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CURRENT STATUS AND FUTURE DIRECTIONS IN COUPLE THERAPY

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■ **Abstract** Couple therapy research affirms that various approaches to couple treatment produce statistically and clinically significant improvement for a substantial proportion of couples in reducing overall relationship distress. Recent studies have extended these findings in indicating the effectiveness of couple-based interventions for a broad range of coexisting emotional, behavioral, or physical health problems in one or both partners. In contrast to these encouraging results, research also indicates that a sizeable percentage of couples fail to achieve significant gains from couple therapy or show significant deterioration afterward. Research on processes of change and predictors of treatment outcome in couple therapy provides preliminary evidence regarding factors potentially contributing to variable treatment response. The chapter concludes with 12 recommendations regarding future directions in couple therapy research and clinical training.

CONTENTS

INTRODUCTION

The fundamental challenges of psychotherapy research—whether evaluating individual, couple, or family interventions—are to identify effective treatments, understand their underlying mechanisms of change, and delineate aspects of the therapist, client, or context that influence their outcome. In this chapter, we examine the effectiveness of couple-based interventions for treating general relationship distress as well as coexisting emotional, behavioral, and physical health problems. We discuss methods for evaluating processes of change in couple therapy and predictors of treatment outcome, along with empirical findings in these domains. We conclude with recommendations for future research and clinical training in couple therapy.

THE PREVALENCE AND IMPACT OF COUPLE DISTRESS

Couple therapy continues to gain in stature as a vital component of mental health services. Three factors contribute to this growing recognition: (*a*) the prevalence of couple distress in both community and clinic samples; (*b*) the impact of couple distress on both the emotional and physical well-being of adult partners and their offspring; and (*c*) increased evidence of the effectiveness of couple therapy not only in treating couple distress and related relationship problems but also as a primary or adjunct treatment for a variety of individual emotional, behavioral, or physical health disorders.

Couple distress is prevalent in both community epidemiological studies and in research involving individual treatment samples. In the United States, the most salient indicator of couple distress remains a divorce rate of approximately 50% among married couples (Kreider & Fields 2002), with about half of these occurring within the first seven years of marriage. Independent of divorce, the research literature suggests that many, if not most, marriages experience periods of significant turmoil that place them at risk for dissolution or symptom development (e.g., depression or anxiety) in one or both partners at some point in their lives. In a recent national survey, the most frequently cited causes of acute emotional distress were relationship problems including divorce, separation, and other marital strains (Swindle et al. 2000). Other recent studies indicate that maritally discordant individuals are overrepresented among individuals seeking mental health services, regardless of whether they report marital distress as their primary

complaint (Lin et al. 1996). In a study of 800 employee assistance program (EAP) clients, 65% rated family problems as "considerable" or "extreme" (Shumway et al. 2004).

The linkage of relationship distress to disruption of individual emotional and physical well-being emphasizes the importance of improving and extending empirically based strategies for treating couple distress. Research indicates that couple distress covaries with individual emotional and behavioral disorders beyond general distress in other close relationships (Whisman et al. 2000). Moreover, couple distress—particularly negative communication—has direct adverse effects on cardiovascular, endocrine, immune, neurosensory, and other physiological systems that, in turn, contribute to physical health problems (Kiecolt-Glaser & Newton 2001). Nor are the effects of couple distress confined to the adult partners. Gottman (1999) cites evidence indicating that "marital distress, conflict, and disruption are associated with a wide range of deleterious effects on children, including depression, withdrawal, poor social competence, health problems, poor academic performance, a variety of conduct-related difficulties, and markedly decreased longevity" (p. 4). In brief, couple distress has a markedly high prevalence; has a strong linkage to emotional, behavioral, and health problems in the adult partners and their offspring; and is among the most frequent primary or secondary concerns reported by individuals seeking assistance from mental health professionals.

THE EFFECTIVENESS OF COUPLE THERAPY IN TREATING RELATIONSHIP DISTRESS

How effective is couple therapy? Previous reviews affirm that various versions of couple therapy produce moderate, statistically significant, and often clinically significant effects in reducing relationship distress. In this section, we examine current findings regarding the effectiveness of couple therapy for treating overall relationship distress. In the subsequent section, we review evidence regarding the effectiveness of couple therapy for co-occurring individual and relationship problems.

Since Christensen & Heavy's (1999) review of couple therapy in the *Annual Review of Psychology*, several qualitative and quantitative (meta-analytic) reviews of couple therapy have appeared. Shadish & Baldwin (2003) reviewed six previous meta-analyses of studies comparing couple therapy versus no-treatment control groups, including four published reviews (Dunn & Schwebel 1995, Hahlweg & Markman 1988, Johnson et al. 1999, Shadish et al. 1993) and two unpublished reviews (Dutcher 1999, Wilson 1986). The samples of couple therapy studies included in each of these reviews ranged from 4 [Johnson et al.'s (1999) review of emotion-focused couple therapy (EFCT)] to 163 [Shadish et al.'s (1993) review of couple and family therapy, of which 62 studies emphasizing couple therapy were reanalyzed by Wilson (1986)]. Mean effect sizes across these six meta-analyses

ranged from approximately 0.50 (Wilson 1986) to 1.30 (Johnson et al. 1999). Based on their review of these studies, Shadish & Baldwin (2003) reported an overall mean effect size of 0.84 for couple therapy, indicating that the average person receiving treatment for couple distress was better off at termination than were 80% of individuals in the no-treatment control group.

Shadish & Baldwin (2003) also noted that their mean effect size for couple therapy was generally comparable to or larger than that obtained by alternative interventions ranging from individual therapy to medical interventions. They found little evidence of differential effectiveness across different theoretical orientations to couple therapy, particularly once other covariates (e.g., reactivity of measures) were controlled. Noting the small number of couple therapy approaches listed by the American Psychological Association Division 12 Task Force (Chambless & Hollon 1998) as either well established [behavioral couple therapy (BCT)] or probably efficacious [EFCT and insight-oriented couple therapy (IOCT)], Shadish & Baldwin (2003) argued that clinicians should also consider "meta-analytically supported treatments" such as cognitive-behavioral, systemic, and eclectic approaches to couple therapy as viable approaches to treating general couple distress. They also noted that numerous studies of couple therapy (particularly those emphasizing behavioral treatments) raised unanswered questions regarding their clinical representativeness in that they failed to use clients referred through usual routes and experienced therapists in actual clinic settings. Finally, among those studies reporting data from follow-up at six months or longer, treatment effects tended to be reduced but still significant.

