

BRIEF REPORT

Your Place or Mine?: Examining the Accessibility and Efficacy of a Brief, Home-Based, Couple Intervention

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Interventions for couples that can be flexibly delivered (e.g., home) are gaining traction in the field of couple therapy, particularly for underserved couples who experience barriers to accessing traditional methods of care. However, questions remain regarding what types of couples prefer the home over traditional clinic settings and whether there are differences in treatment effectiveness in the home versus a clinic setting. The present study sought to address these gaps in the literature. Using a secondary data analysis approach, data from 339 couples who participated in a brief, relationship intervention were examined. Couples were able to select where they wanted to participate (i.e., their home or a local clinic). Logistic regression analyses revealed that parents were significantly more likely to choose to participate in the intervention at their home relative to nonparents. No differences in intervention setting emerged as a function of marital status, racial/ethnic minority status, or poverty status. Three 2-level multilevel models indicated that, at baseline, couples presented with similar attitudes toward relationship help seeking and relationship satisfaction across settings as well as established a similar alliance with the facilitator at 1 month after the intervention. Additionally, a series of 3-level multilevel models found that rates of change did not significantly differ between groups on attitudes toward relationship help seeking and relationship satisfaction across the intervention. Thus, despite the potential chaos of the home, home settings appear to be an equally effective delivery setting relative to traditional settings for this brief relationship intervention and may be particularly useful for reaching parents.

Keywords: home visitation, brief relationship intervention, parents

Couple-based interventions seek to reduce relationship distress and improve relationship functioning, yet there are a variety of barriers that can make engaging in these interventions challenging. Factors such as time and logistics (e.g., childcare, aligning sched-

ules, transportation), along with general apprehension and low motivation, are a few of the common impediments reported (e.g., Hoge et al., 2004). These barriers are even more pronounced among economically disadvantaged and racial/ethnic minority individuals (Phillips, Mayer, & Aday, 2000).

Researchers have exerted considerable effort to address barriers that hinder underserved couples from accessing these services. Federally funded initiatives such as Building Strong Families (BSF; Wood, McConnell, Moore, Clarkwest, & Hsueh, 2012) and Supporting Healthy Marriage (Knox & Fein, 2009) were developed specifically to reach underserved couples and families. Although Supporting Healthy Marriage evidenced small, yet consistent, change across the intervention (Hawkins, Amato, & Kinghorn, 2013), BSF indicated no significant improvements in relationship functioning (Wood et al., 2012). Furthermore, although these interventions made strides to target underserved couples and families, the interventions were time intensive and conducted in a group format, which may explain why a substantial number of couples did not participate. For example, only 55% of the couples enrolled in the BSF program attended at least one

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session, and 29% attended at least half of the sessions (Wood, Moore, & Clarkwest, 2011).

Researchers have begun to apply flexible delivery formats (i.e., delivery in settings other than a traditional clinic setting) to established couple and family interventions to ameliorate couples' barriers to care. These adaptations include online programs (Doss et al., 2016) or a hybrid program with self-guided components that the couple could complete at home (Petch, Halford, Creedy, & Gamble, 2012) among others. Interventions utilizing flexible delivery mediums have reported success in recruiting and retaining underserved populations, likely because of the reduction of common barriers to care (Doss et al., 2016; Petch et al., 2012).

Home-based interventions are a flexible delivery option that is becoming more widely used in health care settings, mainly when working with at-risk populations (Olds, 2006; Pollak et al., 2015). Formats of home-based interventions can range from primary to tertiary treatment and can be utilized for individuals, couples, and families. Home-visitation interventions such as Nurse-Family Partnership and Parents and Children Together have evidenced significant benefits for at-risk pregnant mothers and their offspring (see Olds, 2006). Furthermore, home-based primary care interventions have evidenced utility in reducing smoking behavior among expecting and new fathers (Pollak et al., 2015) or aiding mothers with postpartum depression (Leis, Mendelson, Tandon, & Perry, 2009). Despite the utility of home-based interventions for individuals and families, these types of interventions are only recently being implemented for relationship functioning. The Relationship Checkup (RC; Gordon et al., 2018), an adaptation of the Marriage Checkup (Cordova et al., 2014), sought to reach underserved populations by offering the intervention in either a home or a clinic setting, depending on couple preferences, to reduce common barriers to care (Hoge et al., 2004; Phillips et al., 2000). The researchers were successful in reaching more economically diverse populations and reported significant improvements in relationship functioning that were maintained through 6 months after the intervention (Gordon et al., 2018). However, these original findings combined outcomes from couples who participated in the home and couples who participated in a clinic setting.

