AAMFT Journal of Marital & Family Therapy

Journal of Marital and Family Therapy
doi: 10.1111/j.1752-0606.2011.00249.x
January 2012, Vol. 38, No. 1, 145–168

# RESEARCH ON THE TREATMENT OF COUPLE DISTRESS

Jay L. Lebow and Anthony L. Chambers
*Northwestern University*

Andrew Christensen
*University of California, Los Angeles*

Susan M. Johnson
*University of Ottawa*

*This article reviews the research on couple therapy over the last decade. The research shows that couple therapy positively impacts 70% of couples receiving treatment. The effectiveness rates of couple therapy are comparable to the effectiveness rates of individual therapies and vastly superior to control groups not receiving treatment. The relationship between couple distress and individual disorders such as depression and anxiety has become well established over the past decade. Research also indicates that couple therapy clearly has an important role in the treatment of many disorders. Findings over the decade have been especially promising for integrative behavioral couples therapy and emotion-focused therapy, which are two evidence-based treatments for couples. Research has also begun to identify moderators and mediators of change in couple therapy. Finally, a new and exciting line of research has focused on delineating the principles of change in couple therapy that transcends approach.*

It has been a complex decade for the growth of knowledge of the treatment of couple distress. This complexity has been driven by two transcendent factors. First, this is a time during which the vast importance of couple distress for the partners involved and the family and social systems in which they live has become increasingly clear. Closely related to this has been the growth of a body of research pointing to the factors that promote strong marriages and the processes that lead to relationship distress and dissolution as well as the negative effects that accompany marital conflict and divorce. These threads of research have constituted part of the base for the development and dissemination of many programs to support marriage, largely psychoeducational (see the chapter by Markman et al. in this volume). Yet, this also has been a decade in which government funding priorities, especially in the United States, have limited the funding of treatment research to treatments focused on disorders catalogued in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* of the American Psychiatric Association (1994) and thus have made it virtually impossible to fund large-scale marital therapy research specifically targeted at marital distress, which has yet to be recognized in the *DSM* as a disorder. This despite the fact that couple therapy has become one of the most widely practiced treatments and for much of our society has emerged as the expected course to take when marriages become distressed.

Jay L. Lebow, PhD, and Anthony L. Chambers, PhD, The Family Institute and Center for Applied Psychological and Family Studies, Northwestern University; Andrew Christensen, PhD, Department of Psychology, University of California at Los Angeles; Susan M. Johnson, PhD, School of Psychology, University of Ottawa.

The authors would like to express our sincere gratitude to the graduate students who helped in the preparation of this article including Aliza Kravitz, Patrick Tennant, Jillian Thomas, and Einav Zohar.

Address correspondence to Jay L. Lebow, The Family Institute and Center for Applied Psychological and Family Studies, Northwestern University, Evanston, Illinois 60201; E-mail: j-lebow@northwestern.edu

The result has been that over this decade, while we have learned a good deal about marriage and the impact of marital factors on individual problems such as depression and substance use disorders, research focused on the treatment of marital problems has become principally a cottage industry.

Many researchers have obviated the lack of government funds by conducting small-scale treatment research, which can sometimes be more informative than larger-scale research and has the capacity to be more innovative in charting new territory. Yet, realistically, good research must include large-scale studies, which require significant funding. The treatment of couple distress simply has not been a priority of government funding over the last decade. It is perhaps the most important conclusion of this review that, given all we have come to know about the toxicity of relationship distress and the processes that engender such distress, funding priorities should be altered so that more large-scale quality research focused on marital therapy can be conducted.

Changes in culture also make it essential at the beginning of this review to crisply delineate what we mean by "marital" or "couple," because the use of the terms has changed considerably in meaning over this decade. Most societies today have a wide range of committed relationships, some of which are formally recognized as marriage by the state and some not. Given this trend, it has become a core understanding in this field of endeavor that the term "couple distress" or "marital distress" applies to long-term committed unions of romantic partners whether or not these unions are recognized by the state. Thus, for purposes of this review, we include gay and lesbian committed relationships and other long-standing relationships whether or not they are recognized by the state as "marriage." It should be stressed that, probably stemming from the limited funds available for research on couples therapy, although our knowledge about diverse couples is increasing, we still know very little from research specifically about how treatments impact in diverse populations including nontraditional couples such as gay and lesbian couples.

This review summarizes the research on couple therapy from the years 2000–2009 and the state of this field of endeavor. We limit our coverage to the findings of the decade, though we also place these findings in the broader context of what has come to be known over time about couple therapy. The article begins with a consideration of the epidemiology of couple distress and its relation to individual psychopathology, followed by sections focused on research methods. Meta-analytic studies of the effectiveness of couple therapy in practice are also reviewed. Because much of the quality research on couple therapy specifically targeted at couple distress over this decade primarily focuses on two approaches, integrative behavioral couple therapy (IBCT) and emotion-focused couple therapy (EFT), we then explore the findings about IBCT and EFT in depth. The article concludes with a consideration of the process research and the emerging concept of principles of change applicable across all couple therapies.

## EPIDEMIOLOGY

Couple distress continues to number among the most frequently encountered difficulties. The divorce rate in America continues to hover around 50%, with half of these divorces occurring in the first 7 years of marriage. Rates of marital distress in presently married couples approximate 20% of couples at any time, with marital satisfaction decreasing considerably over the first decade of marriage (Bradbury, Fincham, & Beach, 2000).

Over the last decade, considerable research has accrued that suggests couple distress has a strong relation to an individual's level of mental and physical problems. Moreover, evidence is beginning to accrue that couple distress is not only correlated with but also has a causal role in the generation and maintenance of individual psychopathology (Whisman & Uebelacker, 2006). Whisman and Uebelacker (2006) evaluated associations between marital distress and *DSM* Axis I psychiatric disorders in a U.S. population-based survey of married individuals. They found that marital distress was associated with broad classifications of anxiety, mood, and substance use disorders and with all narrow classifications of those specific disorders except for panic disorder. The strongest associations obtained were between marital distress and bipolar disorder, alcohol use disorders, and generalized anxiety disorder.

It has also been established that certain couple events experienced as humiliating, such as infidelity and separation, often lead to anxiety and depression and vice versa (Cano & O'Leary, 2000). That is, the presence of Axis I and Axis II diagnoses and relationship distress is circular: each begets the other. Evidence has also accumulated for the effects of physiological factors in these associations; for example, Kiecolt-Glaser, Bane, Glaser, and Malarkey (2003) found higher levels of stress hormones, specifically epinephrine, norepinephrine, and adrenocorticotropic hormone in dissatisfied and divorcing couples than in happily married couples.

The effects of relationship distress are clearly salient not only in the individual but also throughout the family system. Whisman and Uebelacker (2006) found that relationship distress is related to social role impairment with family and friends, impaired work functioning, general distress, poorer health, and increased likelihood of suicidal ideation. Evidence has also accrued about the ways that individual psychopathology can lead to marital violence (Holtzworth-Munroe & Meehan, 2004).

Studies have also shown that marital distress leads to poorer treatment outcome in the treatment of problems such as depression, anxiety, and substance use disorders and in relapse following treatment (O'Farrell, Hooley, Fals-Stewart, & Cutter, 1998; Whisman, 2001). Thus, couple distress clearly has a pervasive effect on individual problems, and thus, it would behoove clinicians and researchers focused on treating individuals to screen for couple distress as well as address it if present.

Looking at who does couple therapy, the largest international study of psychotherapists (Orlinsky & Ronnestad, 2005) found an astounding 70% of psychotherapists treat couples. This is a remarkable statistic, which may give some pause when one considers the limited training in couple therapy in professions other than marriage and family therapy and family psychology. In fact, the lack of couple therapy training may account for why, although couple therapy is highly effective when studied (Shadish & Baldwin, 2003, 2005; Snyder, Castellani, & Whisman, 2006), couple therapy is among the lowest rated for consumer satisfaction in the *Consumer Reports* study of psychotherapies (Seligman, 1995), which did not control for therapist training.

## COUPLE DISTRESS

The growth of knowledge about couple distress over the last decade has been enormous, rendering any review of this body of work in the context of this review of couple therapy impossible. Having said that, much has been learned about attributions (Fincham, Reis, & Rusbult, 2004), emotion (Hawkins, Carrere, & Gottman, 2002), attachment (Whiffen, 2003), love (Berscheid, 2010), romance (Marston, Hecht, Manke, McDaniel, & Reeder, 1998), sexuality (Bodenmann, Ledermann, & Bradbury, 2007), forgiveness (Fincham & Beach, 2003), neuroscience (Fishbane, 2007), hostility (Rogge, Bradbury, et al., 2006), conflict (Bradbury, Rogge, & Lawrence, 2001), and exchanges (Klein, Izquierdo, & Bradbury, 2007) in marriage, to name only a few of the areas of research exploration. These findings stand as potential pillars for furthering the science of couple therapy.

## ADVANCES IN ASSESSMENT

Assessment of couple distress has advanced considerably over the decade. Snyder et al. have provided an authoritative evidence-based guide to such assessment (Snyder, Heyman, & Haynes, 2005). More specifically, there have emerged a number of well-validated measures of couple functioning; many of these are now quite brief (Snyder et al., 2005). Scales have also been developed and revised to measure specific important aspects of marital life, such as forgiveness and marital violence. Other better measures have also been developed for assessing the alliance in couple therapy.

An important thread of research has been pursued by Whisman, Beach, and Snyder (2008) to identify whether couple distress can be separated as a taxon, i.e., whether a group that is particularly distressed and different from the continuous range of couple distress can be identified. Their work has successfully pointed to a group for whom distress is not only high, but

which can also clearly be psychometrically separated from the range of those with various levels of marital satisfaction.

## ADVANCES IN METHOD IN TREATMENT RESEARCH

The decade has also seen considerable advances in methods of treatment research. Once an outback of poorly controlled research compared to research on individual psychotherapy, this generation of marital therapy research is subject to far fewer threats to validity. In particular, the research program of Christensen et al. (2004), Christensen, Atkins, Yi, Baucom, and George (2006), Christensen, Atkins, Baucom, and Yi (2010) stands out as the state of the art research thus far of couple therapy.

The primary problem that remains with research on treatment of couple distress is concerned with external validity. Patient samples often do not typify the general population. Wright, Sabourin, Mondor, Mcduff, and Mamodhoussen (2006) assessed outcome studies for clinical representativeness, finding that overall, couple therapy outcome studies' representativeness was only rated "fair." Rogge et al. have provided a lens into how exclusion criteria in the selection of patients can add up to samples that do not represent the general population (Rogge et al., 2006).

Christensen, Baucom, Vu, and Stanton (2005) and Heatherington, Friedlander, and Greenberg (2005) have offered state of the art reviews of methods in couple therapy outcome and process research, respectively. Christensen et al. (2005) made several methodological recommendations that should guide high-quality, cost-effective future research on couple therapy outcomes.

## META-ANALYTIC AND EFFECTIVENESS STUDIES

Over the past 30 years, there have been a plethora of research studies examining the efficacy of marital therapy. Shadish and Baldwin (2003) have offered the definitive meta-analytic reviews of couple therapy. They reviewed six previous meta-analyses reporting an overall mean effect size of 0.84 for marital therapy, suggesting that a couple receiving treatment was better than 80% of the couples who did not receive treatment, a level comparable to meta-analyses of the impact of individual therapy on individual disorders.