Findings from alternative viewpoints or more recent research provide complementary perspectives to conclusions reached by Shadish & Baldwin in their 2003 summary. One such addition involves a follow-up meta-analysis of 30 randomized experiments with distressed couples contrasting BCT with a no-treatment control (Shadish & Baldwin 2005). Their more recent analysis included 13 studies (7 published in journals and 6 unpublished dissertations) not included in the Shadish et al. (1993) review. Overall, these 30 studies of BCT yielded a mean effect size of 0.59, which was smaller than the mean effect size of 0.84 for couple therapy pooled across theoretical approaches reported by Shadish & Baldwin (2003), and which indicated that the average individual receiving BCT was better off at the end of treatment than were 72% of individuals in the control condition. In accounting for the more recent, smaller effect size obtained for BCT, the authors noted the consequence of including nonpublished dissertations with smaller sample sizes and small or negative effect sizes. They also reported that of the various components comprising behavioral couple interventions (e.g., communication training, problem-solving training, contingency contracting, behavior exchange, desensitization, cognitive restructuring, and emotional expressiveness training), only communication and problem-solving training led to larger effects, whereas use of cognitive restructuring actually led to smaller effects. Shadish & Baldwin (2005) found that the effects of BCT were unrelated to "dose" (defined by number and length of sessions), reactivity of the dependent variables considered

(e.g., self-report measures of affect or cognition versus observational ratings of communication behavior), or clinical representativeness.

Other than BCT, the sole approach to couple therapy evaluated in multiple trials is EFCT, which combines an experiential, intrapsychic focus on inner emotional experience with an emphasis on cyclical, self-reinforcing interactions (Johnson et al. 1999). In four randomized trials, EFCT was superior to a waiting-list control condition in reducing relationship distress, yielding recovery rates of 70%–73% and a weighted mean effect size of 1.31 (Johnson 2002).

In addition to the two couple therapy approaches evaluated in multiple clinical trials, several approaches have demonstrated positive outcomes in treating couple distress in only one trial. First, Snyder & Wills (1989) compared insight-oriented approaches to couple therapy with behavioral approaches in a controlled clinical trial involving 79 distressed couples. The insight-oriented condition emphasized the interpretation and resolution of conflictual emotional processes related to developmental issues, collusive interactions, and maladaptive relationship patterns. At termination after approximately 20 sessions, couples in both treatment modalities showed statistically and clinically significant gains in relationship satisfaction compared with a wait-list control group. Treatment effect sizes at termination for behavioral and insight-oriented conditions were 1.01 and 0.96, respectively; treatment gains were substantially maintained at six-month follow-up. However, at four years following treatment, 38% of couples in the behavioral condition had experienced divorce, in contrast to only 3% of couples treated in the insight-oriented condition (Snyder et al. 1991).

Second, Goldman & Greenberg (1992) compared integrated systemic couple therapy (ISCT) and EFCT with each other and with a wait-list control condition in a randomized clinical trial of 42 couples. ISCT sought to disrupt repetitive, self-perpetuating negative interactional cycles by changing the meaning attributed to these cycles; changes in meaning were promoted by restructuring interactions and reframing the problems using positive connotation followed by prescribing of the symptom, encouraging the couple to "go slow," and finally prescribing a relapse or reenactment of previous negative interactions. At the end of 10 one-hour weekly sessions, ISCT and EFCT were both found to be superior to the control condition and to be equally effective in alleviating marital distress, facilitating conflict resolution and goal attainment, and reducing target complaints. Moreover, couples who received ISCT showed greater maintenance of gains in marital satisfaction and goal attainment at four-month follow-up.

More recently, findings have emerged for an integrative behavioral approach to couple therapy (IBCT; Jacobson & Christensen 1996) that combines traditional behavioral techniques for promoting change (specifically, communication and behavior-exchange skills training) with strategies aimed at fostering emotional acceptance. Interventions aimed at increasing acceptance include promoting tolerance and encouraging partners to appreciate differences and to use them to enhance their marriage. In the largest randomized clinical trial of couple therapy ever conducted, Christensen and colleagues (2004) compared the expanded IBCT

with traditional BCT by assigning 134 distressed couples to the two conditions, stratified into moderately and severely distressed groups. Couples in IBCT made steady improvements in satisfaction throughout the course of treatment, whereas BCT couples improved more quickly than IBCT couples early in treatment but then plateaued later in treatment. Both treatments produced similar levels of clinically significant improvement by the end of treatment (71% of IBCT couples and 59% of BCT couples were reliably improved or recovered, based on self-reports of overall relationship satisfaction).

Although various specific approaches to couple therapy have now demonstrated effectiveness in reducing relationship distress in controlled trials, a substantial percentage of individuals fail to show significant improvement from these treatments and an even greater percentage of individuals show deterioration in gains at follow-up. Specifically, previous research has shown that about one third of couples fail to achieve significant gains from treatment, and in only half of treated couples do both partners show significant improvement in marital satisfaction at termination. Moreover, assessment at two years or longer after termination indicates significant deterioration among 30%–60% of treated couples (Cookerly 1980, Jacobson et al. 1987, Snyder et al. 1991). Such findings have fostered two alternative lines of attack for treating couple distress: (*a*) distillation and emphasis of common factors hypothesized to contribute to beneficial effects across "singular" treatment approaches, and (*b*) pluralistic models incorporating multiple components of diverse treatment approaches.

Adopting the former strategy, Sprenkle & Blow (2004) argued that common mechanisms of change cutting across the diverse couple therapies account for the absence of significant differences in their overall effectiveness. They cited five types or classes of common factors characterizing psychotherapy in general, and three factors specific to couple or family therapy. Common factors viewed as generic to psychotherapy include (*a*) client characteristics (e.g., learning style, perseverance, and compliance with instructions or assignments), (*b*) therapist characteristics (e.g., abilities to foster a therapeutic alliance and to match activity level to clients' expectations or preferences), (*c*) characteristics of the therapeutic relationship (e.g., emotional connectedness and congruence between the therapist's and client's specific expectations or goals), (*d*) expectancy or placebo effects, and (*e*) nonspecific interventions promoting emotional experiencing, cognitive mastery, and behavioral regulation. Those common factors viewed by Sprenkle & Blow (2004) as specific to couple or family therapies include (*a*) emphasis on the interpersonal context in which specific problems occur, (*b*) inclusion of multiple members of the extended family system in direct treatment, and (*c*) fostering an expanded therapeutic alliance across partners or multiple members of the family as a whole. To date, there has been little research documenting specific treatment effects attributable to proposed common factors—and no efforts in designing couple treatment approaches explicitly intended to maximize the therapeutic impact of common factors (Sexton et al. 2004).