The convenience of the home setting has several strengths. First, offering the home setting may improve access to care among populations that are hindered by impediments encountered in traditional settings (e.g., Gordon et al., 2018; Petch et al., 2012; Pollak et al., 2015). That is, it may be easier to reach parents because the obstacle of arranging childcare is removed (e.g., Petch et al., 2012; Pollak et al., 2015). Alternatively, the home setting may be more enticing for satisfied couples who may not feel as motivated to put forth significant effort to attend a preventative relationship intervention when things are going well in their relationship. Additionally, offering the home setting may reach more couples who have less favorable attitudes toward relationship interventions (or health care more broadly) because we are coming to them. The providers coming to the couple's home may evidence the researchers'/providers' investment in the couple's well-being, which may counter previous, and potentially negative, experiences the couple has had with providers. Countering negative attitudes may be particularly important when seeking to reach economic and racial/ethnic minority populations, given that previous research has cited mistrust as a significant barrier to care among low-income populations (Betancourt, Green, Carrillo, & Ananeh-Firemping,

2003). Relatedly, given the benefit of having the intervention delivered in a familiar and comfortable setting (i.e., one's home), couples may be able to align with the facilitator more quickly rather than developing an alliance with a system (i.e., the clinic setting) in addition to the facilitator. Previous research assessing facilitators' experiences delivering home-based interventions found that facilitators believed delivering services in the home created an alliance more quickly than when delivered in other settings (Worth & Blow, 2010). Quickly establishing an alliance may be even more crucial in the context of a brief intervention in which time is more limited than in traditional therapies (Hughes, 2017).

Although the home setting offers the benefits of convenience and comfort, it is not without challenges. Consequently, it is essential to consider whether the quality of the intervention is affected by the distractions inherent in a convenient setting. For example, qualitative data collected from facilitators who delivered home-based interventions indicated that managing distractions in the home is critical, and such distractions could detract from the treatment efficacy (Worth et al., 2010). Additionally, anecdotal evidence from supervision of facilitators in the assessment/feedback RC intervention (Gordon et al., 2018) detailed accounts of children interrupting sessions, pets distracting the couple or facilitator, problems with noise in other rooms of the home, and also couples feeling at home and thus more inclined to engage in various other activities during the intervention (e.g., getting a drink of water, smoking a cigarette, sending a text, or taking a phone call, etc.). Such distractions are often more easily contained, or even avoided, in a clinic setting in which the environment is more controlled and minimal distractions are present. This potential disadvantage to convenience calls into question whether these possible interferences with attention may have implications for intervention effectiveness. These problems may outweigh the potential benefit of increasing the intervention's reach.

In sum, the convenience of the home, may have implications for who participates in a relationship intervention both demographically (e.g., economically disadvantaged couples, racial/ethnic minorities, parents) and their baseline presentation (e.g., attitudes toward relationship help seeking and relationship satisfaction). However, the convenience of the home may have implications for the quality of the intervention (e.g., alliance with the facilitator, change in attitudes toward relationship help seeking and relationship satisfaction), given the potential chaos of the home. Given that the RC is one of the first couple interventions delivered in a home setting, it is important to consider whether there are differences in the effectiveness of the intervention when conducted outside a more controlled clinic setting. Because couples who participated in the RC chose what setting they preferred to participate in (i.e., their home or a local clinic), these data offer a unique opportunity to consider within a couples' context, who chooses what intervention setting, and whether differences in intervention effectiveness exist across intervention settings. Using a secondary data analytic approach, the present study examined three research aims.

