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Interventions for Couples

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Abstract

Because relationship discord and dissolution are common and costly, interventions are needed to treat distressed couples and to prevent distress among vulnerable couples. We review meta-analytic evidence showing that 60–80% of distressed couples benefit from behavioral and emotion-focused approaches to couple therapy, but we also note that treatment effects are weaker in actual clinical practice than in controlled studies, dissipate following treatment for about half of all couples, and may be explained by factors that are common across models. Meta-analyses of prevention programs reveal reliable but smaller effects, reflecting a need to know more about whether and how communication mediates effects, about how risk and diversity moderate effects, and about how technology-enabled interventions can reduce attrition in vulnerable populations. Interventions for couples are improving and expanding, but critical questions remain about how and for whom they work.

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1. BACKGROUND AND RATIONALE FOR INTERVENING WITH COUPLES

In all societies and cultures, people derive security, contentment, and a sense of purpose from their intimate relationships. Establishing a committed partnership is a major developmental milestone (see, e.g., Arnett 2014), and adults often invest great effort in initiating and nurturing these close social bonds. Our instinct to form pair-bonds is well founded. Loneliness, or the absence of close social ties, is profoundly debilitating at all stages of life (see, e.g., Holt-Lunstad et al. 2015), while stable and fulfilling relationships promote emotional well-being, success at work, better health habits, lower health care costs, and longer lives (see, e.g., Holt-Lunstad 2018, Kiecolt-Glaser & Wilson 2017). Lasting partnerships also facilitate effective parenting, contribute to the healthy development of any children that couples are raising, and enable adults to accumulate more wealth and pass it along to the next generation. While selection effects account for some of these benefits—that is, healthier individuals tend to enter into and enjoy healthier relationships as a consequence—people also appear to derive real protection from their intimate relationships that is not readily attained elsewhere (for a review, see Halford & Snyder 2012).

Unfortunately, the fact that relationships can yield great benefits provides no guarantee that they will do so. Creating and maintaining relationships is challenging, individuals and their life circumstances can change in unexpected ways, partners will inevitably disagree about their goals and interests, and a relationship that was once sought as a refuge from the demands of daily living often becomes an acute source of stress instead (see, e.g., Am. Psychol. Assoc. 2010). Ample evidence documents the instability and unhappiness that people experience within intimate relationships. At least 40% of all first marriages end in divorce or permanent separation, roughly 30% of people in intact marriages report being unhappy, and distress and dissolution rates for remarried and unmarried couples are even higher (Copen et al. 2012, Whisman et al. 2008). While not everyone who is in a distressed or deteriorating relationship will seek professional help—estimates suggest that roughly one-third of all divorcing couples do so (Johnson et al. 2002)—many unhappy couples do take steps to preserve their relationship, making relationship problems the most common reason why anyone seeks formal counseling (Swindle et al. 2000).

As scholars and as practitioners, clinical psychologists have been at the forefront of meeting this need by developing and testing interventions that prevent or alleviate relationship distress and by working directly with couples to generate lasting improvements in their relationships. Many of the

aforementioned factors that make relationships challenging also compromise professional efforts to modify couples' interpersonal repertoires, including enduring characteristics of the partners themselves (e.g., early traumas, disrupted family relationships, enduring psychological vulnerabilities); patterns of interaction that reflect or portend distress (e.g., hostile conflict, emotional disengagement); unresolved betrayals that instill fear or mistrust (e.g., infidelity, aggression); and various forms of stress, social and economic disadvantage, and unexpected life events (e.g., job loss, infertility, chronic health problems). Couple relationships and relationship distress are remarkably heterogeneous, and the impact of interventions designed to change couples must be judged in light of these complexities.

Despite these challenges, notable progress has been made in the past decade toward improving intimate relationships, as evidenced by major new outcome studies, innovative efforts to specify treatment mechanisms, growing appreciation for the diverse needs of couples, and ambitious calls for integration across treatment models. In this review we summarize and evaluate this literature, drawing upon core themes used in prior reviews (Christensen & Heavey 1999, Fincham & Beach 1999, Halford & Snyder 2012, Johnson & Lebow 2000, Lebow et al. 2012, Snyder et al. 2006) to identify critical research needs for the decade ahead. We consider interventions for distressed couples as well as interventions designed to prevent relationship distress; we begin by discussing the established effects of couple therapy on relationship distress.

2. INTERVENTIONS DESIGNED TO ALLEVIATE RELATIONSHIP DISTRESS

Although couple therapists monitor outcomes that are not overtly relational (e.g., depressive symptoms, health-related concerns, child well-being) and sometimes collaborate with couples to dissolve their relationship, couple therapy is typically undertaken with the goal of enhancing partners' subjective evaluations of the relationship. Determining how well couple therapy enhances relationship quality involves critiquing the magnitude and durability of treatment effects, the clinical practices and mechanisms hypothesized to generate these effects, and the extent to which robust effects are obtained across a wide range of settings, couples, and presenting problems (Sexton et al. 2011).

2.1. Established Effects of Couple Therapy

Scholars and practitioners seeking to understand the effects of couple therapy are able to draw from an extensive body of research. As summarized below, meta-analytic syntheses within this literature are frequently employed to establish how well treatments perform in research settings and in clinical settings with couples experiencing relatively common concerns (e.g., unresolved conflict, growing disengagement) as well as special relationship issues (e.g., infidelity, physical aggression) and for relationships in which one partner is contending with a chronic medical or psychological condition.

2.1.1. Treatment effects in controlled settings. Many approaches to couple therapy are in use (see Gurman et al. 2015), and meta-analyses of randomized controlled trials (RCTs) of several such approaches demonstrate that the average distressed partner reports better relationship functioning at the end of treatment than 80% of otherwise identical couples receiving no treatment (mean $d = 0.84$) (see Shadish & Baldwin 2003). Only a small subset of these treatments have been subjected to repeated empirical tests, however, and research attention has largely converged on two promising models. Behavioral couple therapy (BCT), which arose from principles of

operant learning theory, aims to restore positive exchanges between partners while also neutralizing actions that interfere with their effective problem solving (Jacobson & Margolin 1979, Stuart 1969). Emotion-focused couple therapy (EFCT), which arose from principles of attachment theory, aims to facilitate expression of primary emotions (e.g., vulnerability, hurt, inadequacy) rather than divisive secondary emotions (e.g., anger, contempt, scorn), thereby enhancing empathy and reducing attachment insecurity (Johnson & Greenberg 1985, Johnson et al. 1999). As detailed below, BCT and EFCT are the strongest couple therapies evaluated to date, and at present, claims about treatment efficacy are largely restricted to these models and others with highly similar conceptual emphases and formats (e.g., cognitive behavioral couple therapy) (D.H. Baucom et al. 2015).