An alternative to the common factors approach involves efforts to incorporate active, specific treatment components from diverse approaches into multicomponent interventions in a systematic manner. Such approaches have variously been described as "integrative" (e.g., Gurman 1981, 2002) or "pluralistic" (Snyder 1999), and are distinguished from eclecticism by their systematic selection or synthesis within a conceptually coherent model. Gurman (2002) described a "depth-behavioral" integrative approach to couple therapy that emphasizes the critical interrelation of intrapsychic and interpersonal factors in couples' interactions and defines the goal of couple therapy as the loosening and broadening of each spouse's implicit matrix of assumptions, expectations, and requirements of intimate interpersonal contact. This is accomplished through interpretation, cognitive restructuring, and creation of therapeutic tasks to promote each spouse's exposure to those aspects of him- or herself and his or her partner that are blocked from awareness. Snyder (1999) proposed a hierarchical approach to couple therapy incorporating structural, behavioral, and cognitive techniques earlier in the therapeutic sequence and drawing on insight-oriented techniques termed "affective reconstruction" later in treatment primarily if relationship problems prove resistant to the earlier interventions. In affective reconstruction, previous relationships, their affective components, and strategies for emotional gratification and anxiety containment are reconstructed, with a focus on identifying for each partner recurring maladaptive patterns in their interpersonal conflicts and coping styles across relationships. In addition, interventions examine ways in which previous coping strategies vital to prior relationships represent distortions or inappropriate solutions for emotional intimacy and satisfaction in the current relationship. Neither the integrative depth-behavioral approach proposed by Gurman (2002) nor the pluralistic approach advocated by Snyder (1999) has been subjected to empirical evaluation, although both approaches build on couple treatment approaches previously supported in randomized clinical trials.

THE EFFECTIVENESS OF COUPLE THERAPY IN TREATING COMORBID DISORDERS

The co-occurrence between overall couple distress and specific relationship problems, as well as individual emotional or behavioral disorders, has been well established in the research literature over the past decade. Based on these findings, new couple-based treatments have emerged for treating distressed couples for whom one or both partners have coexisting emotional, behavioral, or physical health problems (Snyder & Whisman 2003). Snyder & Whisman (2004a) examined the covariation between general relationship distress and problems in specific areas of the couple's relationship in a sample of 1020 community couples and 50 couples in therapy, based on partners' scores on the Marital Satisfaction Inventory—Revised (Snyder 1997). Results indicated that individuals reporting moderate or higher

global relationship distress were five to six times more likely than nondistressed persons to report specific relationship problems in the areas of physical aggression, the sexual relationship, finances, and child rearing. Whisman (1999; Whisman & Uebelacker 2005) evaluated the association between marital distress and 12-month prevalence rates of 13 psychiatric disorders in 2538 married persons comprising the National Comorbidity Survey. Results indicated that maritally distressed persons were two to three times more likely than were nondistressed persons to experience disorders involving mood, anxiety, or substance abuse.

The co-occurrence between overall couple distress and specific individual or relationship problems has led to three couple-based treatment strategies for addressing these comorbid difficulties (Baucom et al. 1998). The first uses general couple therapy to reduce overall relationship distress based on the premise that marital conflict serves as a broad stressor that contributes to the development, exacerbation, or maintenance of specific individual or relationship problems. The second strategy involves developing disorder-specific couple interventions that focus on particular partner interactions presumed to directly influence either the co-occurring problems or their treatment. The third couple-based strategy involves partner-assisted interventions in which one partner serves as a "surrogate therapist" or coach in assisting the other partner with individual problems.

Couple-Based Treatment of Specific Relationship Problems

Couple-based interventions have been well established as effective in treating two specific components of relationship functioning: difficulties in the sexual relationship and problems of physical aggression. Recent findings also suggest the effectiveness of couple therapy in treating couples dealing with issues of infidelity.

SEXUAL DIFFICULTIES Epidemiological data indicate that 43% of women and 31% of men will experience sexual dysfunction during their lifetime (Laumann et al. 1999). A recent review of couple-based treatments for sexual dysfunctions (Regev et al. 2003) concluded that (*a*) sex therapy, primarily consisting of sensate focus, is comparable to communication therapy in primary and secondary anorgasmic women; (*b*) couples receiving couple therapy in addition to sex therapy demonstrate more pronounced and comprehensive treatment gains, including significantly more intense experiences of sex and sexual desire; and (*c*) sex therapy positively influences both sexual and marital problems, whereas general couple therapy appears to facilitate resolution of marital problems only. Baucom et al. (1998) identified several couple-based interventions with documented effectiveness in treating female sexual dysfunctions related to lifelong or situational orgasmic disorders or hypoactive sexual desire. In partner-assisted treatment of orgasmic disorders, male partners participate with their female partner in techniques of sensate focus; toward the end of treatment, women are coached in sharing effective techniques of masturbation with their partners. Couple-based interventions also assist couples in discussing and resolving specific difficulties they experience in their sexual

interactions. Findings have affirmed the efficacy of couple interventions in treating women with primary or secondary orgasmic disorders, with improvement rates ranging from 65% to 90%. Additional evidence supports combining general behaviorally oriented couple therapy with orgasm-consistency training in the treatment of women reporting hypoactive sexual desire (Hurlbert et al. 1993). Baucom et al. (1998) noted that few studies of couple-based interventions have targeted male sexual disorders despite evidence that sexual and marital problems are more closely linked in men than in women and despite reports of recent increases in male complaints of low sexual desire.

PHYSICAL AGGRESSION Mild to moderate physical aggression (e.g., pushing, grabbing, shoving, or slapping) occurs in more than half of couples seeking couple therapy (Holtzworth-Munroe et al. 2003). Among couple therapy samples, as much as 85% of partner aggression is reciprocal, with both partners engaging in primarily low levels of aggression. Moreover, psychological aggression (e.g., verbal abuse or threats of violence) predicts physical abuse a year later (Murphy & O'Leary 1989). Although most therapists agree that couple therapy is inappropriate for couples characterized by severe physical aggression (primarily violence by male partners resulting in female partners' injuries), couple-based interventions have been effective in treating mild to moderate levels of aggression. Such interventions emphasize anger management (e.g., recognition of anger, time-outs, and self-regulation techniques) and communication skills (e.g., emotional expressiveness and problem solving). In their review of randomized trials comparing conjoint treatment to gender-specific treatment, Holtzworth-Munroe et al. (2003) concluded that conjoint couple therapy that has a direct and specific focus on eliminating violence "may be as effective as the more widely utilized gender specific treatments" (p. 227). A more recent study compared the outcomes of a domestic violence-focused treatment for 51 couples randomly assigned to either individual couple therapy, a multicouple group treatment, or a no-treatment comparison group (Stith et al. 2004). Male partner rates of physical aggression at six-month follow-up were highest in the comparison group (66%) and lower in the multicouple group (25%) than in the individual-couple therapy group (43%). Moreover, both marital aggression and acceptance of physical aggression decreased significantly among participants in the multicouple group therapy but not among participants in either the individual-couple therapy or no-treatment comparison conditions, a finding that suggests the multicouple group format has an incremental impact in changing underlying attitudes toward relationship aggression.

