CHAPTER 13
Behavioral Couple Therapy

Past, Present, and Future

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INTRODUCTION

In Gurman and Kniskern's *Handbook of Family Therapy* (1981), our late friend, colleague, and mentor Neil Jacobson commented, "What distinguishes [Behavioral Couple Therapy] from other approaches to treating couples is its single-minded commitment to empirical investigation as the optimal road to development" (p. 557, Jacobson, 1981). We believe that this statement is as true today as it was then. To be clear, other couple therapies have demonstrated empirical support (see Christensen & Heavey, 1999, for a review), but behavioral couple therapy (BCT) is unique in both the quantity of empirical support it has received and the role that research plays in its ongoing evolution. Far from being a static treatment, BCT faces constant scrutiny and revision as researchers and clinicians try to develop an ever more potent therapy.

This chapter presents both the research support for and the clinical application of BCT. We will focus primarily on two versions of BCT. The first is the “classic” BCT of Jacobson and Margolin (1979) that focuses on skills and behavior change. We refer to this as traditional behavioral couple therapy (TBCT). The second version of BCT, and perhaps the most radical revision to date, is integrative behavioral couple therapy (IBCT), which emphasizes emotional acceptance and tolerating partner differences, in addition to behavior change (Christensen & Jacobson, 2000; Jacobson & Christensen, 1996).*

HISTORY AND BACKGROUND OF BCT

Most BCT researchers point to Stuart’s (1969) report as the first published example of the application of behavioral psychology principles of reinforcement with couples. At that time behaviorism had shown great success with certain clinical issues such as phobias, mental retardation, and behavior problems on inpatient psychiatric wards (Masters, Burish, Hollon, & Rimm, 1987). Behavioral researchers, buoyed by their successes, were rapidly targeting new disorders and problems. In addition to Stuart’s work, a group of researchers at the University of Oregon was studying problem behaviors in children and...
developing behavioral interventions for parents (Patterson, 1982). In the course of their research, they observed that some couples needed parenting skills; however, other couples needed relationship skills in addition to parenting skills. The research group began to study relationship problems in their own right and published a series of case studies applying behavioral principles to relationship distress (Patterson, Hops, & Weiss, 1975; Weiss, Hops, & Patterson, 1973).

Research and clinical work on BCT gained momentum at the end of the 1970s and the beginning of the 1980s, as several books were published that described behavioral approaches to couple therapy (Jacobson & Margolin, 1979; Stuart, 1980). Research evidence (reviewed in the section “Research Evidence That Supports the Model”) rapidly accumulated, showing that BCT was an effective approach to increasing relationship satisfaction and stability, yet there was also evidence that not all couples were being helped (Jacobson, Follette, Revenstorf, Baucom, Hahlweg, & Margolin, 1984; Jacobson, Schmaling, & Holtzworth-Munroe, 1987). In fact, the accumulating evidence suggested that not all couples benefited in therapy and that some couples relapsed shortly after finishing therapy. These findings led BCT researchers to explore various ways to extend the basic model of couple therapy and gave rise to cognitive-behavioral couple therapy (CBCT; Baucom & Epstein, 1990; Halford, Sanders, & Behrens, 1993) and integrative behavioral couple therapy (IBCT; Jacobson & Christensen, 1996). Research into the efficacy of these “post-TBCT” therapies is ongoing, including the recent completion of the largest trial of couple therapy to date, comparing TBCT and IBCT (Christensen, Atkins, Berns, Wheeler, Baucom, & Simpson, 2003).

MAJOR THEORETICAL AND RESEARCH-BASED CONSTRUCTS

BCT is a behavioral therapy and, as such, was developed from the basic principles of learning and conditioning. For many clinicians, behavior therapy connotes a mechanistic therapy, in which there is little regard for the person and the focus of therapy is on specific, prescribed interventions. Although this stereotype may be appropriate for particular instances where behavior therapy has been applied, we believe that nothing in the theory mandates such a mechanistic focus and that much in the theory, particularly its emphasis on context and unique individual histories, would promote regard for the complex, whole individual human being. Although it is beyond the scope of this chapter to provide a thorough

*We will use the overarching term BCT when referring to behavioral couple therapy in general and TBCT and IBCT when we are referring to the specific versions covered in this chapter.

review of behavior therapy (see Goldfried & Davison, 1994, or Masters et al., 1987), in this section we introduce some of the key theoretical constructs of BCT; we hope to do this in a way that minimizes jargon and that conveys BCT for what it is: a flexible, clinically sophisticated therapy constructed from the solid science of behavioral theory.
Any coherent model of couple therapy must contain an understanding of why partners form relationships, and consequently, what goes wrong in relationships. This framework guides the process of assessment and the direction of treatment. From a behavioral point of view, people form relationships because they find their partner and the relationship rewarding. We use the term *reward* not in a generic sense but in the specific sense of operant conditioning (Skinner, 1974); that is, a reward or a reinforcer is something that increases the frequency of the behavior in question. Thus, in the case of intimate relationships, being with one’s partner is a reinforcing experience, to the extent that it increases one’s wanting to be with one’s partner in the future. Simultaneously, there must be relatively fewer aversive qualities in the partner. Thus, there is a positive ratio of reinforcing to punishing qualities. In fact, work by Gottman and Levenson (1999) has shown that there are different ratios of positive to negative behaviors among happy couples, as compared with distressed couples. However, it is crucial to keep in mind that reinforcers are not generically “good” behaviors; reinforcers are defined by their function, not by their normative value. Thus, it is impossible to form a general list of reinforcers that works with couples because reinforcers are specific to each individual within a couple.

In fact, reinforcers do not have to be “good” at all; if something serves to increase the rate of a given behavior, it is by definition a “reinforcer.” For example, attention from a partner, even if that attention consists of criticism and complaints that would be widely viewed as “negative,” may function as a reinforcer in some relationships. Conversely, just because a given behavior is positive or pleasurable does not imply that it will be an effective reinforcer for a given behavior. For example, most people find backrubs enjoyable. However, this does not necessarily mean that a backrub will be an effective reinforcer for washing dishes. This idiographic and functional nature of reinforcers is essential to behavior therapy and lies at the heart of a core element of behavior therapy: functional analysis.

Very simply put, a functional analysis is an analysis that reveals the immediate, proximal contingencies of a given behavior. Said another way, a functional analysis answers the question: What controls a given behavior? In conducting a functional analysis, the therapist focuses on the antecedents and consequences of behavior: What came before and what was the effect? For example, in understanding why one partner is critical of the other, the therapist may observe what occurs just before the criticism. This analysis may reveal the “triggers” of the criticism (e.g., the partner is sarcastic), which can then be targeted for intervention. In addition, the functional analysis may focus on the consequences of the criticism (e.g., the criticized partner refuses to communicate).