Meta-analytic summaries of pre–post effects are highly varied but support the efficacy of learning-based and attachment-based approaches to alleviating distress. For BCT, reported effect sizes include $d = 0.53$ (21 studies; Rathgeber et al. 2019), $d = 0.59$ (30 studies; Shadish & Baldwin 2005), $d = 0.79$ (11 studies; Dunn & Schwebel 1995), $d = 0.82$ (17 studies; Baucom et al. 2003), and $d = 0.95$ (7 studies; Byrne et al. 2004). For EFCT, pre–post reported effect sizes include $d = 0.73$ (12 studies; Rathgeber et al. 2019), $d = 1.27$ (7 studies; Byrne et al. 2004), $d = 1.31$ (4 studies; Johnson et al. 1999), and $d = 2.09$ (9 studies; Beasley & Ager 2019). Recent studies not included in these meta-analyses corroborate the pre–post effects of BCT [yielding a d of 0.86 and leaving 44% of couples fully recovered, 17% improved but not fully recovered, 21% unchanged, and 18% dissolved or reporting greater distress at termination; $N = 134$ (Christensen et al. 2004)] and the pre–post effects of EFCT [yielding a d of 0.81, with 61% fully recovered, 11% improved but not recovered, 25% unchanged, and 4% deteriorating; $N = 28$ (Wiebe et al. 2017)]. Taken together, meta-analyses of existing efficacy studies continue to support an approximate d of at least 0.80 for BCT and EFCT, with 60–72% of couples experiencing reliable pre–post improvements in satisfaction.

Interpretation of these effects is qualified by the marked heterogeneity in the meta-analyses and in the studies and samples included in these meta-analyses, by small sample sizes in many trials, and by the tendency for the developers of the interventions to be centrally involved in testing them. Furthermore, interpretation must consider the possibility that uncontrolled placebo effects are inflating treatment effects to an unknown degree, insofar as passive no-treatment groups are employed as comparison conditions. Meaningful conclusions about the relative effects of behavioral and emotion-focused models are unwarranted because they have not been compared directly and because studies supporting BCT and EFCT may not draw from the same population of relationship distress in the same ways.

Over the years, growing evidence reaffirming the efficacy of couple therapy at termination has spawned RCTs intended to yield incremental benefits beyond established treatment models. These head-to-head comparisons of alternative interventions rarely reveal any approach as superior (see, e.g., Shadish & Baldwin 2005), and research in the past decade has confirmed this conclusion. Most notably, Christensen and colleagues' (2004) study of BCT also randomized couples to a second intervention—integrative behavioral couple therapy (IBCT) (Jacobson & Christensen 1996)—which “focuses more on the emotional reactions of partners to the difficulties they encounter in their relationships and less on the active solutions they can take to resolve these difficulties, especially for what seem to be insoluble problems” (Christensen et al. 2004, p. 180). Despite a large sample and demonstrably different approaches to treatment, BCT and IBCT couples did not differ at termination on change in satisfaction, affective communication, or problem-solving communication. Overall, at termination, 48% of BCT and IBCT couples had recovered, another 18% had improved in satisfaction but not to the point of full recovery, 21% had not changed, and 13% had deteriorated ($N = 130$) (see Christensen et al. 2006). Earlier

concerns that low statistical power might account for the failure to find differential treatment effects have been largely allayed by this important study.

As enduring change in relationships is the overriding goal of couple therapy, long-term follow-up data are essential for evaluating claims of treatment efficacy. Such data are rare, but studies in the past decade have shed new light on couple outcomes 2 and 5 years after termination of treatment. At 2 years, BCT leads to full recovery for 37% of couples, to improvement without full recovery for 23%, to no change for 15%, and to deterioration or dissolution for 25% ($N = 60$ couples) (Christensen et al. 2006). EFCT leads to full recovery for 39% of couples, to improvement but not full recovery for 7%, to no change for 21%, and to deterioration or dissolution for 32% ($N = 28$ couples) (Wiebe et al. 2017; see also Beasley & Ager 2019). Thus, 2 years following termination, nearly 40% of distressed couples participating in one of the two leading forms of couple therapy will have moved into the satisfied range of functioning. Another 23% (in BCT) and 7% (in EFCT) will have improved but remain distressed, and 40–51% will have deteriorated, dissolved, or gone unchanged. Five years after BCT, 33% of couples will have recovered, 13% will have improved but remain distressed, and 54% will have deteriorated, dissolved, or gone unchanged ($N = 61$ couples); parallel figures for IBCT are similar, with 31% recovering, 19% improving but still distressed, and 50% deteriorating, dissolving, or not changing ($N = 58$ couples) (Christensen et al. 2010).

Caution should be exercised when interpreting these outcome statistics, particularly with rates of dissolution. As Lebow (2015, p. 447) notes, “Although divorce can be taken as obvious evidence of the failure of couple treatment to improve marital satisfaction, it can also represent a transition through which one or both partners come to feel better and improve in individual functioning.” Thus, the clinical significance of tested interventions may be stronger than the simple box score suggests, as some couples assigned to the dissolved category may be treatment successes depending on the nature of the case. On balance, then, many distressed couples will experience lasting benefits from behavioral and emotion-focused interventions, with the majority of these successful cases entering the satisfied range of functioning.

2.1.2. Treatment effects in applied settings. Couple therapy as tested in randomized, controlled efficacy studies bears little resemblance to couple therapy as it is commonly practiced, and as a consequence outcome research provides therapists with little immediate guidance for improving their day-to-day clinical practice (Gurman 2011, Halford et al. 2016). Effectiveness studies, in comparison, scrutinize treatment effects in natural settings and provide a glimpse into whether interventions also benefit treatment-seeking couples in more typical settings. Publication of effectiveness studies has accelerated in recent years, and 9 pertinent studies can now be combined to produce an unweighted within-group pre–post effect size of approximately $d = 0.45$ – 0.50 across a variety of theoretical approaches (see Hewison et al. 2016, Owen et al. 2019). About half of all couples in effectiveness studies fail to complete therapy, and while as many as 40% of couples will achieve a nonclinical level of relationship adjustment at their last session, 30–60% of them will relapse back to pretreatment levels at some point after termination (Roesler 2019).

Several factors constrain interpretation of these effects, some that probably suppress effects (e.g., fewer sessions of treatment compared with efficacy trials), some that probably inflate effects (e.g., high rates of attrition, absence of randomization and thus self-selection of motivated couples into treatment), others that limit comparisons among studies (e.g., heterogeneity in settings, measures, samples, and theoretical orientations), and others still that preclude strong conclusions about the durability of effects (i.e., lack of long-term follow-up data; see, e.g., Nowlan et al. 2017). Bearing these constraints in mind, while the modal couple seeking treatment in a typical community setting probably does not benefit from couple therapy, the couple receiving treatment likely experiences moderate pre–post gains in satisfaction, albeit of unknown durability.

