Enhancing Couples
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Preface

The Klaus-Grawe-Stiftung für Psychologische Therapy (Klaus Grawe Foundation for Psychological Therapy) in Zurich, Switzerland, decided to stimulate coordinated strategies in the field of clinical psychology and psychotherapy through the development of the Klaus Grawe Think Tank Meetings (KGTMs), which will bring together leading researchers, trainers, and clinicians in various fields of mental health. The goals of the KGTMs are to encourage cutting-edge, creative, daring ideas and research related to the prevention and treatment of psychological problems and disorders, as well as to disseminate empirically supported programs to the public through a variety of delivery systems for individuals, couples, families, businesses, and institutions.

Every two years a specific, socially relevant topic will be decided on. The five to seven best-known experts within the chosen topic area will be invited together with junior colleagues to discuss the latest findings in prevention of a psychological disorder and empirically based intervention procedures in order to bring them to the public and to develop an agenda for future research and dissemination into practice and into public awareness in general.

The participants at the meeting will emphasize new methodological approaches that are available to address complex issues relevant to the topic which might be of importance to the general public. They will also make efforts to integrate various specific findings into a comprehensive, cohesive organization to develop a set of actions that serve the public on various levels. This includes using new media to assist in disseminating findings as well as gathering data. Research findings will be put into an understandable and attractive language for the public and institutions. New means of reaching the population with a variety of delivery options will be developed. The invitation of junior researchers is a unique feature of these meetings and intends to support and encourage talented young researchers. The participants of the KGTMs will form an international network inspired by Klaus Grawe’s research and his innovative, interdisciplinary way of thinking. Most important, these people will contribute in an important way to the dissemination of research results and their consequences for training and practice.

The first of these meetings was held in Zurich and Zuoz, Switzerland, in September 2007, focusing on couple therapy and prevention. As an outgrowth of that meeting, the current volume evolved. Investigators from several continents gathered to discuss the current status of the field and to make recommendations for the future.

The current volume includes two types of papers: (a) overviews of the field with recommendations for the future from more senior investigators and (b) representative research in these same areas from younger scholars who provide current relevant findings as well as glimpses of what is ahead in research for the future. These two types of papers are organized around several central themes in the couple area: models of intervention, models of prevention, new approaches to assessment, and transmitting programs to the consumer. It is our hope that the reader will find this volume to be informative regarding
the current status of the field and join in our efforts to improve the quality of couple functioning in all its diverse forms, one of the richest and potentially most rewarding sets of relationships for adults across all cultures.

Zurich, Fall 2009
Kurt Hahlweg, Mariann Grawe-Gerber, and Donald H. Baucom

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We give our sincerest thanks to Barbara, Franz, Lukas, and Thomas, who made the think tank meeting and this book possible.
Introduction
Strengthening Couples and Families

Dissemination of Interventions for the Treatment and Prevention of Couple Distress

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Abstract

The quality of family life is fundamental to the well-being of the community. The stability of the family has a pervasive influence on the psychological, physical, social, economic, and cultural well-being of children and parents. Strengthening couple, parenting, and family skills has the potential to improve the quality of life and health status of children, our future generation. Over the past 30 years, approximately 100 clinical trials have demonstrated the efficacy and effectiveness of couple therapy and interventions to prevent relationship distress and divorce. However, the impact of these programs on a public health level is highly questionable. Few therapists and counselors actually use evidence-based interventions; likewise, few couples actually use counseling or treatment services whenever they experience a deteriorating relationship. Therefore, the most important question for the next 10 years is: Are we ready to disseminate our effective interventions to the public? This chapter describes the steps necessary to disseminate a public health model of couple therapy and prevention. For example, do we have sufficient knowledge of risk and protective factors? Are there “ready-to-use” resources (e.g., treatment manuals and psychoeducational materials)? Are there effective training and supervision programs available? Do strategies exist that help to build sustainability? And: Do we have continuous quality control measures to monitor the ongoing implementation of the interventions?

