healthy relationships, intercultural couples use humor about differences, gender role flexibility, recognition of similarities, cultural reframing, or deferring to one of the partner's cultures as coping strategies. | Recommendations included: therapists maintaining awareness of their own biases, developing intake questions that target potential cultural influences on the relationship, encouraging the couple in therapy to gain awareness of their cultural differences, and facilitate intimacy through curiosity. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
|---|---|---|---|---|---|---|---|
| Camarota, S. A. (2001). Immigrants in the United States–2000: A snapshot of America's foreign-born population. | Statistical Report:<br><br>Center for Immigration Studies | Purpose:<br>To discuss the recent rise of immigrants to the United States and it's impact on population growth. To discuss historical comparisons and examine characteristics of immigrants, including countries of origin, employment status in US, and education. | N/A | N/A | N/A | N/A | Immigration largely responsible for population growth in the U.S. More than half of immigrants after 1970 live in or near the poverty line due in part to nation's attempt to incorporate large number of newcomers into it's society. Statistics predicted a large number of immigrants are to be expected and that immigration will continue to impact population growth. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
|---|---|---|---|---|---|---|---|
| Christensen, A., Doss, B.D., & Jacobson, N.S. (2014). Reconcilable Differences. | Book | Purpose:<br>Provide a non-practitioner guide for couples who seek relationship satisfaction. Intended for general population. | N/A | N/A | N/A | N/A | Guide for couples originating on IBCT research. Aims to help couples build stronger relationships and provides vignettes to help describe acceptance and change in practical terms. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
|---|---|---|---|---|---|---|---|
| Christensen, A., Atkins, D.C., Berns, S., Wheeler, J., Baucom, D.H., & Simpson, L.E., (2004). Traditional versus integrative behavioral couple therapy for significantly and chronicall | Journal Article | Purpose: To examine overall and comparative efficacy of TBCT vs. IBCT in treating couples who are "stably and seriously distressed." (p. 177).<br><br>Hypotheses:<br>1) TBCT and IBCT will provide improvement to individuals and their relationship, 2) the greatest impact will be | 134 seriously and chronically distressed married couples in Los Angeles (71) and Seattle (63). Mean age of wives was 41.2 and mean age of husbands was 43.39. Couples were married an average of 10 years | IV(s):<br>TBCT and IBCT<br>DV: Marital satisfaction, relationship stability, communication, spouses' individual functioning, and client reactions to treatment.<br>Outcome Measures:<br>Short therapeutic bond measure, dyadic adjustment scale, Global Distress Scale | Experimental | "TBCT couples improved at a faster rate than those in IBCT who plateaued while IBCT couples showed slow but steady improvement across treatment with no flattening out or deterioration" (p. 183). No differences were found between | First Hypothesis:<br>TBCT and IBCT are effective treatments for both moderately and seriously distressed couples. Statistically significant effects indicated that couples ended treatment with improved relationship satisfaction, stability, and communication. Individual functioning improved only to the extent that marital satisfaction improved. Second |

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| y distressed married couples | | observed earlier in treatment, 3) IBCT will show greater impact on the individuals and their relationships over TBCT, 4) the greatest impact of both these treatments will be observed mostly in moderately distressed couples, and 5) different responses are predicted between husbands and wives, with husbands responding better to TBCT. | and with an average of 1 child. Mean years of education for wives were 16.97 and for husbands were 17.03. Most were Caucasian (79% of husbands and 76% of wives). Other ethnicities included African American, Asian or Pacific Islander, Latino/a, Native American, or Alaskan Native. | of the Marital Satisfaction Inventory-Revised [MSI-R, Problem Solving Communication (from the MSI-R), Affective Communication (from the MSI-R), Marital status inventory (steps toward divorce), Compass outpatient treatment assessment system. (individual functioning), Client evaluation of services questionnaire | | spouses in the amount of change over the course of treatment. Based on the DAS, 71% of IBCT couples and 59% of TBCT couples showed reliable improvement or recovery. Also, 73% of moderately distressed couples and 54% of severely distressed couples were improved or recovered at the end of treatment. Individual mental health changed only to the extent that marital satisfaction changed (changes in MHI scores highly correlated with changes in DAS scores). | Hypothesis: Satisfaction does not necessarily improve more rapidly early in treatment. More treatment is conducive to greater satisfaction and both treatments performed similarly across measures. Third Hypothesis: TBCT couples tended to improve more quickly but then flatten out over the remainder of therapy, whereas IBCT couples had reliable and steady improvement over the course of therapy. Fourth Hypothesis: Husbands improved more rapidly than wives early in treatment. Fifth Hypothesis: significant finding that severely and moderately distressed couples improve at a comparable rate. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
|---|---|---|---|---|---|---|---|
| Christensen, A., Wheeler, J. G., & Jacobson, N. S. (2008). Couple distress. | Book Chapter | Purpose: To describe changes in technique and conceptualization of couple therapy that led to a new name for approach: "integrative behavioral couple therapy." New IBCT strategies illustrated in this case study chapter. | N/A | N/A | N/A | N/A | Therapist utilized empathic joining, unified detachment, and then tolerance building interventions in order to foster acceptance with one couple in distress over the course of 25 sessions. A history of each partner and an assessment of their problems are illustrated in the early phase of treatment. Each intervention is then described and then illustrated through |

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| | | | | | | | transcripts of the couple's therapy session. The couple completed treatment with reported increase in satisfaction, reframing of their problems, and an increase in positive behaviors. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
|---|---|---|---|---|---|---|---|
| Crippen, C., Brew, L. (2013). Strategies of cultural adaptation in intercultural parenting. | Journal Article | Purpose: To understand how intercultural couples navigate cultural differences within the family. | 21 heterosexual participants who have different sociocultural heritages with distinct cultures of origin (i.e., either they or their parents were born and raised in a different country of origin from that of their partner's) | Interview questions | Qualitative: Grounded Theory Methodology | Data analysis developed typology of cross-cultural parenting, which included strategies at negotiating diversity based on their cultural differences and their degree of acculturation. Strategies of adaptation that emerged included assimilation, cultural tourism, cultural transition, cultural amalgamation, and dual biculturalis. | Many couples are able to adapt to their cultural differences through negotiating strategies in order to form healthy families. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
|---|---|---|---|---|---|---|---|
| Doss, B.D., Thum, Y.M., Sevier, M., Atkins, D.C., & Christensen, A. (2005). Improving relationships: mechanisms of change in couple therapy. | Journal Article | Purpose: To examine how measures of communication, behavior frequency, and emotional acceptance act as mechanisms of change , toward relationship satisfaction, and the roles of these mechanisms early vs. late in therapy. | 34 seriously and chronically distressed married couples in Los Angeles (71) and Seattle (63). Mean age of wives was 41.2 and mean age of husbands was 43.39. Couples were | Predictor Variables: Changes in Emotional acceptance, communication, and relationship behaviors<br><br>Criterion Variables: Marital satisfaction measured by Dyadic Adjustment Scale, Frequency and Acceptability | Correlational | A multivariate hierarchical growth curve analysis using latent variable regression was used. Results revealed that measures of communication, behavior frequency, and emotional acceptance acted as mechanisms | Overall, both TBCT and IBCT suggest increases in frequency of behaviors and acceptance relate to satisfaction early in therapy for both husbands and wives. While acceptance in second half of both therapies remains beneficial, acceptance late in therapy as seen in IBCT related to greater relationship satisfaction than frequency of |

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| | | | married an average of 10 years and with an average of 1 child. Mean years of education for wives were 16.97 and for husbands were 17.03. Most were Caucasian (79% of husbands and 76% of wives). Other ethnicities included African American, Asian or Pacific Islander, Latino/a, Native American, or Alaskan Native. | of Partner Behavior Inventory, Communication Patterns Questionnaire | | of change. TBCT led to greater changes in frequency of targeted behavior early in therapy, whereas IBCT led to greater changes in acceptance of targeted behavior both early and late in therapy. Improvements in satisfaction early in therapy were related mostly to increase in frequency of behavioral change, but changes in satisfaction related to emotional acceptance were stronger in the second half of therapy. | behaviors, suggesting that change in the frequency of partner behaviors becomes less critical. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
|---|---|---|---|---|---|---|---|
| Eldridge, K., Christensen, A., & Jacobson, N. (1999). Integrative Couple Therapy. | Book Chapter | Illustrate the use of integrative couple therapy through examination of a case study. | N/A | N/A | N/A | N/A | Case study of a couple who entered therapy and reported decrease in levels of distress post treatment. General decline in marital distress and incline in marital satisfaction was observed in their scores on MSI and DAS. ACAQ indicated that female partner perceived less positive behaviors in her partner than he observed in her; however, post treatment, male partner perceived more positive behaviors in his partner than she did. |