EXTRAMARITAL AFFAIRS Research suggests that, on average, between 1.5% and 4% of married individuals will engage in extramarital sex in any given year (Allen et al. 2005), and approximately one in three men aged 60–69 and one in five women aged 40–49 report engaging in extramarital sex at some point in their lives (Wiederman 1997). Although couples report extramarital affairs as a leading cause of divorce and couple therapists describe infidelity as among the most difficult

problems to treat (Whisman et al. 1997), until recently there has been almost no empirical study of interventions for couples dealing with affairs. Atkins and colleagues (2005b) examined treatment outcomes for 19 couples reporting an affair by one of the partners participating in the randomized trial of IBCT versus BCT by Christensen and colleagues (2004). Results showed that couples who reported infidelity were more distressed when they began treatment than were couples who did not report infidelity, but couples for whom there had been an affair also improved at a greater rate during the course of therapy than did couples not dealing with infidelity. Gordon et al. (2004) reported findings from a replicated case study of an integrative approach designed specifically to assist couples recovering from an extramarital affair. The six-month intervention comprised three phases that targeted (*a*) coping with initial emotional and behavioral disruption of individual and relationship functioning following discovery or disclosure of the affair; (*b*) exploring individual, relationship, and outside contextual factors contributing to the initial onset or maintenance of the affair; and (*c*) reaching an informed decision about how to move on, either individually or as a couple. At termination, the majority of participants in the study reported less emotional and marital distress, and individuals whose partner had participated in the affair reported greater forgiveness toward their partner.

Couple-Based Treatment of Mental and Physical Health Problems

Research has documented the effectiveness of couple-based interventions for a broad range of emotional and behavioral dysfunctions, including alcohol and related substance-use disorders, mood and anxiety disorders, and chronic pain and related health problems. Promising couple-based interventions have also recently emerged for a variety of other difficulties; interventions that have received at least preliminary empirical evidence of their effectiveness are described here.

SUBSTANCE-USE DISORDERS Alcohol- and drug-use disorders comprise the most common psychiatric disorders in the general population, with lifetime prevalence rates of 23.5% and 11.9%, respectively (Kessler et al. 1994). BCT for alcoholism and drug abuse aims to alter couple and family interaction patterns to promote a family environment more conducive to abstinence and sobriety (e.g., by reducing the partner's recurring complaints about past drinking and promoting attention to positive aspects of current sober behavior), as well as to improve communication and positive activities (Fals-Stewart et al. 2003). BCT for alcohol and drug abuse typically involves 15–20 outpatient couple sessions over five to six months. In their review of the literature regarding BCT, O'Farrell & Fals-Stewart (2000) concluded:

> First, BCT for both alcoholism and drug abuse produces more abstinences and fewer substance-related problems, happier relationships, fewer couple separations and lower risk for divorce than does individual-based treatment. Second, domestic violence is substantially reduced after BCT for both alcoholism

> and drug abuse. Third, cost outcomes after BCT are very favorable for both alcoholism and drug abuse, and are superior to individual-based treatment for drug abuse (p. 51).

Recently, Fals-Stewart and colleagues (2005a) examined the clinical efficacy and cost-effectiveness of a shortened version of BCT with 100 alcoholic male patients and their partners. In the shortened version, couples participated in only 6 rather than 12 conjoint sessions; alcoholic clients participated in an additional 12 weekly individual sessions. Results indicated that those assigned to the brief version had posttreatment and 12-month outcomes equivalent to clients receiving standard BCT, thereby supporting the cost-effectiveness of this shortened intervention.

MOOD DISORDERS Lifetime prevalence rates for major depressive episode and dysthymia are estimated at 17.1% and 6.4%, respectively (Kessler et al. 1994). Three clinical trials have shown that behavioral couple interventions for depression emphasizing behavior exchange, communication and problem-solving skills, and cognitive interventions (e.g., cognitive reframing and directing attention to positive change) are effective in relieving depression when provided to maritally distressed couples with a depressed partner (Gupta et al. 2003). Furthermore, compared with individual-based therapies, BCT has the incremental benefit of improving overall relationship satisfaction. Clinical guidelines for providing BCT for depressed individuals are provided by Beach & Gupta (2003). Similarly, conjoint couple therapy incorporating components of interpersonal psychotherapy for depression aimed at helping depressed individuals better understand and negotiate their interpersonal relationships has been shown to be effective in treating depression (Foley et al. 1989). More recently, Leff et al. (2000) reported promising results for systemic couple therapy, using interventions designed to reduce problematic patterns of interacting, for depressed married individuals with a critical spouse. Finally, Dessaulles et al. (2003) compared 14 sessions of EFCT with pharmacotherapy in treating wives' major depression in 18 couples randomly assigned to treatment condition. Both interventions were equally effective in reducing depressive symptoms, although there was some evidence that women receiving EFCT made greater improvement following termination than those receiving pharmacotherapy.

ANXIETY DISORDERS Excessive anxiety is one of the most frequent mental health problems in the United States, with a lifetime prevalence rate of developing any anxiety disorder at 24.9% (Kessler et al. 1994). In their review of couple-based interventions for anxiety disorders, Baucom et al. (2003) noted that anxiety disorders may negatively impact couple functioning by disrupting interaction patterns, increasing tension and arguments, restricting relationship activities, or decreasing attention to the needs of the nonanxious partner. Baucom et al. (2003) described ways in which efficacious treatments for anxiety disorders (e.g., exposure and response

prevention, cognitive restructuring, and relaxation training) can be incorporated into either (*a*) partner-assisted interventions using the partner to assist with exposure exercises and provide support or (*b*) couple-based interventions focusing on ways in which couple functioning maintains anxiety symptoms, as well as ways in which the anxiety influences couple functioning. In their review of specific couple-based interventions for various anxiety disorders, Baucom et al. (1998) concluded that partner-assisted exposure treatment of obsessive-compulsive disorder is at least as effective as treating the patient without such assistance; they also determined that exposure interventions for agoraphobia may show enhanced benefit from involving the partner even when there is no overt relationship distress, a conclusion affirmed in a recent review by Byrne et al. (2004).

PAIN AND PHYSICAL ILLNESS Over the past 15 years, psychosocial pain researchers have become increasingly interested in the role that partners play in how patients adjust to pain and in involving partners in psychosocial pain-management efforts (Keefe et al. 2006). For example, partners can encourage patients in acquiring more effective pain-control strategies, and can be discouraged themselves from criticizing appropriate coping skills, enforcing the patient's rest, or insisting that pain medication is the only way to manage pain. Moreover, couple-based interventions for chronic pain—and for physical illness more generally—can help partners to cope with their own emotional struggles with caretaking, promote more effective communication around pain and emotional distress, and facilitate couple processes for providing emotional and tangible support, dealing with conflict, and expressing affection and intimacy (Keefe et al. 2006).

Keefe and colleagues (1996) randomly assigned 88 patients with osteoarthritic knee pain to spouse-assisted coping skills training, a conventional coping skills training condition alone, or an arthritis education and partner-support control condition. Patients in the spouse-assisted coping skills training condition received training in a variety of cognitive and behavioral pain-coping skills (e.g., relaxation, imagery, distraction techniques, activity pacing, goal setting, and cognitive restructuring) and they and their partners received training in various couples skills (e.g., joint practice, communication skills, behavioral rehearsal, problem solving, and maintenance training). Patients in the partner-assisted coping skills training had the best outcomes across multiple criteria, whereas those in the arthritis education–social support control condition had the worst outcomes. Moreover, patients in the partner-assisted coping skills training who showed increases in marital adjustment were more likely to show lower levels of psychological disability, physical disability, and pain behavior at 12-month follow-up.

