THE ENHANCEMENT OF TRADITIONAL BEHAVIORAL COUPLES THERAPY: CONSIDERATION OF INDIVIDUAL FACTORS AND DYADIC DEVELOPMENT

Erika Lawrence, Kathleen A. Eldridge, and Andrew Christensen

University of California, Los Angeles

ABSTRACT. There has been little effort by behavior therapists to develop couple interventions that view marriage from a content-relevant or developmental perspective. Consequently, we have delineated ways in which a perspective of intimate relationships including individual factors and dyadic development might guide the enhancement of traditional behavioral couples therapy (TBCT) with novel and improved techniques that will ultimately allow us to reach a wider range of distressed couples than our current interventions allow. Specifically, we examined the potential benefits to intervention that could occur by considering the impact of individual factors on relationship quality, using the literature on attachment patterns as an example. Further, we have discussed the potential gains to couple interventions that could occur by considering the impact of dyadic development on relationship satisfaction. We first addressed gradual changes in marriage, using intimacy as an example. Next we examined “stage of marriage” issues, using child behavior problems as an example. Finally, we considered whether or not a problem was chronic. Throughout, we have proposed utilizing TBCT as a starting point, and considering ways to enhance TBCT specifically, as it is the marital therapy for which we have the most information and empirical support. © 1998 Elsevier Science Ltd

THE STRATEGIES associated with Behavioral Marital Therapy, or Traditional Behavioral Couples Therapy as it is now also called (TBCT; Jacobson & Margolin, 1979), have been utilized widely by clinicians to improve relationship satisfaction in distressed couples. TBCT has also been extensively researched and evaluated in the U.S. and other countries (e.g., Hahlweg & Markman, 1988; Jacobson & Addis, 1993). These investigations have produced consistent findings. A majority of couples participating in TBCT exhibit significant improvement in relationship satisfaction over the course of treatment. However, a portion of those couples who initially respond well to treatment later relapse to distressed levels one to two years after they terminate treatment.

Correspondence should be addressed to Erika Lawrence, Department of Psychology, University of California, 405 Hilgard Avenue, Los Angeles, CA 90095-1563; E-mail: elawrence@ucla.edu.
Consequently, only about 50% of couples in TBCT experience relationship improvement and maintain their improvements for at least 2 years (Jacobson, Schmaling, & Holtzworth-Munroe, 1987). Nevertheless, TBCT is currently the only intervention for distressed couples that is designated as an empirically validated treatment (under the name Behavioral Marital Therapy; Chambless et al., 1996; Task Force on Promotion and Dissemination of Psychological Procedures, 1995).

In this article, we suggest that consideration of factors in each partner and of the development of the relationship will elicit more effective treatment strategies for couples than those currently used in TBCT, and would likely yield interventions that may be effective with a wider variety of couples. We propose utilizing TBCT as a starting point, as it is the marital therapy about which we have the most empirical information. We will first describe TBCT in its current format and then outline individual factors and dyadic developmental issues relevant to subsequent marital distress. Finally, we will introduce current efforts, and suggest future efforts, to incorporate a consideration of individual factors and dyadic development to enhance TBCT.

**TBCT: OVERVIEW AND COMMENTARY**

**Overview of TBCT**

In TBCT, marital dissatisfaction is conceptualized as arising from a low ratio of positive to negative behaviors in the relationship. This low ratio is typically due to the combination of two processes: (1) a failure to use effective behavioral skills such as communication and problem-solving, and (2) reinforcement erosion, that is, when partners habituate to once-pleasing behaviors from their partner and no longer find them rewarding. Consistent with these ideas, TBCT clinicians theorize that restoring relationship satisfaction and reducing conflict requires that partners make significant behavioral changes. Following traditional behavioral principles, TBCT is focused on producing behavior changes by encouraging positive behaviors in partners and reinforcing demonstrations of those behaviors. Theoretically, the reinforcement given by the therapist, and perhaps by the partner “receiving” the behavior, eventually translates into acquisition of the positive behavior and, consequently, increased satisfaction in the relationship due to the higher frequency of positive behaviors (or lower frequency of negative behaviors). TBCT traditionally consists of three behavioral strategies to bring about change: behavior exchange, communication training, and problem-solving training. In addition, homework assignments are given routinely throughout treatment to encourage generalization of skills learned in therapy to the natural setting.