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| | | | | | | | Overall, integrative couple therapy created positive behavior changes and increased acceptance of the partner. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Epstein, N. B., & Baucom, D. H. (2002). E nhanced cognitive-behavioral therapy for couples: A contextual approach. | Book | To provide practical guidance for conducting psychotherapy with couples from a cognitive-behavioral perspective. This book provides behavioral interventions, ways to modify cognitions, and how to address emotions. Effects of individual psychopatholog y, environmental demands, community influences, family systems, and life circumstances are also explained. | N/A | N/A | N/A | N/A | Every couple is unique and working with distressed couples can be complex and demanding. Understanding various patterns for couples' behaviors begins with uncovering positive and negative behaviors in the relationship, the reasons for these behaviors, their patterns, and their impact on the relationship. Followed by a "detangling" of behaviors from emotions, couples (and clinicians) learn about the couple's beliefs and feelings about their relationship, and how they affect the individuals, their partners, and the relationship as a whole. Following assessment of the couple's potential for adaptation, couples gain skills to modify behaviors, effectively express emotions, and break maladaptive patterns. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Falicov, C. J. (1995). Cross-cultural marriages. | Book | Case studies used as a clinical guide for practitioners. | N/A | N/A | N/A | N/A | Clinical examples illustrate how couples use cultural differences in their relationship to thrive by developing balanced views of their similarities and differences. Explains the use of |

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| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
|---|---|---|---|---|---|---|---|
| Frame, M. W. (2004). The challenges of intercultural marriage: Strategies for pastoral care. | Journal Article | Purpose: To describe unique issues associated with intercultural marriages and provide counseling strategies for clergy and pastoral counselors working with intercultural couples. | N/A | N/A | Literature Review | N/A | There is an increase of individuals from different cultural backgrounds choosing to get married, which raises cultural differences as concerns in their marriages. Clergy and pastoral counselors are encouraged to increase effectiveness in supporting these couples. Strategies to increase this effectiveness include learning about the couple's couple's cultural values, assessing their worldviews and acculturation, creating spiritual and cultural genograms, reframing cultural challenges, collaborating with indigenous healers, inventing new rituals, and developing the advocacy role. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Giorgi, A. (2009). The descriptive phenomenological method in psychology: A modified Husserlian approach. | Book | A guide for researchers conducting psychological research from a phenomenological and qualitative approach. | N/A | N/A | N/A | N/A | Author proposes a theoretically grounded method in phenomenological philosophy for conducting qualitative research. He postulates that a broad phenomenological theory is conducive to more psychological development. A |

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| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Hays, P. A. (2001). Addressing cultural complexities in practice: A framework for clinicians and counselors. | Book | Purpose: To address the "multiplicity of cultural influences" involved in the development of identities. To introduce a framework for recognizing and working with cultural influences, and to understand identity as multidimensional. | N/A | N/A | N/A | The framework developed to better understand the concept of identity is best applied when practitioners engage in their own cultural self-assessment and exploration. Next, therapists are encouraged to learn and understand the diverse identities their clients hold about themselves and to take steps to increase accuracy of their understanding. | Identity is a multidimensional combination of age, developmental and acquired disabilities, religion ethnicities, socioeconomic status, sexual orientation, indigenous heritage, national origin, and gender (ADDRESSING). |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Heller, P. E., & Wood, B. (2000). The influence of religious and ethnic differences on marital intimacy: Intermarriage versus intramarriage. | Journal Article | Purpose: To investigate whether religious and ethnic similarities and differences function in the development of intimacy in the early stage of marriage. Hypothesis: similarly acculturated intramarried couples in the | Two groups of couples, intramarried (both partners were raised and currently identify as Jews) couples (N = 25) and intermarried (one partner was raised and | Subjective and objective analysis using Personal Assessment of Intimate Relationships (PAIR); Demographic and Attitudinal Questionnaire; vignettes and interview questions | 2 groups were examined with respect to three aspects of marital intimacy: (1) couple level of intimacy, (2) similarity of intimate experience, and (3) couple accuracy of prediction of | Intramarried couples appear to experience greater personal similarity and mutual understanding rooted in their ethnic bond, which aids the development of intimacy. Intermarried couples | These findings indicate that clinicians and religious leaders should not assume that intermarriage constrains levels of intimacy. Nor should it be assumed that intramarriage assures high intimacy. |

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| | | first 5 years of marriage would report significantly greater intimacy than a comparable group of intermarried couples. | currently identifies as a Jew and the other partner was raised in a different religious and ethnic background ) couples (N = 25); all resided in easter US, between 26 and 35 years of age, All but 3 subjects completed undergraduate studies, and 52% of the husbands and 64% of the wives received masters' and/or professional/doctoral educations. | | partners' feelings of intimacy (i.e., mutual understanding). | appear to find that the very process of negotiating ethnic differences leads to greater mutual understanding and intimacy. | |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Hsu, J. (2001). Marital therapy for intercultural couples. | Book Chapter | Purpose: In a clinical guide to practice that addresses culture and psychotherapy, this chapter focuses on the stressors faced by intercultural couples due to their cultural gaps and illustrates them through case vignettes and discussions. Each vignette addresses clinical points of interest and how to effectively treat unique differences in each intercultural relationship. | N/A | N/A | N/A | Some of the commonly seen stressors in intercultural marriages include individuals who may view the ethnic or racial group of their partner as either inferior or superior. The author also speaks of gaps between individuals' fantasies and realities of what marriage will be like with someone from a different cultural | "Intermarriage" should not be conceptualized as inherently consumed with problems or assumed to be unsatisfactory. It is important for clinicians working with "intermarried couples" to remain sensitive to perceptions held by each partner about their own culture and their partner's culture. Clinical considerations include, ethnic matching and therapeutic neutrality, an emphasis on positive forces in order to build common ground between partners, promoting knowledge about their partners' |

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| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Jacobson, N.D., & Christensen, A. (1996) Integrative couple therapy: promoting acceptance and change. | Book chapter | A clinical guide for practitioners. | N/A | N/A | N/A | N/A | Book chapter in Culture and Psychology: A Guide to Clinical Practice. Incorporates understanding of cultural diversity into clinical practice with couples by identifying underlying stressors. Couples where partners identify as culturally different already enter the marriage with an increased risk for experiencing stress because they bring more differences into their relationship. Emphasis is recommended on identifying key stressors of the intercultural couple (e.g., child rearing, gender roles, |