In a more recent and specific meta-analysis, Shadish and Baldwin (2005) summarized the results of 30 randomized experiments comparing behavioral marital therapy (BMT), the most researched marital therapy, to no-treatment controls. The results of the meta-analysis found that BMT is better than no treatment, producing a mean effect size of 0.59, but in comparing this effect size to their previous meta-analyses (Shadish & Baldwin, 2003; Shadish, Ragsdale, Glaser, & Montgomery, 1995; Shadish et al., 1993), they concluded that BMT did not produce superior outcomes to other forms of couple therapy. Shadish and Baldwin (2005) also found the effects of BMT unrelated to number and length of sessions, the measures employed, or the clinical representativeness of the treatment; they further concluded that component studies indicated that communication and problem-solving strategies led to most of the treatment effects. Another meta-analysis by Wood, Crane, Schaalje, and Law (2005) also found little difference between the different forms of marital therapy.

In a German effectiveness study conducted with heterogenous treatments in real-world treatment settings, Klann, Hahlweg, Baucom, and Kroeger (2009) found improved global scores on the Marital Satisfaction Inventory (MSI) after couple therapy. This followed an earlier study in Germany that showed effectiveness of marital therapy in community studies lower than in typical efficacy studies (Kroger, Klann, Hahlweg, & Baucom, 2005), a result that typifies effectiveness studies of individual and family therapy. A Swedish study (Lundblad & Hansson, 2005) of a very brief couple therapy found that one-half the clients showed clinically significant improvement in symptoms and expressed emotion.

In summary, studies continue to show that most couple therapy has an impact, with about 70% of cases showing positive change. These build on the already two decades of existent findings suggesting couple therapy is an effective mode of treatment (Johnson, 2002b). These findings are particularly notable in light of research by Baucom, Hahlweg, and Kuschel (2003),

who found in their own meta-analysis that marital distress is typically an unremitting problem that does not improve without treatment. Thus, they argue that there may be no need for waitlist control groups in studies of efforts to impact couple distress (Baucom et al., 2003).

## INTEGRATIVE BEHAVIORAL COUPLE THERAPY

Developed by Andrew Christensen and Neil Jacobson, IBCT (Christensen & Jacobson, 2000; Jacobson & Christensen, 1998) is part of what has been called the "third wave" behavioral approach. IBCT includes aspects of private experience such as emotions and emphasizes concepts such as acceptance and mindfulness in addition to the typical cognitive-behavioral strategies. IBCT focuses on broad themes in partners' concerns and puts a renewed emphasis on a functional analysis of behavior. It emphasizes emotional acceptance as well as behavioral change and creates a joint awareness of the difficult patterns couples get into and an emotional distance from those patterns so that couples can look at them more objectively and perhaps even see the humor and paradox in them. IBCT also emphasizes "contingency-shaped" rather than rule-governed change, in which change occurs not through the deliberate employment of rules or guidelines but by exposing partners to new experiences that create contingencies that shape new behavior.

## METHODOLOGY OF THE CLINICAL TRIALS OF IBCT

Jacobson, Christensen, Prince, Cordova, and Eldridge (2000) conducted a small clinical trial in which 21 distressed married couples were randomly assigned to IBCT or traditional behavioral couple therapy (TBCT). Results indicated that therapists administering both treatments could keep them distinct and that IBCT produced greater improvements in marital satisfaction and stronger effect sizes than TBCT, but not significantly better given the small sample size. This pilot study encouraged a large clinical trial comparing IBCT and TBCT on 134 couples that was conducted through the University of California, Los Angeles, and the University of Washington and constitutes the basis for the findings reported in the remainder of this section.

This latter study was designed to be a challenging test of couple therapy, so only chronically and seriously distressed couples were included. Couples had to meet criteria for dissatisfaction at three different time points on three different measures of marital satisfaction. Almost 100 couples who sought treatment were turned away because they did not meet this distress criteria; a follow-up showed that about half of these couples who were rejected from the study as not meeting the criteria of chronic and serious distress sought couple therapy in the community. Furthermore, couples were usually allowed into the treatment even if they qualified for an Axis I or Axis II disorder; only a few of these disorders, such as psychotic disorders and antisocial personality disorder, were exclusionary criteria. Second, exclusionary as well as inclusionary efforts was made so that couple therapy was appropriate for those admitted to the program. Given the emphasis upon serious and chronic distress, a large number of couples in which the husband was violent showed interest in the study. Almost 100 couples in which the male was moderately to severely violent were excluded from participation. Third, the study was designed to be a test of couple therapy at its best. Thus, only experienced, closely supervised therapists were used in the study. Fourth, the study was designed to show the trajectory of change in marital status and satisfaction, not just the final outcome on these measures. Thus, repeated measures of marital status and satisfaction were taken throughout the study. Finally, the study was designed to examine the long-term effects of couple therapy, and so extensive follow-ups were collected through 5 years posttherapy. In over 90% of couples, at least one partner was contacted at the 5-year follow-up. By supplementing these personal contacts with a search of Internet records, relationship status on all of the couples was obtained at the 5-year point.

## OUTCOME FINDINGS ON IBCT AND TBCT

### *Marital Satisfaction and Marital Status*

Findings reported in this section come from Christensen et al. (2004, 2006, 2010).

During the clinical trial, couples in both TBCT and IBCT improved in satisfaction as expected. However, their trajectories were significantly different. TBCT couples improved quickly early on but then tapered off, whereas IBCT couples improved gradually but consistently throughout the course of treatment. The authors' interpretation of these findings is that TBCT strategies of behavioral exchange, which delay attention to long-standing issues but focus instead on increasing the frequency of positive activity, may create an initial boost in satisfaction, but when the focus shifts to those long-standing problems, satisfaction may taper off. In IBCT, there is no delay in focusing on long-standing issues, which may account for the slower but continual increase in satisfaction. There was also a difference in the trajectories of husbands and wives, with husbands improving significantly more rapidly than wives in satisfaction. Husbands are generally more reluctant than wives to enter therapy, and this was true in their sample as well (Doss, Atkins, & Christensen, 2003). The authors speculated that husbands may fear that therapists will unite with their wives in documenting their limitations; when husbands experience therapy as something that may benefit them as well as their wives, their satisfaction may show a faster improvement than their wives'.

Couples were followed approximately every 6 months for 5 years after the completion of couple therapy. Following treatment termination, couples showed an immediate drop in satisfaction but then a gradual rise in satisfaction and, for couples who stayed together, considerable maintenance of that higher level of satisfaction. The authors speculated that the immediate drop in satisfaction after treatment termination might be a natural result of ending the regular focus on the relationship that therapy provides. However, they also offered the alternative possible explanation that the final assessment of satisfaction right after therapy termination may reflect an overestimation of relationship improvement. For the first 2 years after treatment termination, IBCT couples maintained their satisfaction at significantly higher rates than TBCT couples. However, after 2 years of follow-up, differences between the two treatments disappeared.

Both treatments showed substantial effect sizes on relationship satisfaction at posttreatment and at 5 years after treatment termination. At termination, 70.4% of IBCT couples and 60.6% of TBCT couples showed clinically significant improvement (reliable improvement or recovery). At 5-year follow-up, 50% of IBCT couples and 46% of TBCT couples showed clinically significant improvement. At 5-year follow-up, 25.7% of IBCT couples and 27.9% of TBCT couples were divorced or legally separated. A statistical comparison of these separation or divorce rates with other published divorce rates from long-term follow-ups of couple therapy indicated that these divorce rates were significantly lower than those reported by Cookerly (1980) at 5 years posttreatment for couples who received conjoint couple therapy (43.6% divorced) and for couples who received nonconjoint therapy (70.2% divorced). The rates were also significantly lower than the 4-year separation or divorce rate of 38% for BMT reported by Snyder, Wills, and Grady-Fletcher (1991). The current separation or divorce rates were significantly higher than the impressive rate of 3% separation or divorce rate for insight-oriented couple therapy reported by Snyder et al. (1991); however, these latter couples were significantly less distressed at the beginning of treatment than couples in the current study.

*Other Outcomes of Couple Therapy*

Findings reported in this section come from the articles cited in the above section and from Atkins, Dimidjian, Bedics, and Christensen (2009), Sevier, Eldridge, Jones, Doss, and Christensen (2008), and Williams-Baucom, Sevier, Doss, Eldridge, and Christensen (2009).

Self-reports of communication showed significant improvement during treatment and maintenance over the first 2 years of follow-up (subsequent follow-up has not been examined yet). Observational measures of communication showed significant improvement during treatment, with TBCT showing greater improvement than IBCT. This treatment difference was expected, as TBCT trains couples in communication and the posttreatment assessment would presumably capitalize on this training as well as on demand characteristics of the assessment. Preliminary analysis of the 2-year follow-up observational assessments suggests

that observed communication in IBCT couples maintains better over 2 years than in TBCT couples.

Self-report measures of individual functioning, including a mental health index and a measure of psychological symptoms, did not change overall during treatment or follow-up. However, variability in both of these measures was significantly associated with changes in marital satisfaction. Thus, as marital satisfaction changed, so did the mental health index and the measures of psychological symptoms. Looking specifically at depression, there was an association between marital discord and depression at intake, but not a dramatic one (many distressed couples include individuals who are not depressed). The treatment of marital discord was associated with statistically significant, but not dramatic, improvements in individual depression, presumably because there was a limited range of depression. Changes in depression were associated with changes in marital satisfaction.

*Predictors of Outcome*

Findings reported in this section come from Atkins et al. (2005) and Baucom, Atkins, Simpson, and Christensen (2009).

A variety of demographic, interpersonal, and intrapersonal factors were examined as potential predictors of immediate posttreatment outcome as well as of 2-year follow-up outcome (predictors of 5-year outcome have not yet been examined). An important methodological feature of these studies was to separate the prediction of initial satisfaction from the prediction of change in that satisfaction. A variety of variables, particularly interpersonal variables, predict initial satisfaction. Many fewer variables predict the more important feature of change during treatment and follow-up. Couples who were married longer tended to perform better overall, perhaps because of greater commitment. It was easier to predict the course of moderately distressed couples than severely distressed couples, perhaps in part because the latter are high on so many potential predictor variables. Moderately distressed couples who had lower levels of wife arousal during problem-solving discussions and who used less hard influence tactics (that give the partner little room to respond) tended to perform better in treatment than moderately distressed couples with higher levels of arousal or those who used hard influence tactics. Couples in IBCT tended to do better than their counterparts in TBCT when the wife had higher levels of arousal and when couples used soft influence tactics. Although all of these findings need to be replicated, it may be that the strategies of IBCT, which emphasize emotional expression, work better than TBCT strategies when there is high emotional arousal and when partners are more open to influence.

*Process Findings on IBCT and TBCT*

Findings in this section come from Cordova, Jacobson, and Christensen (1998), Doss, Thum, Sevier, Atkins, and Christensen (2005), and Sevier et al. (2008).

Research on the process of couple therapy with IBCT and TBCT can be divided into two parts: (a) research on the mechanisms of change, which is research on the variables that might be directly affected by treatment and which in turn lead to improvements in relationship satisfaction, and (b) research on in-session behavior by therapists and clients. Three variables have been investigated as potential mechanisms of change: communication, behavior change in target problems, and acceptance of target problems. Process research indicated that each of these variables improved over the course of treatment and that improvement was related to improvement in satisfaction, consistent with the notion of mechanisms of change. However, the frequency of targeted behavior was only related to improvements in satisfaction early in treatment, but acceptance was related to improvements in satisfaction both early and late in treatment. Mechanisms of change did not differ by treatment, but TBCT brought about greater improvements in the frequency of targeted behavior early but not later in treatment, whereas IBCT brought about greater improvements in acceptance both earlier and later in treatment.