Couple-based interventions for patients dealing with cancer have resulted in similar findings. Specifically, Keefe and colleagues (2005) recently completed a study that tested the effects of a partner-guided pain management intervention for 78 patients with end-of-life cancer pain. The intervention, delivered by a nurse, integrated information about cancer pain with training in three pain-coping skills and emphasized the role these skills could play in controlling patient and

partner emotional responses and relational exchanges. Results indicated that patients receiving this intervention tended to report reduced levels of pain, and that their spouses improved in their sense of efficacy for helping the patient control pain and tended to report reduced levels of caregiver strain.

Finally, a recent study examined the impact of an eight-session couple therapy for nine couples in which one partner was diagnosed with a terminal illness (Mohr et al. 2003). Conjoint sessions emphasized (*a*) helping patients and their partners to find meaning together through examining beliefs, goals, and values; (*b*) increasing intimacy, emotional support, and reciprocity; and (*c*) facilitating conversations about death and dying. Results indicated improvements in couples' relationship quality and significant decreases in patients' distress about dying and the frequency of partners' worry about their partner dying.

Given the direct adverse impact of couple distress on cardiovascular and immunological functioning (Kiecolt-Glaser & Newton 2001)—and the indirect negative effects on health through couple influences on nutrition, substance use, and exercise—it is not surprising that couple-based interventions have been developed for a range of health-related concerns including obesity and nicotine use as well as alcohol- and drug-use disorders as described above. Common to such treatments are specific interventions aimed at changing patients' interpersonal environments linked to health-risk behaviors, encouraging healthy alternatives through partners' use of social reinforcement, and generally decreasing relationship stress (see also Schmaling & Sher 2000). Although evidence for some of these treatments emerged almost 25 years ago (e.g., spouse involvement in the behavioral treatment of overweight women; Pearce et al. 1981), other promising developments (e.g., couple-based interventions for patients diagnosed with coronary artery disease; Sher et al. 2002) await further empirical evaluation.

EMERGING TREATMENTS FOR OTHER DISORDERS Couple-based treatments continue to be developed at an increasing pace for a broad spectrum of individual emotional, behavioral, and health-related difficulties. Although evidence for these treatments' effectiveness remains primarily anecdotal, several noteworthy exceptions exist. Monson et al. (2004) described recent findings from cognitive-behavioral couple treatment of posttraumatic stress disorder (PTSD) in a pilot study of seven couples in which the husband was diagnosed with PTSD secondary to Vietnam combat experiences. The treatment emphasized three components involving psychoeducation about PTSD and relationship problems, communication skills training, and interventions targeting cognitions contributing to the association between PTSD and relationship problems. Following the 15-session treatment, clinicians' and partners' ratings of the veterans' PTSD symptoms showed significant improvement, with effect sizes exceeding 1.00; the veterans' self-reported reductions in PTSD symptoms were not statistically significant (in part due to the small sample), but still yielded a moderate effect size of 0.64. Wives' own ratings of anxiety also improved with this couple-based intervention, and both partners reported improved social functioning in the household.

Finally, two couple-based treatments have been developed for couples in which one partner has been diagnosed with borderline personality disorder (BPD). The first (Fruzzetti & Iverson 2006) builds on dialectical behavior therapy (DBT) for individuals with BPD. In a sample of 22 couples participating in a six-session couples group, decreases in invalidating behaviors (e.g., dismissive, minimizing, or rejecting statements) and increases in validating responses (e.g., acceptance and understanding) pre- to posttreatment predicted decreased levels of individual and relationship distress in a moderately distressed sample (Lillis & Fruzzetti 2004). More recently, Kirby & Baucom (2004) reported results of a couple-based group intervention combining elements of DBT with cognitive behavioral couple therapy (CBCT) for 10 couples in which one partner had been diagnosed with BPD and had already received individual DBT. Following 16 two-hour sessions (with five couples per group), the women partners showed less depression and related negative affect, increases in positive affect, and improved ability to regulate their own emotions; effect sizes ranged from 0.72 to 1.00.

PROCESSES OF CHANGE IN COUPLE THERAPY

How does couple therapy work? Although each of the empirically supported approaches to couple therapy posits specific processes or mechanisms of change, there has been little research explicitly indicating these proposed mechanisms as responsible for observed therapeutic effects. In this section, we briefly describe three approaches to examining change processes in couple therapy. We then summarize the few available empirical findings related to change mechanisms in the context of theoretical formulations underlying the major approaches to couple therapy.

Methods of Investigating Change Processes

REGRESSION ANALYSIS OF MEDIATION Probably the best-known and most widely used approach for examining change processes in therapy involves use of regression analysis, following procedures outlined by Baron & Kenny (1986), for establishing mediation effects. Using these guidelines, a proposed mediating variable (e.g., communication processes) is shown to account (either entirely or partially) for the relation between some predictor variable (e.g., treatment condition status) and some outcome variable (e.g., relationship satisfaction) when the following four conditions are met: (*a*) The predictor affects the criterion (e.g., treatment leads to increased relationship satisfaction); (*b*) the predictor affects the mediator (e.g., treatment leads to gains in communication skills); (*c*) the mediator affects the criterion (e.g., gains in communication skills lead to increased relationship satisfaction), controlling for the predictor; and (*d*) the relation between the predictor and the criterion is reduced (partial mediation) or eliminated (complete mediation) after controlling for the relation between the mediator and the criterion. In

"moderated mediation" (see Whisman & Snyder 1997), the mediating or change mechanisms are demonstrated to have a stronger effect for one group than for another (e.g., mediating effects of therapeutic alliance for couples receiving BCT versus EFCT, or effects of behavior-exchange skills training for younger couples relative to older ones).

HIERARCHICAL LINEAR MODELING ANALYSIS OF CHANGE PROCESSES More recently, couple researchers (e.g., Doss et al. 2005) have examined the relation between proposed mechanisms of change and outcome variables through the use of hierarchical linear modeling (HLM; Raudenbush & Bryk 2001), also known as growth curve analysis. This approach to identifying change mechanisms involves two steps. First, multiple assessments of some criterion variable are used to estimate a trajectory, or growth curve, which allows investigators to describe the nature of change for a given criterion or outcome within a sample. In the second step of growth curve analysis, the parameters summarizing change of each person are treated as new dependent variables that are then predicted from other within- or between-subject variables proposed as mechanisms of change.