First, we sought to examine who selects what intervention setting by comparing couple demographic differences across settings (i.e., marital status, racial/ethnic minority status, parenting status, and poverty status). We hypothesized that couples who elected to participate in the intervention in their home would be

more likely to be racial/ethnic minorities, below the poverty line, and parents compared with couples who elected to participate in a clinic setting. Second, we sought to examine whether couples differed on baseline attitudes toward relationship help seeking and relationship satisfaction and alliance with the facilitator across intervention settings. We hypothesized that couples who elected to participate in their home would report poorer baseline attitudes toward relationship help seeking, greater relationship satisfaction, and greater alliance with the facilitator after the intervention relative to couples who elected to participate in a clinic setting. The third aim of the study sought to examine whether rates of change from baseline to 1 month after the intervention in attitudes toward relationship help seeking and relationship satisfaction differed across groups. We hypothesized that couples who participated in the home would evidence a greater rate of change in attitudes toward relationship help seeking from baseline to 1 month after the intervention relative to couples who participated in the clinic and that couples who participated in the clinic would evidence a greater rate of change in relationship satisfaction from baseline to 1 month after the intervention relative to couples who participated in the home. The fourth and final aim of the present study sought to examine whether rates of change in relationship satisfaction from baseline to 6 months after the intervention differed across settings. We hypothesized that couples who participated in the clinic would evidence a greater rate of change in relationship satisfaction from baseline to 6 months after the intervention relative to couples who participated in the home.

Method

Participants

Couples were recruited to participate in a larger study, the RC (Gordon et al., 2018). The RC delivered a brief, two-session relationship intervention at a setting of the couples' choice (i.e., home or clinic setting). Couples were recruited using flyers and tabling methods at local community health clinics, community events, and referrals. To be eligible to participate, couples had to be in a committed, monogamous relationship, married or cohabiting, and feel physically and emotionally safe in their relationship. The original study included 656 couples recruited from the southeastern United States, Appalachian region. The majority of the couples were married (59% married; 41% cohabiting) and living above the poverty line (73% above; 27% below). The racial identities of the sample reflected that of the Appalachian region (white: 80%; black 15%, less than 5% identifying as Pacific Islander, Native American, or Asian). The majority of couples were in the 25- to 34-year age range (aged 18–24 years: 13%; aged 35–44 years: 36%; aged 45–54 years: 16%; aged 55+ years: 8%).

For the present study, inclusion criteria included: (a) consented to having one session video recorded (to retroactively record intervention setting location; see *Procedure*) and (b) consented to using video data for research. Thus, 339 couples were examined in the present analysis.¹ Of these couples, 244 couples (72%) elected to participate in their home, and 95 (28%) chose to participate in a clinic setting. See Table 1 for the present study's sample demographics across setting options (home vs. clinic setting).

Procedure

Upon recruitment, couples were given informed consent and asked where they wanted to participate in the intervention. They chose between their home or a clinic setting (i.e., local integrative health care facilities). To further reduce barriers, on-site child care was offered to couples, regardless of setting. Partners were mailed a baseline questionnaire containing various demographic, individual, and relationship functioning assessments to be completed separately from each other before the first meeting. Couples participated in a two-session intervention in the setting of their choice. If the couple consented, sessions were video recorded. The first session of the intervention facilitated a guided discussion of each partner's perceived relationship strengths and areas of improvement. Principles from integrative behavioral couple therapy were used to promote empathy and acceptance toward more challenging aspects of relationship functioning and to understand their patterns of interactions. In the second session, the facilitator and the couple worked together to develop solutions to the issues discussed in the first session, and if the couple was stuck, the facilitator offered a number of recommendations to the couple that may be useful (see Cordova et al., 2014; Gordon et al., 2018 for more information). Upon the conclusion of the intervention, couples were followed up at 1- and 6-month postintervention intervals. To improve response rates and reduce burden, the 6-month interval collected only relationship and intervention satisfaction data. The present study was approved by the University of Tennessee's Institutional Review Board.

Measures

Demographics. Each partner self-reported their gender (1 = male; 2 = female), race, individual income, number of children, and relationship status (i.e., married or cohabiting). In the present study, demographics were coded into binary variables: marital status (0 = *cohabiting*; 1 = *married*), racial/ethnic minority status (0 = *nonminority*; 1 = *minority*), parenting status (0 = *nonparents*; 1 = *parents*), and poverty status (0 = *nonpoverty*; 1 = *poverty*); poverty was calculated by using the combined household income, based on each partner's individual self-reported income while accounting for the number of individuals the income supports (i.e., adults and children and referencing the 2016 poverty threshold).