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| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Jacobson, N.D., & Christensen, A. (1998) Acceptance and change in couple therapy. | Book | A clinical guide for practitioners. | N/A | N/A | N/A | N/A | First edition on integrative couple therapy: Traditional behavioral therapy is not sufficient in producing long-term relationship satisfaction and acceptance is missing in couples that focus on changing their partner and their partner's behaviors. Explains acceptance as not resignation, but redefine problems as "vehicles for intimacy" that bring the couple together to generate closeness, and by letting go of the struggle to change each other. This guide also teaches clinicians how to assess and develop clinical formulations, as well as implementing specific techniques. Lastly, it offers considerations in therapy, such as diversity in gender, ethnicity, class, and sexual orientation; also, indicates that couples that engage in domestic violence should be assessed for appropriateness of couple therapy. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Jacobson, N.S., Christensen, A., Prince, S.E., Cordova, J., & Eldridge, K. (2000). Integrative behavioral couple therapy: an acceptance-based, promising new treatment for couple discord. | Journal Article | Purpose: To provide preliminary data on IBCT, a new approach to couple therapy that focuses on acceptance of aspects of one's partner that appear unchangeable. This strategy is secondary to behavior change as seen in traditional behavioral couple therapy (TBCT). Purpose of this study also aims to determine how strategies to create intimacy around unsolvable problems can lead to acceptance and paradoxically lead to change. | 21 legally married couples, who requested therapy for marital distress. These couples were required to be living together, legally married, and between 21 and 60 years old. Measure used to determine clinically significant marital distress included the MSI Global Distress Scale (GDS > 58) | Independent Variable: 2 independent variables: Integrative Behavioral Couple Therapy (IBCT) and Traditional Behavioral Couple Therapy (TBCT).<br><br>Dependent Variable: 1 dependent variable: Marital Satisfaction<br><br>Level of satisfaction was measured by Global Distress Scale (GDS) of the Marital Satisfaction Inventory and the Dyadic Adjustment Scale.<br><br>Additional measures included: Adherence Scale and Behavioral Couple Therapy Competence Rating Scale. | Experimental | Change oriented interventions are significantly more likely to be used in TBCT whereas acceptance-based interventions are significantly more likely to be used in IBCT. Therapists were also shown to be adhering to treatment models and those conducting both were able to keep them distinct. Regarding treatment outcome, both husbands and wives experienced greater improvements in their satisfaction following IBCT than they did following TBCT. Lastly, 64% of TBCT couples either improved or recovered and 80% of IBCT couples either improved or recovered. | IBCT was demonstrated to be a distinct and effective treatment as compared to TBCT. Therapists were successfully able to implement interventions in IBCT and change-oriented interventions in TBCT. Results suggest that acceptance interventions may be a more efficient way at producing behavior change than the more direct attempts found in TBCT. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Johnson, S. M. (2004). The practice of emotionally focused coupled therapy. | Book | A clinical guide for practitioners. | N/A | N/A | N/A | N/A | Findings indicate that EFT couple interventions have been systematically and empirically validated. EFT arose from family therapy techniques that could be applied to couples. Focus of this therapy is to access the key emotional responses of partners that underlie how they interact with one another. New emotional experiences modify patterns in the relationship. Emphasizes attachment and creating a secure attachment within the relationship. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Johnson, M. D., Cohan, C. L., Davila, J., Lawrence, E., Rogge, R. D., Karney, B. R., & Bradbury, T. N. (2005). Problem-solving skills and affective expressions as predictors of change in marital satisfaction. | Journal Article | Purpose: To test three hypotheses 1) most correlations between skills and affects would be reliable but not statistically or conceptually redundant, 2) changes in satisfaction predicted by negative but not positive skills, by negative affect, and by positive affect. 3) couples would decline most rapidly in satisfaction to the extent that their interactions are characterized by high levels of negative skills and low levels of positive affect, | 172 couples; wives averaged 26 years of age, 16.2 years of education, and with a median annual income between $11,000 and $12,000 with 61% being Caucasian, 15% Asian American-Pacific Islander, 5% African American, 16% Latina-Chicana, 2% Middle-Eastern, and 1% other. Husbands | Predictor Variables: Husbands' vs. wives' topics under discussion; skills; affect Criterion Variable: husbands' vs. wives' satisfaction<br><br>Behavioral assessment and self-report assessments used the following questionnaires: Marital Adjustment Test (MAT), Inventory of Marital Problems (IMP). Behavioral observations incorporated the Specific Affect (SPAFF) Coding System | Correlational | Wives displayed significantly more negative affect than husbands in husband-selected topics and in wife-selected topics; no reliable differences in husbands' behavior or in wives' behavior as a function of whether they or their partner identified the topic for discussion; the mean correlation between negative skills and negative affect is .49 | Skills, affect, and their statistical interaction account for unique variance in rates of change in marital satisfaction. The interaction between positive affect and negative skills was particularly robust, indicating that (a) low levels of positive affect and high levels of negative skills foreshadowed rapid rates of deterioration and that (b) high levels of positive affect buffered the effects of high levels of negative skills. Findings suggest specific targets for intervention in programs for developing marriages. |

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| | | and low levels of positive skills and high levels of negative affect. | averaged 27.6 years of age, 15.6 years of education, and a median annual income between $21,000 and $30,000 with 67% being Caucasian, 13% Asian American-Pacific Islander, 4% African American, 15% Latino-Chicano, 1% Middle-Eastern, and none as other. | Version 1.0. The Kategoriensystem fu¨r Partnerschaftliche Interaktion (KPI) was used to code skills that spouses displayed during problem solving interactions. | | and the mean correlation between positive skills and positive affect is .18; there are robust correlations between husbands' and wives' positive affects (.80 and .64, in the wives' and husbands' topics, respectively), negative effects (.69 and .60), positive skills (–.34 and .29), and negative skills (.60 and .55). | |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Johnson, S. M., Hunsley, J., Greenberg, L., & Schindler, D. (1999). Emotionally focused couples therapy: Status and challenges. | Journal Article | Purpose: To describe the theoretical context of EFT; To outline nature of clinical interventions and steps hypothesized to be crucial to change in couples. To review outcome and process research on EFT and provide meta-analysis data. | N/A | N/A | Meta-analysis | N/A | Emotional responses and patterned interactional cycles, reliably predict long-term relationship distress and disruption. Main contribution of EFT: provided way to work with emotion and focus on the individual and couple simultaneously. Strategies have been adapted to different populations (diagnoses, settings, etcs.). Methodological limitations: almost all (but one) study involved the developers of EFT, and low generalizability. Data on how change occurs is also limited. Lastly, EFT might be more suitable for couples who demonstrate |

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| | | | | | | | anxious attachment styles than avoidant attachment. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Jurek, J., Janusz, B., Chwal, M., & de Barbaro, B. (2014). Premature terminatio n in couple therapy as a part of therapeuti c process: Cross case analysis. | Journal Article | Purpose: To answer why couples drop-out from couple therapy at the early stage of Treatment and to examine the phenomenon of early drop-out from three different perspectives: from therapists and both spouses point of view. | Three selected couples; derived from the middle class with an average economic status. All couples came to therapy on their own will. | N/A | Qualitative; interviews with therapists as well as both partners and the therapy records; cross-case analysis | Categories were singled out which were characteristic for those three cases of drop-out: 1) 'the split of the working alliance' and 2) 'the split of the therapeutic bond' showed that the conflict which the couple brought to the therapy was reflected in their experience of the therapy and the therapist. | Premature termination in couple therapy is a part of therapeutic process. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Kim, H., Prouty, A. M., & Roberson, P. E. (2012). Narrative therapy with intercultur al couples: A case study. | Journal Article | Purpose: To present an example of the use of narrative therapy with an intercultural couple and to examine issues that may be facing many intercultural couples, including acculturation, societal pressures, and differences in role beliefs. The case application intends to illustrate two | Female participant: 29 years old, Haitian of African decent, with English as her second language. She had a master's degree.<br><br>Male participant: 29 years old, US-born, Italian-American, with a two- | N/A | Qualitative: Case Study | A "multi-voiced" sense of identity helped this couple draw on many of their values and traditions in order to negotiate and establish norms for their unique relationship. Developing this capacity, to consciously co-construct a | Narrative therapy is intended to create "externalizing conversation" when utilized with couples, which help partners separate the problem from each other's identities. It is a flexible model that helps intercultural couples develop a larger understanding of how their cultures influence their perspectives, expectations, values, behaviors, and interpretations. |

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| | | specific narrative interventions with this population. | year college degree. | | | relationship, helps couples move more freely between their individual cultures. | |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Lebow., J.L., Chambers, A.L., Christensen, A., & Johnson, S. (2012). Research on the treatment of couple distress. | Journal Article | Purpose: To review and summarize the research on couple therapy between the year 2000 and 2009, as well as the state of the field of couple therapy. Article begins with epidemiology of couple distress and its relation to individual psychopathology. Integrative Behavioral Couple Therapy (IBCT) and Emotion-Focused Therapy (EFT) are specifically reviewed. | N/A | N/A | Meta-analysis | N/A | Couple therapy generally has the desired impact despite problems of couples being known to be difficult to change. In IBCT specifically, even the most distressed couples can and do benefit from couple therapy. Other than IBCT, EFT, Behavioral Couple Therapy (BCT) and Insight-Oriented Couple Therapy (IOCT), no other additional treatment approaches have moved to empirical support.<br><br>Marital distress is difficult to treat because: many who need couple therapy do not seek it out, there remain some couples in every treatment who do not improve with treatment, and most-term follow-up studies have shown a considerable reduction in impact o f treatment over long periods of time. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Lofquist, D., Lugaila, T., O'Connell, M., & Feliz, S. (2012). Households and families: 2010: 2010 census brief. | Online Government Report | Purpose: To define "household" and report on the relationship of each member of the household to the householder or the person designated as the individual who owns or rents the housing unit. Provides information about individuals as well as the composition of families and households. | N/A | N/A | N/A | N/A | Interracial or interethnic opposite-sex married couple households grew by 28% over the last 10 years from 7% in 2000 to 10 % in 2010. States with higher percentages of couples of a different race or Hispanic origin in 2010 were primarily located in the western and southwestern parts of the US, along with Hawaii and Alaska. A higher percentage of unmarried partners were interracial or interethnic than married couples. Nationally, 10% of opposite-sex married couples had partners of a different race or Hispanic origin, compared with 18% of opposite-sex unmarried partners and 21% of same-sex unmarried partners. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Mabry, C.R. (2010). The browning of America: Multicultural and bicultural families in conflict. | Journal Article | Purpose: To define culture and explain why it leads to dissolution of marriage, to explain how custody is determined by courts in many states and how culture is absent in these considerations, to explain why culture should not be the sole factor in consideration of custody, to show which criteria mental | N/A | N/A | Qualitative: Case Study | N/A | Because our country is seeing growing numbers in multicultural families, more emphasis on culture is needed in matters regarding dissolution of marriage that affect families. The best interest of the child should take into consideration the cultural context in which the child was raised and everyone who is involved in the ruling should take into consideration the parents' cultural beliefs which |