Behavioral research has also demonstrated that reinforcers are not static. We can habituate to reinforcers over time, so that the jokes and funny faces that used to elicit laughter and affection from our partner now bring forth eye rolling and exasperation. This process has been coined *reinforcement erosion* (Jacobson & Margolin, 1979). The changing value of reinforcers highlights the dynamic nature of relationships; the skills that were necessary for a happy relationship at the start are likely to be different from...
those that are necessary for a happy relationship 10 years into the marriage.

The behavioral theory of relationships is quite simple, in that it rests on the functional analysis; however, the simplicity of the theory does not translate into “easy” therapy. A functional analysis is a very powerful tool, yet it can be exceedingly difficult to understand the contingencies of a given behavior! In fact, how to address the inherent challenges and difficulties of conducting a functional analysis represents one of the key differences between TBCT and IBCT.

Theoretical Differences Between TBCT and IBCT

The two styles of BCT presented in this chapter have much in common, theoretically. Nonetheless, a few key theoretical differences undergird and explain the divergence in therapeutic interventions between the two approaches. In this section, we discuss four primary differences between TBCT and IBCT: the unit of analysis, how the functional analysis is used, the issue of rule-governed versus contingency-shaped behavior, and the target of treatment. In discussing the differences, we focus mainly on the theory in this section. How the theoretical differences are translated into practice is described in the intervention section.

The first difference between the two therapies is that TBCT tends to focus on small, specific behaviors, whereas IBCT tends to focus on larger “themes.” TBCT places great emphasis on identifying discrete and specific behaviors that can be targeted for intervention. Indeed, this is the main focus of assessment in TBCT, something we return to later in greater depth. IBCT also acknowledges the importance of identifying specific behaviors for intervention, but it takes a wider view than does TBCT. Different behaviors can serve the same function, and in IBCT, the therapist works to identify classes of behavior based on shared function. These themes are common patterns that may appear in several spheres of couples’ lives but serve the same function.

A second difference has to do with the functional analysis. Conducting a functional analysis is much like conducting an experiment; ideally, all sources of influence are held constant while a single antecedent influence is manipulated. Because TBCT focuses on such small events, there are a bewildering number of behaviors to subject to a functional analysis. Imagine two partners discussing something important about their relationship for 5 minutes; there are innumerable antecedents and consequences to explore. In describing TBCT, Jacobson (1981) put it this way:

In a marital dyad, behavior exchanges are continuous, and the behavior of each member serves as both antecedent and consequence for the behavior of the partner. As a result, any attempt to establish functional relationships between behavior and the environment by applying a unidirectional cause-effect model was unsatisfactory…. The solution to this dilemma has been to emphasize the skills which couples need to sustain a satisfying relationship over a long period of time. (pp. 557–558)

The traditional approach to BCT contends that in most instances, it is simply too difficult to conduct functional analyses of problematic partner behavior. Thus, although TBCT
acknowledges the utility of functional analysis, it steers away from an idiographic approach and assumes that a set of core skills exists that is useful in most relationships. Following from this basic assumption, the primary interventions in TBCT are a prescribed set of skills thought to have general use. In contrast to TBCT, IBCT attempts to remain true to a functional analytic approach. This is accomplished by broadening the targets of the functional analysis. As we noted earlier, IBCT focuses on patterns and themes, as opposed to small, discrete behaviors. These patterns and themes become the focus of the functional analysis in IBCT.

The third significant difference between the two therapies relates to relative emphasis of the treatments on rule-governed versus contingency-shaped behavior (Skinner, 1966). Up to this point, our description of the behavioral theory of relationships has focused on contingency-shaped behavior, behavior that is controlled via the rewards and punishments that it “naturally” elicits. Behaviorists have noted, however, that some behavior is controlled by rules (Kohlenberg & Tsai, 1991). A rule is a statement of relationship, “If you do X, then Y will occur.” From an early age, we are reinforced for following rules, and parenting involves many rules: “If you have a snack late in the day, you’ll ruin your appetite for dinner.” For the behaviorist, the important point is that rules specify contingencies, and people often behave according to those contingencies because of the rules. For example, a child’s behavior may be elicited by a rule (“I need to eat my vegetables before I get dessert”) and reinforced because it meets the requirements of the rule (“Now I get dessert because I have finished my vegetables”). If someone behaves in a certain manner because of a rule, behaviorists refer to this as “rule-governed” behavior. Rules are neither good nor bad; they are essential in learning many tasks in life. However, natural contingencies also come into play that may be consistent or inconsistent with the rule. For example, the parent in our example may prepare vegetables in an attractive way that appeals to the child (e.g., the “ants on a log” for celery) so that the child eats the vegetables, not because of the rule, but because of the reinforcement that comes from observing, discussing, and eating the attractive vegetables. In contrast, the vegetables may be unappealing, the interaction around their eating may be negative, so that repeated appeals to the rule and strict application of the reinforcers specified by the rule are necessary to ensure any vegetable consumption. Rules are instituted because desired behavior does not occur naturally. If children typically liked broccoli as much as they do ice cream, there would never need to be rules like the previously mentioned one. However, one ideally structures the environment to “naturally” promote “good” behavior, either in addition to or instead of a rule. Otherwise, continued vigilance about the relevant behavior and regular applications of the reinforcers set forth by the rule are necessary.

From this vantage point, TBCT is largely a rule-governed therapeutic approach. In introducing the skills, the therapist is teaching the couple a rule, “If you learn these skills, your relationship will improve.” For example, one of the components of TBCT is communication training, including training in “I statements” and paraphrasing (described in depth in the section “Treatment Protocols for TBCT and IBCT”). Couples vary in their assimilation of these new communication skills. Some couples are able to assimilate the skills into their relationships; the couple’s experience benefit from the skills (the skills
achieve reinforcing effects), and the skills subsequently become contingency-based, rather than rule-governed. Thus, they use “I statements,” no longer because the therapist said that was the right way to talk, but because they have experienced more rewarding interactions as a result. In contrast, other couples are not able to assimilate the skills in the same manner. For these couples, the skills remain rule-governed, under the control of the therapist’s instruction and guidance. While the couple is in therapy, the therapist may serve to reinforce the rule (i.e., “You should use these skills”), but when the couple ends therapy, the partners are unlikely to sustain the therapeutic behaviors. These couples are at high risk of relapse. The rule-governed nature of the TBCT intervention was a primary motivation in the development of IBCT. Unlike TBCT, IBCT uses a functional analysis to identify and target the specific contingencies of behavior in a given relationship. Ideally, the change that occurs in IBCT should all be contingency-shaped, as opposed to rule-governed. Thus, couples in IBCT should be able to maintain their therapeutic gains after therapy ends, as the reinforcers that were used were specific to their relationship. This is one of the primary hypotheses of our recent clinical trial (Christensen et al., 2003).