Intervention setting. Because intervention setting data were not deliberately collected during data collection, the intervention setting was determined retroactively using video data from the intervention sessions to determine setting location. Three trained research assistants individually coded each videotaped session for intervention setting. The first and third authors reviewed videos with nonconsensus ($n = 6$) for final determination. Clinic settings were coded as 0, and home settings were coded as 1.

¹ Multilevel logistic regression results revealed that there were no significant differences between couples that we had intervention setting data for (and were therefore included in the study) and couples that we did not have these data for (and were therefore excluded from the present study): marital status: $B (SE) = .30 (.18)$, $\beta = .08$, $p = .10$; $B^e = 1.35$; racial/ethnic minority status: $B (SE) = -.33 (.20)$, $\beta = -.07$, $p = .11$; $B^e = .72$; parenting status: $B (SE) = .02 (.17)$, $\beta = .01$, $p = .91$; $B^e = .91$; poverty status: $B (SE) = .05 (.20)$, $\beta = .05$, $p = .80$; $B^e = .80$.

Table 1
Descriptive Summary of Participants

Variables	Home <i>n</i> = 244 (72%) couples (Male = 222; Female = 243)				Clinic <i>n</i> = 95 (28%) couples (Male = 91; Female = 95)			
	<i>n</i> of couples		Percentage of couples within total sample		<i>n</i> of couples		Percentage of couples within total sample	
Marital status								
Married	156		47.2%		54		16.4%	
Cohabiting	80		24.3%		40		12.1%	
Minority status								
Nonminority	179		55.5%		75		22.6%	
Minority	52		15.8%		21		6.1%	
Parenting status								
Parents	146		44%		41		12.7%	
Nonparents	90		15.5%		51		27.8%	
Poverty								
Above poverty line	153		54.5%		55		19.7%	
Below poverty line	48		17.2%		24		8.5%	

Variables	Baseline		1 Month		6 Months		Baseline		1 Month		6 Months	
	<i>M</i> (<i>SD</i>)	Range										
Relationship length (years)	10.15 (9.97)	0–56	—	—	—	—	9.04 (8.95)	.5–47	—	—	—	—
Attitudes	13.30 (4.27)	0–18	14.03 (3.73)	0–18	—	—	13.46 (4.03)	0–18	14.47 (3.41)	3–18	—	—
Relationship satisfaction	59.43 (16.96)	2–81	64.30 (14.23)	10–81	65.04 (15.06)	7–81	57.02 (18.73)	3–80	61.66 (18.76)	3–81	63.82 (18.63)	1–80
Alliance	—	—	54.06 (7.87)	0–60	—	—	—	—	53.78 (8.43)	11–60	—	—

Note. Demographics are reported at the couple level. Percentages reported represent percentage of total sample.

Relationship satisfaction. Baseline and 1- and 6-month postintervention data on relationship satisfaction were measured using the 16-item Couples Satisfaction Index (Funk & Rogge, 2007). The measure assesses one's overall satisfaction with their relationship using a Likert scale. Total scores can range from 0 to 81, with higher values representing greater relationship satisfaction. This measure has shown high internal consistency, $\alpha = .98$ (Funk et al., 2007) and demonstrated excellent internal consistency in the present sample (baseline: $\alpha = .95$; 1 month: $\alpha = .95$; 6 month = $.97$; see Table 1).

Attitudes. Baseline and 1-month postintervention data on attitudes toward relationship help seeking (hereafter referred to as attitudes) were measured using an adapted version of the Attitudes Toward Seeking Professional Psychological Help scale (Fischer & Farina, 1995). Six items were adapted to be relevant to couple interventions rather than individual therapy; four items were removed because they were unable to be adapted to a couple intervention context. The measure assesses one's overall propensity toward seeking professional psychological help for their relationship. Total scores can range from 0 to 18, with higher scores suggesting more favorable attitudes toward seeking professional help. This measure has evidenced adequate internal consistency ($\alpha = .84$). Internal consistency in the present study was acceptable (baseline: $\alpha = .86$; 1 month: $\alpha = .80$; see Table 1).