The field of couple therapy and prevention has made great strides over the past decades, and innovations continue to evolve as theoreticians, researchers, trainers, and clinicians employ recent findings to benefit couples and families. In order for the field to benefit maximally from these ongoing findings and recommendations, it is important that coordinated efforts be made, such as those in the recommendations discussed in this chapter.
Across all countries and cultures, most people are involved in intimate couple relationships at some point in their lives, whether it be marriage or cohabitation (Buss, 1995). Since 1970, marriage rates have been declining in most Western countries; the average age at marriage is increasing, and the rate of cohabitation is growing. Be that as it may, intimate couple relationships continue to be viewed as the best forum for meeting individual needs for affection, companionship, loyalty, and emotional and sexual intimacy, even among those individuals who have experienced prior relationships as unsatisfactory (Halford, Kelley, & Markman, 1997). Marriage remains the most popular means of expressing commitment in a couple’s relationship. Based on data from the 1990s, within 5 years of cohabitation, between 50% and 66% of couples in most European countries (US: 82%) had married (with the exception of Sweden: 33%), while between 25% and 33% had dissolved their relationship (US: 47%; see Kiernan, 2004). At least until the 1990s, by the age of 50, approximately 90% of the population in Western countries had been married at least once (McDonald, 1995). In Germany, approximately 16 million married couples live in one household; of those 52% do not have children. In 2006, about 380,000 couples got married.

As common as intimate relationships and marriage are, in industrialized Western countries approximately 40% of marriages end in divorce. And in approximately 70% of the divorces, children are involved with negative consequences for their future well-being. In Germany alone, about 170,000 children were affected in 2004. Not only do children experience their parents’ divorce, but they also witness or experience parental conflict and distress as well as the lack of a warm positive relationship with parents, insecure attachment, and harsh, inflexible, and inconsistent discipline tactics. These are risk factors for a range of poor child outcomes including depression, withdrawal, conduct disorder, poor social competence, health problems, and academic underachievement (Amato, 2001; Hetherington & Elmore, 2004; Zimet & Jacob, 2001). These negative effects impact upon children long term. Adult offspring of divorce have substantially higher rates of psychological disorders and an elevated risk to become divorced themselves when in their own marriage: For example, in Germany, boys have a fourfold increase in divorce compared to boys from a non-divorced family (girls: twofold increase). Therefore, divorce seems to be “socially inherited” (Diekmann & Engelhardt, 1995).

The quality of family life is fundamental to the well-being of the community. The stability of the family has a pervasive influence on the psychological, physical, social, economic, and cultural well-being of children and parents. Many significant health, social, and economic problems are linked to the breakdown of family relationships. Strengthening couples, parenting, and family skills has the potential to improve the quality of life and health status of children, our future generation.

Over the past 30 years, approximately 100 clinical trials have demonstrated the efficacy and effectiveness of couple therapy and interventions to prevent relationship distress and divorce (Hahlweg, 2004; Snyder, Castellani, & Whisman, 2006). The empirical evidence especially for programs with a cognitive-behavioral emphasis, is impressive. However, the impact of these programs on a public health level is highly questionable.
Few therapists and counselors actually use evidence-based interventions; likewise, few couples actually use counseling or treatment services whenever they experience a deteriorating relationship. Even when they ask for help, the data on the long-term outcome indicate that in many cases counseling is undertaken too late to repair the damage of years of destructive conflict.

Therefore, the most important questions for the next 10 years are: Are we ready to disseminate our effective interventions to the public? If the answer is yes, how do we organize the dissemination process and how will we motivate couples to use the services? This chapter describes the steps necessary to disseminate a public health model of couple therapy. Our ideas are heavily influenced by the successful implementation of the Triple P system, a parent-training model developed by Sanders and colleagues (1999). When treatments such as couple-based interventions are to be delivered on a broad, public health scale, several important questions must be addressed (Flay et al., 2005; Sanders, 2008):

1. Is the base rate of relationship problems large enough to be of concern for society?
2. Do we know enough about risk and protective factors, which are in principle modifiable?
3. Do we have efficacious and effective interventions?
4. Are the interventions culturally appropriate and available?
5. Do we have “ready-to-use” resources (e.g., treatment manuals and psycho-educational materials) that can be made available to service providers?
6. Is an effective training and supervision program available?
7. Are the couple interventions widely available?
8. Do strategies exist that help to build sustainability?
9. Are continuous quality control measures to monitor the ongoing implementation of the interventions built into the system?

Is the Base Rate of Relationship Problems Large Enough to Be of Concern for Society?