The final difference between the two therapies involves the target of treatment. In TBCT, there is an exclusive focus on actions and lack of actions: Which behaviors need to be increased and which decreased? In contrast, IBCT places great importance on reactions in addition to actions; in particular, the functional analysis often reveals how reactions maintain negative behavior and interfere with positive behavior. For example, Jim’s strong negative reaction when Sue is not interested in sex with him actually reduces Sue’s own sexual interest, which is a major reinforcer for him. Feedback loops such as the one just described are quite common in couple interactions. TBCT, with its emphasis on actions, may miss the dynamic interplay of couple’s behavior, whereas IBCT focuses on the wider patterns of action and reaction. Thus, IBCT focuses on negative reactions and works toward having partners accept one another’s behaviors. This acceptance counters the negative reactions that serve to maintain cycles of punishing exchanges.

RESEARCH EVIDENCE THAT SUPPORTS THE MODEL

TBCT is, by far, the most commonly studied couple therapy. Over two dozen controlled studies have empirically tested the efficacy of TBCT (for reviews, see Baucom, Shoham, Mueser, Daituo, & Stickle, 1998, and Christensen & Heavey, 1999). Moreover, using the criteria established by Chambless and Hollon (1998) for delineating empirically supported treatments, TBCT was the only couple therapy noted as an “efficacious and specific treatment.” IBCT has not yet received similar empirical scrutiny, though there is some preliminary support for its efficacy (Jacobson, Christensen, Prince, Cordova, & Eldridge, 2000). In addition, IBCT is currently being tested in the largest trial of couple therapy to date (Christensen et al., 2003). The results of that study will provide important information regarding its efficacy. In this section, we will review the empirical support for both TBCT and IBCT.
TBCT

Early research on TBCT included reports of case studies by Weiss et al. (1973) and Patterson et al. (1975). Jacobson (1977) conducted the first randomized clinical trial of TBCT with a modest sample size of 5 couples in active treatment and 5 couples in a wait-list control group. TBCT led to impressive gains in marital satisfaction with a very large effect size \( (d>2) \). Several additional clinical trials rapidly expanded the evidence that TBCT could affect significant improvements in relationship satisfaction. Moreover, Hahlweg and Markman (1988) conducted the first metaanalysis of couple therapy, in which they examined 17 studies of TBCT. They found that TBCT produced a large amount of change compared with control groups \( (d=0.95) \) and that most couples maintained their improvements over the year following therapy.

Unfortunately, not all of the findings were so encouraging. Virtually all outcome studies use inferential statistics to determine whether a statistically significant difference exists between change that occurs in couples during therapy, compared to change in control couples who did not receive therapy. However, as Jacobson, Follette, and Revenstorf (1984) noted, statistically significant change does not imply that a distressed couple would be considered nondistressed at the end of therapy. To address the issue of how individuals (or couples) change in therapy, Jacobson et al. proposed a method of clinical significance. Clinical significance classifies individuals (or couples) at the end of therapy into one of four categories: Deteriorated, Unchanged, Improved, or Recovered.

When TBCT was evaluated in terms of clinical significance and long-term outcome, the picture was not so optimistic. Approximately one third of couples received no benefit from TBCT, and one third of those couples who were classified as Recovered at the end of treatment relapsed during the 1–2 years following therapy (Jacobson et al., 1984; Jacobson et al., 1987). Moreover, two additional studies have shown poor long-term outcomes of TBCT at longer post-therapy assessments. Snyder, Wills, and Grady-Fletcher (1991) found that 38% of couples who had received TBCT divorced within 4 years following therapy, compared to only 3% who had received insight-oriented couple therapy. More recently, Halford, Sanders, and Behrens (2001) found that low-distress couples who had received a premarital intervention based on TBCT were more distressed than a no-treatment control group at 4 years post-intervention. Thus, although TBCT has proven its efficacy to improve relationship satisfaction in a number of studies, there are ongoing concerns about the post-therapy adjustment of couples who improve with TBCT and those couples who never respond to TBCT.

Post-TBCT Behavioral Couple Therapies

The research findings reviewed here have led researchers to try to improve upon the basic TBCT intervention model. Several researchers have explored the possibility of enhancing TBCT by including interventions focused on the cognitions of the partners and emotional expressiveness (Baucom & Lester, 1986; Baucom, Sayers, & Sher, 1990; Halford, Sanders, & Behrens, 1993). Each of these studies compared TBCT to an “enhanced”
version of TBCT that included cognitive interventions. However, in each instance, TBCT performed just as well as the enhanced version. Thus, the addition of cognitive strategies was not effective in increasing the percentage of couples that responded to TBCT nor did those strategies lead to reduced relapse among those couples who did respond. Recently, Epstein and Baucom (2002) have published a description of an enhanced cognitive-behavioral couple therapy model, which broadens the context of this approach by paying greater attention to the environment in which the couple functions, factors within the individual partners themselves, and developmental change in the relationship. However, there is no research as yet on this important revision of the cognitive behavioral approach.

Integrative behavioral couple therapy is an extensive revision of TBCT that has received empirical support. Two unpublished studies (cited in Christensen & Heavey, 1999) and a small clinical trial (Jacobson et al., 2000) suggest that IBCT is better than no treatment and possibly more effective than TBCT. However, the most convincing evidence for IBCT comes from a recent large randomized clinical trial (N=134 couples) that compared IBCT to TBCT (Christensen et al., 2003). There are several interesting findings from this study. First, therapeutic interventions from over 200 sessions of therapy were coded by raters who were uninformed about the treatments involved. These ratings showed that the two therapies were quite different. Greater than three times the number of “acceptance-oriented” interventions occurred in IBCT as compared to TBCT, and over three times the number of “change-oriented” interventions occurred in TBCT as compared to IBCT. The adherence coding shows that TBCT and IBCT have little overlap in their interventions and can be considered distinct therapies.

Second, consistent with previous studies, TBCT and IBCT demonstrated similar and large levels of change in marital satisfaction from pretreatment to post-treatment. However, there were some notable differences in how this change occurred. Change in TBCT occurred rapidly during the initial phases of therapy but then slowed later in therapy. In IBCT, change occurred at a constant rate over the entire course of therapy. Moreover, the most highly distressed couples in both therapies showed early gains that slowed later in therapy. Thus, in highly distressed couples in TBCT, their improvement in therapy not only slowed down but reversed direction such that at the end of therapy, these couples were beginning to deteriorate (Christensen et al., 2003). We believe that these differences in the course of therapy will have implications for couples’ relationship satisfaction following therapy. In particular, we predict that couples who received IBCT will have lower levels of relapse relative to couples who received TBCT. At the present time, however, these are only hypotheses, as the study is ongoing.