Facilitator alliance. The facilitator alliance was assessed at 1 month after the intervention using the 15-item Facilitation Assessment Scale (Weyers, 2007). The scale assesses the individual's perception of their facilitator's ability, style, and comfort with the facilitator. Scores can range from 0 to 60, with higher scores indicating greater alliance with the facilitator. The scale has dem-

onstrated acceptable internal consistency ($\alpha = .78$ – $.90$; Weyers, 2007). Internal consistency in the present sample was good ($\alpha = .86$; see Table 1).

Data-Analytic Strategy

Analyses were conducted using Mplus 7.0 (Muthén & Muthén, 1998–2012). The intervention setting, predictor variable, and demographic information of marital status, parenting status, and poverty status were already couple-level variables. For racial/ethnic minority status, couples were coded as 1 (i.e., presence of) if one partner identified as a racial/ethnic minority. All outcome variables, attitudes, relationship satisfaction, and alliance with the facilitator were examined on the individual level at each time point.

Missing values were handled using full information maximum likelihood estimation, which assumes data are missing at random. To test our first hypothesis, who selected what intervention setting, the demographic variables marital status, racial/ethnic minority status, parenting status, and poverty status were included together in a multilevel logistic regression.

To address our second hypothesis, we examined whether couples presented differently at baseline on outcome variables. To test this, we conducted three, two-level, multilevel models (MLM). In each model, intervention setting was entered as the predictor variable (Level 2), and attitudes, relationship satisfaction, and alliance (assessed only at 1 month after the intervention) represented the outcomes variables (Level 1).

Lastly, for our third and fourth hypotheses, we examined whether intervention effectiveness (i.e., change in attitudes from

baseline to 1 month after the intervention and relationship satisfaction from baseline to 1 month and baseline to 6 months after the intervention) across the intervention differed as a function of intervention setting. To test this, we conducted three three-level multilevel models with time points nested within individuals, nested within dyads. Time (Level 1), intervention setting (Level 3), and an Intervention Setting \times Time interaction (Level 1) were entered as predictor variables, and attitudes and relationship satisfaction, respectively, represented the outcome variables. We controlled for parenting status (Level 3) because it significantly varied across intervention settings and for gender (Level 2) to account for gender differences in our outcome variables (Gordon et al., 2018).

Results

First, we examined how couple demographics (i.e., marital status, racial/ethnic minority status, parenting status, and poverty status) differed across intervention setting selection. Parenting status emerged as the only demographic variable that significantly differed across intervention settings ($B [SE] = .76 [.28]$, $\beta = .20$, $p = .01$, $d = .11$; $B^e = 2.15$). According to the odds ratio ($OR = 2.15$), parents were 115% more likely to choose to participate in the home than in a clinic setting relative to nonparents. Of the parent couples, 78% chose to participate in the home compared with 22% of parents participating in a clinic setting. Of the nonparent couples, 64% chose to participate in the home compared with 36% selected a clinic setting. No other demographic factors differed across intervention settings: marital status: $B (SE) = .28 (.30)$, $\beta = .07$, $p = .35$, $d = .04$; $B^e = 1.32$; racial/ethnic minority status: $B (SE) = -.03 (.35)$, $\beta = -.01$, $p = .93$, $d = -.003$; $B^e = .97$; poverty status: $B (SE) = -.14 (.32)$, $\beta = -.08$, $p = .93$, $d = -.02$; $B^e = .87$.

Next, we sought to examine whether baseline attitudes, relationship satisfaction or alliance (assessed 1 month after the intervention) differed across intervention settings while controlling for gender and parenting status. Neither baseline attitudes nor relationship satisfaction differed across intervention settings (attitudes: $B [SE] = -.14 [.46]$, $\beta = -.02$, $p = .76$; relationship satisfaction: $B [SE] = 3.22 [2.09]$, $\beta = .10$, $p = .12$). Alliance with the facilitator (assessed 1 month after the intervention) also did not differ across intervention settings ($B [SE] = .39 [.91]$, $\beta = .05$, $p = .67$). Thus, regardless of intervention setting, couples evidenced similar baseline attitudes and relationship satisfaction and developed a similar alliance with the facilitator (see Models 1–3 in Table 2).