2.1.3. Couple therapy for special relationship issues. Evidence for the maturation of couple therapy comes from studies testing behavioral and emotion-focused interventions with couples who are undergoing emotionally charged events within their relationship (see Baucom et al. 2017). With infidelity, for example, couples enter therapy with very low satisfaction levels and go on to divorce at high rates even with therapy, particularly if the affair is not disclosed during treatment (Marín et al. 2014). When infidelity is raised as a topic in therapy, however, these couples respond as well to BCT and IBCT as those couples with no experience of infidelity, with no differences in 5-year relationship satisfaction levels or divorce rates (Marín et al. 2014). EFCT casts a broader net around betrayals, recognizing that a variety of attachment injuries—that is, “perceived abandonment, betrayal, or breach of trust in a critical moment of need” (Makinen & Johnson 2006, p. 1055)—can transform the injured partner’s perceptions of the offending mate, instigate self-perpetuating cycles of blame and withdrawal, and thus block repair efforts (Halchuk et al. 2010). EFCT aims to resolve these betrayals through a series of phases (e.g., the injured partner conveys the pain that he or she has experienced and the loss of attachment that he or she has suffered, while the offending partner empathizes with these feelings of vulnerability and expresses remorse) and generates improvements in relationship satisfaction, trust, and forgiveness that persist over 3 years (Halchuk et al. 2010). When coupled with meta-analytic findings showing that BCT can reduce male- and female-perpetrated acts of situational couple violence ($d = 0.84$ with 6 studies) (Karakurt et al. 2016), we see good evidence that leading models of couple therapy can accommodate problems that go well beyond emotional disengagement, poor problem solving, and simple deficits in communication.

2.1.4. Couple therapy for psychopathology and medical conditions. Couple therapy is commonly aimed at improving relationship quality, yet the principles used to change relationships can be adapted and directed toward reducing symptoms of psychopathology and improving adjustment to chronic health problems (see Meis et al. 2013). Indeed, compared with individual therapy, couple therapy may hold a special advantage for treating individually based conditions as practitioners gain access to the immediate interpersonal contexts in which many maladaptive individual behaviors occur (e.g., alcohol and drug consumption, medication noncompliance) and to the supportive behaviors that partners exchange (and neglect to exchange) as they contend with these difficulties. Working with couples to address individual problems dramatically expands the reach of couple therapy, and over the past decade the empirical foundation for this work has grown considerably. Cognitive behavioral formulations guide most tested treatments, though individual studies vary widely in approach, setting, and rigor and in the degree to which relational versus individual concerns are addressed in treatment.

The accumulated evidence on couple therapy for psychopathology closely tracks those conditions that are most prevalent and costly. A meta-analysis of couple therapy effects on depression—primarily moderate levels of depression—revealed no clear differences between couple therapy and a range of effective individual psychotherapies ($d = -0.17$ on 9 studies) (Barbato et al. 2018). However, couple therapy outperforms individual therapy for relationship distress ($d = 0.50$ on 6 studies), particularly for the most distressed couples ($d = 1.1$). This suggests that couple therapy is the treatment of choice when one partner is depressed within a distressed relationship (Barbato et al. 2018). A recent effectiveness study of 61 couples receiving an average of 11 sessions of behavioral couple therapy for depression (BCT-D) yielded large effects on depression for the depressed client (within-group $d = 2.2$) and for the partner ($d = 0.79$) and smaller effects on relationship satisfaction for the depressed client ($d = 0.43$) and the partner ($d = 0.21$). When depression is treated in higher-functioning couples, a therapeutic focus on dyadic coping and stress management appears to be effective, in part because it reduces criticism directed at the depressed

patient (Bodenmann et al. 2008). Thus, evidence now consistently validates the view that the couple relationship is a useful setting for treating moderate symptoms of depression (Baucom et al. 2014).

Alcohol and drug problems commonly come to the attention of couple therapists, and emphases within the behavioral perspective make BCT especially applicable to substance use treatment (e.g., reducing specific behaviors that trigger use, decreasing situational exposure to alcohol and drugs, recognizing consequences that maintain consumption; see McCrady et al. 2016, O'Farrell & Clements 2012). A meta-analysis of RCTs testing behavioral treatments for alcohol use disorders demonstrated that BCT was stronger than individual-based treatment for decreasing frequency of use (e.g., proportion of days absent) and the adverse consequences of use (e.g., arrests, hospitalizations) while also increasing relationship satisfaction (overall $d = 0.54$ at termination and 0.48 through 6- to 12-month follow-ups) (Powers et al. 2008). While it is not yet clear whether treatment-instigated improvements in a relationship mediate treatment effects on substance use (McCrady et al. 2016), the identified patient's growing awareness of the partner's compassion and care appears to be a crucial element in treatment (Walitzer et al. 2013). In turn, enhancing focus on the quality of couple communication (i.e., by treating couples in conjoint couple therapy rather than in couples' groups) serves to increase the effects of BCT on adverse consequences of consumption (from $d = 0.91$ to 1.68) and on relationship satisfaction ($d = 0.23$ to 0.82) (O'Farrell et al. 2016), underscoring potential advantages that the relational context has for decreasing alcohol dependence.

Finally, recognition that many medical conditions have repercussions beyond the diagnosed patient has led to the development of interventions for couples contending with various cancers, cardiovascular disease, pain, HIV, diabetes, and other chronic health conditions (Fischer et al. 2016). While couple-level interventions hold great potential in this domain, realization of this potential has been hampered by the highly varied nature of treatment targets and by uncertainty over the relational processes most likely to yield changes in these targets (Baucom et al. 2012, Fischer et al. 2016). Nevertheless, couple-based interventions for patients with cancer, in particular, show promise: Meta-analyses demonstrate small but reliable effects on the cancer patient's quality of life, psychosocial distress, couple communication, and relationship satisfaction [e.g., d ranging from 0.25 to 0.31, based on 10–17 studies (Badr & Krebs 2013)] relative to standard care. The psychological and relational well-being of partners typically improve as well, with d ranging from 0.21 to 0.24 across 7–12 studies (Badr & Krebs 2013; see also Badr et al. 2019, Berry et al. 2017).

Careful management of the emotional disclosures and supportive behaviors exchanged between patients and partners may be a critical ingredient in these interventions (Traa et al. 2015). For example, in an RCT comparing treatment-as-usual with a four-session BCT-based intervention designed to promote discussion of cancer-related concerns and feelings, couples improved in intimacy and relationship quality—particularly if the patient was inclined at baseline to hold back on sharing these emotions (Porter et al. 2009). EFCT, which frames serious medical problems as an opportunity to increase emotional engagement and strengthen partners' attachment bonds in the face of profound threat, shows success with couples in which one partner has terminal metastatic cancer: Compared with standard care, EFCT improved patients' relationship satisfaction and perceptions of caregiver empathy ($d = 1.0$) and resulted in high rates of clinical improvement in satisfaction (91% versus 28% of controls) (McLean et al. 2013). In short, while their generalizability and adaptability to other medical diagnoses are not yet established, interventions that exploit partners' capacities to form strong emotional connections work reasonably well for couples facing cancer and therefore might serve as a template for other disabling and destabilizing conditions.

2.2. Increasing the Impact of Couple Therapy

With increased clarity about the benefits, and limits, of couple therapy, attention is now shifting to consider ways in which the impact of couple therapy can be increased. Five strategies, primarily oriented toward extracting more information from couples and deploying it in real time during treatment, hold special promise.