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| | | health experts consider in custody evaluations, and to discuss the need for culturally competent parents, judges, lawyers and mental health professionals. | | | | | played roles in the decision-making of their child-rearing. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Mahgereft eh, H. (2015). Integrativ e behavioral couple therapy: A case study. | Dissertation | Purpose: To illustrate the use of Integrative Behavioral Couple Therapy and examine change processes and change mechanisms observed in successful treatment of a couple. | A male and female in their late 20's and early 30's who had been married for five years. They had two children together at the time of treatment. | N/A | Qualitative: Discovery-oriented Case Study. | Both husband and wife's level of distress decreased overtime. Wife's marital satisfaction increased more than husband's by the end of treatment. Acceptance of partner's behaviors and marital satisfaction increased in both husband and wife. Both demonstrated an increase in positive behaviors, and a decrease in negative behaviors. Regarding change processes, unified detachment was used most frequently, followed by empathic joining, and then tolerance interventions , which were used in only two sessions. | IBCT interventions for unified detachment and empathic joining help foster acceptance and increase marital satisfaction. Inducing vulnerability was particularly important for this couple throughout therapy, as it served as a de-escalating mechanism. Overtime, the couple demonstrated ability to elicit vulnerability without the help of the therapist. Change processes also transformed into change mechanisms. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Mahrer, A. R., & Boulet, D. B. (1999). How to do discovery-oriented psychotherapy research. | Journal Article | Purpose: To provide logistics and steps in conducting discovery-oriented psychotherapy research. | N/A | N/A | Literature Review | N/A | Discovery-oriented research must rely on research questions. It is important to also have a large research team that is enthusiastic about the topic. Also, continuously developing and refining categories that emerge produce richer findings. Lastly, authors make the case that discovery-oriented research makes for an "elegant way to find and to describe," explaining that this approach offers more careful and sensitive exploration of events and changes. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| McGoldrick, M., Giordano, J., Garcia-Preto, N. (2005). Overview: Ethnicity and Family Therapy. | Book | Purpose: To define "ethnicity" and illustrate how different families relate to their ethnic heritages in order to understand cultural implication for therapy. | N/A | N/A | N/A | N/A | The term "cultural competence" is becoming a more accepted value in the field, as it recognizes the importance in the development of an individual's ethnic and racial identity as an essential component for group identity and mental health. Culturally competent healthcare also now addresses sociocultural barriers to treatment of diverse populations. Lastly, ethnicity is understood as only one cultural dimension. This book recognizes other cultural dimensions affecting individual and group identity (as well as treatment), including gender, |

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| | | | | | | | SES, geography, race, religion, and politics as other influences. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Nelson, T. S., & Allred, D. D. (2005). Survey research in marriage and family therapy. In D. H. Sprenkle, F. P. Piercy (Eds.) , *Research methods in family therapy (2nd ed.)* | Book Chapter | Purpose: To discuss survey methods that describe, explain, and/or explore (1) aspects of participants' experience, (2) how the data relates to each other and to other data, and (3) how results can draw generalizations about larger populations. | N/A | N/A | N/A | N/A | The history of survey research goes back to ancient civilizations (e.g., Egyptians and Romans) that used census surveys to gather information about their citizens for various reasons pertaining to national interest. Today, surveys in family therapy research are designed to understand clinicians' experiences (i.e., what they think or do), in various clinical situations, as well as their attitudes, opinions, and views on various clinical matters. In planning and designing survey research, a clinician must 1) determine purpose and set goals, 2) develop research questions carefully with appropriate and clearly defined variables, 3) establish sampling and data-gathering techniques (e.g., telephone interviews, self-administered questionnaires), 4) determine how data will be stored, coded and analyzed, and 5) establishing where and how the results will be reported. Lastly, because survey research can easily use clinicians and their clients as participants, this type of research methodology is useful in bridging the gap between researchers and |

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| | | | | | | | clinicians in the field. And with advancement in technology, future survey research will see more electronic media (e.g., email, web-based research). |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Noy, C. (2008). Sampling knowledge: The hermeneutics of snowball sampling in qualitative research. | Journal Article | Purpose: Two illustrate how snowball sampling methodology can generate a unique type of social knowledge through "constructivist and feminist hermeneutics." The author poses two scenarios that demonstrate interrelations between sampling and interviewing facets, which reconceptualize snowball sampling to highlight power relations, social networks, and social capital. | N/A | N/A | Literature Review | N/A | Snowball sampling is effective when research involves organic social networks because it allows for a social structure. A social network helps members access opportunities. Sampling and interviewing are interrelated. In sum, participants in the examples provided demonstrated how they significantly influence the research and how the research plays into existing social dynamics among participants. Lastly, it demonstrates how additional knowledge is gained through snowball sampling. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Perel, E. (2000). A tourist's view of marriage: Cross-cultural couples—Challenges, choices, and implications for therapy. . | Book Chapter | Purpose: To address issues related to cross cultural marriages and implications for therapy. | N/A | N/A | N/A | A model is presented of how high- and low-context cultures define individualism, time, the nature of the universe and attitude toward life, family structure, emotional expressiveness and communication, thinking, and power | High-context cultures tend to value intragroup dependence, predictability, and the maintenance of "face," whereas lowcontext cultures tend to value independence, self-sufficiency, and a direct communication style. This framework could be used as a starting point for couples to consider how cultural differences relate to marital difficulties. |

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| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Rowley, J. (2002). Using case studies in research. | Journal Article | Purpose: To draw on established texts on case study research and related areas in order to uncover key principles that would be applicable to researchers. This article also discusses different elements involved in case study research, including how and when it can be used, basics of design, data collection procedures, and data analysis. Finally, the article provides recommendations for drawing on evidence in order to write up a report or dissertation. | N/A | N/A | Literature Review | N/A | Case study research investigates a real life phenomenon in its context and can be studied through direct detailed observations, interviews, and/or documents. The design involves single or multiple cases. It includes multiple components, such as the study's questions, the study's propositions, units of analysis, the logic used to link data collected to previous propositions made, and the criteria for making interpretations. Data collection should be guided by protocol. Evidence can be gathered through triangulation, a database, or chain. Good analysis makes use of all the relevant data, considers all alternative interpretations, addresses the most significant aspects, and draws on prior research. Finally, in writing a report or dissertation, it is most important for the researcher to understand the methodology and how the research makes an important contribution to existing knowledge. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Schachter, J.S. (2015). Processes and mechanisms of change | Dissertation | Purpose: To increase understanding of IBCT and expand upon existing | One of 134 couples from the original clinical trial of couple | N/A/ | Qualitative: Case Study | Pretreatment, wife reported general distress and decreased distress at 13 | Acceptance grew consistently for couple over the course of treatment and ended therapy with great |

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| in integrative behavioral couple therapy: A case study of one couple with distress over child rearing. | | literature related to marital conflict and child rearing. This author sought to answer research questions through the Doss et al. (2005) framework for studying change in psychotherapy. These changes were studied through a case study of a selected couple that presented with conflict over child rearing, in order to examine change processes, change mechanisms, and treatment outcomes following IBCT. | therapy (Christensen et al., 2004, 2008, 2014). The couple was a Caucasian male in his early 60s and a Caucasian female in her early 40s who had been married for over 10 years. They had a schooled aged son. The couple successfully completed treatment in IBCT. | | | weeks and then later at 26 weeks. Marital satisfaction score steadily increased through treatment. Husband's marital distress scores were relatively similar, but wife reported more distress over child rearing at 26 weeks than did husband. Regarding change mechanisms, wife reported a general increase in acceptance of husband's behavior over the course of treatment, with a particularly large increase between pre-treatment and 13 weeks. The husband's level of acceptance of his wife's behavior also steadily increased throughout treatment, with a steady increase of reported positive behaviors of his wife. Regarding therapy change processes, frequent utilization of empathic joining (e.g., reformulation of the problem) was observed, as | improvements in their martial satisfaction. Positive behaviors increased while negative behaviors decreased for both husband and wife. Unified detachment and empathic joining were utilized most by the therapist interacted with change processes and resulted in greater vulnerability, which then encouraged positive behavior change.<br><br>It is important to utilize behavioral interventions with consideration of "timing" as moving into behavior changes with this couple prematurely led to led to rejection of the interventions. Acceptance interventions were more impactful at the beginning of therapy and opened the couple to behavioral interventions/ homework assignments at the end of therapy. |