TREATMENT PROTOCOLS FOR TBCT AND IBCT

Assessment and Case Formulation

The structure of the assessment portion of therapy is identical for TBCT and IBCT; however, the focus and goals are quite different. A hallmark of behavior therapy is a thorough assessment that includes both subjective and objective measures. In research
studies, the first four sessions are typically set aside for assessment, including an initial conjoint session, an individual session with each partner, and a conjoint feedback session. In community settings, the two individual sessions are sometimes condensed into a single session, with half of the session spent with each partner.

As in all couple therapies, the BCT therapist wants to hear the couple’s story and each partner’s views on how their problems developed. In addition to this verbal report, it is equally important to use objective assessment measures, most often questionnaires. This is important for several reasons. First, questionnaires are often more comprehensive than an interview alone, covering more relationship areas. Second, they also allow comparisons and feedback about a given couple’s problems relative to couples in general, via normative data for the questionnaires. Third, for sensitive topics (e.g., domestic violence and extramarital affairs), research has shown that individuals are more likely to endorse these issues on questionnaires than in interviews (O’Leary, Vivian, & Malone, 1992).

Listed as follows is a summary of the primary questionnaires that were used in our recent study comparing TBCT and IBCT (Christensen et al., 2003), which we believe are most relevant for clinical purposes.

- **Dyadic Adjustment Scale (DAS; Spanier, 1976):** The most widely used global measure of relationship satisfaction. There is normative data on the DAS that is useful for gauging the couple’s level of distress.
- **Frequency and Acceptability Partner Behavior (FAPB; Christensen & Jacobson, 1997):** The FAPB has each partner rate both the frequency and the acceptability of a number of positive and negative behaviors.
- **Marital Satisfaction Inventory—Revised (MSI-R; Snyder, 1997):** A multiscale measure of relationship functioning that provides a profile of couple distress.
- **Marital Status Inventory (MSI; Weiss & Cerreto, 1980):** The MSI measures the steps taken toward divorce. It is a useful gauge of commitment.
- **Conflict Tactics Scale (CTS; Straus, Hamby, Boney-McCoy, & Sugarman, 1996):** The CTS is a widely used measure of domestic violence.

In research studies, couples will complete the questionnaires at a pre-therapy assessment. In the community, couples are typically given the questionnaires at the first session and instructed to bring the completed questionnaires to their individual session; however, therapists could also mail the packet of questionnaires to couples prior to the first appointment. Couples often expect that “therapy” (i.e., intervention) will begin immediately, and it is essential to orient the couple that the first few sessions will be assessment and that therapy will not begin until the assessment is completed. In our experience, couples respond positively to the notion of an extended assessment; it conveys to the partners that their problems are serious and that the therapist wants to have a thorough understanding before proceeding with therapy.

The first session is a mixture of hearing about the presenting problems and about the history of the relationship. Therapists in both TBCT and IBCT are interested in hearing a thorough description of the present problems from each partner’s point of view. However, it is also essential to gather some information about the relationship history. In
particular, it is useful to hear about the early stages of the relationship: What initially attracted the partners to one another? In the early phases of the relationship, what were the strong points of the relationship? When did things begin to change? It is also helpful to look at the couple’s experience of stressful events, transitions or both, such as changing jobs, having children, moving, and so forth. Throughout the first session, it is important for the therapist to listen attentively to both partners, making sure that they feel that they are being heard and understood.

The individual sessions are a crucial part of the assessment process. Oftentimes, important information about the relationship is revealed during the individual sessions that would not have been revealed were the other partner present. Before the therapist begins the individual interview, it is crucial to clarify confidentiality, and we typically begin by noting, “Unless you tell me otherwise, I will assume that everything you say today will be okay to share in our conjoint sessions.” The primary focus of the individual sessions is to hear each partner’s view on the relationship, which can be notably different from what was shared in the initial, conjoint interview! In addition, it is useful to hear about the individual’s family of origin, which provides the model of relationships that each partner learned growing up. Finally, issues of individual pathology, such as depression, can be explored in the individual interview.

In addition to these overarching guidelines, several specific topics should be covered in the individual session. First, the therapist should assess each partner’s level of commitment to the relationship. If the partners completed the MSI (Weiss & Cerreto, 1980), the therapist can discuss their responses to the questionnaire. Second, the therapist should assess to what extent the individual feels that he or she contributes to the relationship problems. If the individual asserts that the problems are wholly due to the partner, therapy will likely need to begin by looking at the ways in which both partners are involved in and contribute to the problems.

Third, the individual sessions afford an opportunity to assess several sensitive topics. Domestic violence is not uncommon in relationships, particularly in distressed relationships (Holtzworth-Munroe, Meehan, Rehman, & Marshall, 2002). We believe it is crucial—especially in the individual session with the wife—to assess for domestic violence. If the couples completed the CTS (Straus et al., 1996), the therapist can use their responses to guide the assessment by following up on specific behaviors that they endorsed. Use of measures such as the CTS is strongly recommended, given that research suggests that significantly more individuals will disclose violence on such measures, when compared to general intake forms or clinical interviews (O’Leary et al., 1992). If, however, the CTS was not used, it is important to ask verbally about specific behaviors (e.g., “Has your partner ever slapped or pushed you?”), as opposed to asking generally about abuse or violence (e.g., “Have you ever been abused by your partner?”). Some experts also suggest using statements such as “Describe your worst argument” as a method of assessing domestic violence (e.g., Holtzworth-Munroe et al., 2002). Whether the CTS is used or not, we believe it is important to inquire about the frequency of violence, the extent of injury, and the worst case of violence. When there is evidence of violence, it is crucial to assess certain safety issues, such as whether weapons were involved or available and whether children were involved or present during violent
episodes. We also try to assess whether or not the violence constitutes battering. By battering, we mean “the use of violence to control, intimidate, or subjugate another human being” (Jacobson & Gottman, 1998). In assessing for battering, we look for a history of injury and fear. If there is evidence of battering, we believe that couple therapy is contraindicated (Bograd & Mederos, 1999) and that individual therapy for the perpetrator of the violence is the preferred therapy modality. Holtzworth-Munroe et al. (2002) provide further details about handling domestic violence in couple therapy.

Extramarital relationships should also be assessed during the individual interviews. Like domestic violence, affairs are quite common and are not likely to be mentioned if not directly assessed. Therapists should inquire about sexual or significant emotional relationships or both outside of the primary relationship. In general, we believe that couple therapy when there is an undisclosed affair is counterproductive, at best. When a spouse reveals an affair that is unknown to the partner, we encourage the spouse to either tell the partner or end the affair with the other person. If the individual is not willing to take either of these courses of action, then we believe the therapist should indicate that couple therapy is inappropriate at this time and should refer for individual therapy. For further discussion of affairs and couple therapy, see Glass (2002) and Gordon and Baucom (2000).