TASK ANALYSIS OF CHANGE PROCESSES A third approach to investigating change processes involves task analysis of proximal outcomes that occur within or between sessions by focusing on specific therapeutic events (Heatherington et al. 2005, Rice & Greenberg 1984). Such task analysis involves disassembling the therapeutic process into smaller, measurable in-session units or events to capture the actual sequence of therapist-client interactions and then delineating the linkage of these events to proximal or "mini" outcomes that presumably build on each other and contribute to molar, more distal outcomes (e.g., relationship satisfaction at termination). For example, an investigator examining presumed mechanisms of change in EFCT might examine events delimited by therapist clarification of underlying primary attachment-related fears and the client's owning and expressing those fears in a "softened" manner, and the linkage of this sequence to the other partner's likelihood of shifting from antagonistic or defensive responses to empathic or nurturing ones.

Empirical Findings Regarding Change Processes

Previous reviews (e.g., Gottman 1998, Lebow 2000) have generally concurred in their conclusion that little empirical evidence exists regarding presumed mechanisms of change in couple therapy. Such conclusions rest in part from disappointing findings from mediation analyses adopting the traditional regression approach. For example, whereas BCT emphasizes the importance of improving communication skills as a means of reducing relationship distress—and although such skills do typically increase among couples receiving BCT—several studies have failed to find an association between the magnitude of changes in communication behaviors and gains in relationship satisfaction. Similarly, although CBCT has been

shown to produce positive change in targeted cognitions (e.g., expectancies and attributions), changes in these cognitions have not been linked to couples' gains in satisfaction following CBCT (see Whisman & Snyder 1997 for a summary of relevant studies).

However, recent findings drawing on HLM and task analysis offer encouragement regarding significant developments in identifying change mechanisms in couple therapy. For example, Doss et al. (2005) used hierarchical growth curve analysis to examine mechanisms of change in 134 couples randomly assigned to either traditional BCT or ICBT. Both therapies were effective in increasing emotional acceptance and improving communication behaviors across the course of therapy; however, these changes differed by treatment modality in a manner consistent with their respective presumed change mechanisms. Specifically, acceptance increased significantly more for couples in IBCT than for couples in BCT, whereas couples in BCT showed larger gains in positive communication. Moreover, examination of change separately in the first and second halves of therapy indicated that change in targeted behaviors was a powerful mechanism of change early in therapy, whereas in the second half of therapy, emotional acceptance was more strongly related to changes in relationship satisfaction.

Task analysis has been used successfully to examine change processes in both IBCT and EFCT. In a pilot study with 12 distressed couples randomly assigned to either IBCT or traditional BCT (Cordova et al. 1998), couples in IBCT showed relatively more constructive detachment (i.e., talking about problems without blaming or being compelled to solve them—both indicators of acceptance) over the course of therapy and more "soft expressions" of emotion in late sessions relative to earlier ones. Changes in husbands' and wives' constructive detachment from early to late sessions predicted couples' gains in relationship satisfaction.

The most compelling findings regarding specific change processes in couple therapy have emerged using a task-analysis approach to investigating change in EFCT. An early study by Johnson & Greenberg (1988) comparing partner exchanges in "best" sessions of three successfully treated couples versus those for three couples with poor outcome showed that high-change couples exhibited more frequent "softening" events in which a previously critical partner expressed vulnerability and asked for comfort and connection from his or her spouse. A second report regarding three task analytic studies of EFCT (Greenberg et al. 1993) showed that (*a*) couples receiving EFCT demonstrated more shifts from hostility to affiliative behaviors than did wait-list couples; (*b*) best sessions as identified by couples were characterized by more depth of experiencing and affiliative and autonomous statements than were sessions identified as poor; and (*c*) intimate, emotionally laden self-disclosure by one partner was more likely to lead to affiliative statements by the other partner than were other randomly selected responses. Finally, a recent task analysis of four EFCT sessions by Bradley & Furrow (2004) found that emotional experiencing and the disclosure of attachment-related affect and fears were the key client features of successful softening events; consistent with proposed mechanisms of change in EFCT, specific therapist interventions linked

to softening events involved intensifying a couple's emotional experience and promoting intrapsychic awareness and interpersonal shifts in attachment-related interactions.

PREDICTORS OF COUPLE THERAPY OUTCOME

For whom does couple therapy work? As documented in the preceding sections, there is considerable variability in individuals' response to couple therapy. Hence, investigators have been interested in predicting outcome to treatment. In this section, we briefly describe methods for identifying predictors of treatment response, distinguishing between methods emphasizing prognostic versus prescriptive indicators. We then review empirical findings regarding predictors of couple therapy outcome.

Methods of Identifying Predictors of Treatment Outcome

IDENTIFYING PROGNOSTIC INDICATORS FROM ANALYSES OF MAIN EFFECTS In evaluating predictors of treatment outcome, investigators have made a distinction between prognostic indicators, which predict response to a particular treatment (or response across treatments, irrespective of specific approach), and prescriptive indicators, which predict response to one versus another treatment (Hollon & Najavits 1988). Identifying a prognostic indicator requires only evaluating the association between the predictor variable and some outcome measure. This can be done by regressing posttreatment outcome scores on the predictor, controlling for pretreatment scores on the outcome variable; similar analyses can be done with dichotomous outcomes (e.g., clinical significance outcomes) using logistic regression analyses. The overwhelming preponderance of research on predictors of response to couple therapy has emphasized the delineation of these more general prognostic indicators.

IDENTIFYING PRESCRIPTIVE INDICATORS FROM ANALYSES OF INTERACTIONS Evaluating whether some variable predicts outcome to one specific treatment versus another treatment—that is, identifying prescriptive indicators—requires testing for an interaction or moderator effect. Prescriptive indicators are examined using the aptitude-treatment interaction (ATI) paradigm (Cronbach & Snow 1977, Dance & Neufeld 1988). In using regression to identify prescriptive indicators, one tests for a significant treatment $\times$ predictor interaction indicating that the association between the predictor and treatment outcome varies as a function of the type of treatment (i.e., that the type of treatment moderates the association between the predictor and outcome). Alternative approaches for identifying prescriptive indicators exist when using analysis of individual growth curves (Rogosa 1991).

Research design requirements for identifying prescriptive indicators are more rigorous than those for identifying more general prognostic indicators, particularly

as these relate to adequate power for detecting effects (Whisman & McClelland 2005). For example, using Cohen's (1987) power tables, an investigator would need to obtain minimum sample sizes of 26, 55, or 392 participants in order to have adequate power (i.e., power of .80, at $\alpha = .05$) for detecting large, medium, or small effect sizes, respectively. However, prescriptive indicators generally offer far greater usefulness for clinicians than do prognostic indicators in that the former go beyond the question of who responds well to therapy to address issues of treatment selection in evaluating who responds well to which kinds of intervention.

Empirical Findings Regarding Predictors of Couple Therapy Outcome

PROGNOSTIC INDICATORS OF TREATMENT RESPONSE Over the past several decades, a substantial body of research has identified general prognostic indicators of response to couple therapy including demographic, relationship, and individual characteristics. Most of these findings have been derived from controlled clinical trials of BCT and are reviewed in greater detail by Whisman et al. (2005); exceptions are noted where applicable.