Observational coding of therapist behavior during treatment sessions indicated that, as expected, TBCT therapists used about three times as many interventions focused on change as therapists in IBCT (e.g., interventions focused on increasing positive behavior and

improving communication and problem solving which are emphasized as proximal goals in TBCT), whereas IBCT therapists used about three times as many interventions focused on acceptance as therapists in TBCT (interventions designed to facilitate empathic joining and unified detachment, which both are specific proximal goals in IBCT). Observational coding of a small number of couples revealed that, in the later stages of therapy, IBCT couples showed more nonblaming descriptions of problems and more soft emotions than did TBCT couples. Increases in nonblaming communication were significantly associated with improvements in marital satisfaction.

## SUMMARY OF FINDINGS AND FUTURE OUTLOOK

The clinical trials by Christensen, Jacobson, and their colleagues have shown that both behavioral couple therapies produce substantial improvements in even seriously and chronically distressed couples. Their research also demonstrated that improvements are maintained for a substantial portion of the couples for 5 years after treatment termination. This is clearly encouraging news about couple therapy. Some new and potentially important variables that may predict response to treatment are encoded arousal and language during difficult problem-solving discussions; these variables are particularly important because they can be objectively and automatically obtained. The two types of couple therapy, IBCT and TBCT, are clearly different in terms of what the therapist does in session and in terms of how the clients respond in and out of session. However, the overall impact is quite similar, but with an edge to IBCT. During the first 2 years of follow-up, IBCT produced greater significantly greater improvements in marital satisfaction, but over longer time periods, differences between the two treatments dissolved. Booster sessions during the 5-year follow-up might have increased the power of each of the treatments in general and, given the level of impact achieved, may have maintained the superiority of IBCT in particular.

What does the future hold for IBCT? Systematic training and dissemination of IBCT has begun in the U.S. Veteran's Administration, which has recently adopted IBCT as an empirically supported treatment that will be offered throughout the VA system. Further research on IBCT continues, particularly in the areas of therapeutic process, mechanisms of change, and prediction of long-term outcome. Also, research has recently begun on an Internet application of IBCT that could potentially reach a larger audience of couples at low cost.

## EMOTION-FOCUSED THERAPY

As we have moved into the 21st century, emotionally focused couple therapy (EFT; Johnson, 2004), a couple intervention that is based on a humanistic, experiential perspective that values emotion as an agent of change and on an attachment orientation to adult love relationships, has continued to grow and develop. At the end of the last century, a meta-analysis of the four most rigorous studies (Johnson, Hunsley, Greenberg, & Schindler, 1999) found a 70–73% recovery rate for relationship distress (86% significant improvement over controls) and an effect size of 1.3. Results have been found to be stable, even with couples who are at high risk for relapse (Clothier, Manion, Walker, & Johnson, 2002). Process studies suggest that the active ingredients of EFT are depth of emotional experience in key sessions and the shaping of new interactions where partners are able to clearly express attachment fears and needs and be emotionally responsive to the other's needs. The empirical base of attachment as a model of intimate relationships that is the foundation of EFT is substantial and has continued to expand over the last decade (Mikulincer & Shaver, 2007). Recent research into emotion and the impact of emotional support on the perception of threat emphasizes the powerful physiological and emotional impact that attachment figures have on each other (Coan, Schaefer, & Davidson, 2006; Gross, 2001).

Given that EFT has proven itself effective, that the theory of relationship on which it is based has powerful empirical validation and the key elements in change have been explored, what new directions have emerged in the last decade? Logically, in the growth of EFT, the next step was to conduct a series of relatively small exploratory studies on the use of EFT with

different kinds of clients facing different kinds of problems, i.e., to explore the application of EFT in different clinical contexts.

Emotion-focused couple therapy, focusing as it does on affect regulation and the creation of a secure connection that fosters resilience, is particularly applicable to couples whose relationship is impacted by traumatic stress and the symptoms of posttraumatic stress disorder (PTSD; Johnson, 2002a). Four studies have recently been conducted focusing on couples dealing with trauma. First, a recent randomized controlled trial (Dalton, Johnson, & Classen, 2009) examined the efficacy of EFT for women with a history of childhood abuse. The high prevalence of childhood abuse among women coupled with its association with marital distress highlights the importance of developing couple-based interventions that target comorbid relationship distress and trauma symptoms. Twenty-four distressed couples in which the female partner had a severe history of childhood abuse were randomly assigned to either 20 sessions of EFT or a waitlist control group. As predicted, couples in the treatment group experienced a statistically and clinically significant reduction in relationship distress (70% of couples scored as nondistressed or "recovered" at the end of treatment). Women in the treatment group also reported a reduction in trauma symptoms, such as dissociation, interpersonal sensitivity, and phobic avoidance.

A second study (MacIntosh & Johnson, 2008) also examined the effectiveness of 19 sessions of EFT with a small group ($N = 10$) of survivors of severe chronic childhood sexual abuse and their partners. Many such survivors show a fearful or avoidant style of attachment to others (Simpson & Rholes, 1998). Half of the couples in this study reported clinically significant improvements on the Dyadic Adjustment Scale (DAS; Spanier, 1976) and significant improvement in trauma symptoms measured by the Trauma Symptom Inventory and a structured interview, the Clinician administered PTSD scale (CAPS). Given the very high level of symptomatology and relationship distress, the fact that survivor partners reached criteria for complex PTSD, and that some couples presented with dual trauma, these results are considered very encouraging. A thematic analysis of treatment issues was also conducted; emotional flooding and numbing and the difficulty of risking relying on others stood out. The findings of the study basically supported the specific adaptations to the EFT model offered in the literature to promote positive change with traumatized clients (Johnson, 2002b).

Trauma can take many forms. Upwards of 40% of breast cancer survivors report depression and anxiety that reaches PTSD proportions (Kissane, Clarke, & Ikin, 1998). A small study ($N = 12$) was also conducted with maritally distressed breast cancer survivors. A multiple baseline design was used so that clients acted as their own controls. Couples were randomly assigned to 20 sessions of psychoeducation (three couples) or to EFT (nine couples) and tested at pretreatment intervals, midtreatment, termination, and follow-up (Naaman, Johnson, & Radwan, in press). The results were that 50% of the couples who received EFT showed significant improvement on the DAS measure of marital adjustment, quality of life, mood disturbance, and trauma symptoms. There was no evidence of relapse at follow-up; in fact, marital adjustment and quality of life continued to improve and no improvements on any variables occurred in the educational group.

An outcome study by Denton, Nakonezny, Wittenborn, and Jarrett (2010) also extends the literature on the impact of EFT on major depression that co-occurs with relationship distress. EFT was combined with antidepressant medication in one group while another received just medication. Women in both groups significantly improved in their depressive symptoms, with no differences between groups. However, women receiving EFT experienced a significantly greater improvement in relationship quality. Given that depression is robustly associated with relationship distress, this could portend a better long-term prognosis.

Another development in EFT research focused on exploring an impasse in the change process in EFT where a past injury arose that blocked the creation of trust and connection in Stage 2 of EFT and developing a model to successfully address such impasses. These injuries conceptualized as abandonments and betrayals at key moments trigger attachment panic and general insecurity. Steps in the process of forgiving these injuries were outlined, and one outcome study (Makinen & Johnson, 2006) found that in a brief EFT intervention 63% of all distressed injured couples moved out of distress and were able to forgive the injury and complete key bonding events that predict success in EFT. The results of this study were found

to be stable at 3-year follow-up (Halchuk, Makinen, & Johnson, 2010). Couples for whom intervention was less effective had multiple injuries and lower levels of initial trust, and they indicated that the intervention offered (only 13 sessions) was too brief.

Emotion-focused couple therapy research has always focused on explicating how in-session change occurs, both from the point of view of steps in the client change process and key therapist interventions. A recent process study (Zuccarini, 2010) validated the EFT model of forgiveness finding that steps in the process as outlined were indeed reflected by scores on process measures such as the Depth of Experiencing Scale (Klein, Mathieu, Gendlin, & Kiesler, 1969) and Levels of Client Perceptual Processing and differed for resolved and nonresolved couples. The therapist interventions of evocative questioning, heightening emotional engagement, and shaping enactments were most frequent in key therapy components with resolving partners who reached high levels of forgiveness. Partners who were able to resolve their injury and move out of distress were able to process their primary attachment emotions in a clear, reflective, and integrated manner and become more responsive to and trusting of their partner.

The results of this process of change study echo an earlier study (Bradley & Furrow, 2004) that allowed for more detailed mapping of the softening change event in EFT (Bradley & Johnson, 2005) that predicts successful outcome. Deepening of emotional experience and specific kinds of affiliative disclosing interactions in key sessions were consistently associated with the completion of change events and positive outcome in EFT. Again, therapist interventions such as evocative questioning and heightening process patterns and emotions were associated with change.

In another study, Meneses and Greenberg (2011) found couples rated sessions containing the revealing of underlying emotions significantly more positively than randomly selected control sessions on a global measure of session outcome. In addition, following sessions in which underlying vulnerable emotions were revealed, those who witnessed their partners reveal felt significantly less troubled and significantly more understanding toward their revealing partners. Finally, couples who revealed underlying vulnerable emotion improved significantly more from pre to post on a measure of relationship satisfaction than couples who did not reveal these emotions.

The final development in EFT research in the last decade is still in process and is in keeping with the key role of attachment theory and research in the EFT model. This is a study to specifically examine the effectiveness of EFT in creating more secure attachment bonds and how these bonds function to modify the perception of threat and so create a functional safe haven and secure base for partners. The present study focuses on how partners use their bond to regulate affect and accomplish key tasks in attachment relationships, such as being able to reach for each other. Self-report, the coding of interactional tasks, and fMRI images that capture how contact with a loved one impacts coping with danger cues, such as the threat of electric shock, are being used.

In the last decade, EFT has also begun to address the areas of sexuality (Johnson & Zuccarini, 2010), and cultural diversity and differences (Greenman, Young, & Johnson, 2009). Programs have also been developed, based on the book *Hold Me Tight* (Johnson, 2008b) that outlines attachment theory and the steps of EFT for the public, for military postdeployment couples (Johnson & Rheem, 2006), and for general enrichment and relationship education groups (Johnson, 2009).

In brief, EFT continues to grow and its application to various populations facing diverse relationship issues continues to expand. The theory base of attachment and new understandings of emotion (Johnson, 2009) also continue to grow. The study of treatment outcome in EFT is now moving beyond a concern with relationship adjustment or satisfaction to a focus on the creation of the safe attachment bonds that are associated with resilience and health in partners and in families.

## COUPLE THERAPY FOR SPECIFIC COUPLE DIFFICULTIES

The decade has seen the beginnings of research on couple therapies for particular relationship difficulties. Snyder, Baucom, and Gordon (2008) have developed and investigated a

treatment for couples experiencing infidelity. There are three phases in this treatment: first, coping with the initial emotional and behavioral disruption, then exploring factors contributing to the onset or maintenance of the affair, and then reaching an informed decision about how to resolve the issues. At termination, the majority of a group of single cases reported less emotional and marital distress and partners reported greater forgiveness toward their partners.

In another study examining forgiveness in the wake of a broader range of injuries, Greenberg, Warwar, and Malcolm (2010) examined the impact of EFT in 12 couples who experienced injury and found that 11 of 12 couples rated themselves at the end of treatment as completely forgiving their partners. These couples were able to maintain their gains at 3-month follow-up.