Before turning to the feedback session, we would like to comment briefly on differences between TBCT and IBCT during the assessment phase. As we noted earlier, the structure is identical, but there are important differences in what the therapist attends to during the assessment, how the information is gathered, and how it contributes to the case formulation. In TBCT, therapists use the assessment period to identify discrete behaviors that can then be targeted during the intervention phase of therapy. For example, if partners mention that they have trouble communicating and cannot agree about finances, the therapist will note these areas as targets for communication and problem-solving training interventions. At the feedback session, the therapist will present the couple with his or her understanding of the couple’s problems and also describe how the skills of TBCT can target each of these problems. In addition, the therapist will present an overview for how therapy will progress.

In IBCT, the therapist looks for themes and patterns among the specific problems that couples mention. The problems that the couple notes may represent a single instance of a broader underlying problem. Focusing on the particular instances as separate and distinct may miss the “true, important controlling variables in marital interaction” (Christensen, Jacobson, & Babcock, 1995, p. 35). As noted previously, IBCT takes as its aim a functional analysis of the couple’s problems. For example, imagine a couple in which the wife feels ignored by her husband. There are likely a number of ways that the husband may act that will lead to his wife feeling ignored: deciding to spend time with friends, spending time alone, not showing any interest in his wife’s activities, and so forth. In TBCT, these specific behaviors would become the target list for skills, whereas in IBCT, the therapist would look for the pattern or underlying theme (i.e., feeling ignored) that gives rise to the various problems.

In accordance with this emphasis on larger patterns, the case formulation plays an important role in IBCT and consists of three important pieces: the theme, polarization
process, and mutual trap. As noted earlier, the theme is a fundamental difference between partners that runs throughout the couple’s various problems and complaints. Oftentimes, the theme can be seen in the partners’ initial attractions to one another. The qualities that once seemed novel and interesting have become grating and hurtful. The wife who naturally connects to and depends upon other people was initially attracted to her husband because of his independence and autonomy. Now, the couple’s problems revolve around a theme of “closeness-distance,” in which the wife wants greater contact and connection, and the husband wants to maintain his autonomy. Often, the differences between partners are made emotionally volatile by the emotional vulnerabilities that they touch. For example, if the previously mentioned wife is afraid of being abandoned or the husband is fearful of being suffocated in the relationship, then the differences in closeness and distance will be especially problematic. As the partners struggle with their differences, they will often engage in a pattern of interaction that attempts to solve the problem but usually makes it worse. In the previous example, the husband may withdraw to achieve his desired distance and the wife may push to achieve her desired closeness. A reciprocal, escalating pattern of interaction, which we call the “polarization process,” may then ensue, in which each partner’s attempts to solve the problem serve to make it worse. The more he withdraws, the more she pursues, and vice versa. This polarization process only serves to alienate the partners from each other, as they demand change and stake out their own positions. Finally, the “mutual trap” refers to the natural endpoint of the polarization process. It is the point at which the partners feel despairing, discouraged, and trapped.

In IBCT, the therapist focuses on identifying the theme, polarization process, and mutual trap during the assessment phase. In the feedback session, the therapist presents this information as a model of the couple’s distress and invites the couple’s response. It is important that the feedback session be a collaborative process between the therapist and the couple, not one in which the therapist hands out a prescription for the couple’s problems. In addition, the therapist also presents an overview of therapy, which serves to transition the therapy from assessment to intervention.

**TBCT Interventions**

**BEHAVIORAL EXCHANGE**

TBCT therapists often begin the treatment phase of therapy with behavior exchange (BE). By the time that couples enter therapy, their relationships have ceased to be an enjoyable and rewarding aspect of their lives. Instead, they find their partners irritating and difficult to be around. Behavior exchange seeks to increase the positive behaviors in the relationship. For many couples, it quickly increases relationship satisfaction and provides momentum in the early phase of therapy.

Couples entering therapy are working very hard to change their relationship; however, almost all of the partners’ efforts are aimed at changing the other person! Behavior exchange takes the opposite tactic. The fundamental principle underlying BE is that individuals are better (and more successful) at changing themselves than at changing their
partners. The basic task in BE is for each partner to perform pleasing behaviors for each other, thereby increasing the overall positivity in the relationship. There are several different formats for conducting BE (Jacobson & Margolin, 1979), but all contain the same basic elements. The following description is the typical format used in our treatment outcome research (Christensen et al., 2003; Jacobson et al., 2000).

At the end of the feedback session, partners are given a homework assignment: both are asked to make a list of behaviors that they believe their partner would enjoy. They are asked to do this separately and not to share their lists. At the following therapy session, each list is read aloud, and the “receiving” partner has a chance to rate how pleasing each behavior would be. It is important that each partner generate his or her own list, as opposed to simply asking the partner, “What would you like me to do?” Sometimes, partners will feel cared for even through the simple act of hearing the lists of things that their partners have created. After the lists are read, the therapist works with the couple to ensure that each list contains items that would be truly pleasurable, avoiding any “off-target” items. As part of this process, the therapist may ask each partner to add pleasing behaviors to the list that the other person created. Finally, each partner is instructed to perform several of the items from his or her list in the upcoming week. Specific days are sometimes set aside for the positive behaviors, called caring days (Stuart, 1980) An important aspect of BE is that partners do not commit to performing specific behaviors, only that they will do one or more behaviors from the list. At the following therapy session, the therapist has each person describe his or her experience of both performing pleasing behaviors for the partner and also being the recipient of pleasing behaviors.

BE directly targets the problem of reinforcement erosion. It teaches couples to monitor their own behavior more closely and to evaluate the impact of their behavior on their partners. Moreover, BE provides a means for spouses to get feedback from one another on what they each enjoy and do not enjoy. At times, partners are very mistaken about what the other really likes! Finally, as we have noted, couples change, and the events and behaviors that used to be pleasing may no longer be so. BE can highlight this state of affairs and provide a framework for learning new behaviors.

COMMUNICATION/PROBLEM-SOLVING TRAINING

Following BE, TBCT generally progresses to communication training, consisting of didactic teaching, practice, and reading. The communication/problem-solving training interventions deal with two of the most common presenting problems in couple therapy: difficulty in communicating and intractable problems that couples have been unable to solve on their own. In our research work, therapists use the Gottman, Notarius, Gonso, and Markman (1976) book as a guide to teaching communication skills.

One of the initial (and most difficult) skills is the speaker/listener task. Couples are instructed that at any given time in their discussion, one partner is designated as the speaker and the other partner is designated as the listener. Speakers are encouraged to “level” with their feelings and edit overly negative comments (Gottman et al., 1976). They should be open and honest about their feelings and avoid overly critical statements. In addition, they should be specific, rather than global, in their concern and take responsibility for their concerns through the use of “I” statements (e.g., “I get irritated
when you repeatedly ask me to take out the garbage”; as opposed to, “You always nag me.”). Listeners are instructed to closely follow what their spouses are saying and to paraphrase what was said after the speakers finish. Finally, listeners verify with the speakers that the message they received is the message that was intended (for a thorough treatment of communication training, see Gottman et al., 1976).