2.2.1. Assessing goals and commitment early in treatment. Given that many couples in efficacy and effectiveness studies either fail to respond or respond poorly to treatment, efforts are underway to determine the extent to which partners' concerns and goals prior to therapy foreshadow eventual outcomes. While many couples seek therapy to improve their relationship, as many as half present with concerns about a possible divorce or separation, feelings of hopelessness about improvement, and uncertainty about whether the relationship can be preserved (Doss et al. 2004). For those couples seeking improvement, fewer than 10% eventually separate within 6 months of treatment. In contrast, whereas 45% separate if only one partner seeks improvement, 56% will separate if both partners enter therapy with the goal of determining whether the relationship is viable (Owen et al. 2012). Lower pretreatment reports of commitment also predict poorer treatment response 5 years after terminating IBCT or BCT (B.R. Baucom et al. 2015). Because treatment effects are likely moderated by initial goals for therapy and by commitment to the relationship, inclusion of couples who are already far down the path toward separation inadvertently reduces effect sizes. Systematic identification and triaging of these couples to services focused specifically on constructive separation (Lebow 2015) or on reconciling and restoring commitment prior to formal couple therapy (i.e., discernment counseling; see Doherty et al. 2016) would strengthen effect sizes by ensuring closer alignment between client goals and the primary intent of couple therapies.

2.2.2. Implementing measurement-based care. Close correspondence between clients' goals for relationship improvement and the intervention designed to generate that improvement provides no assurance that treatment will progress as intended. Couples' needs and concerns may not conform to structured treatment protocols, the strength of alliances between therapists and partners can fluctuate, and therapists often overlook client downturns in motivation and functioning (see, e.g., Hatfield et al. 2010). To counteract these effects, session-by-session monitoring and feedback of symptoms have been used to generate better treatment outcomes, at least in individual therapy ($d = 0.4$) (Lambert et al. 2018). In couples therapy, monitoring relationship quality reveals that roughly 33% of couples are "off track" after three sessions of treatment and that 59% are off track after seven sessions (Pepping et al. 2015); nearly 70% of off-track couples fail to benefit from treatment compared with only 29% of the "on-track" cases (Halford et al. 2012).

Experimental studies show that session-by-session monitoring of treatment progress and alliance formation, when made available to clients and therapists, more than doubles the likelihood of recovery or reliable improvement at termination relative to an unmonitored control group [23% versus 51% in the study by Anker et al. (2009); 32% versus 65% in the study by Reese et al. (2010)], a difference that is sustained over 6 months (19% versus 48%) (Anker et al. 2009). The eventual success of such patient-focused research or measurement-based care (Lambert et al. 2001) will likely depend on whether assessment tools provide couple therapists with actionable information that is unavailable from other sources. Nevertheless, the immediacy of session-by-session data appears to enable reliable detection and correction of off-track cases through specific if-then contingencies (e.g., if no progress is evident over recent sessions, then backtrack and re-double efforts on prior modules, revisit alliances, or introduce alternative treatment components; see Halford et al. 2016).

2.2.3. Restoring positive exchanges in couples' repertoires. Efficacy studies are now clear in demonstrating that the beneficial effects of all leading treatments fade with the passing of time (Christensen et al. 2010, Wiebe et al. 2017) and that they do so in a predictable pattern. With BCT and IBCT, for example, 87% of couples who show deterioration at termination remain in this category 5 years later (Christensen et al. 2010), consistent with evidence that relationship distress rarely remits spontaneously (Baucom et al. 2003). Among couples who reliably improve or fully recover by the end of treatment, only about half remain in these categories over the next 5 years, and the other half revert to pretreatment levels of satisfaction or deteriorate even further (Christensen et al. 2010). These results prompt important questions about whether long-term posttreatment effects can be strengthened by engendering specific behavioral changes in the later stages of therapy.

What can we learn from couples' behavioral changes over the course of therapy, or from their behavioral performance at the end of therapy, that would help explain why some sustain their gains while others do not? With BCT and IBCT, those who continue to respond favorably to treatment 5 years following termination are distinguished by greater levels of problem solving, more positive behavior, more reciprocation of positive behavior, more empathy during posttreatment problem-solving conversations, and increases in observed positivity from pretreatment to posttreatment. In contrast, changes in negativity and withdrawal, and posttreatment levels of negativity and withdrawal, are unrelated to 5-year outcomes (Baucom et al. 2011, K.J. Baucom et al. 2015). While couple therapy reduces negativity and withdrawal on average for all couples in BCT and IBCT (Baucom et al. 2011), this new evidence indicates that positive behaviors and emotions in couples' behavioral repertoires at the time of termination will prove most diagnostic in predicting which couples will sustain their benefits after treatment is complete. Unfortunately, improving partners' positive experiences in relationships is substantially more difficult than reducing their negative experiences [e.g., $d = 0.15$ versus 0.57 (Doss et al. 2016)]. Thus, systematic assessment of couples' capacities to create, share, and capitalize on positive experiences, particularly in moments of vulnerability and in conversations where partners might be inclined to respond with complaints or criticism, could indicate when different interventions or booster sessions might be useful, thereby strengthening long-term treatment effects.

2.2.4. Explaining how couple therapy generates effects. Although judicious use of RCTs has been instrumental in clarifying how specific approaches to treatment yield outcomes of a particular magnitude, this approach fails to provide a detailed accounting of the changes that partners and couples undergo as they achieve these outcomes. Filling this gap is likely to be crucial for strengthening treatment effects because "by understanding the processes that account for therapeutic change one ought to be better able to optimize therapeutic change. . . . If we know how changes come about, perhaps we can direct better, stronger, different, or more strategies that trigger the critical change process(es)" (Kazdin 2007, p. 4).

Early studies showed that behavioral and emotion-focused treatments did sometimes elicit desired changes in key therapy targets (e.g., observed communication), yet in many instances these changes were unrelated to changes in satisfaction at termination (Doss 2004). Clearer results emerged, however, when more frequent assessments were conducted over the course of treatment (e.g., Doss et al. 2005) and when observational data were used to analyze therapy sessions (e.g., Bradley & Furrow 2004), thus prompting a new wave of couple therapy process research.

Consistent with the premises of EFCT, for example, improvements in relationship satisfaction have been shown to correspond with specific in-session evidence of deeper emotional responses, intimate disclosures and the affiliative responses they elicit, and resolution of attachment injuries (see, e.g., McKinnon & Greenberg 2017). In particular, blamer-softening events—wherein the

blaming partner's newly expressed need for closeness is rewarded by a previously withdrawn partner's empathy (Johnson & Whiffen 1999)—have been the focus of several analyses, which have demonstrated that the process of softening covaries with session-by-session increases in satisfaction and in attachment security (e.g., Burgess Moser et al. 2018). Discrete therapist tactics that shift clients away from divisive secondary emotions and toward vulnerable primary emotions are also being specified (e.g., Zuccarini et al. 2013), as are therapist tactics that result in greater displays of warmth between partners (e.g., Schade et al. 2015).

More general mechanisms believed to underlie treatment effects have also been examined, often with larger samples, more frequent assessments, and formal tests of mediation. For example, prior to each session of a communication-based treatment, Doss and colleagues (2015) asked partners to evaluate their preceding week, focusing on reports of communication quality, emotional closeness, frequencies of specific partner behaviors targeted during treatment, and psychological distress. Men and women subsequently reported greater relationship satisfaction to the extent that they had experienced greater emotional closeness (and, for men, less psychological distress); communication and the frequency of specific partner behaviors made no incremental contribution to satisfaction ratings (Doss et al. 2015).