Relationship Satisfaction

At the beginning of committed relationships, almost all couples report high levels of relationship satisfaction. There is some evidence that many of these couples are making unrealistically positive predictions about the stability of their own relationship. At the beginning of their partnership, most partners believe that there is a zero probability that they will ever divorce, despite the well-publicized evidence of how common divorce is (Fowers, Lyons, & Montel, 1996). The mean level of relationship satisfaction typically declines each year over at least 10 years (Glenn, 1998) and is particularly notable after
the birth of the first child. For many couples, the erosion of satisfaction leads them to seek divorce. This unrealistic expectation (it will not happen with us) seems to be a solid barrier for couples to participate in some form of relationship enhancement intervention.

Divorce

About 55% of American, 40–45% of Australian, English, German, or Swiss first marriages end in divorce (Halford et al., 1997). About 50% of the divorces occur in the first seven years of the marriage. In 2006, 200,000 couples got divorced in Germany. Many other couples, about 10–25% (Gallup, 1990; Hahlweg, 2004; for Germany: 1.6–4 million), live in stable but unhappy relationships for various reasons: e.g., the financial implications of divorce, personal and cultural expectations about divorce, or because no alternative partner is available. As painful as the experience of divorce is for many people, about 75% of divorced men and 66% of divorced women remarry within 3 years. Unfortunately, the divorce rate in second marriages is even higher than in first marriages (Cherlin, 1992).

Often, the public and researchers have taken a pathogenic view of divorce and have focused on the stresses and adverse outcomes associated with marital breakup. However, it should also be recognized that divorce can offer an escape from an unhappy, abusive, conflictual, or demeaning marriage and an opportunity to build new, more harmonious, fulfilling relationships, and increase personal growth and individuation (Hetherington & Elmore, 2004).

Consequences of Relationship Dissatisfaction and Divorce

Marital distress and divorce are the most severe, commonly occurring stresses that adults experience. As highlighted in a NIMH report on prevention (Coie et al., 1993), marital distress and destructive marital conflict are major generic risk factors for many forms of dysfunction and psychopathology, and may have long-lasting consequences for the children.

Individual Psychopathology

Relationship distress is linked with the onset, course, and poorer response to the treatment of individual adult psychiatric disorders. Using data from over 2,500 married participants of the National Comorbidity Survey, Whisman (1999) reported that marital distress was correlated with the 12-month prevalence rate of 12 specific psychiatric disorders. In comparison to non-distressed individual patients, maritally distressed individuals are up to three times more likely to have a psychological disorder, including depression (particularly in women), alcohol abuse (particularly in men), and anxiety disorders. Children from high relationship conflict couples, divorced, and remarried families exhibit more problems in
adjustment than do those in low conflict, non-divorced two parent families. These children
are more likely to have academic problems, exhibit externalizing and internalizing disorders,
be less socially responsible and competent, have lower self-esteem, and have more
problems in their relationship with parents, siblings, and peers (Amato, 2001; Zimet &
Jacob, 2001). Adolescents from divorced families are more likely to drop out of school,
be unemployed, become sexually active at an earlier age, be involved in delinquent activi-
ties and substance abuse, and associate with antisocial peers (Hetherington & Elmore,
2004). In adulthood, the offspring of divorced and high conflict families are less satisfied
with their lives, have lower socioeconomic status, have more problems with their intimate
partners, and experience a higher rate of marital instability.

Physical Health
Relationship problems also are correlated with poorer physical health. Distressed individ-
uals are more likely to have major somatic illness and recover more slowly when they
become ill (Burman & Margolin, 1992; Kiecolt-Glaser & Newton, 2001). There are
several mechanisms by which being distressed can have effects on health through
health-related behaviors. For example, distressed partners smoke more tobacco, drink
more alcohol, and exercise less than non-distressed partners. Moreover, distressed partners
make less use of health promotion and early detection of disease services (Schmaling &
Sher, 2000). Evidence for the influence of marital distress and divorce on longevity and
death was reported in a study by Friedman et al. (1995). The authors followed up
Terman’s sample of 1,528 gifted children by collecting death certificates. Adult children
of divorced parents faced a one third greater mortality rate than people whose parents
remained married. Among men from divorced families, the mean age of death was 76
years; for men whose parents did not divorce the mean age was 80 years (for women:
82 and 86 years, respectively).

Family Violence
In the US, approximately 12.5% of men are physically aggressive (e.g., grab, push, and
slap) toward their wives, and 1.5–2 million women are severely assaulted by their hus-
bands per year (Holtzworth-Monroe, Smutzler, Bates, & Sandin, 1997). In Germany, the
1-year prevalence rate of physical aggression among partners between 20 and 45 years
of age is about 8.5% (Wetzels, Greve, Mecklenburg, Bilsky, & Pfeiffer, 1995).