In discussing difficult topics, partners often interrupt one another and dispute the claims of the other person. Communication training, with its emphasis on speaker and listener, provides needed structure so that partners can express their point of view and be assured that their spouses will hear them out. Couples are instructed to start using the skills with smaller, less conflictual problems, as it is extremely difficult to learn and practice communication skills with highly volatile topics. In the first few sessions of teaching the skills, the therapist acts as both coach and referee. As the partners learn the skills, they are encouraged to use the format for increasingly difficult problems.

Oftentimes, there is a natural progression with communication skills. Initially, the couple finds the new skills difficult and unnatural. Once these are learned, the couple can see the benefit of using the structured communication skills. However, there comes a point when partners may become frustrated that even after communicating effectively, they are still stuck at an impasse with a particular problem. Problem-solving training (PST) picks up where communication training ends. PST defines a clear set of procedures for addressing problems, emphasizing a collaborative approach. It should be noted, however, that the skills learned in communication training are also used throughout PST.

In addressing problems, couples are encouraged to see the ways in which each partner plays a role in the problem. Some partners are very resistant to the idea that they contribute to the problem, focusing entirely on how their partner is the cause of the problem. However, as much as possible, partners are encouraged to have a collaborative approach to problem solving. The first step in PST is arriving at a clear definition of the problem. Distressed couples often have a difficult time defining a single problem; their arguments move from one source of disagreement to another. Nonetheless, it is essential that both partners agree upon a clearly defined problem. Once the problem is defined, partners brainstorm a number of possible solutions, with the help of the therapist. Yet again, this can be very challenging for couples. They have seen the problem in a single light for so long that it can be excruciating for them to see it any other way. One strategy that can be effective in such a situation is for the therapist to suggest extreme (and often ridiculous) solutions to jar the partners free from their entrenched views.

After a number of possible solutions have been generated, they discuss the various options. The therapist serves as instructor and coach throughout the process, encouraging them to consider all the possibilities and to use their communication skills. Finally, when a single solution has been reached, the couple works out a “contract” specifying the exact terms of the agreement—who will do what, when, and for how long. The couple then implements its plan and debriefs its success or failure with the therapist at the following session. If the solution was not successful, the couple can then discuss and negotiate a better solution.
IBCT Interventions

IBCT interventions are broken down into two broad classes, acceptance interventions and change interventions. The primary acceptance strategies include empathic joining and unified detachment; these interventions help the partners to discuss their problems in a nonjudgmental fashion. The goal of these acceptance interventions is to create intimacy between the partners, as they are able to experience and see their problems in a new way. The second class of IBCT acceptance interventions, called tolerance interventions, is unlikely to promote greater intimacy by itself. However, as the name suggests, tolerance interventions can promote tolerance of aversive behaviors. Tolerance interventions include positive aspects of negative behavior, practicing negative behavior in session, faking negative behavior at home, and self-care. These strategies tend to be used after the primary acceptance interventions. Change interventions are the interventions described previously under TBCT. However, they are typically only employed when acceptance interventions have not achieved the desired results. Also, they tend to be applied in a less structured fashion than in TBCT, and the therapist moves easily back and forth between acceptance and change interventions. Because we described change interventions earlier, we will describe only acceptance interventions in the following pages.

Primary Acceptance Interventions

Empathic Joining. Couples in therapy are in a lot of pain. Yet they are so frustrated and angry that this pain is most often expressed through accusation and blame, which serves only to increase their distress. In empathic joining, the goal is to get past the anger and accusation to the original hurt. However, expressing the pain behind the accusation is a vulnerable thing to do, and typically, the last thing partners want to do in therapy is be vulnerable with one another.

The primary technique in empathic joining is for the therapist to help each partner express his or her strong emotions in ways that will lead to closeness and understanding through empathy. The formulation in the feedback session takes the first step toward empathic joining by reformulating the couple’s problems in light of their theme. As an example, Mary and Jim were in therapy following a brief affair by Jim. Following the revelation of the affair, the theme that ran through many of their arguments was control versus trust. Mary felt like she needed to have complete control in the relationship, virtually dictating everything Jim could and could not do, whereas Jim was very remorseful of his affair and wanted her to begin to trust him again. During the course of therapy, the therapist reformulated Mary’s controlling behavior, which was very aversive to Jim, as coming from her hurt and humiliation from the affair, as opposed to her desire to punish him or because of a “personality flaw” (e.g., “That’s just the way she is!”). The goal of empathic joining is to give both partners a different emotional view of their problems; ideally, they will experience the problem through their partner’s eyes.

Another useful approach in empathic joining is for the therapist to elicit the “soft” emotions underlying the “hard” emotions. As we noted, partners typically express their anger and frustration about problems. However, many times there is hurt or vulnerability.
at the root of the anger. Therapists may ask a partner directly whether there is an underlying, softer emotion, or they may suggest it (e.g., “If I were in your place, I might feel sad that your partner did what he did. Do you feel that way at all?”). An important aspect of a soft disclosure is that the primary “target” of the intervention is the partner hearing the soft disclosure and not necessarily the partner making the soft disclosure. Certainly, the intervention teaches partners to be vulnerable with one another, but a primary goal is that hearing the partner’s pain will provide a radically different view of the problem to the other partner. When one partner sees and hears the other’s sadness, it will cause the first partner to change his or her own perspective and behavior around the problem.

There is one final point to be made about “soft” and “hard” emotions. More often than not, couples in therapy express anger rather than hurt or express hurt in an angry way. Generally, a shift toward the expression of hurt without anger leads to a less adversarial, more constructive relationship. However, a different pattern may exist. For example, Aaron was threatening to leave Heidi. When he made his threats, Heidi would become very sad and cry, which served to infuriate Aaron and shut down any discussion of their problems. When the therapist helped Heidi to express some of her anger, Aaron experienced her not as pathetic but as strong. His view of her changed, and they were able to seriously discuss their relationship problems, as partners. Thus, although there are certainly common themes and patterns across couples, we never take behavior at face value; the function of the behavior always needs to be taken into account in fashioning interventions.

Unified Detachment. When couples arrive for therapy, there are typically several “lightning rod” topics. Often, partners are unable to discuss these issues because mere mention of the topics elicits extreme emotion. From a behavioral perspective, the topic has been repeatedly paired with an intense emotion, such that it is now classically conditioned. The mere presentation of the topic elicits the emotion without any intervening thought or discussion. As therapists, we would like to interrupt this sequence so that the couple can once again discuss the topic. One avenue for this is unified detachment.