In-session behaviors have also been examined in relation to treatment outcome. For example, observational coding of positive and negative behaviors displayed over the course of nine IBCT therapy sessions per couple revealed that couples responding favorably to treatment experienced their lowest levels of positivity and highest levels of negativity about midway through treatment. Nonresponders, in contrast, simply decreased in positivity and increased in negativity across sessions (Sevier et al. 2015). These findings track the manner in which IBCT is designed to progress: Sources of friction are aired, unified detachment and empathic joining are then encouraged, and growth in acceptance and tolerance results in more positive and fewer negative exchanges (Jacobson & Christensen 1996). In sum, while formal experiments and discriminative tests are needed to establish that hypothesized mechanisms are responsible for treatment progress and treatment outcomes, recent work has broken new ground by suggesting that intensive assessments can illuminate the psychological and behavioral processes that restore healthy relationship functioning.

2.2.5. Developing a unified protocol for couple therapy. The quest for better couple therapies has been guided by a few powerful and encompassing conceptions of intimacy, and translation of these concepts into testable interventions has produced treatments that we now know to be efficacious. Far less is known about how couple therapies generate their effects, and several factors suggest that treatment effects are unlikely to grow much stronger with current approaches. For example, theory-driven RCTs as currently conducted may be reaching their upper limit on treatment effects and, as noted earlier, are unlikely to reveal any one model as superior. Second, practitioners are unlikely to change their approach to treatment based on efficacy studies; they are more likely to adapt their preferred approach based on general principles that are shown to improve outcomes (Gurman 2011). And third, common factors covary with treatment outcomes. While the evidence remains largely correlational (Cuijpers et al. 2019), the quality of the alliance between clients and the therapist reliably predicts outcomes in individual therapy ($d = 0.58$ on 295 studies) (Flückiger et al. 2018) and in couple and family therapy ($d = 0.62$ on 48 studies) (Friedlander et al. 2018).

On this point, Davis et al. (2012) argue that precedence should be given less to overarching models and more to their common principles, particularly because most models likely overlap in their capacity to bring about change in key couple processes. Tested couple therapies therefore might all perform to the same standard because they are equally proficient at tapping similar

mechanisms at pivotal moments, and effects might all deteriorate at comparable rates because treatments are similar in their inability to help couples sustain their relationships long after treatment (Davis et al. 2012). Broad treatment models remain important for directing practitioners through the complexities of any given case, yet as Davis et al. (2012, p. 44) indicate, the common-factors view challenges “the claim that models work primarily through mechanisms that are unique to that model. Rather, we believe effective models are the vehicles through which common factors operate.”

What might these common factors be? To the list of characteristics that would be desirable for any form of effective therapy—for instance, competent therapists, motivated and engaged clients, session-by-session monitoring of progress (Davis et al. 2012)—Christensen (2010) adds five goals that practitioners must accomplish to bring about improvements in couple relationships:

1. Provide a contextualized, dyadic, objective conceptualization of problems.
2. Modify emotion-driven, dysfunctional, and destructive interpersonal behavior.
3. Elicit avoided, emotion-based private behavior.
4. Foster productive communication.
5. Emphasize strengths and encourage positive behavior.

Important questions remain about how to sequence these principles, how to activate them with specific couples, and how to study them, but a common-factors, mechanism-based approach to understanding processes of couple therapy could prove advantageous (*a*) for increasing uptake of empirically supported treatment principles into applied clinical settings, (*b*) for gaining clarity on the changes that must occur during treatment to produce lasting effects, (*c*) for encouraging routine data collection in clinical practice along dimensions that would be familiar to practitioners and researchers, (*d*) for identifying highly specific and effective tactics that practitioners of all orientations can incorporate into their work, and (*e*) for establishing a core set of treatment targets that could be adapted across a wide range of psychological disorders and medical conditions. Perhaps the most sweeping implication of a “bottom-up” approach (Christensen 2010) to improving couple therapy outcomes is that any couple therapy case could be subjected to empirical analysis, as practitioners revise and refine the specific tactics that will instigate change in specific mechanisms and in partners’ global experience of their relationship.

3. INTERVENTIONS DESIGNED TO PREVENT RELATIONSHIP DISTRESS

Whereas clinical interventions focus on couples seeking to alleviate an acute state of distress, preventive interventions aim to reduce the chances that a well-functioning relationship will ever become distressed or that a vulnerable relationship will deteriorate further. Couple therapists, as we have seen, tailor their approach to the unique demands of a specific couple, deliver their intervention intensively in conjoint sessions over a span of several months, and develop a working alliance with the couple to effect long-term change. Prevention programs, in contrast, adopt an educational format, providing relatively similar content and experiences to many couples, often in group settings and over shorter spans of time, with far less emphasis on the therapeutic alliance. Because many distressed couples dissolve their relationships without seeking couple therapy, or seek help too late for therapy to be beneficial, prevention programs fill an important gap in the field and have great potential to help many couples. Below, we review prevention programs for couples, which we define as all interventions for couples that take place outside of a traditional clinical context.

3.1. Established Effects of Prevention Programs for Couples

Although preventive interventions for couples were developed in the shadow of couple therapy, this subfield has grown rapidly on its own and now encompasses a range of educational interventions aimed at large segments of the population, including those couples who are generally faring well in their relationships (i.e., primary prevention) as well as the subset of couples who are at elevated risk for relationship difficulties but who are not yet acutely distressed (i.e., secondary prevention). Separate interventions are also undertaken with couples who may require special attention, by virtue of key developmental milestones within their relationship (e.g., the impending arrival of the first child) or the social and demographic circumstances within which their relationship is located (e.g., economic deprivation). Communication processes have typically served as the central target within these interventions, but, as we note below, this emphasis is now expanding to consider the unique idiographic features that characterize couples' relationships.

3.1.1. Primary prevention of relationship distress. Prevention programming for couples, also known as couple relationship education (CRE), first gained momentum after relationship scientists recognized a consistent correlation between specific patterns of maladaptive communication and relationship dissatisfaction among established couples (see, e.g., Margolin & Wampold 1981). Working from the assumption that these interactional patterns were modifiable among satisfied couples and were a cause of eventual distress, intervention programs were designed to teach couples how to communicate more effectively—in general, but particularly while discussing their differences (see Bradbury & Fincham 1990). The content of these behaviorally based programs has since expanded to include commitment, friendship, dyadic coping and stress management, and relationship maintenance (Bodenmann & Shantinath 2004, Halford 2011, Markman et al. 2010), but their common aim is to prevent declines in satisfaction by teaching couples better ways to communicate.