Another specific variation of couple therapy has focused on intimate partner violence. Stith, Rosen, and McCollum (2003) and Stith, Rosen, McCollum, and Thomsen (2004) completed a randomized clinical trial comparing couple group therapy to individual therapy. Stith et al. (2004) found that couples group therapy was the most effective in terms of decreased violence, increased marital satisfaction, and improved beliefs about intimate partner violence. Moreover, men who participated in the couple treatment group were less likely to recidivate than men in the individual treatment group. In another study of the conjoint treatment of partner violence, LaTaillade, Epstein, and Werlinich (2006) found conjoint cognitive-behavioral couple therapy and treatment as usual produced increased relationship satisfaction, decreases in partner hostile withdrawal, fewer humiliating behaviors, and decreased psychological aggression with few differences across treatments. Neither treatment as usual nor the conjoint treatment reduced physical aggression, though this finding may have been an artifact of low baseline rates of physical abuse in the sample (LaTaillade et al., 2006). The research on the treatment of spousal abuse is more completely described in this volume in the chapter by Stith et al.

## TREATMENTS OF DSM AXIS I AND AXIS II DISORDERS WITH COUPLE THERAPY

A considerable body of work has emerged that suggests that couples therapy (in most cases variants of BMT) is helpful in the treatment of disorders conceived of through the lens of individual diagnosis. Some of this work has been summarized in the section about EFT above, and the many studies involving variants of BMT are reviewed elsewhere in this volume in the chapters by O' Farrell, Beach, Rowe, and Shields dealing with specific problem areas. Here, we highlight only a few representative BMT studies targeting individual psychopathology, referring the reader to other chapters in this volume for a more complete summary. In considering these studies, it should be highlighted that although these studies have the ultimate goal of affecting individual problems, they share with all couple therapy the proximate goal of improving the couple relationship as a step toward accomplishing those goals.

The largest number of studies of this kind has been conducted in the context of alcohol and other substance use disorders (Haaga, McCrady, & Lebow, 2006). Research has consistently found that a couple's relationship is characterized by elevated levels of relationship dissatisfaction and dysfunction when there is one partner in the couple who has a substance use disorder (e.g., Fals-Stewart, Birchler, & O'Farrell, 1999) and that relationship discord is often a precursor to relapse (Fals-Stewart, O'Farrell, Birchler, & Lam, 2009). Behavioral couples therapy (BCT) for alcohol and substance use disorders has an alcohol-focused component, which includes interventions that directly support abstinence, and it has a relationship-focused component, which includes interventions aimed at increasing positive feelings, shared activities, and constructive communication (O'Farrell & Fals-Stewart, 2003). Numerous studies have found these treatments efficacious in treating alcohol and drug substance use disorders (Fals-Stewart, Klostermann, Yates, O'Farrell, & Birchler, 2005; Fals-Stewart & Lam, 2008; O'Farrell, Murphy, Alter, & Fals-Stewart, 2008a, 2008b; Winters, Fals-Stewart, O'Farrell, Birchler, & Kelley, 2002).

A meta-analysis (Powers, Vedel, & Emmelkamp, 2008) of 12 clinical trials comparing BCT to individual treatment for alcohol and drug problems revealed a clear overall advantage of including BCT compared to individual-based treatments. This was true across outcome

domains of frequency of use, consequences of use, and relationship satisfaction. The pattern of results varied as a function of time. BCT was superior to control conditions only in relationship satisfaction at posttreatment. However, at follow-up, BCT was superior on all three outcome domains. In addition to other control conditions, BCT also outperformed individual cognitive-behavioral therapy (CBT) without couple therapy.

Over the last decade, Fals-Stewart, Birchler, and Kelley (2006) have extended their treatment to female alcoholics, finding superior outcomes compared to individual alcohol treatment in marital satisfaction both after treatment and at 1-year follow-up and in alcohol-related behaviors at 1-year follow-up. Similarly, McCrady, Epstein, Cook, Jensen, and Hildebrandt (2009) found their version of BCT outperformed individual treatment of women with alcohol use disorder both in alcohol- and relationship-related outcomes; the difference in effects was strongest in those with the more severe relationship problems and comorbid psychopathology. BCT has also been found to have an effect in reducing marital violence in these couples, the change in violence being mediated by changes in drinking (O'Farrell, Murphy, Stephan, Fals-Stewart, & Murphy, 2004).

The second major focus of couple therapy in treating individual syndromes has been the treatment of depression. Couples therapy has already been established as an evidence-based treatment for depression (Beach & O'Leary, 1992; Jacobson, Dobson, Fruzzetti, Schmaling, & Salusky, 1991), particularly for women in distressed relationships. Furthermore, only couple therapies have been shown to impact equally on depression and marital distress.

More recently, Bodenmann et al. (2008) conducted a randomized clinical trial to compare the effectiveness of treating depression with coping-oriented couple's therapy (COCT) compared to individual CBT and interpersonal psychotherapy for depression (IPT). COCT is a therapy that utilizes behavioral exchange techniques and training in communication and problem solving to help couples in distressed marital and nonmarital relationships deal with having a depressed partner. The study included 60 couples where one member of the couple met the *DSM-IV* criteria for major depression or dysthymia, and each couple had to be in a close and stable relationship for at least 1 year. The study found that patients in all three groups reported significant and similar decreases in depressive symptomatology. However, the COCT group had a lower relapse rate compared to the CBT and IPT groups. In addition, the patients in the COCT group reduced the amount of expressed emotion directed from partners toward their depressed spouses more than the other groups, although COCT did not produce more relationship satisfaction than in the other treatments. The authors suggest that the reduction in expressed emotion may be related to the low relapse rate in the COCT group.

Couple therapy also has been shown to be very useful in the treatment of anxiety in a partner-assisted format (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998), PTSD (Rotunda, O'Farrell, Murphy, & Babey, 2008), and borderline personality disorder (Fruzzetti & Fantozzi, 2008; Kirby & Baucom, 2007). It also has been successfully employed in the treatment of physical health problems, most notably breast cancer (see the review of health-related treatment studies by Shields).

## PROCESS STUDIES

Although outcome studies elucidate whether or not therapy works, these studies do not address how therapy works. Process studies address these pathways. It remains an unfortunate reality that process research remains relatively undeveloped in couple therapy. The major exceptions have occurred in the context of larger outcome research projects such as those focused on TBCT, IBCT, and EFT; these process studies have already been reviewed above.

Within the realm of process-oriented research with couples, the topic that has probably received the most research attention is the therapeutic alliance. Pinsof et al. have highlighted in a series of studies (Pinsof, 1994; Pinsof & Catherall, 1986; Pinsof, Zinbarg, & Knobloch-Fedders, 2008) that the alliance in couple therapy has several distinct components that emerge in confirmatory factor analysis: the alliance between self and therapist, the view of partner's alliance with therapist, the view of couple alliance with therapist, and the alliance with each other about the therapy. Strikingly, in their confirmatory factor analysis, no division between

tasks, bonds, and goals emerged in alliance, as is typically the case in individual therapy. These findings suggest that couples experience the alliance differently than do individuals in therapy.

Research indicates that a good couple-therapist alliance needs to be formed within the first few sessions of therapy to prevent premature termination of the therapy (Mamodhoussen, Wright, Tremblay, & Poitras-Wright, 2005). Further, more distressed couples tend to have poorer alliances. In an effectiveness study of 80 couples, Knobloch-Fedders, Pinsof, and Mann (2004) found level of marital distress predicted quality of alliance with more distressed couples having poorer alliances at Session 1 and Session 8. The ability to form a good therapeutic alliance appears to be independent of the level of psychiatric symptoms (Mamodhoussen et al., 2009).

The relationship between alliance and outcome in couple therapy is a complex one impacted by a combination of gender and the extent to which partners share the same view of the alliance. For example, although overall Symonds and Horvath (2004) found a weak relation between alliance and outcome, this correlation was much stronger when the partners agreed about the strength of the alliance (low or high). Symonds and Horvath (2004) also found that the male partner's alliance was more predictive of a positive outcome than the female's alliance and that when males' alliance was greater than females' and when the alliance was improving, correlations between alliance and outcome were strong.

Knobloch-Fedders et al. (2004) found alliance did not predict changes in individual functioning but did predict 5–22% of improvement in marital distress. They also found when men's midtreatment alliances were higher than their partner's, positive outcomes were more likely and that outcome was more closely related to women's ratings of their partner's alliance than to their own level of alliance. Further, women's midtreatment alliance predicted improvement above and beyond early treatment alliance. All told, it seems clear that split alliances, especially when the male's alliance is lower, present special challenges for couple therapy. It may be that given the frequent finding of greater engagement by women in all forms of therapy, indications that the male in a heterosexual couple is engaged may be the strongest predictor of good outcome in heterosexual couples.

An effectiveness study with a sample of 205 couples examined the impact of client feedback on couple therapy outcomes (Anker, Duncan, & Sparks, 2009). Their study involved randomly assigning couples to one of two therapist groups: therapists providing treatment as usual or therapists receiving and providing feedback about client progress based on instruments completed by clients during treatment. The study found that providing treatment progress and alliance information to both clients and therapists during couple therapy had a positive effect on the therapy outcome. In addition, the study found that feedback had the most impact with less effective therapists and for couples who are considered to be the most at risk. Other similar efforts to study the impact of feedback to therapists about treatment progress are underway utilizing the systemic therapy inventory of change (STIC; Pinsof et al., 2009).

## PRINCIPLES OF COUPLE THERAPY

An exciting preliminary development over this decade has been the beginning of the generation of evidence-based principles for the practice of couple therapy that transcends approach. Following the methods suggested by Castonguay and Beutler (2006), statements of principles are hypothesized from a thorough reading of the research, looking for common threads across successful treatments. Christensen (2010) has offered a very interesting proposed set of such principles for couple therapy consisting of five principles that transcend approach: (a) dyadic conceptualization challenging the individual orientation view that partners tend to manifest, (b) modifying emotion-driven maladaptive behavior by finding constructive ways to deal with emotions, (c) eliciting avoided, emotion-based, private behavior so that this behavior becomes public to the partners, making them aware of each other's internal experience, (d) fostering productive communication, attending to both problems in speaking and listening, and (e) emphasizing strengths and positive behaviors. Although Christensen's list provides only the launching point for a consideration of universal processes (his proposed processes require

further discussion and hypothesis testing while other candidates for universal principles could be suggested, e.g., creating a balanced alliance), such efforts are timely in pushing beyond a model-centered view toward a universal effective couple therapy with a common base of understandings and strategies, and a range of specific strategies that build on this set of shared understandings.

In parallel with such efforts, integrative and pluralistic models have been emerging. The three most recent models with extensive research support have an integrative focus: EFT, IBCT, and the therapies developed by Doug Snyder et al. (insight-oriented couple therapy and the treatment for couples with infidelity already described). Numerous other promising yet untested integrative couple therapies have also been developed.

From a similar perspective, Sprenkle, Davis, and Lebow (2009) have highlighted the importance of common factors in couple therapy, including the expanded relationship system, the generation of new hope in the context of demoralization, a systemic viewpoint, adapting to client stage of change, and intervention strategies that work with emotion, cognition, and behavior. It also appears that transcendent aspects of relationships such as attachment, exchanges, skill building, attributions, biology, and personal histories typically all need addressing, directly or indirectly, in an effective couple therapy. Research has only begun to address issues of the effectiveness of integrative versus traditional therapies and how much treatment outcomes depend on dealing with one or another set of issues.