Several studies have found that younger couples respond more favorably to BCT (Baucom 1984, Hahlweg et al. 1984, O'Leary & Turkewitz 1981), whereas others have found no association between age and treatment outcome (Crowe 1978, Jacobson et al. 1986). In addition, Crowe (1978) found that less-educated couples had better response to BCT than those with higher education. A prediction study collapsing across behavioral and insight-oriented treatment conditions (Snyder et al. 1993) found that initial status of being unemployed or employed in a position of unskilled labor predicted poor treatment outcome four years after termination. In a controlled trial of IBCT versus traditional BCT, couples who were married longer showed greater treatment gains, regardless of condition (Atkins 2005a).

Results from various studies indicate that couples having the greatest difficulties in their relationship are less likely to benefit from treatment, with initial levels of relationship distress accounting for up to 46% of the variance in treatment outcome (Johnson 2002). Lack of commitment and behavioral steps taken toward divorce have been associated with poor treatment outcome to BCT in two studies (Beach & Broderick 1983, Hahlweg et al. 1984) but not in another (Jacobson et al. 1986). Hahlweg et al. (1984) found that BCT outcome was predicted by negative communication behavior. Snyder et al. (1993) found that poorer outcome to couple therapy was predicted by lower relationship quality, greater negative relationship affect and disengagement, and greater desired change in the relationship. By contrast, initial levels of relationship distress were not significantly related to treatment outcome in a study of EFCT (Johnson & Talitman 1997), although partners' therapeutic alliance accounted for 22% of the variance in response to treatment.

Whisman & Jacobson (1990) operationalized inequality of partners' power in their marriage in terms of asymmetry in the relative frequencies of verbal communication content patterns, and found that power inequality prior to therapy predicted positive treatment outcome at posttest and at six-month follow-up. Gray-Little et al. (1996) operationalized power in terms of which partner had more influence in a problem-solving interaction, and found that wife-dominant couples improved the most in response to couple therapy in terms of increased satisfaction and improved communication. In a study of EFCT, Johnson & Talitman (1997) found that the best predictor of outcome was the wife's belief that her partner still cared for her.

Greater interpersonal sensitivity and emotional expressiveness—as determined by measures of "femininity"—have been found to predict better outcome at termination (Baucom & Aiken 1984) and long-term follow-up (Snyder et al. 1993) but were not predictive in a third study (Jacobson et al. 1986). Couples in which partners exhibit a higher degree of traditionality (i.e., higher affiliation needs in the wife and higher independence needs in the husband) have been shown to have poorer response to BCT (Jacobson et al. 1986). Partners' higher levels of depressed affect have been linked to poorer outcome in one study (Snyder et al. 1993) but not in another (Jacobson et al. 1986).

Although findings regarding prognostic indicators of couple treatment response are mixed and the predictive utility of any single predictor appears modest, incremental prediction from multiple indicators pooled across predictor domains can be substantial. For example, in the study comparing BCT with IOCT (Snyder et al. 1991), the unconditional probability (base rate) of divorce or relationship distress four years after completing couple therapy was .35. In their analyses pooling replicated predictors across partners and across demographic, individual, and relationship domains, Snyder et al. (1993) were able to double the accuracy in predicting four-year follow-up status from prognostic indicators obtained either at intake or termination (with conditional probabilities of .71 and .86, respectively).

PRESCRIPTIVE INDICATORS OF TREATMENT RESPONSE In contrast to findings regarding general prognostic indicators of response to couple therapy, research identifying prescriptive indicators of couple treatment response has been rare. An early study by O'Leary & Turkewitz (1981) suggested that younger couples responded better to behavioral interventions emphasizing behavior-exchange skills, whereas older couples showed more favorable response to general communication skills training. More recently, research comparing IBCT with traditional BCT suggests that severely distressed couples may respond more favorably to BCT than to IBCT during the initial stages of treatment, although both treatments produce equivalent gains at outcome and preliminary findings indicate that IBCT may produce more enduring gains at extended follow-up (Atkins & Christensen 2004). Moreover, exploratory analyses from this clinical trial reported by Atkins et al. (2005a) suggested that sexually dissatisfied couples showed slower initial response but more consistent gains overall in IBCT versus BCT.

DIRECTIONS FOR FUTURE RESEARCH AND TRAINING

Previous reviews of couple therapy have identified a variety of directions for further research and training in couple-based treatments. Based on these reviews and our own evaluation of the literature, we have extracted 12 essential directions for future research and training.

Directions for Research

Couple therapy outcome research will benefit from smaller-level studies such as single- or replicated-case designs, analysis of treatment components, and open clinical trials. We adopt this conclusion without alteration from a review of methodological issues in couple research by Christensen et al. (2005). Christensen and colleagues noted limitations in funding for large clinical trials of couple therapy, and emphasized that "working with a smaller number of couples in a more detailed manner often can provide the understanding and insight needed before launching a more time-consuming and expensive randomized clinical trial" (Christensen et al. 2005, p. 13). Such smaller-scale investigations also promote outcome research in community agency and private practice settings potentially addressing issues of representativeness remaining from studies conducted exclusively within the university research context.

Couple therapy research needs to extend beyond initial treatment impact to identify individual, relationship, and treatment factors contributing to deterioration or relapse and effective means of reducing or eliminating these effects. Among those individuals who initially respond favorably to couple therapy, approximately 30%–60% subsequently evidence significant deterioration. Numerous reviews (e.g., Johnson 2002, Lebow & Gurman 1995) have noted the need to develop specific interventions targeting relapse as well as guidelines regarding their delivery (e.g., timing and format of their delivery as well as criteria for targeting couples at greatest risk) to reduce deterioration effects.

Research on couple therapy needs to move beyond existing therapies to examine integrative approaches—including indicators for selecting, sequencing, and pacing specific treatment components, alternative integrative models, and moderators of therapeutic effectiveness. This conclusion was asserted by Snyder & Whisman (2003, 2004b) specifically as it relates to treating couples with coexisting mental and physical disorders, but has also been voiced by others (e.g., Lebow & Gurman 1995) as it applies to couple therapy more generally. Efforts to decompose couple-based interventions into their smallest transportable components should lead to research on the most effective ways of reassembling these in a manner uniquely tailored to couples' variation in individual and relationship functioning (Snyder et al. 2003). Each intervention incorporated into an integrative approach needs to be considered with respect to its necessity, sufficiency, and interactive effects.

Couple-based interventions for specific individual and relationship problems need to be developed and examined for both their intermediate and long-term

effectiveness. Significant progress in this regard has been achieved over the past decade; however, much of the literature espousing couple-based interventions for emotional and behavioral disorders relies on qualitative analyses or anecdotal evidence. Evaluations of existing or new couple therapies for specific disorders need to be complemented by studies examining the adaptation of existing approaches to couple distress when specific dysfunctions (e.g., personality disorders)—although not an explicit target of treatment—moderate both treatment process and outcome.