Meta-analyses of RCTs demonstrate that prevention programs outperform control conditions at posttest for communication ($d = 0.44$ on 37 studies) and for relationship quality ($d = 0.36$ on 46 studies) (Hawkins et al. 2008) with evidence of some benefits lasting 1 year or longer in 14 of 17 controlled studies (Halford & Bodenmann 2013). Well-designed and well-controlled studies, however, sometimes yield results that run counter to the basic assumptions of this approach. For example, an intervention designed to modify problem-solving behaviors failed to produce consistent changes during 14 months in positive or negative behaviors across husbands and wives and across the two settings in which the intervention had been delivered (Laurenceau et al. 2004). More recently, newlywed couples randomized to intensive 14-hour programs teaching skills in either conflict resolution or social support were found to have better 3-year relationship outcomes than no-treatment control couples (Rogge et al. 2013). However, neither of the treatment groups differed from couples who were simply instructed to watch and discuss movies with their partner, indicating that declines in satisfaction can be slowed without communication skills training. A meta-analysis showed that preventive interventions that were more rigorous or systematic or that specifically emphasized communications skills training were no more effective than other programs (Hawkins et al. 2012), suggesting that common factors and weak control conditions may drive program results. Finally, few studies of CRE have demonstrated that untreated couples dropped into the distressed range by the time of the final follow-up—a result that would be necessary to conclude that relationship distress had been prevented among the treated couples (see Bradbury & Lavner 2012). In sum, early successes with CRE suggested that “it may be easier to prevent relationship problems than to treat them once they emerge” (Jacobson & Addis 1993, p. 86), but evidence now casts doubt on this possibility, at least when standard forms of communication training are provided to unselected couples.

3.1.2. Secondary prevention of relationship distress. Whereas primary prevention of relationship distress assumes that most couples could benefit from CRE without regard to their strengths and weaknesses, secondary prevention—also known as selective prevention—posits that some couples are at elevated risk for eventual relationship distress and therefore warrant special attention before more serious distress can occur. To select couples at elevated risk, secondary prevention relies upon presumed causal knowledge about why relationships deteriorate, and the empirical justification for secondary prevention is typically provided by studies showing that couples characterized by specific risk factors benefit more from treatment than couples without these risk factors (Sullivan & Bradbury 1996). Thus, in contrast to couple therapy, where greater distress at intake warns of poor outcomes, in CRE, more vulnerable couples are expected to respond better than those with very low levels of risk.

Couples at relatively high risk for eventual relationship distress typically respond better to prevention programs than couples with less risk, even as they receive identical interventions. For example, immediately after participating in a six-unit, 18-hour weekend workshop focusing on communication, conflict, and stress management, couples initially low in satisfaction experienced greater change than those who were initially high in satisfaction ($d = 0.44$ versus 0.00) (Halford et al. 2015). Similarly, following a six-unit, 12-hour intervention aimed at communication, sexuality, and managing differences, couples who entered the program with low levels of satisfaction improved more than couples with high levels of satisfaction at posttest (71% versus 10%) (Halford et al. 2017). These less satisfied couples also showed stronger treatment effects at a 6-month follow-up ($d = 0.47$) compared with satisfied couples ($d = 0.17$), though unfortunately these gains reversed after 4 years ($d = -0.60$ and -0.10) (Halford et al. 2017).

These results suggest that the factors that led couples to rate their relationship as low in satisfaction were overcome temporarily by CRE, only to exert their effects later as treatment effects subsided. Consistent with this possibility, in a 3-year RCT with newlyweds, those couples with lower levels of commitment and satisfaction at baseline responded better to preventive interventions than control couples—again supporting selective prevention—but couple outcomes were worse than those of controls when risk was defined in terms of aggression and higher alcohol use (Williamson et al. 2015). Taken together, studies indicate that treatment effects are reliably stronger for couples who have more room for improvement (see also Bodenmann et al. 2014, Quirk et al. 2014) and are often ineffective for low-risk couples. Important questions remain, however, about how to characterize the many risk factors that differentiate couples prior to intervention and how to mitigate these factors with specific interventions.

Risk for adverse relationship outcomes can be identified at the level of individual couples, as we have just seen, but risky couples also can be identified on the basis of the circumstances in which they live. Relationship difficulties are overrepresented among couples living with low incomes, for example, as the likelihood of divorcing within the first 10 years of marriage is 40% for women with a high school diploma or less compared with 15% for women with a bachelor's degree or more (Copen et al. 2012). Tasked with the responsibility of strengthening the relationships of impoverished couples, largely as a means of promoting the health and well-being of children, the US Administration for Children and Families launched the multi-million-dollar Healthy Marriage Initiative (HMI) in the late 1990s. This initiative funded several large research projects (see Cowan & Cowan 2014, Johnson 2012, Karney et al. 2018), and in the wake of the HMI, the past decade witnessed a surge of new research examining whether communication skills training could improve relationships among underresourced people.

According to meta-analyses of controlled studies, relationship education programs delivered to couples living with low incomes generate very small effects over short intervals. An overall effect of $d = 0.06$ was reported in a review of 22 tests of CRE, with comparable effects on relationship

satisfaction ($d = 0.07$), communication ($d = 0.06$), and relationship aggression ($d = 0.06$) but no effect for relationship stability ($d = 0.00$) (Hawkins & Erickson 2015). A more recent review of 16 tests of CRE estimated effects of $d = 0.11$ on relationship satisfaction and $d = 0.12$ on communication, equivalent to treated couples performing better than roughly 5% of control couples (Arnold & Beelmann 2019). In one large multisite RCT funded by the HMI, randomization to skills-based communication training revealed very small effects on relationship satisfaction and communication ($N = 6,298$ couples; mean $d = 0.09$) and no effects on relationship dissolution despite use of a passive no-treatment control condition (Hsueh et al. 2012).

Much like effectiveness studies of couple therapy, tested interventions in the CRE literature are highly varied, attrition rates tend to be high, and long-term follow-ups are rare. The more general concern with this approach, however, is that provision of communication skills training—an intervention originally intended for middle- and upper-income couples—fails to address the economic hardships that can destabilize intimate relationships (Johnson 2012, Lavner et al. 2015). That is, “The stress and complexity of life for the poorest may provide rocky soil for healthy relationship knowledge and skills to take root; modest educational programs may not be enough to overcome these challenges” (Hawkins & Erickson 2015, p. 64).

3.1.3. Prevention programs for special populations. Prevention holds appeal because it promises to cover large segments of the population with educational content that is relatively uniform across couples. But the advantages of this approach can come at the cost of suppressing participation rates and treatment effects. To compensate, CRE programs are sometimes adapted for couples at specific stages in life and for couples who are difficult to reach via conventional strategies. To reach two-parent African American families living with low incomes, for example, Barton and colleagues (2017, 2018) developed a 12-hour in-home intervention in which each of six sessions identified a specific stressor (e.g., work, racism, finances, extended family) and then provided interactive instruction in cognitive and behavioral techniques that would enable adult partners to work together as a mutually supportive team. More than 81% of the couples completed all sessions, and intent-to-treat analyses showed that treated couples reported stable satisfaction and communication 17 months after randomization, while couples who received a workbook on relationship communication declined on these dimensions (Barton et al. 2018). This project exemplifies the broader potential of integrating relationship change principles with the concerns of specific segments of the population, an approach that is now developing rapidly.

The transition to parenthood is widely considered to be a transformative and challenging time in couples' lives, and a meta-analysis indicated that specialized interventions for couples navigating this transition generated small effects on relationship satisfaction ($d = 0.12$) and communication ($d = 0.29$) across 12 months (11 studies) (Pinquart & Teubert 2010). Couples entering parenthood with more risk—as reflected by parental divorce, low education, low income, relational aggression, and unplanned pregnancy—have been shown to respond better to a relationship and coparenting intervention than low-risk couples (Petch et al. 2012), consistent with aims of secondary prevention. A recent well-powered study using a very similar intervention and risk index, however, uncovered few treatment effects, little moderation by risk, and increasing attrition over the 24-month follow-up period (Heyman et al. 2019). Thus, while there is likely to be merit to tailoring interventions to the unique needs of specific populations, significant challenges remain to accessing populations of interest and to providing vulnerable couples with interventions that are brief and flexible but also potent.