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| | | | | | | well as the use of unified detachment through therapist's attempt to summarize the problem in a non-blaming way, and tolerance building by instructing partners to exaggerate negative behaviors. No change in body language was observed at any point during treatment, which was consistent with a reported marital problem of lack of physical intimacy. However, with greater emotional vulnerability, each partner reciprocated by expressing deeper more vulnerable emotions in return. Behavior change was evident in decreased conflict and increase in acts of affection and physical intimacy over time, with communicati on noted as increasing most. | |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Seshadri, G., & Knudson-Martin, C. (2013). How couples manage interracial and intercultural differences: Implications for clinical practice. | Journal Article | Purpose: To understand how couples manage their intercultural and interracial differences. | 17 participant couples in California, who were identified through snowball methodology. Couples had to define themselves as an interracial couple (grew up with different customs, traditions, and expectations), be heterosexual, and be married for at least 2 years. Nine of the couples had at least 1 partner who was foreign born. Twelve couples had children. Multiracial individuals were included as well. All participants included a wide range of educational and occupational backgrounds. | N/A | Qualitative: Grounded Theory | Couples organized around their cultural differences into four distinct categories: Integrated, coexisting, singularly assimilated, and unresolved. Several relational strategies emerged, including: creating a co-constructed narrative of reality (creating a "we"--developing friendship, common ground, similar goals, and working together over time and commitment), framing differences, emotional maintenance, and positioning themselves with family and social contexts. | Four major strengths of couples who manage interracial and intercultural differences: Couples who created a "We" are couples who developed a new co-constructed narrative of the reality of their relationship. Framing differences required couples refrain from making racial and cultural issues central. Instead, they shared differences as an attractive quality of their partner, while demonstrating flexibility, respect, and seeing their differences as opportunities to learn and celebrate one another. Emotional maintenance is demonstrated in couples that turn to one another for emotional support through communication about their feelings and insecurities, especially as they pertain to cultural issues in their relationship. Lastly, through appropriate positioning in relation to societal and familial context, couples successfully deal with issues such as discrimination and negative judgments by others about their relationship. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Sevier, M. & Yi, J.C. (2008). Cultural considerations in evidence-based traditional | Journal Article | Purpose: To examine common cultural assumptions and cultural considerations in conducting couples therapy | N/A | N/A | Literature Review | N/A | It is important for clinicians to refrain from common assumptions, such as: focusing on behaviors as a problem rather than proximal variables like family history |

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| and integrative behavioral couple therapy. | | (including specific interventions requiring careful cultural consideration), to discuss the importance of cultural competence, and to provide suggestions for training, supervision, and personal reflection. | | | | | and culture, maintaining different expectations in the role of the therapist (e.g., some cultures perceive therapist as a teacher/prescriptive doctor), expecting the couple to begin speaking openly about their problems when, in fact, it could be uncomfortable for some couples to disclose problems within their family. Within the interventions, therapist must be careful to assume that behavior exchange in an effort to achieve romantic love might be a Western notion that is incongruent with some cultures who may not believe in the egalitarian assumption embedded in TBCT. The openness of IBCT in regards to differences between partners, however, already makes this treatment approach more effective with a diverse population. Even still, assumptions can include directly focusing on and exploring problems, or talking about emotions, as utilized in IBCT, as the best strategies for relationships. Cultural considerations in interventions, such as unified detachment and empathic joining, should include sensitivity and understanding of individualistic vs. collectivistic cultures, especially when considering differences in communication styles. Supervision recommendations |

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| | | | | | | | include, fostering an environment where trainees feel comfortable bringing forth cultural issues and/or areas for further development. Cultural competence training also requires a wide range of knowledge and lessons to trainees about where to obtain that knowledge. Topics for reflection encourage clinicians to gain self-awareness. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Shadish, W.R. & Baldwin, S.A. (2003). Meta-analysis of MFT interventions. | Journal Article | Purpose: To provide a brief history of meta-analysis and then describe 20 meta-analyses that have already been done on the effects of both therapy and enrichment interventions with couples and families. | N/A | N/A | Meta-analysis | N/A | Marriage and family interventions are efficacious compared to no treatment. Those interventions are at least as efficacious as other modalities (e.g., individual therapy), and perhaps more effective in at least some cases. There is little evidence for differential efficacy among the various approaches, particularly if mediating and moderating variables are controlled. Evidence that marriage and family interventions are effective in clinically representative conditions remains generally sparse.<br><br>There is increased evidence for the clinical significance of the effects of marriage and family interventions. This is shown across several methodologies. Meta-analyses of marriage and family interventions are beginning to use |

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| | | | | | | | more sophisticated meta-analytic methods. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
|---|---|---|---|---|---|---|---|
| Silva, L. C., Campbell, K., & Wright, D. W. (2012). Intercultural relationships: Entry, adjustment, and cultural negotiations. | Journal Article | Purpose: To explain how partners choose one another as a result of specific developmental outcomes by the interaction of the individual with his/her environment. In other words, how the development of relationships is a result of person-enrvironment interactions, with "person" referring to biological and psychological characteristics, and "environment" referring to physical, social, cultural and historical contexts of individuals. Lastly, to provide clinical recommendations for treating intercultural couples. | N/A | N/A | N/A | Bronfenbrener's environmental systems explains how people from different cultural backgrounds meet each other through the macrosystem, exosystem, microsystem (family; individual), and chronosystem, and how they adjust within their relationships through these systems. | When entering an intercultural relationship through the macrosystem, immigration, globalization, and acculturation are important factors. Adjustment within the macrosystem is based level of acculturation to each other's cultures and within their own society. When entering an intercultural relationship through the exosystem, the communities in which families and individuals grow become important factors (e.g., religious groups, neighborhoods). Adjustment at this level may depend on the level of acceptance within the couple's community, circle of friends, neighborhood, etc. When entering an intercultural relationship through the microsystem (family and individual), family factors that influence individuals (learned roles, exposure to cultural norms, views, expectations) as well as intrapersonal characteristics that differentiate people (personality, openness to intercultural relationships) are considered. Adjustment within this system might depend on level of familial support, proximity, and individual's acceptance/acknowl |

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| | | | | | | | edgement of the existence of cultural differences. Lastly, on a chronosystemic level, couples are more likely to enter intercultural relationships due to the fact that these relationships are more socially acceptable during this time period. Adjustment may rely on the extent to which couples have developed a shared meaning system and merged desired elements of their cultural backgrounds. Overall, strategies for improved adjustment include: frequent intercultural contact and agreement on core values, commitment to learning about each other's culture, blending cultural scripts to create one scripts unique to the couple, involvement and communication with culturally liberal communities, exploring in depth each family's views on intercultural relationships and the roles that family will be play in each of their lives, tolerance for ambiguity, "attraction to exotic," and curiosity. Narrative therapy can help these couples explore the meanings they ascribe to multiple cultural factors in their lives. Culturally competent therapists are especially helpful to these couples. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
|---|---|---|---|---|---|---|---|
| Stake, R. E. (1995). The art of case study research. | Book | Purpose: Guide to conducting case-study research. Introduces theoretical principles of qualitative research and discusses different types of qualitative designs: naturalistic, holistic, ethnographic, phenomenological, etc. | N/A | N/A | N/A | N/A | N/A |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Strauss, A., & Corbin, J. (1998). Basics of qualitative research (2nd ed). | Book | Purpose: To define qualitative research and offer useful procedures for conducting qualitative research. To define grounded theory and describe the characteristics of grounded theorists. To describe methodology and methods of data analysis. | N/A | N/A | N/A | N/A | Qualitative research is research that produces findings that are not grounded in statistical procedures. Data is not quantified and processes are not mathematical. Data can consist of interviews, documents, and tapes, for the purpose of discovering concepts, relationships, and patterns that are organized and developed into explanations for particular phenomena. Grounded theorists aim to produce a theory based upon research data. They must have the ability to recognize bias, think abstractly and critically, analyze situations well, and remain sensitive toward participants. Book emphasizes that procedures and techniques are tools that enable one to conduct this research, but that they are not meant to be used rigidly; rather, tools are |

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| | | | | | | | used to instill confidence in the researcher in order to promote creativity as a driving force. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Sullivan, C., & Cottone, R. (2006). Culturally based couple therapy and intercultural relationships: A review of the literature. | Journal Article | Purpose: To provide a review of the literature on intercultural couples counseling and critique the racially based definition of intercultural. To explore how intercultural couples are conceptualized in treatment, to discuss issues that come up in counseling, and delineate therapeutic strategies for working with these couples. | N/A | N/A | Literature Review | Race, religion, ethnicity, and national origin are the primary factors differentiating partners from one another in intercultural relationships. One difference may not have a greater impact on another, but combination of differences can lead couples to greater distress. Intercultural couples deal with differences that other couples don't have—macrocultural characteristics (e.g., societal attitudes) and microcultural individual differences (e.g., habits, customs). Therapeutic strategies include educational and psychological components. Cultural competence on the part of the therapist is also essential, as well as the role of the therapist as a "referee" that clarifies and reframes behaviors causing | The field of couples counseling has made many advances in working with a diverse population, but more research is necessary in regards to intercultural couples, especially in the context of how race and oppression affects relationships and contributes to couple discord. Increase in cultural competence will help clinicians better identify the multitude of stressors that affect these couples. More research is encouraged to learn more about couples who are not simply "intercultural" on a racial level, but have different cultural arrangements. |