The goal of unified detachment is for the partners to get some distance from the problem so that they are able to discuss the problem in an intellectual, nonemotional manner. One strategy to seek unified detachment is to discuss the problem as something beyond the two partners, as a kind of “third party”; this intervention is sometimes called “treating the problem as an ‘it.’” The therapist walks the couple through the sequence of events in a typical argument about the issue and may highlight when the problem “takes over.” For example, the therapist might note, “So that’s the point at which the problem gets the two of you. You go into this frustrating routine that neither of you feels able to stop.” Another strategy is to name the couple’s difficult interaction or the partners’ roles in it. This also serves to highlight the problem as an “it,” as opposed to a “you,” and can also inject some humor. For example, a couple in a pattern of criticism and defensiveness might label themselves the “district attorney” and the “hostile witness,” as a way of distancing themselves from the intense emotion involved in their pattern. In other strategies of unified detachment, the therapist engages the partners in an analytic effort to
compare and contrast different incidents of their problematic interactions or to rate their responses in a particular problematic incident. All of the strategies help the partners to step back, get “out of the ring,” and view their problems together with some intellectual detachment.

When unified detachment is successful, several changes take place. First, the couple’s experience of the problem changes from one in which the partners feel swept away by the problem to one in which they see the problem coming and have choices about how to proceed. Second, the couple is able to discuss the issue in a less emotional manner. Whereas previously intense emotion was always intertwined with the problem, now the couple is able to discuss it in a rational fashion. Finally, sometimes the process of identifying the problem as a third party gives the partners enough distance that they are able to completely stop the negative sequence. They see it coming and say, “Wait. Here comes the problem to get us. Let’s just side-step it.”

TOLERANCE INTERVENTIONS

As an adjunct to our primary acceptance strategies, we include tolerance interventions. IBCT therapists typically start off therapy with the primary acceptance interventions, but if those interventions do not prove effective, tolerance interventions are used. They can make difficult interactions less offensive, and when successful, they can provide an occasion for primary acceptance interventions.

Positive Aspects of Negative Behavior. The goal in this intervention is to highlight how issues and behaviors that the couple identifies as problems actually have certain positive characteristics. However, we need to raise a point of caution about this intervention. This is not a “silver lining” intervention, in which the therapist asserts, “There must be something positive in here.” For many problems that couples face, nothing is positive about them, and therapists should use this intervention only when they truly feel there is a positive component to the problem.

Oftentimes, the qualities that initially attracted the partners to one another now are a source of annoyance. These types of problems can be effectively targeted with positive aspects of negative behaviors. In these cases, the therapist may remind the partners of the aspect of the behavior that was once a source of attraction. For instance, the therapist can point out how the partners are very different in a certain way, and that this difference can be perceived in both a positive and a negative light. Whereas Kari once found Terence’s spontaneity fun and exciting, she now sees him as irresponsible. When the therapist presented the “two sides” of Terence’s behavior, Kari was able to recall that she valued this quality of Terence’s when they first met and to admit that there were things about Terence’s spontaneity that she continued to find enjoyable. It is important to keep in mind that tolerance interventions do not aim to create greater intimacy, though sometimes they can lead to that. The message is not that “Everything will be better” but that “This is the way things are, and there are some positive components to it.”

We have also used this intervention with affair couples. After the initial turmoil of the discovery has passed, many couples in which there has been an affair want to “just move on“ or get back to the relationship they had before the affair. We often note that they will never be the couple to whom the affair didn’t happen. However, for couples who have
made progress in therapy, we also may highlight the things they have learned about themselves and their relationship—the unanticipated, positive sequela of a negative event. For instance, Beth and Mark worked very hard in therapy for a year after Mark disclosed his affair. Although it was painful for both to realize the ways in which they would never be able to recapture elements of their pre-affair relationship, both acknowledged the value of what they had learned in the past year. Beth acknowledged a deeper understanding of Mark’s need for closeness and physical intimacy, which he often had difficulty expressing, and Mark acknowledged a more thorough understanding of Beth’s strong professional ambitions and goals, which previously he had tended to minimize or ignore.

Practicing Negative Behavior in Session. Another tolerance intervention is to have the partners “practice” their negative behavior during a therapy session. This intervention is somewhat similar to paradoxical interventions used in strategic therapy, in which the partners are instructed to engage in precisely the behaviors that they want to stop. The two interventions are similar, in that sometimes couples find it difficult to be negative “on demand,” though the intended effect is different. In IBCT, the primary purpose of practicing negative behavior in IBCT is to alter the context in which these negative behaviors occur and thus give the couples a different experience of the negative behaviors. This experience may desensitize couples to areas of significant distress; also, the exercise gives the therapist a firsthand experience of their problems. The therapist can intervene as needed if an argument escalates. In addition, this intervention affords an opportunity to move directly to empathic joining or unified detachment. If one or both members of the couple react emotionally to the negative behavior, then the therapist might use the occasion to promote empathic joining. If the couple reacts humorously to the enactment or is able to see it at a distance, then the therapist might use the occasion to foster unified detachment.

Emily would often criticize Jason, which would lead him to feel overwhelmed and not know how to respond. In these times, he would simply stare back at Emily, without saying anything. This would infuriate her all the more. The therapist asked the two of them to enact one of these interactions during session. Upon seeing their reenactment, the therapist was able to use empathic joining to expose the strong and vulnerable feelings that each experienced in these difficult interactions.

Faking Negative Behavior at Home. A similar tolerance strategy is to have the couple “fake” negative behavior at home. One partner is instructed to perform some negative behavior at home when he or she would not normally do so. It is crucial that this be done when the individual truly does not feel like engaging in the behavior. The person is instructed to “act out” the behavior for just a few minutes and then inform the partner that he or she was faking. Then, the two of them should debrief the experience together; specifically, the partner who faked the behavior can share with the partner what it was like to see that individual’s reaction. The intervention is designed so that, ideally, the person faking the behavior is not emotionally involved in the interaction and thus should be able to observe the partner from a detached position.

The primary goal of the intervention is to interrupt the couple’s negative interaction around the problematic issue, and this is accomplished in several ways. First, the
instructions are given in front of both partners. As a result, the “receiving” partner knows that the other one will fake behavior at some point during the week and often will be wondering when this will happen. This alone can serve to interrupt the negative behavior in some instances. Similarly, the partner who is planning to fake the argument will tend to monitor his or her own behavior more closely. If an actual argument does occur, it will likely be less emotional and less damaging. As we noted in our description of unified detachment, couples often experience their problems as being out of control—once the volatile topic is breached, they are on a roller coaster not of their own choosing. Through interrupting the typical progression of the argument, faking negative behavior can lead to a greater experience of control in heated exchanges. Whereas previously, the couple felt helpless to stop the interactions and the emotions that went along with it, now couples are able to see the argument coming and choose to stop it or at least discuss the topic in a much less heated fashion.