In this same vein, special dissemination efforts are being devoted to moderately distressed couples who are not inclined to seek a full course of couple therapy. To lower barriers to treatment

seeking, couples have been offered a two-stage Relationship Checkup (RC) intervention, which consists of an initial assessment of their relationship (e.g., focusing on their history, reconnecting them with their strengths and goals, addressing partners' concerns about the relationship) followed by a feedback session in which couples discuss how they would like to maintain and nurture their relationship in the future (see Córdova 2014). This brief intervention presents personalized educational content in a nonthreatening manner, often drawing upon principles of IBCT and motivational interviewing to give couples direction on how to build on their strengths while heightening their inclination for doing so (Córdova et al. 2001).

A meta-analytic review of 8 studies revealed a short-term effect size of $d = 0.23$ for RC compared with control conditions, with effects then remaining stable for 6 months (Fentz & Trillingsgaard 2017; see also Kanter & Schramm 2018). In individual studies, short-term effects are robust, especially following booster sessions. Longer-term effects on satisfaction have been in the small range [$d = 0.20$ across 1 year (Trillingsgaard et al. 2016); $d = 0.10$ across 2 years (Córdova et al. 2014)], but treated couples report larger improvements in responsiveness ($d = 0.43$) (Trillingsgaard et al. 2016) and intimacy ($d = 0.36$) (Córdova et al. 2014) compared with controls. With lower-income couples, RCs produce 1-month improvements in satisfaction (within-group $d = 0.29$) that are substantially greater for distressed couples (within-group $d = 0.68$) than for satisfied couples (within-group $d = 0.09$), moving 13% of couples out of the distressed range of functioning (Gordon et al. 2019). Studies of RCs therefore reveal notable gains in self-reports of important relationship processes (e.g., acceptance and intimacy), and while the durability of effects remains to be fully established, this approach underscores the value of personalized and readily accessed interventions for couples who might not otherwise receive professional attention (Morrill et al. 2011).

While proponents of couple therapy and CRE have been understandably preoccupied with maximizing the magnitude of treatment effects, a focus on prevention brings with it the realization that expanding the reach of interventions is also a crucial metric for progress. Technology-enabled interventions considerably reduce barriers to access and, with well-designed programs, expose couples to broad domains of content that they can adapt to their individual interests in a sequence that suits their goals. Initial work suggests that self-directed tools are comparable in their effects to in-person interventions (e.g., Zemp et al. 2017; see also Braithwaite & Fincham 2014), with web-based programs proving to be accessible to large numbers of distressed couples from diverse backgrounds who are unlikely to present for couple therapy.

For example, with OurRelationship, an interactive web-based program developed and advertised as a self-help “relationship counseling alternative,” couples are invited to first observe the current state of their relationship and identify one or two problems that they would like to address together; to then understand those concerns by seeing how hidden emotions, stress, and communication patterns might be fueling their difficulties; and finally to respond to those concerns using principles of acceptance and guidelines for effective problem solving (see Doss et al. 2013). Couples also participate in four semistructured conversations with a coach to ask questions, review progress, and tailor the program to their needs. In an RCT with 300 couples in which one or both partners reported relationship distress, treated couples reported greater satisfaction at posttest than couples in a wait-list control condition ($d = 0.69$); 57% either recovered or improved in their relationship, 36% experienced no change in satisfaction, and 7% deteriorated (Doss et al. 2016). These effects were stable among treated couples over a 12-month follow-up (Doss et al. 2019). In short, innovations in technology-enabled interventions are now showing strong promise for delivering flexible content to large and diverse groups of couples with some reduction in effect sizes relative to traditional couple therapy.

3.2. Increasing the Impact of Prevention Programs for Couples

Altering the course of relationships with educational programs has proven to be more challenging than originally anticipated. In response to these challenges, attempts to strengthen and stabilize relationships have evolved well beyond their early emphasis on improving communication skills among well-educated, well-functioning couples. Three key shifts—away from primary prevention, away from a strict focus on communication skills, and away from intensive face-to-face interventions—all hold promise for increasing the impact of future preventive interventions with couples.

3.2.1. Understanding diversity and risk for relationship distress. Although the scientific yield of the HMI was disappointing, this undertaking focused attention on the large and diverse population of couples without ready access to services for relationship concerns. As a consequence, couples-oriented prevention now encompasses a much wider variety of couples than in past decades—including many couples contending with social and economic adversity as well as those varying in sexual orientation, commitment, relationship stage, relationship status, and relationship quality—greatly enriching the field but also raising challenges over how best to strengthen effects and implement prevention efforts. Findings along known dimensions of risk are difficult to synthesize, ranging from consistently better outcomes for couples with lower pretreatment levels of satisfaction (Halford & Bodenmann 2013) to weak results for couples living with low incomes ($d < 0.12$) (Arnold & Beelmann 2019, Hawkins & Erickson 2015). While evidence now undermines arguments favoring unselected primary prevention, at least with conventional skill-building programs, frameworks for capturing dimensions of couples' risk and diversity have yet to emerge.

Because samples of couples in prevention trials now vary considerably, and far more so than in couple therapy studies, effect sizes in CRE meta-analyses may be losing their diagnostic value. A moderate effect size obtained with a difficult-to-reach population, for example, is more consequential than an identical effect obtained with a low-risk population, and a weak effect obtained with a low-risk sample is more troubling than the same effect obtained with a high-risk sample. Unfortunately, reports of CRE studies rarely allow comparisons along a meaningful dimension of risk. Moderators and meta-analyses of moderators help to solve this problem but are typically unidimensional and therefore fail to characterize the full range of diversity or risk in any given sample. To complicate matters further, robust effects do not routinely translate into estimates of prevention, particularly when the average couple in the control group remains within the satisfied range of functioning at posttest; again, this is more troubling with a low-risk sample than with a group known to be at elevated risk for distress (e.g., unmarried couples undergoing the transition to parenthood). Initial progress has been made toward studying multidimensional indices of risk as treatment moderators (e.g., Heyman et al. 2019, Petch et al. 2012, Williamson et al. 2016), and greater attention to quantifying the full array of the characteristics that couples bring to CRE would enable more precise analysis of specific studies and interventions.

3.2.2. Explaining how prevention programs generate effects. The behavioral perspective that provided the initial foundation for CRE was straightforward and elegant: Common patterns of interaction were believed to be a root cause of variability in relationship outcomes; lasting changes to these patterns were believed possible; and treated couples, because of their improved communication, would consistently outpace couples with no such training. Yet support for this view has weakened in the past decade because of evidence suggesting, for example, that communication is as much a consequence of relationship satisfaction as it is a cause (Lavner et al.

2016) and that changes in observed behavior do not mediate treatment effects on satisfaction (e.g., Williamson et al. 2016). These results create a paradox for CRE in that interpersonal processes are a defining feature of all intimate relationships, yet consistent, lasting, and consequential changes in couple communication have not been documented.