Greater attention needs to be focused on the generalizability of research findings across such potential moderators as age, family life stage, gender, culture and ethnicity (including interethnic couples), family structure (including composition of stepfamily and extended family systems), and nontraditional relationships (including cohabiting and same-gender couples). Virtually every recent review of couple therapy research has decried the lack of findings regarding the generalizability of treatment outcome and processes across these or similar potential moderators. Among the clinical trials of couple therapy reviewed in the preceding sections, only the comparison of IBCT with traditional BCT (Christensen et al. 2004) included significant representation (22%) from ethnically diverse groups. Cross-cultural comparisons of couple therapy—particularly couple-based treatments of individual emotional or health problems—are rare, despite documented differences in how couples of diverse cultural backgrounds contend with mental and physical illness (Osterman et al. 2003). Research on couple therapy for specific disorders tends to focus on one gender to the exclusion of the other—e.g., sampling men with substance use disorders or women with affective disorders. Empirical studies of couple therapy with same-gender couples are virtually nonexistent.

Because of the growing concerns about spiraling health care costs, research needs to assess the costs, benefits, cost-benefit ratio, and cost-effectiveness of couple-based interventions. We embrace this conclusion verbatim as asserted by Fals-Stewart et al. (2005b) in a recent article defining various components of cost analysis and methods for calculating these indices. Fals-Stewart and colleagues determined that the few evaluations of cost-benefit and cost-effectiveness of couple- and family-based interventions completed to date have yielded favorable results; nevertheless, they noted that evaluations of this sort for couple and family therapies have lagged behind those for other psychosocial interventions.

Studies of couple therapy outcome need to be complemented by research on change processes. Again, this recommendation regarding future research has been articulated in virtually every review of couple therapy appearing in the past decade. Further bolstering the appeal for research on mechanisms of change are encouraging findings from recent studies drawing on HLM and especially those using an events-based or task analysis approach. In their recent review of change process research in couple and family therapy, Heatherington et al. (2005) identify five critical foci toward which future process research should be oriented: (*a*) midrange theories about systemic change processes; (*b*) client change processes (e.g., partner behaviors facilitating proximal outcomes); (*c*) intrapersonal processes (e.g., emotion and cognition); (*d*) strategies for analyzing data from multiple participants;

and (*e*) consistent with a recommendation noted above, investigation of the degree to which various change processes generalize across diverse populations.

Research regarding mediators and moderators of treatment outcome requires attention to critical design issues to ensure the potential for identifying relevant effects. Recent papers have emphasized methodological issues in examining change processes in psychotherapy generally (e.g., Doss 2004) and moderators in couple and family research specifically (Whisman & McClelland 2005). For example, the power to detect small or moderate effects may be enhanced not only by increasing sample size but also by using more reliable and accurate measures and by increasing variance of the predictor or moderator variable. The latter point is particularly important because inclusion and exclusion criteria for clinical trials often result in restricted range of predictor variables. For example, one is prohibited from examining the effects of individual psychopathology on couple therapy process or outcome if individuals with emotional or behavioral disorders are excluded from the clinical trial.

Couple-based interventions likely will be enhanced by incorporating basic research on emotion regulation processes. There has been growing interest over the past decade in the role of emotion regulation processes in couples and families (Snyder et al. 2006). Individuals' ability to regulate their emotions effectively—especially in interpersonal contexts that involve potentially caustic exchanges—plays a pivotal role in keeping individuals and their significant relationships functioning well. Poor or inadequate emotion regulation at either the intrapersonal or the interpersonal levels may be a major contributing factor in relationship dissatisfaction and dissolution. Moreover, research on emotion regulation may facilitate better understanding of the role of individual psychopathology on couple therapy processes and outcomes.

Directions for Clinical Training

Couple therapists should be trained in common factors and mechanisms of change that potentially undergird most forms of successful treatment. We concur with this conclusion as asserted by Sprenkle & Blow (2004) while also recognizing caveats noted by Sexton et al. (2004) that the common factors perspective may "overlook the multilevel nature of practice, the diversity of clients and settings, and the complexity of therapeutic change" (p. 131). Recognizing the therapeutic effects of nonspecific (common) treatment components does not obviate attending to the critical role of specific treatment counterparts (Snyder et al. 1988). For example, fundamental but nonspecific interventions facilitating the therapeutic alliance may be necessary but insufficient for treating relationship distress unless followed by specific interventions such as challenging dysfunctional attributions, emphasizing and heightening primary emotions, or interpreting recurring maladaptive relationship patterns.

Couple therapists need to be trained to conceptualize and practice integratively across diverse theoretical orientations. The complexity of individual,

interpersonal, and situational factors contributing to the development, exacerbation, or maintenance of couple distress often requires selecting, sequencing, and pacing multiple interventions falling outside of any one theoretical approach (Snyder et al. 2003). Therapists are often vulnerable to viewing presenting complaints through the filtering lens of their own preferred theoretical or treatment modality. Treating difficult couples with coexisting mental or physical health problems, in particular, may be hindered if interventions are restricted to one particular theoretical tradition. Even when practicing within a given treatment approach, couple therapists need to be trained in how to "make their next move" (Sprenkle 2002a) in terms of selecting among either specific or nonspecific interventions consistent with that approach.

Couple therapists need to be competent in recognizing and treating the recursive influences of individual and relationship difficulties. Given robust findings regarding the comorbidity of relationship distress with individual emotional and behavioral problems in both community and clinical samples, couple therapists must be schooled in psychopathology and principles of individual assessment and treatment, including familiarity with biological interventions for relationship difficulties rooted at least in part in physical or mental illness of one or both partners. Similarly, couple therapists need to be familiar with both existing and emerging couple-based interventions for individual emotional and physical health problems, as well as adaptations of existing treatments made necessary by such difficulties. As evidence of the disconnection between research findings and clinical practice, Fals-Stewart & Birchler (2001) surveyed program administrators from 398 community-based outpatient substance abuse treatment programs in the United States regarding use of different family- and couple-based therapies in their programs. Whereas 27% of the programs provided some type of couple-based treatment, less than 5% of the agencies used behaviorally oriented couple therapy and none used BCT specifically. Consequently, greater efforts are needed to identify possible barriers impeding the transfer of couple-based interventions from research to practice settings and to develop strategies aimed at reducing or eliminating these barriers.

CONCLUSIONS

Couple therapy comprises an essential component of mental health services. Research demonstrates its effectiveness in treating generalized relationship distress as well as comorbid relationship problems and individual emotional and behavioral difficulties. Systematic investigations delineating processes of change and prescriptive indicators of treatment response will be critical to narrow the oft-cited gap between clinical research and practice. Recent findings offer considerable encouragement for translating the results of couple therapy research into improved training of couple therapists and more effective interventions in community agency and practice settings.

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