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| | | | | | | partners distress. "Third reality" is a concept that defines couples that have merged their differences and view their experience of their partner as a "tour" in a foreign country to elicit curiosity, interest, and sensitivity. | |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Tellis, W. (1997). Introduction to case study. | Journal Article | Purpose: The development and use of case methodology is discussed, as well as how to design a case study and analyze the data. | N/A | N/A | N/A | N/A | Case study methodology was first used in the United States in the early 1900s, and mostly in the field of sociology. Criticism focused on its inability to generalize results. Acceptance of case studies found that these studies are useful in that they aim to describe, understand, and explain in ways that experimental or quasi-experimental research do not. Case studies encourage critical thinking, "holistic understanding of cultural systems," and the development of theory. Designing a case study should include: study questions, propositions, units of analysis, the logic that links the data together, and appropriate criteria for how to interpret data. Before analysis, the research must develop a strategy that will successfully lead to conclusions (e.g., theoretical propositions or case |

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| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Therapists. (n. d.). Integrative Couple Behavioral Therapy (ICBT) Website | N/A | Website provides basic information about IBCT, useful resources and links, research publications, and presentations, as well as contact information of practicing IBCT therapists. | N/A | N/A | N/A | N/A | N/A |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Trimmer, J. & Warnock, T. (1992). Understanding others: Cultural and cross-cultural studies and the teaching of literature. | Book | Purpose: To provide varying perspectives to college teachers about cultural issues in literature programs. The book presents ideas in 19 essays from 19 scholars and teachers. Discusses culture-oriented criticism and teaching, contexts for activities, and specific texts that emphasize culture and are useful for college courses. | N/A | N/A | N/A | N/A | N/A |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
|---|---|---|---|---|---|---|---|
| Waldman, K., & Rubalcava, L. (2005). Psychotherapy with intercultural couples: A contemporary psychodynamic approach. | Journal Article | Purpose: To propose a methodology for working with couples through inter-subjectivity and self-psychology. To explain how culture plays an important role in the construction of the individual's | Two intercultural couples: 1) Male is first generation Chicano born; female is third-generation Mexican-American, and couple struggled to | N/A | Qualitative: Case Study Research | 1) Male and female partners had two distinct ways of organizing cultural principles. Female learned that she was acting like her dominant mother and was able to | The self-psychology concept of "good enough mother" is used in this article to define "good enough marriages" where partners can provide for one another with selfobject functions while experiencing relational ruptures through misunderstandings as a result of |

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| | | subjectivity. This is explained in the context of the intercultural couple's psychodynamics. These theoretical assumptions are illustrated in two case studies. | mediate their collectivistic and individualistic cultures, respectively. 2) Male immigrated to US during his teens and came from a small traditional village in rural part of Mexico; female immigrated to US during her teens and grew up in a large, progressive, and industrial, Mexican urban center. | | | explore how her familial upbringing affected her relationship. Male learned that his behavior was seen as dependent by his wife, who came from an individualistic culture, and that his culture led him to perceive her behavior as self-centered and insensitive. 2) Male learned to differentiate from his mother (emotionally) and female learned that she perceived her husband as an ideal father, which caused great disappointment when he behaved in ways she perceived as disloyal. This couple learned how to initiate and grow their own "relational culture." | cultural differences. Culture, in this sense, contributes to the construction of individual subjectivity within the intercultural relationship. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Ward, D.B., & Wampler, K.S. (2010). Moving up the continuum of hope: Developing a theory of hope and understanding its influence in couples therapy. | Journal Article | Purpose: To address the need for a clearer understanding and conceptualization of "hope" in couple therapy. To develop interventions that utilize hope as part of the treatment of couples in distress and gain knowledge of when to use these interventions. | Fifteen active & experienced marriage and family therapists from across the US participated in hour-long phone interviews about hope in couples therapy. Therapists averaged 8-10 hours per week conducting | Interview questions: (a) What does hope mean to you? (b) What other ideas come to mind when you think of hope? (c) What's been your experience of hope in your clinical work with couples? (d) In what ways, if any, does hope influence therapeutic change? (e) | Qualitative: Grounded-Theory | Four properties of hope were identified: Evidence, Options, Actions, and Connections. In order for hope to maintain, it must be backed up by evidence within the relationship. Options indicate that couples that feel and | Hope was defined in this study as "a belief and a feeling that a desired outcome is possible.'' Therapists interviewed also spoke to "hope" as a continuum, in addition to the four properties identified in their responses. Categories along this continuum include: Lost, Lost/Ambivalent, and Solid—each with varying levels |

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| | | | couple therapy. | Please provide me with as many specific examples, from your work or work you've seen with couples, where hope was a component of therapy; (f) Please provide me with as many specific examples, from your work or work you've seen with couples, where hope was lacking; and (g) Is the therapist's hope important? If so, why? If so, how do you maintain it? | | believe that they have the ability to choose a pathway/direction toward positive outcomes for their relationship are likely to maintain hope. Action refers to their beliefs about being able to achieve their desired relationship outcome, and Connections refers to partners' belief that they can achieve their desired outcome based on the fact that their partner is able to have connections with other human beings or a higher power. | of the four previously identified properties.<br><br>Three major processes were discovered that help couples to increase hope: Creating a Hopeful Context, Cutting the Engine on the Freight Train, and Getting Over the Hump. |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
|---|---|---|---|---|---|---|---|
| Yin, R.K., (2014). Case study research: Design and methods. | Textbook | Purpose: To offer comprehensive coverage of the design and use of the case study method as a valid research tool. The book defines case study method and discusses design and analysis techniques. Includes case studies and tutorials, covers values and ethics, and discusses logic models. | N/A | N/A | N/A | N/A | N/A |

| Author, Year, Title | Publication Type | Objectives/ Hypothesis | Sample | Variables/ Instruments | Research Design | Results/ Statistics | Major Findings |
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| Zucker, D.M., (2009). How to Do Case Study Research. | Book Chapter | Purpose: This paper discusses step-by-step methods to conducting case study research for beginning researchers. Definitions for case study are provided, as well as preparation tools (developing goals, ideas, and a purpose for conducting a case study). Additionally, the author presents strategies, descriptions of samples, and methods of analysis and how to write up the data. | N/A | N/A | N/A | N/A | N/A |

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APPENDIX B

Phone Script for Initial Contact

**Greeting**

"Hello, may I please speak to Dr./Mr./Ms. _____? My name is Caroline Kalai and I am a doctoral student in clinical psychology at Pepperdine University. I received your telephone number from UCLA's IBCT website (or indicate referral) and I'm calling to ask if you are interested in participating in a research study that I will be conducting for my dissertation on the use of IBCT with intercultural couples."

**Response**

*If they decline*. "Okay, that's not a problem at all. Thank you for taking my call and I appreciate your time. May I leave you my phone number and email address should you know of any other IBCT therapists that may be interested in participating?

*Conclude with:* "Thanks again and please don't hesitate to reach me. My number is [redacted] and my email is [redacted]. Have a great day!"

*If they show interest.* "I am looking for practicing IBCT therapists who can complete an open-ended questionnaire about their experience utilizing this treatment approach with intercultural couples. I can email a packet that includes an information sheet, and a short screening form. All I would need is a preferred email address."

*Conclude with:* "Thank you for your time and I look forward to hearing from you!"

Voicemail script

"Hello Dr./Mr./Ms._____, my name is Caroline Kalai and I am a doctoral student in clinical psychology at Pepperdine University. I received your telephone number from UCLA's IBCT website (or indicate referral) and I'm calling to ask if you are interested in participating in a research study that I will be conducting for my dissertation. Your participation will require you to write responses to open-ended questions about your experience utilizing IBCT with intercultural couples. I would enjoy speaking more with you about my study, so please feel free to call me at [redacted] or send me an email at [redacted]m. I'd be happy to send you an information packet. Thank you, and I hope to speak with you soon!"