This paradox can be reconciled by arguing that change is highly idiosyncratic to each couple and that “the knowledge and skills couples are taught need to change according to the context, life events, and individual characteristics of partners” (Halford & Pepping 2017). Couples are selected into and affected by their contexts and stressors in complex ways (Randall & Bodenmann 2009), and in longitudinal studies couples’ social ties and economic resources are known to moderate the effects of observed communication on changes in relationship satisfaction (Ross et al. 2019). The idea that couple communication is responsive to contextual influences is consistent with a study, reviewed above in Section 3.1.3, in which an in-home intervention focusing specifically on the stress experienced by African American couples living with low incomes was shown to stabilize relationship satisfaction across 17 months compared with controls (Barton et al. 2018).

This promising study suggests that encouraging constructive discussion of outside demands may enable partners to view one another with more sympathy and thus learn how to support one another more effectively, particularly when the intervention is tailored to each couple. The larger theoretical implication of this study, however, is that partners’ communication skills are assumed to be largely intact but are compromised by the chronic and acute hardships they are facing. Additional work on this theme is indicated, particularly because preventing distress may pivot less on changing the objective features of communication skills and more on ensuring that couples’ various resources (including the quality of their communication) are sufficient for maintaining their equilibrium in the face of stress (Bodenmann & Randall 2012).

3.2.3. Extending the reach of prevention programs for couples. Couple therapy and prevention programs are both deemed successful when a high proportion of treated couples experience reliable and durable improvements in relationship functioning. But advocates for prevention often go a step further and adopt a public health perspective on intimate relationships that motivates delivery of effective treatments to large numbers of couples—including couples who might not actively seek professional assistance (see Halford et al. 2008). Reaching large numbers of couples is difficult, particularly when preventive interventions are delivered via intensive face-to-face contacts with couples, often over several weeks, and when the couples of interest are already taxed by other pressing demands in their lives. One enduring lesson from the last decade of prevention work with couples is that although vulnerable couples may benefit the most from services, they are also the least likely to seek help—or, if they do, they are the most likely to end their participation prior to completion (Hawkins & Erickson 2015, Heyman et al. 2019). But a second important lesson from the past decade is that it is now possible to deliver efficacious and scalable interventions that meet the needs of many couples. For example, the Relationship Checkup, an in-person two-session program, generates reductions in distress (Córdova et al. 2014), as does the online OurRelationship program (Doss et al. 2016). Either through their brevity or through careful tailoring of content to couples’ specific needs (or both), these approaches achieve lower rates of attrition and are well positioned to address other concerns in the field.

First, even brief contact with professionals in educational programs can serve as a gateway to connecting couples with therapy should the need arise. Couples participating in prevention programs are more, not less, likely to eventually seek couple therapy, and underresourced couples are especially likely to seek help following their earlier participation in educational interventions (Williamson et al. 2014, 2018). Brief interventions, independent of their efficacy, provide an

efficient means for couples to learn about other treatments available to them later in their relationship. Second, Internet-enabled interventions in particular hold great potential for clarifying how couples engage with prevention programming. Very little is known about how partners pursue, share, and absorb intervention content about their relationships—typically because face-to-face programs provide few systematic opportunities for doing so—but online activities can provide program developers with crucial feedback on how couples learn new information and whether they apply it in their daily lives. Finally, unlike intensive face-to-face interventions, which have a clear beginning and ending that are determined by the program itself, brief interventions and online interventions can be extended and revisited as dictated by couples' interests and needs. A major concern with structured programs is that effects often dissipate, but new approaches to dissemination lend themselves to booster sessions and low-dose implementation over long spans of time, potentially reinforcing newly acquired capacities and thus offsetting the decay of treatment effects. Identifying, sustaining connections with, and motivating vulnerable couples are likely to remain significant challenges in the years ahead, yet new intervention modalities hold strong potential for solving these and other problems in CRE.

4. CONCLUSION

Virtually all couples begin their relationships with high hopes and great expectations, and some of these couples will remain happy, avoid major crises, and support healthy families. Relationship education would be unnecessary for these couples, and as time passes they will neither want nor need couple therapy. But many couples will lose sight of their initial aspirations, struggle to make their relationships work, argue, and grow apart emotionally. Clinical psychologists have developed and tested models intended to treat and prevent distress in these couples, and while the recent meta-analytic findings reviewed here do not permit any simple and unqualified summary of treatment effects, this work highlights significant progress in the field while also throwing notable gaps into sharp relief.

For couple therapy, behavioral and emotion-focused approaches perform well in RCTs, and mechanisms of treatment have become an active focus of research. But more remains to be learned about treatment effects in applied settings and how to strengthen them, and about which couples are most susceptible to poor treatment response initially and following effective treatment. With prevention programs, forays into diverse and difficult-to-reach populations confirm the potential utility of relationship education for many types of couples. But basic questions remain about how to conceptualize and modify communication within these programs and about how to realize this potential among couples living with limited social and economic resources. Advances on these fronts will deepen our understanding of how best to strengthen intimate relationships, enabling more couples to reap the many benefits known to reside within our closest social bonds.

SUMMARY POINTS

1. Because conflicted relationships undermine the benefits that relationships can provide, psychologists develop and deliver interventions to alleviate and prevent relationship distress.
2. Controlled experimental tests of behavioral and emotion-focused approaches improve the relationships of 60–80% of couples by the end of therapy.

3. Head-to-head comparisons of interventions rarely reveal any approach to be superior to any other.
4. About 50% of all treated couples experience reliable improvements in their satisfaction 2 years following treatment, provided that they receive an empirically supported intervention.
5. Treatment effects are weaker in actual clinical settings. About 40% of couples in these settings will be satisfied posttreatment; the remainder relapse to pretreatment levels or deteriorate.
6. Roughly half of all couples that seek couple therapy in applied settings fail to complete treatment.
7. Couple therapies show promise in treating emotionally charged events in relationships and in treating couples contending with common psychological and medical conditions.
8. Prevention programs assume that educating couples about relationships and teaching couples new communication skills will neutralize the problems that eventually jeopardize relationships.
9. Couples who are experiencing minor difficulties in their relationships appear to respond better to prevention programs than couples who are generally functioning quite well.
10. Specialized interventions address the needs of specific groups of couples (e.g., couples living with low incomes). Innovative treatment modalities show promise for reaching these couples.

FUTURE ISSUES

1. Can we reliably predict which couples are unlikely to respond to treatment and thus direct them to more appropriate interventions?
2. How can we best implement session-by-session assessments of relationship functioning and therapeutic alliance to identify when a couple is no longer progressing in therapy?
3. Can we devise new therapies to restore positive exchanges in couples' behavioral repertoires?
4. Can we conduct controlled experiments that test proposed mediators of treatment effects?
5. How can we exploit the common factors that underlie all effective couple therapies as a means of generating incrementally larger treatment effects?
6. How can we best capture the full range of diversity and risk that characterize intimate relationships so that prevention programs can be compared and interventions can be refined?
7. When prevention programs are successful, what changes? Can we study communication as one of many resources that couples deploy to navigate their unique stresses and life circumstances?
8. Can technology-enabled educational interventions deliver effective content to large numbers of couples at a reasonable cost?

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