Next, we tested whether intervention effectiveness (i.e., change in attitudes and relationship satisfaction) differed across intervention settings while controlling for gender and parenting status. Both attitudes and relationship satisfaction improved from baseline to 1 month after the intervention (attitudes: $B [SE] = .92 [.39]$, $\beta = .17$, $p = .02$; relationship satisfaction: $B [SE] = 4.45 [1.25]$, $\beta = .26$, $p < .001$), but the rate of change in attitudes and relationship satisfaction did not differ across intervention settings (attitudes: $B [SE] = .05 [.45]$, $\beta = .01$, $p = .92$; relationship satisfaction: $B [SE] = -1.09 [1.47]$, $\beta = -.05$, $p = .46$). Thus, regardless of the intervention setting, couples changed similarly on attitudes and relationship satisfaction from baseline to 1 month after the intervention (see Models 4 and 5 in Table 2).

Table 2
Multilevel Model Results of Difference in Baseline Presentation and Change Over Time Across Intervention Setting

Models	B (SE)	β	d
Model 1: baseline attitudes			
Gender	1.44 (.29)**	.22	.19
Parenting status	-.52 (.43)	-.10	-.02
Intervention setting	-.14 (.46)	-.02	-.01
Model 2: baseline relationship satisfaction			
Gender	-3.46 (.84)**	-.18	-.16
Parenting status	-4.85 (1.83)*	-.16	-.10
Intervention setting	3.22 (2.09)	.10	.06
Model 3: alliance 1 month after intervention			
Gender	1.58 (.70)*	.11	.09
Parenting status	-.52 (.80)	-.08	-.03
Intervention setting	.39 (.91)	.05	.02
Model 4: change in attitudes 1 month after intervention			
Gender	1.66 (.24)**	.31	.26
Parenting status	-.73 (.37)	-.15	-.08
Intervention setting	-.11 (.38)	-.02	-.01
Time	.92 (.39)*	.17	.09
Time \times Intervention Setting	.05 (.45)	.01	.00
Model 5: change in relationship satisfaction 1 month after intervention			
Gender	-3.50 (.75)**	-.21	-.18
Parenting status	-3.72 (1.68)*	-.13	-.09
Intervention setting	3.15 (1.92)	.10	.06
Time	4.45 (1.25)**	.26	.14
Time \times Intervention Setting	-1.09 (1.47)	-.05	-.03
Model 6: change in relationship satisfaction 6 months after intervention			
Gender	-3.78 (.71)**	-.21	-.20
Parenting status	-3.93 (1.59)*	-.15	-.10
Intervention setting	3.64 (1.86)	.12	.08
Time	1.88 (.92)*	.17	.08
Time \times Intervention Setting	.72 (1.05)	.06	.03

* $p < .05$. ** $p < .01$.

Lastly, we examined whether change in relationship satisfaction from baseline to 6 months after the intervention differed across intervention settings. Results revealed that relationship satisfaction significantly improved across the intervention ($B [SE] = 1.88 [.92]$, $\beta = .17$, $p = .04$), but the rate of change did not differ across intervention settings ($B [SE] = .72 [1.05]$, $\beta = .06$, $p = .49$). Thus, once again, it appears that couples change similarly on relationship satisfaction across both intervention settings (see Model 6 in Table 2).

Discussion

Home delivery of couple and family interventions has documented success in reaching underserved couples (e.g., Olds, 2006; Petch et al., 2012; Pollak et al., 2015) and improving relationship functioning (Gordon et al., 2018). However, questions remained regarding who preferred what intervention setting and whether there were differences in intervention effectiveness across settings.

Regarding who selects what intervention setting, we found that parents were significantly more likely to choose to participate in

their home versus a clinic setting, above and beyond other demographic factors. These findings support and extend the observation of Petch et al. (2012) that a greater representation of at-risk parents presented for a relationship education program when offered in a flexible format. By offering the home as an intervention setting, researchers and clinicians may be more successful in reaching parents, a population more vulnerable to individual and relationship distress (Petch et al., 2012). Of note, in addition to offering the home, we offered on-site child care across both settings. Yet parents still preferred the home, even though their children could have been cared for in either setting. Thus, parents' preference to participate in the home seems more nuanced than the home being the only setting for child care. The home may have been an additional incentive for parents because they would not have to coordinate travel with their children to a clinic, and the children may be more comfortable at their home. Offering the home and on-site child care may be particularly useful for interventions seeking to intervene on the transition to parenthood or parents and families more broadly.