## CONCLUSION

Our knowledge base about marital problems has expanded over the last decade even as the funds to study marital therapies have remained limited. Marital therapy started out as a practical effort to help people in troubled relationships without much of a theoretical or research base to support that work (Gurman & Fraenkel, 2002). Over the last decade, the scientific foundation for understanding relationship processes, how relationships succeed or fail, and the associations between relationship problems and individual difficulties have grown considerably (Johnson & Lebow, 2000). There have been several crucial developments in this understanding of couples in therapy; here, we summarize the most important of these developments.

First, a taxon of distressed marriages can be separated from the broad ever-changing continuum of levels of marital satisfaction (Whisman et al., 2008; Whisman et al., 2009). This suggests that there are two populations that seek out marital therapy that can or should be treated as distinct: those that are beyond the threshold for distressed marriages with all the factors that accompany distressed marriages, including high risk for divorce, and everyone else (including those seeking to simply improve their already adequate marriages). It appears clear that the taxonic group is clearly "in need" of treatment, falling in the range of what is called in insurance terms "medical necessity." This demarcation might also suggest that different treatment strategies may fit best with these different groups of clients.

Second, there are circular and pernicious cycles that occur between marital distress and individual psychopathology (Whisman, 2007; Whisman & Uebelacker, 2003; Whisman, Uebelacker, & Weinstock, 2004). This points to both the individual mental health consequences of relationship distress and to the need to remain sensitive to the presence of individual difficulties in the treatment of couple problems and the complex issues in attending to those difficulties (given that such attention inevitably affects alliances and focus in treatment).

Third, a considerable technology of well-validated instruments now is available for assessing level of marital distress and therefore progress in couple therapy. Both brief and longer instruments are available that readily can be added to practice. Efforts that incorporate results from such instruments into feedback in treatment appear very promising for having a positive impact on outcome.

Fourth, methodological improvements in couple therapy research have remarkably increased the validity of these studies and led to improved confidence in what can be learned from these studies. In particular, the study of Christensen et al. (2006) comparing two couple therapies over many years stands out as an iconic example of the state of the art of research in this field.

We also have seen the emergence of two groupings of treatments that have moved well beyond the threshold for being designated as empirically supported treatments: EFT and BCT. Each of these treatments has a range of forms. EFT has research in support of both the Johnson (Johnson, 2008a) and Greenberg versions (Greenberg & Goldman, 2008). BCT likewise has substantial support, both in its traditional form, which has been demonstrated to be effective now in more than 50 studies (Shadish & Baldwin, 2005) and in the integrative version of this treatment, IBCT (Jacobson & Christensen, 1996), which includes among other adaptations a greater emphasis on acceptance and emotion. Integrative therapies such as Snyder's insight-oriented couples therapy (Snyder et al., 1991) and the Snyder et al. treatment focused on infidelity (Snyder, Baucom, et al., 2008) also have shown promising results.

Based on the results of studies assessing EFT, BCT, and IBCT and on the results of meta-analyses, it appears clear that couple therapy typically has the desired impact despite couple problems being known to be difficult to change. It also seems clear from the research on IBCT that even the most distressed couples can and do benefit from couple therapy.

The challenge continues for the numerous forms of couple therapy other than BCT, EFT, IBCT, and insight oriented couple therapy (IOCT) to demonstrate their efficacy. The last decade has seen no additional broad approaches to couple therapy moving toward becoming empirically tested. This state of affairs exists despite the emergence of a number of new and seemingly useful couple therapies, some of which have a strong evidence-based foundation for their selection of strategies and techniques, such as Gottman's couple therapy or Snyder's affective-reconstructive therapy. Although this is understandable given the limited funding for couples therapy over the last decade, the total lack of support for many methods, especially those quite different in focus than EFT and BCT, cannot be overlooked. Some methods have been present in the field now without testing for generations, such as Bowen therapy, object relations therapies, and strategic therapies. The same lack of data holds true for many methods focused on helping divorcing couples divorce well, couples with extramarital involvements, sexual difficulties, and other specific couple problems. The consumer of those untested therapies might expect at this point at least some effort to show that treatments impact on distressed marriages as expected.

There is, of course, a vociferous debate in the field of psychotherapy between those in support of empirically supported therapies and those who suggest that treatments basically do not differ in impact and thus methods for creating lists of empirically supported therapies are intrinsically flawed. And indeed, the meta-analytic reviews in each version of this series of volumes have failed to show differences in impact between couple therapies (Shadish & Baldwin, 2003; Shadish et al., 1995). Yet, even though the first author of this review is an author of a book about common factors in couple and family therapy, it only can be concluded from the state of today's research that the buyer should beware if a couple therapy moves far afield from either of the threads of strategies that have been demonstrated to work. From such a viewpoint, approaches such as Gottman's sound marital house therapy (Gottman & Gottman, 2008), Snyder's affective-reconstructive therapy (Snyder & Mitchell, 2008), or Pinsof's integrative problem-centered therapy (Pinsof, 2005) that share much common ground with the evidence-based approaches may be taken to have support by proxy (though of course still requiring testing), but other approaches such as Bowen therapy, narrative therapy, and psychodynamic therapies do not. Most of all the research focuses on very few approaches. Given that one of the iconic surveys about psychotherapy, the *Consumer Reports* study of the 1990s (Seligman, 1995), found the one type of therapist rated as unsatisfying and negative in outcome was the "marriage counselor," this clearly is a field of endeavor in which treatment as usual must be regarded with doubt. It may well be that other therapies worthy of study are as effective as the variations of BCT, IBCT, and EFT, but simply because a therapist says he or she practices marital therapy does not mean a good result is likely. That new, untested marital therapies are disseminated on *Oprah* before scientific testing or even much clinical testing does not inspire confidence.

Indeed, one conclusion from research to date is that, while the best treatments are quite effective, marital distress is a difficult to treat problem. First, engagement and retention in couple therapy is clearly a problem. Many who need couple therapy do not seek it out, and many others do not stay long enough to receive a sufficient dose for it to be effective. Second, there remain some couples in every treatment who do not improve with treatment (just as there are

clients who do not improve with every form of individual treatment for individual difficulties). This does not seem so much an indictment of couple treatments as a speaking to a reality about this form of problem; people often develop significant marital problems over a lifetime and for some, the beginning of treatment may come long after those aspects that Gottman has related to marital demise have occurred and been repeated many times over (Gottman & Levenson, 2002). Third, marital harmony presents a major problem in maintenance of gains. Although one study of insight-oriented couple therapy has shown excellent long-term follow-up (Snyder et al., 1991) and some other studies of other treatments fairly good maintenance of change (Christensen et al., 2006; Halchuk et al., in press), most of the few studies that have examined long-term follow-up have shown a considerable reduction in impact over long periods of time (Jacobson, 1989). This should not be taken as a specific indictment of the few specific treatments that have been studied over these long periods but rather as a statement of the problem: how to improve marriages but also inoculate against future problems, problems that may not be able to be anticipated during therapy.

The notion of finding underlying principles of effective treatment seems a way to bridge the alternative perspectives of supporters of empirically supported therapies and those who doubt the merit of that route to effective treatment. It begins to seem clear that while effective treatments differ, they do share certain core ingredients. Most especially, they find cognitive, affective, and behavioral ways to change the cognitive, affective, and behavioral attachments partners have to one another. The decade has seen a beginning of the articulation of principles of couple therapy, which one day may lead to a coherent field of endeavor rather than a group of competing ideologies. That the evidence-based methods seem to be moving toward some convergence of targets for focus (including behavior, cognition, and emotion; acceptance and behavior change) renders this task much easier than it might have been a generation earlier. The next decade likely will find a much more evidence-based approach to articulating and testing such principles.

The idea of articulating such principles in the realm of couple therapy is particularly complex in that there probably is nowhere in the field of psychotherapy that assumptions about the human condition play more of a role than in couple therapy. Couple therapists vary enormously in ideology from those who espouse traditional ways of living to ones who espouse feminist values; and from ones who focus on saving virtually all marriages to others who regard it as beneficial to leave less than optimal relationships. Effective principles of practice and ideology might best be thought of as representing two different dimensions: how to most effectively intervene and ideology about the goals of intervention. When it comes to whether treatment is effective, some core principles of effective treatment transcend ideology.

It should be added here that all of the empirically supported therapies clearly support egalitarian marriage (most prominently BCT, which is predicated on such an idea). Doherty (2001) has also pointed to the problems associated with therapists taking ambivalent stances toward divorce in marital therapy. It is notable that each empirically supported approach to treatment does assume the stance of improving the relationship and thereby takes a definite pro-marriage view of the treatment (with the possible exception of couples in which there is intimate partner violence).

The decade has also seen the beginning of testing of specific treatments for specific couple difficulties, such as Snyder, Baucom, Gordon, and Peluso's (2007) treatment for infidelity and Stith and colleagues' (2004) treatment for marital violence. The early findings about these treatments are not only suggestive of their value but also of the value of developing specific treatments that speak to special marital problems.

Culture also must be more broadly addressed in research. Although the decade has seen greater attention to the representativeness of samples in research, couple therapy research remains extensively the study of White heterosexual European and North American couples. Although there have been thoughtful considerations of culture in relation to couples and even research on couples in specific cultures (Boyd-Franklin, Kelly, & Durham, 2008; Chambers, 2008; Falicov, 2003), culture-specific methods have yet to be studied, and few studies have been demographically balanced.

In summary, it is a rich time for marital therapy investigation, a time in which it may be that research impacts more on practice. The science-practice gap in the field is narrowing as

research comes to focus on the kinds of therapies and issues of most interest to clinicians. It remains to build channels between clinicians and researchers to narrow this gap.

## A CLINICIAN RESPONDS

Jay L. Lebow

Reviews of research, particularly decade reviews, are valuable in describing the state of the field, but what matters most to clinicians is how this state informs the practical aspects of clinical practice. As a clinician, there is much in this review that I apply in my day-to-day clinical practice. Although research is only beginning to address many questions that one wishes were answered (e.g., how to optimally deal with split alliances in treatment) and is not able to speak to other clinical decisions that lie in the realm of values rather than scientific questions (when is divorce preferable to an unsatisfying marriage?), the great news today is that there is a vast array of findings that can provide the foundation for good clinical practice. Here are several of the findings I find most clinically useful:

*Couple Therapy Works*

Distressed couples enter treatment demoralized about their relationships. This state of demoralization with which couples enter treatment often leads to questions of "Can this relationship be helped?" The data from research allow for a strong and unambiguous answer: "Yes, you may not feel hopeful now but three of four couples who complete therapy do emerge much happier in their relationship." In a world in which increasingly people want evidence to make realistic appraisals of their present circumstance, the evidence is available that most treatment helps and that distressed relationships can and do improve.

*The Importance of the Expanded Therapeutic Alliance*

The findings about the alliance in couple therapy mirror findings in other forms of therapy: the alliance matters. This key fact about therapy process has caused me over the years to move from an early treatment focus that was primarily about accentuating understanding about what was going on for the couple (assessment) to one that accentuates joining and building a working alliance as the primary goal of the first phase of treatment. This includes being sure both partners have time to express themselves, shaping goals collaboratively, accentuating hope, and allowing room for personal connection.

The research on the split alliance in couples also tells us a great deal. When one partner has a much different level of alliance than the other, the research indicates that trouble often ensues for the treatment and for outcome. I therefore focus considerable attention on the difficult task of balancing alliances. This task is especially difficult because split alliances are not always obvious and because one runs the risk of alienating the more attached partner in building a better alliance with the less involved partner. For the first problem, I have found that using a simple instrument such as the couple therapy alliance scales (Pinsof et al., 2008) can uncover the sorts of problems a therapist needs to know about. That in turn can lead to an open discussion of how clients feel about the treatment. Paying attention to nonverbal behavior indicative of alliance also helps.