Self-Care. Partners provide many physical and emotional needs for one another. With some couples, one person may be particularly demanding that he or she needs the partner to perform some specific behavior. When these demands stall therapy or do not seem amenable to other interventions, we sometimes work with the individual to get his or her needs met in ways that do not involve the partner. When these needs are met from a different source, therapy can move forward again.

For example, Charleen was a very extraverted person and felt that she and James should talk much more frequently than they did. This was very difficult for James, as he was quite introverted and felt uncomfortable with frequent demands for verbal expression. The therapist affirmed that the two of them had different personalities and that neither one was right or wrong to want more or less conversation. In addition, the therapist encouraged Charleen to talk with her friends and family, while working to make conversation between James and Charleen more comfortable. With other outlets for her need for conversation, Charleen made fewer demands on James. With less demands, James was able to engage in discussion more easily with Charleen.

METHODS OF MODEL EVALUATION

As we noted earlier, the efficacy of BCT is no longer in question. Numerous clinical trials point to the ability of BCT to improve couples’ relationship satisfaction over the course of therapy. However, the question of how the therapy effects this change is largely unanswered, as research on the process of change in BCT is still in its nascent phase. In this section, we briefly review the existing process literature and mention areas for further research.

A number of studies have looked at possible mediators of the treatment effect in BCT. Whisman and Snyder (1997) define mediators in couple therapy as “those characteristics of the individual or couple that are changed by the treatment and which in turn produce change in outcome (e.g., relationship satisfaction)” (p. 683). A number of studies have shown that BCT changes couples’ behavior, including relationship-related behaviors (Baucom & Mehlman, 1984; Halford et al., 1993; Jacobson, 1984; Snyder & Wills, 1989) and communication patterns (Baucom & Mehlman, 1984; Hahlweg, Revenstorf, &
Schindler, 1984; Kelly & Halford, 1995; Snyder & Wills, 1989). Yet these changes in couple functioning have not, in turn, been shown to be related to relationship satisfaction in most instances. When changes in a mediator variable have been shown to be related to relationship satisfaction, the results have been difficult to interpret. For example, two studies have found an association between acquisition of positive communication skills and relationship satisfaction (Emmelkamp, van Linden, van den Heuvell, Sanderman, & Schololing, 1988; Sayers, Baucom, Sher, Weiss, & Heyman, 1991), yet other studies have found negative relationships between communication and outcome (Baucom & Mehlman, 1984; Hahlweg et al., 1984)! Thus, at the present date, the literature on mediators of change in BCT remains ambiguous.

There is a single study that directly assessed the differences between TBCT and IBCT with respect to therapy process. Cordova, Jacobson, and Christensen (1998) examined the impact of TBCT and IBCT on couples’ in-session behavior over the course of therapy. Six sessions (2 early, 2 middle, and 2 late) were rated, using a coding system developed to measure theoretically relevant couple behavior in 12 different couples. Cordova et al. found that couples who received IBCT showed greater expression of “soft” emotions at the end of therapy, relative to couples who had received TBCT. In addition, IBCT couples showed greater detachment in discussing their problems compared to TBCT couples. Finally, there was some modest evidence that increases in these couple behaviors were related to increases in relationship satisfaction. However, there is a possible confound in this study, in that the IBCT couples had greater overall gains in relationship satisfaction (Jacobson et al., 2001). It is possible that the differences in mediators between the two treatments reflect the difference in treatment gains, as opposed to different mechanisms of action.

There is a clear and pressing need for greater research on the process of change in BCT. As we understand how the therapy creates change, it will help us to know which aspects of the therapy are most crucial for that change. In addition, elucidating the process of change in BCT may help create more specific and effective goals in therapy for couples.

IMPLEMENTATION OF THE MODEL IN COMMUNITY/PRACTICE SETTINGS

Another active area of research with BCT is testing its effectiveness in community settings. There is significant anecdotal evidence of the effectiveness of BCT from researchers and research therapists involved in clinical trials, who also use BCT in their private practices. However, we are not aware of any research studies that show that BCT can successfully be transported from the research lab to the community. Although there is no specific research on the effectiveness of BCT in community settings, there are several research studies relevant to this issue.

Fals-Stewart and Birchler (2002) conducted a study examining whether bachelor’s-level counselors could be trained and could achieve similar results with BCT, as compared to master’s-level counselors. The authors found that bachelor’s-level counselors achieved similar ratings of treatment adherence to those of master’s-level
counselors but were rated lower in terms of competence in treatment delivery. However, couples seen by the two groups of counselors showed similar strong gains in relationship satisfaction. Although this was a research study with inclusion and exclusion criteria, the findings hold out optimism that the skills required to effectively deliver BCT can be learned by counselors with little formal training in psychotherapy.

Though not focusing specifically on BCT, we think it is worth briefly mentioning the single, significant study of marital therapy in community settings. Hahlweg and Klann (1997) examined the outcomes of couples receiving marital therapy in Germany. Therapy was in no way limited to BCT, and, in fact, only 17% of the therapists identified themselves as behavior therapists. The marital therapy outcomes achieved in this community-based sample were far below what is typically found in research studies. The overall effect size was small ($d=0.28$), compared to that found for efficacy studies of marital therapy in general ($d=0.60$; Shadish et al., 1993) and efficacy studies of BCT in particular ($d=0.95$; Hahlweg & Markman, 1988). However, the Hahlweg and Klann study did not specifically look at BCT, and there are many alternative explanations for the small effects. Nonetheless, it is a discouraging finding regarding the effectiveness of marital therapy in the community.

One final obstacle to the effective dissemination of BCT to the community is the lack of research on diversity. It is true that BCT has been shown to be effective in several countries outside the United States, including Germany, Australia, and the Netherlands. However, these countries all share a similar Western worldview, and the research samples have been largely Caucasian. Thus far, there have been no studies specifically focusing on the efficacy of BCT with ethnic minorities, either within the United States or elsewhere. Like much clinical research, samples have been largely Caucasian and middle class. There is a pressing need for greater diversity in research samples.

CONCLUSIONS

At this point in its evolution, BCT has arrayed an impressive body of research support, and basic questions regarding its efficacy to help distressed couples have been answered. On-going research explores extensions to the basic TBCT model, and IBCT is one post-TBCT therapy that has shown some promising initial results. Despite this impressive track record, there are still numerous pursuits for researchers and clinicians interested in the ongoing development of BCT. In particular, further research and study are needed to understand how the therapy achieves its results and whether BCT can be as effective in the community as it is in the lab. Furthermore, greater attention needs to be paid to the issue of diversity, particularly with respect to race and socioeconomic status.

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