Bidirectionality of Effects
The cited consequences of relationship distress on adults are mainly based on correlational
studies which do not imply causality. For example, the associations between marital distress
and individual psychopathology or health may be explained bidirectionally: Marital
problems may cause psychological disorder or the individual’s psychological disorder may
cause marital problems. With regard to health, marital distress may lead to drinking more
alcohol or drinking may lead to marital distress. Thus, a simple unidirectional model of
Do We Know Enough About Risk and Protective Factors Which are in Principle Modifiable?

An understanding of how relationships develop, succeed, and fail is best achieved with longitudinal data. Karney and Bradbury (1995) reviewed 115 longitudinal studies, representing over 45,000 couples, and evaluated how the quality and stability of relationships change over time. The weight of the evidence suggests that the quality of the relationship, whether warm and supportive or hostile and negative, relates to the risk for marital distress and instability. Good communication is strongly correlated with relationship satisfaction and stability, specifically the presence of self-disclosing communication, effective conflict management, partner mutual support, positive day-to-day interactions, satisfying sexuality, and shared positive activities. In contrast, negative reciprocity and destructive handling of relationship conflicts predict dissatisfaction and instability, while undermining love, sexual attraction, friendship, trust, and commitment. Consequently, these major dynamic factors (e.g., communication and conflict management) should be the key components of preventive and treatment programs.

Another implication of the longitudinal research on the determinants of marital satisfaction and stability is when the preventive intervention should be offered. Entry to a committed relationship or marriage is a good time because relationship roles, household routines, and means of conflict management and negotiation need to be developed using appropriate communication skills. In addition, other life events such as the transition to parenthood, major illness, and unemployment are associated with relationship deterioration. Interventions at that point in time may help the couple to sustain relationship satisfaction.

Do We Have Efficacious and Effective Interventions?

Empirically Supported Treatments for Couple Distress

Empirical findings from randomized clinical trials support the efficacy of six different couple-based treatments for couple distress. These approaches vary along a continuum anchored by traditional behavioral interventions emphasizing primarily behavior exchange and skill-building interventions at one end, to insight-oriented interventions emphasizing intrapersonal dynamics and enduring relationship patterns at the other end.

Traditional Behavioral Couple Therapy
By far, traditional behavioral couple therapy (TBCT) (Jacobson & Margolin, 1979) has been studied more extensively than any other single approach to couple therapy.
A meta-analysis of 30 randomized trials with distressed couples contrasting TBCT with a no-treatment control (Shadish & Baldwin, 2005) yielded a mean effect size of 0.59, indicating that the average individual receiving TBCT was better off at the end of treatment than 72% of individuals in the control condition. This composite effect size is smaller than previously reported effect sizes for TBCT, and likely results from inclusion of non-published dissertations with smaller sample sizes and small or negative effect sizes. Follow-up studies of TBCT indicate that approximately 30% of couples who had initially improved in response to therapy subsequently showed significant deterioration in the first two years after termination (Jacobson, Schmaling, & Holtzworth-Munroe, 1987).

Cognitive-Behavioral Couple Therapy
Cognitive-behavioral couple therapy (CBCT) builds upon TBCT by incorporating interventions targeting partners’ relationship assumptions and standards, expectancies, and attributions that contribute to or maintain distorted emotions or maladaptive behaviors underlying couple distress. Initial studies of CBCT demonstrated pre- to post-treatment effect sizes averaging 0.72 and ranging from 0.54 to 0.78 across behavioral, cognitive, and affective criteria (Dunn & Schwebel, 1995). Various adaptations of CBCT have since been developed and shown to be efficacious for treating couple distress related to a variety of physical health and emotional/behavioral disorders (Baucom, Epstein, LaTaillade, & Kirby, 2008).

Integrative-Behavioral Couple Therapy
Integrative-behavioral couple therapy (IBCT) (Jacobson & Christensen, 1996) is a different variation of behavioral couple therapy that emphasizes interventions aimed at increasing acceptance, including promoting tolerance and encouraging partners to appreciate differences and to use these to enhance their marriage. In a large randomized clinical trial comparing IBCT with TBCT, Christensen and colleagues (2004) reported that both treatments produced similar levels of clinically significant improvement by the end of treatment; 71% of IBCT couples and 59% of TBCT couples were reliably improved or recovered, based on self-reports of overall relationship satisfaction. At 5-year follow-up, separation/divorce rates for couples in the two treatment conditions were virtually identical at slightly over 25% (Christensen, personal communication, July, 2007).