Surprisingly, economically disadvantaged and racial/ethnic minority couples were equally likely to choose the home or a clinic setting. Intervention setting preference indeed may not vary for these individuals. However, it is important to consider that our recruitment sources included local integrative health care centers. Thus, economically disadvantaged or racial/ethnic minority couples recruited from these centers may have preferred to participate in this clinic setting rather than their home, given their comfort and trust with the setting. Couples not established at these facilities may have preferred their home. Couples may be considering convenience and trust when selecting their setting.

Regarding presentation to the intervention, couples evidenced similar baseline attitudes and relationship satisfaction. Whereas offering the home setting may not attract less satisfied couples or couples with less favorable attitudes toward seeking relationship help, it offers another setting in which to reach more couples who may not have participated in a traditional setting. Future research is needed to explore why couples chose a particular setting.

In sum, the home appeared to be the preferred option for the majority of couples, particularly parents. Home delivery may be among the most flexible of all settings because it requires minimal effort by the couple (e.g., transportation, childcare). Thus, couples who feel overwhelmed by demands on their resources or time (e.g., parents) may be more willing to engage in service options that do not require as much coordination or effort.

Lastly, regarding change across the intervention, we found that couples evidenced similar rates of change in attitudes and relationship satisfaction across the intervention as well as established equally positive alliances with their facilitator across settings. Thus, it appears that the setting in which this intervention takes place may not impede the quality of the intervention; that is, despite the chaos that can be present in home settings, we are not sacrificing quality for convenience, at least for this brief relationship intervention, the RC.

The present study is not without limitations. Given that the present study was a secondary data analysis, intervention setting data were collected retroactively, and consequently, data from all of the study participants were unable to be obtained. Furthermore, we were unable to determine why couples chose what intervention setting. Understanding why couples choose specific settings can

aid in the development and adaptation of couple-based interventions to be more accessible to the populations in which they are seeking to serve. Future research offering more than one intervention setting should take the initiative to record who selects what intervention setting and why to understand differences in setting preference or intervention effectiveness.

This study is the first that we know of within the couple and family literature to examine who chooses what intervention setting and whether intervention effectiveness is compromised in a more flexible setting. It appears that home delivery is a preferred option among couples and is a particularly useful strategy to reach parents. Furthermore, the quality of the intervention is not compromised by the convenience of the home setting. Findings such as these are a step toward identifying what treatment modalities work best for whom. We hope these data motivate further adaptation of couple and family interventions to be flexibly delivered to improve access for all couples.