The second problem may be addressed in part by simply looking for ways of joining better with the partner with the poorer alliance. However, more often, the risky situation of having such an alliance calls for riskier behavior of dealing with whatever the block is to better alliance; this can make for a tear and repair of alliances but also can sometimes simply lead to the end of treatment. However, I seldom find that split alliances improve without special attention. The research does indicate that such situations do make such risks appropriate because of the pernicious effects of the treatment in the presence of a split alliance.

*When Couples Present for Therapy, Therapists Need to Assess and Respond to Comorbid Psychopathology*

The findings of Whisman (2007) and others are clear; being in a distressed relationship is stressful and associated with other comorbid problems. Furthermore, those with other mental

health diagnoses tend to have more relationship problems. These findings have two major impacts on my clinical practice. First, I ask about or provide forms such as the STIC (Pinsof et al., 2009) that track such problems. In this way, one can learn how the individuals in a couple are functioning even if the conversation of the couple may not be about individual functioning. In a related way, such exploration also can lead to the uncovering of issues that are couple issues that often do not surface in couple therapy, such as intimate partner violence or sexual difficulties, which the research shows are notoriously unreported (O'Leary, 2008). Problems such as intimate partner violence, which often accompany couple distress, need to be inquired about in contexts that make reporting more likely.

The second important meaning I take from these findings is that sometimes individual attention to individual problems is needed. Here, again dealing with these issues is a complex matter. Although it is easy to say that when a client presents with a diagnosable problem, he or she should be referred for treatment for that problem, in the context of couple therapy, such referrals may not be desired by the clients because the couple's resources are focused on improving the marriage, or the problem is one for which the person with the problem is in a precontemplative stage of change, or a focus on individual problems may offer some clients a rationale for withdrawing from the more challenging climate of couple therapy, or a focus on individual problems may imbalance the therapeutic alliance with the couple.

Ultimately, therapeutic skillfulness lies in being able to talk about such co-occurring problems and finding a path to helping such problems. I also find it useful to consider the data as to whether couple therapy is likely to positively impact this particular type of problem; with a depressed woman in a distressed marriage, it might make more sense to explore couple therapy first, whereas with a couple with a partner with comorbid obsessive-compulsive disorder, I would be likely to make the referral earlier.

*There Clearly Are Well-Documented Effective Treatments for Treating Couples*

My belief is that the established effective couple therapies do not tell us the entire story about how couples might change in therapy but still offer important clues to effective practice. That is to say, in my own practice, I do not follow a specific manualized therapy but do think the evidence-based therapies point us to much of what is potentially effective in couple therapy and therefore utilize most of the strategies and techniques of those therapies. I find it particularly useful to follow the sorts of principles of couple therapy that Christensen has pointed to in the review of research that transcend approaches. For example, each effective treatment finds a focus the couple can share and thereby helps move the couple into a positive alliance about taking on their relationship problem. Each treatment also moves the focus away from complaints about one another, the bane of couple therapy, to a more useful dyadic focus. As Christensen et al. have highlighted, successful couple therapy must balance mutual acceptance and behavior change. And as Johnson has emphasized, ultimately successful therapy depends on making attachment secure.

Each method also contributes many techniques and strategies for change. My own approach is to try to fit these strategies to the couple's needs and preferences rather than provide the same strategy to each couple. I find it particularly useful myself to draw on the strategies aimed at behavior change from BCT, the strategies aimed at acceptance from IBCT, and the strategies aimed at attachment and emotional connection from EFT. Clearly, the emergence of BCT, EFT, and IBCT as three quite different evidence-based approaches points to there being multiple pathways toward change, but I believe that working with behavior, cognition, and emotion are all vitally important. It seems that change can be initiated along any of these three strategies (with clients typically more responsive to one than another) but that all levels of couple experience must be ultimately directly or indirectly addressed and impacted on for change to occur and be maintained.

*Track Change During Treatment*

It is important to know whether treatment is working, both in terms of the change occurring and state of the alliance. Studies already have begun to show that tracking outcome in

couples therapy even with the simplest of measures helps keep therapy successful (Anker et al., 2009). Early alliance problems, especially split alliances, appear to be particularly difficult to recover from and thus need to be uncovered. In my practice, I believe in both continually asking about the state of the couple relationship and the alliance and employing measures to track the status of the relationship. The latter assumes particular importance because the focus of therapy in a specific session or sessions may not focus on all the aspects of the couple's relationship.

*There Are Limits to the Impact of Couple Therapy*

Marriages are fragile in our society and families are exposed to innumerable life stresses. The research shows that almost all treatments that have been studied over long follow-up periods show diminishing effects over long periods of time. In my therapy, this has led me to greater emphasis on establishing ways of practicing after the end of treatment what they learned in marital therapy skills, especially communication/problem solving about expectations, acceptance, and emotional engagement. I emphasize an ongoing plan of action for working on issues outside of therapy during therapy that easily can be continued after therapy. Of course, whether couples do or do not keep their relationships in focus and continue to work on good enough communication about problems remains highly influenced by the motivation of the couple and the vicissitudes of life.

The tendency for treatment effects to erode over time also causes me to suggest to couples that they return for sessions as problems begin to emerge rather than after a new marital crisis. Given how most people see couples therapy, achieving this goal is difficult. There is the tendency to think, "We've completed our couple therapy," seeing this as a once in the lifetime event rather than as analogous to going to the family physician. I try to the extent possible to remove the constraints about this during the time of the therapy through creating a narrative about this as a way of having a successful marriage rather than as a sign of failure (Lebow, 1995).

In summary, I find the couple therapy research immensely helpful in clinical practice. However, it is not the only input into my therapy. For example, I believe that client culture also matters a good deal in therapy, and this is not a subject that has been explored much in couple research, though research may ultimately tell us a good deal about these issues. It also cannot add much to the thorny questions of the occasional trade-offs between individual happiness and collective happiness in the commitment to marriage. Nonetheless, I believe that today's couple therapy must be informed by the findings of research on couples and couple therapy, and there is a great deal of important information from research available to help guide the clinical practice of couple therapy.

## REFERENCES


American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Anker, M. G., Duncan, B. L., & Sparks, J. A. (2009). Using client feedback to improve couple therapy outcomes: A randomized clinical trial in a naturalistic setting. *Journal of Consulting and Clinical Psychology, 77*, 693–704.

Atkins, D. C., Berns, S. B., George, W., Doss, B., Gattis, K., & Christensen, A. (2005). Prediction of response to treatment in a randomized clinical trial of marital therapy. *Journal of Consulting and Clinical Psychology, 73*, 893–903.

Atkins, D. C., Dimidjian, S., Bedics, J. D., & Christensen, A. (2009). Couple discord and depression in couples during couple therapy and in depressed individuals during depression treatment. *Journal of Consulting and Clinical Psychology, 77*, 1089–1099.

Baucom, B. R., Atkins, D. C., Simpson, L. E., & Christensen, A. (2009). Prediction of response to treatment in a randomized clinical trial of couple therapy: A 2-year follow-up. *Journal of Consulting and Clinical Psychology, 77*, 160–173.

Baucom, D. H., Hahlweg, K., & Kuschel, A. (2003). Are waiting-list control groups needed in future marital therapy outcome research? *Behavior Therapy, 34*, 179–188.

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 of Consulting and Clinical Psychology, 66*, 53–88.

Beach, S. R., & O'Leary, K. (1992). Treating depression in the context of marital discord: Outcome and predictors of response of marital therapy versus cognitive therapy. *Behavior Therapy, 23*, 507–528.

Berscheid, E. (2010). Love in the fourth dimension. *Annual Review of Psychology, 61*, 1–25.

Bodenmann, G., Ledermann, T., & Bradbury, T. N. (2007). Stress, sex, and satisfaction in marriage. *Personal Relationships, 41*, 551–569.

Bodenmann, G., Plancherel, B., Widmer, K., Meuwly, N., Hautzinger, M., Beach, S. R. H., et al. (2008). Effects of coping-oriented couples therapy on depression: A randomized clinical trial. *Journal of Consulting and Clinical Psychology, 76*, 944–954.

Boyd-Franklin, N., Kelly, S., & Durham, J. (2008). African American couples in therapy. In A. Gurman (Ed.), *Clinical handbook of couple therapy* (4th ed., pp. 681–697). New York: Guilford Press.

Bradbury, T. N., Fincham, F. D., & Beach, S. R. H. (2000). Research on the nature and determinants of marital satisfaction: A decade in review. *Journal of Marriage and the Family, 62*, 964–980.

Bradbury, T. N., Rogge, R., & Lawrence, E. (2001). Reconsidering the role of conflict in marriage. In A. Booth, A. Crouter & M. Clements (Eds.), *Couples in conflict* (pp. 59–82). Mahwah, NJ: Erlbaum.

Bradley, B., & Furrow, J. L. (2004). Toward a mini-theory of the blamer softening event: Tracking the moment by moment process. *Journal of Marital and Family Therapy, 30*, 233–246.

Bradley, B., & Johnson, S. M. (2005). Task analysis of couple and family change events. In D. Sprenkle & F. Piercy (Eds.), *Research methods in family therapy* (pp. 254–271). New York: Guilford Press.

Cano, A. M., & O'Leary, K. D. (2000). Infidelity and separations precipitate major depressive episodes and symptoms of non-specific depression and anxiety. *Journal of Consulting and Clinical Psychology, 68*, 774–781.

Castonguay, L. G., & Beutler, L. E. (2006). *Principles of therapeutic change that work*. New York: Oxford University Press.

Chambers, A. L. (2008). Premarital counseling with middle class African Americans: The forgotten group. In M. Rastogi & V. Thomas (Eds.), *Multicultural couple therapy* (pp. 217–233). Thousand Oaks, CA: Sage.

Christensen, A. (2010). A unified protocol for couple therapy. In K. Hahlweg, M. Grawe-Gerber, & D. H. Baucom (Eds.), *Enhancing couples: The shape of couple therapy to come* (pp. 33–46). Göttingen, Germany: Hogrefe.

Christensen, A., Atkins, D. C., Baucom, B., & Yi, J. (2010). Marital status and satisfaction five years following a randomized clinical trial comparing traditional versus integrative behavioral couple therapy. *Journal of Consulting and Clinical Psychology, 78*, 225–235.

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 chronically distressed married couples. *Journal of Consulting and Clinical Psychology, 72*, 176–191.

Christensen, A., Atkins, D. C., Yi, J., Baucom, D. H., & George, W. H. (2006). Couple and individual adjustment for 2 years following a randomized clinical trial comparing traditional versus integrative behavioral couple therapy. *Journal of Consulting and Clinical Psychology, 74*, 1180–1191.

Christensen, A., Baucom, D. H., Vu, C. T.-A., & Stanton, S. (2005). Methodologically sound, cost-effective research on the outcome of couple therapy. *Journal of Family Psychology, 19*, 6–17.

Christensen, A., & Jacobson, N. S. (2000). *Reconcilable differences*. New York: Guilford Press.

Clothier, P., Manion, I., Walker, G. J., & Johnson, S. M. (2002). Emotionally focused interventions for couples with chronically ill children: A two year follow-up. *Journal of Marital and Family Therapy, 28*, 391–399.

Coan, J., Schaefer, H., & Davidson, H. (2006). Lending a hand. *Psychological Science, 17*, 1–8.

Cookerly, J. R. (1980). Does marital therapy do any lasting good? *Journal of Marital and Family Therapy, 6*, 393–397.