# APPENDIX C

## Pepperdine University Information/Facts Sheet for Exempt Research

**INTEGRATIVE BEHAVIORL COUPLE THERAPY WITH INTERCULTURAL COUPLES: HELPING COUPLES NAVIGATE CULTURAL DIFFERENCES**

You are invited to participate in a research study conducted by Caroline Kalai, M.A. and Kathleen Eldridge, Ph.D. at Pepperdine University because you are a practicing IBCT therapist. Your participation is voluntary. You should read the information below and ask questions about anything that you do not understand before deciding whether to participate. Please take as much time as you need to read this document. You may also decide to discuss participation with your family or friends.

**PURPOSE OF THE STUDY**

The purpose of this study is to contribute to the literature on Integrative Behavioral Couple Therapy and the literature on intercultural couples by providing rich case-based descriptions of how therapists use IBCT with intercultural couples, and to provide recommendations for treatment of intercultural couples. This objective will be achieved through use of an explorative and qualitative approach within a multiple case study design. This study is designed to: 1) provide detailed examples of cultural differences among couples seeking therapy, and how those differences are formulated using an IBCT conceptualization, 2) provide detailed descriptions of how specific IBCT interventions are used to bring about change and acceptance in those problematic areas, 3) summarize therapists' perspectives on the utility of specific IBCT techniques with intercultural conflicts, and 4) provide IBCT-specific and general clinical recommendations for working with intercultural couples.

**PARTICIPANT INVOLVEMENT**

If you agree to voluntarily take part in this study, you will be asked to complete a screening form about your experience using Integrative Behavioral Couple Therapy (IBCT) to determine participant eligibility. If you are eligible, you will complete a document with open-ended questions about utilizing this treatment approach with intercultural couples in general, and specifically with one case you select from your experience. You may also be contacted following your participation for clarification of responses.

**PARTICIPATION AND WITHDRAWAL**

Your participation is voluntary. Your refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights, or remedies because of your participation in this research study.

**ALTERNATIVES TO FULL PARTICIPATION**

The alternative to participation in the study is not participating or completing only the items you feel comfortable completing.

**CONFIDENTIALITY**

I will keep your records for this study confidential as far as permitted by law. However, if I am required to do so by law, I may disclose information collected about you. Examples of the types of issues that would require me to break confidentiality are if you tell me about instances of child abuse and elder abuse. Pepperdine's University's Human Subjects Protection Program (HSPP) may also access the data collected. The HSPP occasionally reviews and monitors research studies to protect the rights and welfare of research subjects.

The data will be stored on a password-protected computer in the principal investigators place of residence. The data will be stored for a minimum of three years. The data collected will be coded and de-identified, ensuring numbers and pseudonyms only for therapists and clients. Information packets and questionnaires will be handled electronically, as they will be sent to you via email. Although the screening measure asks for your name (not your clients' names), this document will be stored separately from open-ended responses, which are also emailed separately. No personally identifying information will be requested on the questionnaire itself (e.g., name, license #), although your responses to basic demographic questions (e.g., ethnicity, age, etc.) will be optional and will not directly identify you. Upon return of the questionnaires, each questionnaire will be assigned a number (e.g., therapist 1, therapist 2) in preparation for data analysis. All emails containing attachments with confidential information (i.e., completed screening measure and questionnaire) will be permanently deleted after the data is stored in a password protected computer file so that information is not accessible via Internet. The data will be kept for a maximum of five years.

**INVESTIGATOR'S CONTACT INFORMATION**

I understand that the investigator is willing to answer any inquiries I may have concerning the research herein described. I understand that I may contact the student principal investigator, Caroline Kalai, at [redacted] or her faculty advisor, Dr. Kathleen Eldridge, at [redacted] if I have any other questions or concerns about this research. If you have questions about your rights as a research participant, contact Dr. Thema Bryant-Davis, Chairperson of the Graduate & Professional School Institutional Review Board (GPS IRB) at Pepperdine University, via email at gpsirb@pepperdine.edu or at 310-568-5753.

**RIGHTS OF RESEARCH PARTICIPANT – IRB CONTACT INFORMATION**

If you have questions, concerns or complaints about your rights as a research participant or research in general please contact Dr. Thema Bryant-Davis, Chairperson of the Graduate & Professional School Institutional Review Board at Pepperdine University 6100 Center Drive Suite 500 Los Angeles, CA 90045, 310-568-5753 or gpsirb@pepperdine.edu.

# APPENDIX D

## Participant Screening

Dear colleague,

My name is Caroline Kalai and I am a doctoral candidate in clinical psychology at Pepperdine University. Thank you for your interest in contributing to my dissertation study and to the existing literature on Integrative Behavioral Couple Therapy!

My interest in cultural diversity, relationship satisfaction, and empirically supported treatment for couples has led to my current research examining the application of the Integrative Behavioral Couple Therapy approach (IBCT; Christensen, Doss, & Jacobson, 2014; Jacobson & Christensen, 1996) with intercultural couples. The method of my research is to qualitatively study IBCT therapists' experiences through responses to a questionnaire, in order to:

1) Describe therapists' formulations of the difficulties faced by intercultural couples.
2) Examine how specific IBCT techniques (e.g., empathic joining, unified detachment) have been tailored to accommodate partners' culturally rooted differences.
3) Understand the therapists' perspectives on how IBCT can be used effectively with intercultural couples. What aspects of IBCT are particularly suited for intercultural couples?
4) Develop recommendations for therapists via rich descriptions of therapy processes.

Your participation in my study will help contribute to the growing literature on IBCT and its use with intercultural couples (i.e., partners who differ racially, ethnically, religiously, etc.) in particular. Notably, it will contribute to growing knowledge on its effectiveness with intercultural couples whose presenting and primary relationship discord is rooted in their reported cultural differences, or whose participation in therapy led to the discovery of culturally rooted discord. To be considered as a participant in this study, I appreciatively ask that the following screening be completed in order to determine inclusion in the study.

Should you be qualified to participate in the study, I will email you a questionnaire to complete. Your privacy (and anonymity of your clients) will be maintained through the use of pseudonyms, which will be further outlined in an information/fact sheet.

Please email responses to the short screening in the Word document provided to [redacted]. For any questions or further information, I encourage you to also reach me at [redacted], or my dissertation chair, Dr. Kathleen Eldridge, at [redacted].

Thank you and I look forward to hearing from you!

Caroline Kalai, M.A.

Kathleen Eldridge, Ph.D.

**Name:** _____ **Email:** _____

**Preferred Phone:**_____ **License type (e.g., MFT, PsyD):**_____

**Years in Practice (post-licensure):**_____

**Preferred Psychotherapy Orientation:**_____

**Practice Settings where you have conducted couple therapy:**_____

_____

1) Please provide an estimate of how many couples you see in your clinical work a year.

2) Please list the extent of your IBCT training/experience (e.g., workshops, specific books utilized, formal instruction, supervision, teaching).

3) If/when you work with couples, how often do you utilize IBCT?

1-Never, 2-Rarely, 3-Sometimes, 4-Almost Always, 5-Always.

N/A—I don't work with couples.

4) Do you utilize *some* IBCT techniques, or adhere purely to the approach? If some, please describe.

5) Intercultural couples in this study are defined as couples that identify as culturally different from one another on an ethnic, nationalistic, racial, religious, and/or other multiple levels, not limited to demographic categories, and not solely gender differences. Have you used IBCT with an intercultural couple struggling with culturally rooted relationship discord?
If so, about how many?

6) Can you provide an estimate of the average length that these couples remained in therapy (e.g., about how many sessions)?

7) Would you be able to recall **one** specific intercultural couple with whom you used IBCT to effectively strengthen their relationship despite cultural differences that were causing them distress
(yes, no)?

8) Would you have specific recollections about use of IBCT interventions to help this couple and be able to describe some examples, (yes, no)?

9) How many years have you been using IBCT in your work with couples?

10) Are there any IBCT therapists whom you believe may be interested in participation and recommend I contact? Please provide contact information for them (email preferred). Thank you!

# APPENDIX E

## Email Script to Qualified Participants

Dear _____,

Thank you for your interest in contributing to my dissertation study and to the existing literature on Integrative Behavioral Couple Therapy! Your time and cooperation is greatly appreciated. Based on the information you provided on the participant screening form, it was determined that qualifications for participation are met and a completion of the questionnaire is kindly requested. Please complete the enclosed document and return it via email to [redacted]

Also, I encourage you to contact me if you have any questions as you are completing your responses. Likewise, should I need clarification in your responses, I may contact you via email.

Thank you again, and I look forward to hearing from you!

Sincerely,

Caroline Kalai, M.A.

## **Email Script to Unqualified Participants**

Dear _____,

Thank you for your interest in contributing to my dissertation study and to the existing literature on Integrative Behavioral Couple Therapy! Your time and cooperation in completing the screening form is greatly appreciated. Unfortunately, based on the information you provided and strict inclusion criteria of this study, it was determined that criteria for participation are not met at this time.