Emotionally Focused Couple Therapy and Integrated Systemic Couple Therapy
Emotionally focused couple therapy (EFCT) (Johnson, 2004) combines an experiential, intrapsychic focus on inner emotional experience with an emphasis on cyclical, self-reinforcing interactions. In four randomized trials, EFCT was superior to a wait-list control condition in reducing relationship distress, yielding recovery rates of 70–73%, and a weighted mean effect size of 1.31 (Johnson, 2002). Goldman and Greenberg (1992) compared integrated systemic couple therapy (ISCT) and EFCT with each other and a waiting-list control condition. ISCT sought to disrupt repetitive, self-perpetuating negative interactional cycles by changing the meaning attributed to these cycles. At the end of 10 one-hour weekly sessions, ISCT and EFCT were both found to be superior to the control
condition and to be equally effective in alleviating marital distress; moreover, ISCT couples showed greater maintenance of gains at 4-month follow-up in marital satisfaction and goal attainment.

**Insight-Oriented Therapy**

Snyder and Wills (1989) compared insight-oriented marital therapy (IOMT) with traditional behavioral approaches to couple therapy in a controlled clinical trial involving 79 distressed couples. The insight-oriented condition emphasized the interpretation and resolution of conflictual emotional processes related to developmental issues, collusive interactions, and maladaptive relationship patterns. Couples in both treatment modalities showed statistically and clinically significant gains in relationship satisfaction compared to a waiting-list control group. Treatment effect sizes at termination for behavioral and insight-oriented conditions were 1.01 and 0.96, respectively; however, at 4-year follow-up, 38% of the behavioral couples had experienced divorce, in contrast to only 3% of couples in the insight-oriented condition (Snyder, Wills, & Grady-Fletcher, 1991).

When the above approaches to couple therapy are compared, meta-analyses of couple therapy affirm that various approaches to treating couple distress produce statistically and clinically significant improvement for a substantial proportion of couples, with the average couple receiving therapy being better off at termination than 80% of couples not receiving treatment (Shadish & Baldwin, 2003). However, tempering enthusiasm from this overall conclusion are additional findings that in only 50% of treated couples do both partners show significant improvement in relationship satisfaction, and that 30–60% of treated couples show significant deterioration at two years or longer after termination (Snyder et al., 2006). Meta-analyses provide little evidence of differential effectiveness across different theoretical orientations to couple therapy, particularly once other covariates (e.g., reactivity of measures) are controlled (Shadish & Baldwin, 2003).

**Processes of Change**

Although each of the empirically supported approaches to couple therapy posits specific processes or mechanisms of change, there has been little research explicitly indicating these proposed mechanisms as responsible for observed therapeutic effects (Snyder et al., 2006). For example, mediation regression analyses of data from TBCT clinical trials have failed to find an association between the magnitude of changes in communication behaviors and gains in relationship satisfaction. Similarly, although CBCT has been shown to produce positive change in targeted cognitions (e.g., expectancies and attributions), changes in these cognitions have not been linked to couples’ gains in satisfaction following CBCT (see Whisman & Snyder, 1997, for a summary of relevant studies).

More encouraging results have been reported by Doss and colleagues (Doss, Thum, Sevier, Atkins, & Christensen, 2005) using hierarchical growth curve analysis to examine mechanisms of change in Christensen and colleagues’ (2004) clinical trial comparing TBCT with IBCT. Both therapies were effective in increasing emotional acceptance and improving communication behaviors across the course of therapy; however, these changes
differed by treatment modality in a manner consistent with their respective presumed change mechanisms. Specifically, acceptance increased significantly more for couples in IBCT than for couples in TBCT, whereas couples in TBCT showed larger initial gains in positive communication. Moreover, examination of change separately in the first and second halves of therapy indicated that change in targeted behaviors was a powerful mechanism of change early in therapy whereas, in the second half of therapy, emotional acceptance was more strongly related to changes in relationship satisfaction.