Cordova, J. V., Jacobson, N. S., & Christensen, A. (1998). Acceptance versus change interventions in behavioral couple therapy: Impact on couples' in-session communication. *Journal of Marriage and Family Counseling, 24*, 437–455.

Dalton, J., Johnson, S. M., & Classen, C. (2009). Treating relationship distress and the effects of childhood abuse with emotion focused couple therapy: A randomized controlled trial. Unpublished manuscript, Ottawa, Canada.

Denton, W. H., Nakonezny, P. A., Wittenborn, A. K., & Jarrett, R. B. (2010). *Augmenting antidepressant medication treatment of women with EFT*. In W. Denton (Chair), New research findings in EFT for couples. Paper presented at the EFT Summit, San Diego, CA.

Doherty, W. H. (2001). *Take back your marriage: Sticking together in a world that pulls us apart*. New York: Guilford Press.

Doss, B. D., Atkins, D. C., & Christensen, A. (2003). Who's dragging their feet: Husbands and wives seeking marital therapy. *Journal of Marital and Family Therapy, 29*, 165–177.

Doss, B. D., Thum, Y. M., Sevier, M., Atkins, D. C., & Christensen, A. (2005). Improving relationships: Mechanisms of change in couple therapy. *Journal of Consulting and Clinical Psychology, 73*, 624–633.

Falicov, C. J. (2003). Culture in family therapy: New variations on a fundamental theme. In T. L. Sexton, G. R. Weeks, et al. (Eds.), *Handbook of family therapy: The science and practice of working with families and couples* (pp. 37–55). New York: Brunner-Routledge.

Fals-Stewart, W., Birchler, G. R., & Kelley, M. L. (2006). Learning sobriety together: A randomized clinical trial examining behavioral couples therapy with alcoholic female patients. *Journal of Consulting and Clinical Psychology, 74*, 579–591.

Fals-Stewart, W., Birchler, G. R., & O'Farrell, T. J. (1999). Drug-abusing patients and their intimate partners: Dyadic adjustment, relationship stability, and substance use. *Journal of Abnormal Psychology, 108*, 11–23.

Fals-Stewart, W., Klostermann, K., Yates, B. T., O'Farrell, T. J., & Birchler, G. R. (2005). Brief relationship therapy for alcoholism: A randomized clinical trial examining clinical efficacy and cost-effectiveness. *Psychology of Addictive Behaviors, 19*, 363–371.

Fals-Stewart, W., & Lam, W. K. K. (2008). Brief behavioral couples therapy for drug abuse: A randomized clinical trial examining clinical efficacy and cost-effectiveness. *Families, Systems, and Health, 26*, 377–392.

Fals-Stewart, W., O'Farrell, T. J., Birchler, G. R., & Lam, W. (2009). Behavioral couples therapy for alcoholism and drug abuse. In J. H. Bray & M. Stanton (Eds.), *The Wiley-Blackwell handbook of family psychology* (pp. 388–401). Boston: Wiley-Blackwell.

Fincham, F. D., & Beach, S. R. H. (2003). Forgiving in close relationships. In P. Fittskirk & S. P. Shohov (Eds.), *Focus on behavioral psychology* (pp. 1–33). Hauppauge, NY: Nova Science.

Fincham, F. D., Reis, H. T., & Rusbult, C. E. (2004). Attribution processes in distressed and nondistressed couples: Responsibility for marital problems. In H. T. Reis & C. E. Rusbult (Ed.), *Close relationships: Key readings* (pp. 427–434). Philadelphia, PA: Taylor & Francis.

Fishbane, M. D. (2007). Wired to connect: Neuroscience, relationships, and therapy. *Family Process, 46*, 395–412.

Fruzzetti, A. E., & Fantozzi, B. (2008). Couples therapy and the treatment of borderline personality and related disorders. In A. Gurman (Ed.), *Clinical handbook of couples therapy* (4th ed., pp. 567–590). New York: Guilford Press.

Gottman, J. M., & Gottman, J. S. (2008). Gottman method couple therapy. In A. Gurman (Ed.), *Clinical handbook of couple therapy* (4th ed., pp. 138–164). New York: Guilford Press.

Gottman, J. M., & Levenson, R. W. (2002). A two-factor model for predicting when a couple will divorce: Exploratory analyses using 14-year longitudinal data. *Family Process, 41*, 83–96.

Greenberg, L. S., & Goldman, R. N. (2008). *Emotion-focused couples therapy: The dynamics of emotion, love, and power*. Washington, DC: American Psychological Association.

Greenberg, L., Warwar, S., & Malcolm, W. (2010). Emotion-focused couples therapy and the facilitation of forgiveness. *Journal of Marital and Family Therapy, 36*, 28–42.

Greenman, P., Young, M., & Johnson, S. M. (2009). Emotionally focused therapy with intercultural couples. In M. Rastogi & V. Thomas (Eds.), *Multicultural couple therapy* (pp. 143–166). Los Angeles: Sage.

Gross, J. (2001). Emotion regulation in adulthood: Timing is everything. *Current Directions in Psychological Science, 10*, 214–219.

Gurman, A. S., & Fraenkel, P. (2002). The history of couple therapy: A millennial review. *Family Process, 41*, 199–260.

Haaga, D. A., McCrady, B., & Lebow, J. (2006). Integrative principles for treating substance use disorders. *Journal of Clinical Psychology, 62*, 675–684.

Halchuk, R., Makinen, J., & Johnson, S. M. (2010). Resolving attachment injuries in couples using emotionally focused therapy: A three-year follow-up. *Journal of Couple and Relationship Therapy, 9*, 31–47.

Hawkins, M. W., Carrere, S., & Gottman, J. M. (2002). Marital sentiment override: Does it influence couples' perceptions? *Journal of Marriage and Family, 64*, 193–201.

Heatherington, L., Friedlander, M. L., & Greenberg, L. S. (2005). Change process research in couples and family therapy: Methodological challenges and opportunities. *Journal of Family Psychology, 19*, 18–27.

Holtzworth-Munroe, A., & Meehan, J. C. (2004). Typologies of men who are maritally violent: Scientific and clinical implications. *Journal of Interpersonal Violence, 19*, 1369–1389.

Jacobson, N. S. (1989). The maintenance of treatment gains following social learning-based marital therapy. *Behavior Therapy, 20*, 325–336.

Jacobson, N. S., & Christensen, A. (1996). *Integrative couple therapy: Promoting acceptance and change*. New York: W. W. Norton.

Jacobson, N. S., & Christensen, A. (1998). *Acceptance and change in couple therapy: A therapist's guide to transforming relationships*. New York: Norton.

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 of Consulting and Clinical Psychology, 68*, 351–355.

Jacobson, N. S., Dobson, K., Fruzzetti, A. E., Schmaling, K. B., & Salusky, S. (1991). Marital therapy as a treatment for depression. *Journal of Consulting and Clinical Psychology, 59*, 547–557.

Johnson, S. M. (2002a). *Emotionally focused couple therapy with trauma survivors: Strengthening attachment bonds.* New York: Guilford Press.

Johnson, S. M. (2002b). Marital problems. In D. H. Sprenkle (Ed.), *Effectiveness research in marriage and family therapy* (pp. 163–190). Alexandria, VA: American Association for Marriage and Family Therapy.

Johnson, S. M. (2004). *Creating connection: The practice of emotionally focused marital therapy* (2nd ed.). New York: Brunner/Routledge.

Johnson, S. M. (2008a). Emotionally focused couple therapy. In A. S. Gurman (Ed.), *Clinical handbook of couple therapy* (pp. 107–137). New York: Guilford Press.

Johnson, S. M. (2008b). *Hold me tight: Seven conversations for a lifetime of love.* New York: Little, Brown.

Johnson, S. M. (2009). Extravagant emotion: Understanding and transforming love relationships in emotionally focused therapy. In D. Fosha, D. Siegel, & M. Solomon (Eds.), *The healing power of emotion: Affective neuroscience, development and clinical practice* (pp. 232–256). New York: Norton.

Johnson, S. M., Hunsley, J., Greenberg, L., & Schindler, D. (1999). Emotionally focused couples therapy: Status and challenges. *Clinical Psychology: Science and Practice, 6,* 67–79.

Johnson, S. M., & Lebow, J. (2000). The coming of age of couple therapy: A decade review. *Journal of Marital and Family Therapy, 26,* 23–38.

Johnson, S. M., & Rheem, K. (2006). *Becoming a couple again: A post-deployment retreat for military couples.* Washington, DC: Strong Bonds-Strong Couples, Rheem Media.

Johnson, S. M., & Zuccarini, D. (2010). Integrating sex and attachment in emotionally focused couple therapy. *Journal of Marital and Family Therapy, 36,* 431–445.

Kiecolt-Glaser, J. K., Bane, C., Glaser, R., & Malarkey, W. B. (2003). Love, marriage, and divorce: Newlyweds' stress hormones foreshadow relationship changes. *Journal of Consulting and Clinical Psychology, 71,* 176–188.

Kirby, J. S., & Baucom, D. H. (2007). Treating emotion dysregulation in a couples context: A pilot study of a couples skills group intervention. *Journal of Marital and Family Therapy, 33,* 375–391.

Kissane, D., Clarke, D., & Ikin, J. (1998). Psychological morbidity and quality of life in Australian women with early breast cancer: A cross-sectional survey. *Medical Journal of Australia, 169,* 192–196.

Klann, N., Hahlweg, K., Baucom, D. H., & Kroeger, C. (2009). The effectiveness of couple therapy in Germany. *Journal of Marital and Family Therapy, 35,* 1–9.

Klein, W., Izquierdo, C., & Bradbury, T. N. (2007). Working relationships: Communicative patterns and strategies among couples in everyday life. *Qualitative Methods in Psychology, 4,* 29–47.

Klein, M., Mathieu, P., Gendlin, E., & Kiesler, D. (1969). *The Experiencing Scale.* Madison: Wisconsin Psychiatric Institute.

Knobloch-Fedders, L. M., Pinsof, W. M., & Mann, B. J. (2004). The formation of the therapeutic alliance in couple therapy. *Family Process, 43,* 425–442.

Kroger, C., Klann, N., Hahlweg, K., & Baucom, D. H. (2005). Counseling research: A procedure to assess the effectiveness of couples counseling in field settings. *Verhaltenstherapie and Psychosoziale Praxis, 37,* 531–539.

LaTaillade, J. J., Epstein, N. B., & Werlinich, C. A. (2006). Conjoint treatment of intimate partner violence: A cognitive behavioral approach. *Journal of Cognitive Psychotherapy, 20,* 393–410.

Lebow, J. L. (1995). Open-ended therapy: Termination in marital and family therapy. In R. H. Mikesell, D. D. Lusterman & S. H. McDaniel (Eds.), *Integrating family therapy: Handbook of family psychology and systems therapy* (pp. 73–90). Washington, DC: American Psychological Association.

Lundblad, A.-M., & Hansson, K. (2005). Outcomes in couple therapy: Reduced psychiatric symptoms and improved sense of coherence. *Nordic Journal of Psychiatry, 59,* 374–380.

MacIntosh, H. B., & Johnson, S. (2008). Emotionally focused therapy for couples and childhood sexual abuse survivors. *Journal of Marital and Family Therapy, 34,* 298–315.

Makinen, J., & Johnson, S. M. (2006). Resolving attachment injuries in couples using EFT: Steps towards forgiveness and reconciliation. *Journal of Consulting and Clinical Psychology, 74,* 1055–1064.

Mamodhoussen, S., Wright, J., Tremblay, N., & Poitras-Wright, H. (2005). Impact of marital and psychological distress on therapeutic alliance in couples undergoing couple therapy. *Journal of Marital and Family Therapy, 31,* 159–169.