I am very grateful for your interest and would like to provide you with a copy of my completed work upon request as a token of my appreciation. Also, please do not hesitate to contact me with any questions!

Sincerely,

Caroline Kalai, M.A.
[redacted]

# APPENDIX F

## Survey Questions

In this study, *culture* goes beyond demographic categories (e.g., age, gender, nationality, religion) and socially constructed concepts (e.g., race), and is defined by a wider construct of characteristics that identify and differentiate individuals. Culture incorporates all distinguishable group experiences, including the experiences of particular racial, religious, ethnic, nationalistic, gender, and/or age groups.

With this definition of culture in mind, intercultural couples in this study are defined as couples that identify as culturally different from one another (i.e., each individual identifies with a culture that differs from his/her partner's culture) on an ethnic, nationalistic, racial, religious, and/or other multiple levels, not limited to demographic categories, and not solely gender differences.

**Please pick *one* intercultural couple where your sessions focused on cultural understanding and acceptance using IBCT. Some of the questions ask you to reflect on your selected case while others ask general questions about your experience using IBCT. When writing about your selected case, please use pseudonyms or pronouns, instead of real names of the clients. In order for this researcher to obtain rich and thick descriptions, please write at length and in detail.**

Demographic information of couple:

**Partner 1:**
Gender
Age
Educational Background
Occupation
Ethnicity
Religious Background
National origin (country of birth or ancestors)
Where raised (country, region, urban/rural)
Language(s) spoken in home currently
Language(s) spoken in home growing up
Other cultural details
How does this person describe his/her cultural identity?

**Partner 2:**
Gender
Age
Educational Background
Occupation
Ethnicity
Religious Background
National origin (country of birth or ancestors)
Where raised (country, region, urban/rural)
Language(s) spoken in home currently
Language(s) spoken in home growing up
Other cultural details
How does this person describe his/her cultural identity?

**Relationship of couple:**
Relationship status
Length of relationship at the time of therapy
Presence of children and age(s)

**What is *your*:**
Gender
Age
Ethnicity
Religious Background
National origin (country of birth or ancestors)
Where raised (country, region, urban/rural)
Language(s) spoken in home currently
Language(s) spoken in home growing up
Which aspect of your cultural identity is most salient to you?
Other cultural details

***Objective #1) To provide detailed descriptions of couples' culture-specific differences and how therapists have used IBCT interventions with intercultural couples (e.g., examples of specific interventions used):***

With a selected couple in mind:

1) What was the presenting problem (reason for seeking therapy)?

2) What were the most central and problematic cultural differences experienced by the intercultural couple? For example, what were the specific cultural differences or specific culturally-related struggles/stressors the couple faced in therapy (e.g., child rearing values, relationship with extended family, gender roles, etc.)?

3) What led you to formulate their conflicts as influenced by a cultural difference? For example, did the couple report their conflicts as culturally rooted, or did this understanding emerge, and if so, how?

4) In this case, did you use the concept of culture directly with the couple? For example, to what extent did you present the issue to the couple as being representative of each partner's cultural background, and discuss the difference as cultural directly with the couple? Or did you tend to use other words like family, background, life experiences, etc.

5) What is/was your IBCT conceptualization (DEEP: Differences, Emotional Sensitivities, External Stressors, Patterns of Interaction) of this intercultural couple? Please be as detailed and specific as possible.

a. Differences:

b. Emotional Sensitivities:

c. External Stressors:

d. Patterns of Interaction:

6) With this couple in mind, please provide specific examples (what you said/did) of how you used:

a. Empathic joining interventions

b. Unified detachment interventions

c. Tolerance-building interventions

***Objective #2) To provide detailed descriptions of how intercultural couples changed in IBCT (e.g., client change processes; mechanisms of acceptance and behavior change; breakthrough and turning points in treatment):***

With the same couple in mind:

7) Please provide specific examples of the client change processes you observed. Specifically, what shifts occurred in the couple's interaction patterns during the therapy sessions? For example, what forms/patterns of dialogue or communication between the partners were seen at the beginning of sessions or therapy, and then later in sessions or therapy (within-session shifts and/or shifts that occurred across the course of therapy)?

8) What, if any, were the major breakthroughs or turning points in treatment with this couple?

9) What were specific shifts in change mechanisms (acceptance and behavior change) noticed in this couple over the course of therapy?

    a. What shifts occurred in each partner in terms of acceptance:
        i. Partner 1:
        ii. Partner 2:

    b. What behavior changes were made by each partner:
        i. Partner 1:
        ii. Partner 2:

***Objective #3) To understand therapists' impressions using IBCT with intercultural couples who are struggling to navigate through their differences compared to their experiences using this approach with other couples*:**

10) How has your experience utilizing IBCT with *this* couple been similar to and different from your experience in utilizing it with couples whose differences seem less related to cultural differences?

    a. Similar:

    b. Different:

11) What is your overall impression of how effective IBCT is in treating intercultural couples who are struggling with culturally rooted differences that cause (or exacerbate) relationship dissatisfaction?

***Objective #4: To offer recommendations (i.e., do's and don'ts) for using IBCT interventions with intercultural couples, and general recommendations for working with intercultural couples:***

12) Would you have done some things differently when treating the *selected couple* with IBCT? If so, what?

*Note that the following questions are no longer about the selected couple, but pertain to IBCT with intercultural couples (items 13-15), or working with intercultural couples from any approach (item 16).*

13) Please provide at least two recommendations (do's and don'ts) for using specific IBCT interventions (e.g., for using empathic joining, unified detachment, tolerance building) with intercultural couples (not specific to your selected couple).

14) Which of the IBCT interventions seem best suited for intercultural couples, and why?

15) Other than specific *interventions,* please provide at least two recommendations (do's and don'ts) for therapists interested in using IBCT with intercultural couples.

16) Please provide at least two specific recommendations (do's and don'ts) for working with intercultural couples (generally, not IBCT-specific).

Thank you so much for your time!

# APPENDIX G

## Follow up Requests

**If responses are not submitted within two weeks:**

Dear _____,

I hope this email finds you well. I am writing to follow up on the questionnaire I emailed to you two weeks ago. I would be happy to answer any questions you may have or clarify any items in order to help you complete your responses. Please feel free to contact me anytime. I look forward to hearing from you and receiving your completed questionnaire!

With gratitude,

Caroline Kalai, M.A.

**Request for clarification of participant response(s):**

Dear_____,

Thank you again for completing my questionnaire! In order to uphold the integrity of your responses, I am contacting you to request clarification for your response to item(s) #__.

(Describe understanding of participant's response to aforementioned questionnaire item and include question for clarification here)

I appreciate the time you have spent contributing to the study and for your continued cooperation!

Best regards,

Caroline Kalai, M.A.

APPENDIX H

IRB Approval Letter

# PEPPERDINE UNIVERSITY

## Graduate & Professional Schools Institutional Review Board

September 18, 2015

Caroline Kalai

[redacted]

Protocol #: P0715D02

Project Title: Integrative Behavioral Couple Therapy for Intercultural Couples: Helping Couples Navigate Cultural Differences

Dear Ms. Kalai:

Thank you for submitting your application, *Integrative Behavioral Couple Therapy for Intercultural Couples: Helping Couples Navigate Cultural Differences*, for exempt review to Pepperdine University's Graduate and Professional Schools Institutional Review Board (GPS IRB). The IRB appreciates the work you and your faculty advisor Dr. Eldridge, have done on the proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations (45 CFR 46 - http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.html) that govern the protections of human subjects. Specifically, section 45 CFR 46.101(b)(2) states:

(b) Unless otherwise required by Department or Agency heads, research activities in which the only involvement of human subjects will be in one or more of the following categories are exempt from this policy:

**Category (2) of 45 CFR 46.101**, research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: a) Information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and b) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit a **Request for Modification Form** to the GPS IRB. Because your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the GPS IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite our best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the GPS IRB as soon as possible. We will ask for a complete explanation of the event and your response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the GPS IRB and the appropriate form to be used to report this information can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* (see link to "policy material" at http://www.pepperdine.edu/irb/graduate/).

Please refer to the protocol number denoted above in all further communication or correspondence related to this approval. Should you have additional questions, please contact Kevin Collins, Manager of the Institutional Review Board (IRB) at gpsirb@peppderdine.edu. On behalf of the GPS IRB, I wish you success in this scholarly pursuit.

Sincerely,

Judy Ho, Ph.D., ABPP, CFMHE

Chair, Graduate and Professional Schools IRB Pepperdine University

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives Mr. Brett Leach, Regulatory Affairs Specialist

Dr. Kathleen Eldridge, Faculty Advisor