Several studies have examined change processes using task analysis to link proximal outcomes occurring within or between sessions to specific therapeutic events. In an initial pilot study comparing IBCT with TBCT, Cordova, Jacobson, and Christensen (1998) found that couples in IBCT showed relatively more constructive detachment over the course of therapy, and that these changes predicted couples’ gains in relationship satisfaction. Three task-analytic studies of EFCT (Greenberg, Ford, Alden, & Johnson, 1993) showed that: (a) couples receiving EFCT demonstrated more shifts from hostility to affiliative behaviors than waiting-list couples; (b) best sessions as identified by couples were characterized by more depth of experiencing and affiliative and autonomous statements than were sessions identified as poor; and (c) intimate, emotionally laden self-disclosure by one partner was more likely to lead to affiliative statements by the other partner than were other randomly selected responses. A more recent task analysis of four EFCT sessions by Bradley and Furrow (2004) found that specific therapist interventions linked to “softening events” (reformulations of partners’ hostile or critical comments as expressions of vulnerability) involved intensifying a couple’s emotional experience and promoting intrapsychic awareness and interpersonal shifts in attachment-related interactions.

Predictors of Treatment Outcome

Research targeting predictors of couple therapy outcome has overwhelmingly emphasized prognostic rather than prescriptive indicators (Snyder et al., 2006). The former predict response to a particular treatment (or response across treatments, irrespective of specific approach), whereas the latter predict response to one versus another treatment. Although prescriptive indicators are essential to informed selection of specific interventions in tailoring treatment to partner or relationship attributes, empirical findings in this regard are virtually non-existent.

Studies examining demographic, individual, and relationship prognostic indicators of treatment outcome are more frequent, but their yield has been modest and mixed (see reviews by Snyder et al., 2006; Whisman, McKelvie, & Chatav, 2005). The most consistent finding (but of limited usefulness in selecting interventions) is that couples having the greatest difficulties in their relationship are less likely to benefit from treatment, with initial levels of relationship distress accounting for up to 46% of the variance in treatment outcome (Johnson, 2002). Lack of commitment and behavioral steps taken toward divorce have been associated with poor treatment outcome to BCT in two studies (Beach & Broderick, 1983; Hahlweg, Schindler, Revenstorf, & Brengelmann, 1984), but not in another (Jacobson, Follette, & Pagel, 1986). Snyder, Mangrum, and Wills (1993) found that
poorer response to couple therapy was predicted by lower relationship quality, greater negative relationship affect and disengagement, and greater desired change in the relationship.

**Effectiveness Investigations**

The effectiveness of couple therapy in the field outside of research settings has not been researched sufficiently. In two uncontrolled prospective studies, Hahlweg and Klann (1998) and Klann (2002) investigated the effectiveness of marital counseling in Germany. In total, 139 counselors recruited 1,152 clients into the study. The interpretation of the results is difficult because the attrition rate was high: Only about 50% of the clients participated in the post-assessment six months later. Pre-post comparisons resulted in significant improvements in several scales. The effect size for the Global Dissatisfaction Scale (of the Marital Satisfaction Inventory, MSI; Snyder, 1981) was ES = 0.45, a medium effect size. About 26% reported happy relationships after couple counseling – considerably less than in the Christensen, Atkins, Yi, Baucom, and George (2006) study, which leaves room for improvement of everyday effectiveness.

**Conclusions**

To conclude, couple therapy has been investigated widely demonstrating strong effect sizes. Furthermore, it has been demonstrated that it is effective in changing risk factors: e.g., dysfunctional communication patterns. Research also demonstrates its effectiveness in treating generalized relationship distress as well as comorbid relationship problems and individual emotional and behavioral difficulties.

**Couple Therapy and Child Functioning**

As described, couple conflict, distress and the lack of a warm positive relationship with parents, insecure attachment as well as harsh, inflexible, and inconsistent discipline tactics are risk factors for a range of poor child outcomes. In the context of couple therapy and the prevention of couple distress, the relevance of these findings seems to be obvious: One of the major tasks in couple intervention is to lower the likelihood that children will experience the above-mentioned negative consequences. Between 66% (Christensen et al., 2004) and 78% (Hahlweg & Klann, 1998) of couples in marital therapy have at least one child, on average of 7 years old. Approximately 40% of treatment couples with children report that they frequently fight about child rearing. Couples with children are more distressed than childless couples at the beginning of therapy, and couples with children improve less in marital satisfaction than couples without children, immediately at post therapy and at the 2-year follow-up (Gattis & Christensen, 2004).

Couple therapy seems to have no effects or only small effects on child-related variables. At present, only two studies have investigated the effects of marital treatment on child-related