Marston, P. J., Hecht, M. L., Manke, M. L., McDaniel, S., & Reeder, H. (1998). The subjective experience of intimacy, passion, and commitment in heterosexual loving relationships. *Personal Relationships, 5,* 15–30.

McCrady, B. S., Epstein, E. E., Cook, S., Jensen, N., & Hildebrandt, T. (2009). A randomized trial of individual and couple behavioral alcohol treatment for women. *Journal of Consulting and Clinical Psychology, 77,* 243–256.

Meneses, C., & Greenberg, L. (2011). The construction of a model of the process of couples' forgiveness in emotion-focused therapy for couples. *Journal of Marital and Family Therapy, 37,* ????–????. doi:10.1111/j.1752-0606.2011.00234

Mikulincer, M., & Shaver, P. R. (2007). *Attachment in adulthood: Structure, dynamics, and change.* New York: Guilford Press.

Naaman, S., Johnson, S. M., & Radwan, K. (in press). Evaluation of the clinical efficacy of emotionally focused therapy on psychological adjustment of couples facing early breast cancer. *Psychiatry: Biological and Interpersonal Processes.*

O'Farrell, T. J., & Fals-Stewart, W. (2003). Alcohol abuse. *Journal of Marital and Family Therapy, 29,* 121–146.

O'Farrell, T. J., Hooley, J., Fals-Stewart, W., & Cutter, H. S. G. (1998). Expressed emotion and relapse in alcoholic patients. *Journal of Consulting and Clinical Psychology, 67,* 744–752.

O'Farrell, T. J., Murphy, M., Alter, J., & Fals-Stewart, W. (2008a). Brief family treatment intervention to promote aftercare among substance abusing patients in inpatient detoxification: Transferring a research intervention to clinical practice. *Addictive Behaviors, 33,* 464–471.

O'Farrell, T. J., Murphy, M., Alter, J., & Fals-Stewart, W. (2008b). Brief family treatment intervention to promote continuing care among alcohol-dependent patients in inpatient detoxification: A randomized pilot study. *Journal of Substance Abuse Treatment, 34,* 363–369.

O'Farrell, T. J., Murphy, C. M., Stephan, S. H., Fals-Stewart, W., & Murphy, M. (2004). Partner violence before and after couples-based alcoholism treatment for male alcoholic patients: The role of treatment involvement and abstinence. *Journal of Consulting and Clinical Psychology, 72,* 202–217.

O'Leary, K. D. (2008). Couple therapy and physical aggression. In A. Gurman (Ed.), *Clinical handbook of couple therapy* (4th ed., pp. 478–498). New York: Guilford Press.

Orlinsky, D. E., & Ronnestad, M. H. (2005). *How psychotherapists develop: A study of therapeutic work and professional growth.* Washington, DC: American Psychological Association.

Pinsof, W. (1994). An integrative systems perspective on the therapeutic alliance: Theoretical, clinical, and research implications. In A. Horvath & L. Greenberg (Eds.), *The working alliance: Theory, research and practice* (pp. 173–198). New York: Wiley.

Pinsof, W. M. (2005). Integrative problem-centered therapy. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration. Oxford series in clinical psychology* (2nd ed., pp. 382–402). London: Oxford University Press.

Pinsof, W. M., & Catherall, D. R. (1986). The integrative psychotherapy alliance: Family, couple and individual therapy scales. *Journal of Marital and Family Therapy, 12,* 137–151.

Pinsof, W. M., Zinbarg, R., & Knobloch-Fedders, L. M. (2008). Factorial and construct validity of the revised short form Integrative Psychotherapy Alliance Scales for family, couple, and individual therapy. *Family Process, 47,* 281–301.

Pinsof, W. M., Zinbarg, R. E., Lebow, J. L., Knobloch-Fedders, L. M., Durbin, E., Chambers, A., et al. (2009). Laying the foundation for progress research in family, couple, and individual therapy: The development and psychometric features of the initial Systemic Therapy Inventory of Change. *Psychotherapy Research, 19,* 143–156.

Powers, M. B., Vedel, E., & Emmelkamp, P. M. G. (2008). Behavioral couples therapy (BCT) for alcohol and drug use disorders: A meta-analysis. *Clinical Psychology Review, 28,* 952–962.

Rogge, R. D., Bradbury, T. N., Hahlweg, K., Engl, J., & Thurmaier, F. (2006). Predicting marital distress and dissolution: Refining the two-factor hypothesis. *Journal of Family Psychology, 20,* 156–159.

Rogge, R. D., Cobb, R. J., Story, L. B., Johnson, M. D., Lawrence, E. E., Rothman, A. D., et al. (2006). Recruitment and selection of couples for intervention research: Achieving developmental homogeneity at the cost of demographic diversity. *Journal of Consulting and Clinical Psychology, 74,* 777–784.

Rotunda, R. J., O'Farrell, T. J., Murphy, M., & Babey, S. H. (2008). Behavioral couples therapy for comorbid substance use disorders and combat-related posttraumatic stress disorder among male veterans: An initial evaluation. *Addictive Behaviors, 33,* 180–187.

Seligman, M. E. P. (1995). The effectiveness of psychotherapy: The Consumer Reports study. *American Psychologist, 50,* 965–974.

Sevier, M., Eldridge, K., Jones, J., Doss, B., & Christensen, A. (2008). Observed communication and associations with satisfaction during traditional and integrative behavioral couple therapy. *Behavior Therapy, 39,* 137–150.

Shadish, W. R., & Baldwin, S. A. (2003). Meta-analysis of MFT interventions. *Journal of Marital and Family Therapy, 29,* 547–570.

Shadish, W. R., & Baldwin, S. A. (2005). Effects of behavioral marital therapy: A meta-analysis of randomized controlled trials. *Journal of Consulting and Clinical Psychology, 73,* 6–14.

Shadish, W. R., Montgomery, L. M., Wilson, P., Wilson, M. R., Bright, I., & Okwumabua, T. (1993). Effects of family and marital psychotherapies: A meta-analysis. *Journal of Consulting and Clinical Psychology, 61,* 992–1002.

Shadish, W. R., Ragsdale, K., Glaser, R. R., & Montgomery, L. M. (1995). The efficacy and effectiveness of marital and family therapy: A perspective from meta-analysis. *Journal of Marital and Family Therapy, 21,* 345–360.

Simpson, J. A., & Rholes, W. S. (1998). *Attachment theory and close relationships.* New York: Guilford Press.

Snyder, D. K., Baucom, D. H., & Gordon, K. C. (2008). An integrative approach to treating infidelity. *The Family Journal: Counseling and Therapy for Couples and Families, 16,* 300–307.

Snyder, D. K., Baucom, D. H., Gordon, K. C., & Peluso, P. R. (2007). Treating infidelity: An integrative approach to resolving trauma and promoting forgiveness. *Infidelity: A practitioner's guide to working with couples in crisis* (pp. 99–125). New York: Routledge/Taylor & Francis.

Snyder, D. K., Castellani, A. M., & Whisman, M. A. (2006). Current status and future directions in couple therapy. *Annual Review of Psychology, 57*, 317–344.

Snyder, D. K., Heyman, R. E., & Haynes, S. N. (2005). Evidence-based approaches to assessing couple distress. *Psychological Assessment, 17*, 288–307.

Snyder, D. K., & Mitchell, A. E. (2008). Affective-reconstructive couple therapy: A pluralistic, developmental approach. In A. Gurman (Ed.), *Clinical handbook of couple therapy* (4th ed., pp. 353–382). New York: Guilford Press.

Snyder, D. K., Wills, R. M., & Grady-Fletcher, A. (1991). Long-term effectiveness of behavioral versus insight-oriented marital therapy: A 4-year follow-up study. *Journal of Consulting and Clinical Psychology, 59*, 138–141.

Spanier, G. B. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and the Family, 38*, 15–28.

Sprenkle, D. H., Davis, S. D., & Lebow, J. L. (2009). *Common factors in couple and family therapy: The overlooked foundation for effective practice*. New York: Guilford Press.

Stith, S. M., Rosen, K. H., & McCollum, E. E. (2003). Effectiveness of couples treatment for spouse abuse. *Journal of Marital and Family Therapy, 29*, 407–426.

Stith, S. M., Rosen, K. H., McCollum, E. E., & Thomsen, C. J. (2004). Treating intimate partner violence within intact couple relationships: Outcomes of multi-couple versus individual couple therapy. *Journal of Marital and Family Therapy, 30*, 305–318.

Symonds, D., & Horvath, A. O. (2004). Optimizing the alliance in couple therapy. *Family Process, 43*, 443–455.

Whiffen, V. E. (2003). What attachment theory can offer marital and family therapists. In S. M. Johnson & V. E. Whiffen (Eds.), *Attachment processes in couple and family therapy* (pp. 389–398). New York: Guilford Press.

Whisman, M. A. (2001). The association between depression and marital dissatisfaction. In S. R. H. Beach (Ed.), *Marital and family processes in depression: A scientific foundation for clinical practice* (pp. 3–24). Washington, DC: American Psychological Association.

Whisman, M. A. (2007). Marital distress and DSM-IV psychiatric disorders in a population-based national survey. *Journal of Abnormal Psychology, 116*, 638–643.

Whisman, M. A., Beach, S. R. H., & Snyder, D. K. (2008). Is marital discord taxonic and can taxonic status be assessed reliably? Results from a national, representative sample of married couples. *Journal of Consulting and Clinical Psychology, 76*, 745–755.

Whisman, M. A., Snyder, D. K., & Beach, S. R. H. (2009). Screening for marital and relationship discord. *Journal of Family Psychology, 23*, 247–254.

Whisman, M. A., & Uebelacker, L. A. (2003). Comorbidity of relationship distress and mental and physical health problems. In D. K. Snyder & M. A. Whisman (Eds.), *Treating difficult couples: Helping clients with coexisting mental and relationship disorders* (pp. 3–26). New York: Guilford Press.

Whisman, M. A., & Uebelacker, L. A. (2006). Impairment and distress associated with relationship discord in a national sample of married or cohabiting adults. *Journal of Family Psychology, 20*, 369–377.

Whisman, M. A., Uebelacker, L. A., & Weinstock, L. M. (2004). Psychopathology and marital satisfaction: The importance of evaluating both partners. *Journal of Consulting and Clinical Psychology, 72*, 830–838.

Williams-Baucom, K. J., Sevier, M., Doss, B., Eldridge, K. A., & Christensen, A. (2009, November). Observed behavior in traditional and integrative behavioral couple therapy: Changes through 2-year follow-up. Association of Behavioral and Cognitive Therapies, New York City.

Winters, J., Fals-Stewart, W., O'Farrell, T. J., Birchler, G. R., & Kelley, M. L. (2002). Behavioral couples therapy for female substance-abusing patients: Effects on substance use and relationship adjustment. *Journal of Consulting and Clinical Psychology, 70*, 344–355.

Wood, N. D., Crane, D. R., Schaalje, G. B., & Law, D. D. (2005). What works for whom: A meta-analytic review of marital and couples therapy in reference to marital distress. *The American Journal of Family Therapy, 33*, 273–287.

Wright, J., Sabourin, S., Mondor, J., Mcduff, P., & Mamodhoussen, S. (2006). The clinical representativeness of couple therapy outcome research. *Family Process, 46*, 301–316.

Zuccarini, D. J. (2010). *The attachment injury resolution model in emotionally focused couple therapy: A psychotherapy process study of in-session client performances and therapist behaviours*. Unpublished doctoral dissertation, University of Ottawa.