References

- Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong, O., II (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports*, *118*, 293–302. [http://dx.doi.org/10.1016/S0033-3549\(04\)50253-4](http://dx.doi.org/10.1016/S0033-3549(04)50253-4)
- Cordova, J. V., Fleming, C. J., Morrill, M. I., Hawrilenko, M., Sollenberger, J. W., Harp, A. G., . . . Wachs, K. (2014). The Marriage Checkup: A randomized controlled trial of annual relationship health checkups. *Journal of Consulting and Clinical Psychology*, *82*, 592–604. <http://dx.doi.org/10.1037/a0037097>
- Doss, B. D., Cicila, L. N., GA, E. J., Roddy, M. K., Nowlan, K. M., Benson, L. A., & Christensen, A. (2016). A randomized controlled trial of the web-based OurRelationship program: Effects on relationship and individual functioning. *Journal of Consulting and Clinical Psychology*, *84*, 285–296. <http://dx.doi.org/10.1037/ccp0000063>
- Fischer, E. H., & Farina, A. (1995). Attitudes toward seeking professional psychological help: A shortened form and considerations for research. *Journal of College Student Development*, *36*, 368–373.
- Funk, J. L., & Rogge, R. D. (2007). Testing the ruler with item response theory: Increasing precision of measurement for relationship satisfaction with the Couples Satisfaction Index. *Journal of Family Psychology*, *21*, 572–583. <http://dx.doi.org/10.1037/0893-3200.21.4.572>
- Gordon, K., Cordova, J. V., Roberson, P. N. E., Miller, M., Gray, T., Lenger, K. A., . . . Martin, K. (2018). An implementation study of relationship checkups as home visitations for low-income at-risk couples. *Family Process*, *58*, 247–265. <http://dx.doi.org/10.1111/famp.12396>
- Hawkins, A. J., Amato, P. R., & Kinghorn, A. (2013). Are government-supported healthy marriage initiatives affecting family demographics? A state-level analysis. *Family Relations*, *62*, 501–513. <http://dx.doi.org/10.1111/fare.12009>
- Hoge, C. W., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. I., & Koffman, R. L. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine*, *351*, 13–22. <http://dx.doi.org/10.1056/NEJMoa040603>
- Hughes, J. A. (2017). Examining the role of therapeutic alliance, split alliance, and gender on couples' relationship satisfaction following a brief couple intervention (Doctoral dissertation). University of Tennessee, Knoxville, TN. Retrieved from https://trace.tennessee.edu/utk_graddiss/4694
- Knox, V., & Fein, D. (2009). Supporting healthy marriage: Designing a marriage education demonstration and evaluation for low-income mar-

- ried couples. In H. E. Peters & C. M. K. Dush (Eds.), *Marriage and family: Perspectives and complexities* (pp. 247–280). New York, NY: Columbia University Press. <http://dx.doi.org/10.7312/pete14408-013>
- Leis, J. A., Mendelson, T., Tandon, S. D., & Perry, D. F. (2009). A systematic review of home-based interventions to prevent and treat postpartum depression. *Archives of Women's Mental Health, 12*, 3–13. <http://dx.doi.org/10.1007/s00737-008-0039-0>
- Muthén, L. K., & Muthén, B. O. (1998–2012). *Mplus user's guide* (7th ed.). Los Angeles, CA: Author.
- Olds, D. L. (2006). The nurse-family partnership: An evidence-based preventive intervention. *Infant Mental Health Journal, 27*, 5–25. <http://dx.doi.org/10.1002/imhj.20077>
- Petch, J., Halford, W. K., Creedy, D. K., & Gamble, J. (2012). Couple relationship education at the transition to parenthood: A window of opportunity to reach high-risk couples. *Family Process, 51*, 498–511.
- Phillips, K. A., Mayer, M. L., & Aday, L. A. (2000). Barriers to care among racial/ethnic groups under managed care. *Health Affairs, 19*, 65–75. <http://dx.doi.org/10.1377/hlthaff.19.4.65>
- Pollak, K. I., Lyna, P., Bilheimer, A. K., Gordon, K. C., Peterson, B. L., Gao, X., . . . Fish, L. J. (2015). Efficacy of a couple-based randomized controlled trial to help Latino fathers quit smoking during pregnancy and postpartum: The Parejas trial. *Cancer Epidemiology, Biomarkers & Prevention, 24*, 379–385. <http://dx.doi.org/10.1158/1055-9965.EPI-14-0841>
- Weyers, M. (2007). The Facilitation Assessment Scale (FAS): Measuring the effect of facilitation on the outcomes of workshops. *Social Work Practitioner-Researcher, 19*, 90–110.
- Wood, R. G., McConnell, S., Moore, Q., Clarkwest, A., & Hsueh, J. (2012). The effects of building strong families: A healthy marriage and relationship skills education program for unmarried parents. *Journal of Policy Analysis and Management, 31*, 228–252. <http://dx.doi.org/10.1002/pam.21608>
- Wood, R. G., Moore, Q., & Clarkwest, A. (2011). *BSF's effects on couples who attended group relationship skills sessions: A special analysis of 15-month data* (OPRE Report 2011–17). Washington, DC: Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.
- Worth, J. B., & Blow, A. J. (2010). A survey of the attitudes and practice experiences of home-based practitioners. *Contemporary Family Therapy, 32*, 459–474. <http://dx.doi.org/10.1007/s10591-010-9122-6>

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