Behavior exchange (BE) encompasses several interventions, all of which attempt to instigate change via direct instruction (Jacobson & Margolin, 1979). The clinician enjoys a modicum of “artistic freedom” in choosing which of the numerous BE interventions to implement and when to implement them. One of the most widely used BE interventions is instructing spouses to generate lists of positive behaviors they can perform to increase relationship satisfaction, and then rewarding demonstrations of those behaviors. The clinician encourages each spouse to generate behaviors that are specific, noncontroversial, simple, and easy to implement, then instructs each partner to increase the frequency of those behaviors during the coming week. At the following session, the therapist debriefs the partners about the homework assignment. This particular BE intervention is typically done in the early stages of TBCT treatment to provide couples with immediate, low-cost improvement in the relationship. Such a boost
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in satisfaction sets couples up for success in the subsequent interventions of communication and problem-solving training.

In communication training, the therapist educates the couple about effective speaker and listener skills. The goal of speaker skills is to teach partners to be more direct and less blaming. The goal of listener skills is to teach active listening, including maintaining good eye contact and paraphrasing, reflecting, validating, or summarizing the speaker. The couple practices these skills in the session so the therapist can provide feedback about the positive behaviors by giving praise and reinforcement, and feedback about the negative behaviors by giving further instructions and rationales for why the missing skills are necessary. As therapy progresses, the therapist becomes less directive so couples will become less reliant on the therapist and be able to implement the skills on their own once they terminate.

In problem-solving training, the clinician helps the couple learn effective ways to solve problems and jointly make important decisions. The therapist describes the ideal setting for problem-solving and the two distinct phases of problem-solving: problem definition and problem solution. When defining the problem, partners should each acknowledge their own contributions to the existence of the conflict, discuss only one issue at a time, use the communication skills they have acquired, and refrain from inferring their partner’s feelings or intentions by only discussing observable behavior. When solving the problem, couples brainstorm possible solutions, evaluate the pros and cons of each proposal, and arrive at a mutually agreeable solution. The solution should be specific, involve change on the part of each partner, and be written down. To be successful in problem-solving, couples must employ a collaborative set in which they are willing to acknowledge their responsibility for the problem, compromise, and accommodate each other (Jacobson & Christensen, 1996; Jacobson & Margolin, 1979).

Recent Efforts to Enhance TBCT

Behavior exchange, communication training, and problem-solving training are the three traditional behavioral strategies used to produce behavior changes in distressed partners. Recently, researchers and practitioners have attempted to enhance TBCT by incorporating additional interventions. Because the literature demonstrated a clear difference between distressed and nondistressed partners in causal attributions made for relationship events (Bradbury & Fincham, 1990), and a tendency for distressed spouses to hold dysfunctional beliefs about marriage (Eidelson & Epstein, 1982), cognitive interventions were a natural candidate for enhancing TBCT. In Cognitive Behavioral Couple Therapy (CBCT; Baucom & Epstein, 1990), therapists employ behavioral exchange and communication/problem-solving training similar to that incorporated into TBCT. However, in addition to these interventions, CBCT includes cognitive restructuring to address partners’ maladaptive cognitive processes. Therapists target five types of cognitions—assumptions, standards, selective attention, attributions, and expectancies (Epstein, Baucom, & Daito, 1997). Although cognitive interventions in addition to TBCT strategies seemed a promising combination, the outcome literature is divided. One early analogue study (Margolin & Weiss, 1978) demonstrated that four sessions of a behavioral-attitudinal intervention designed to change attitudes was significantly more effective than four sessions of a behavioral intervention in increasing marital satisfaction, pleasing behaviors, and positive communication among distressed spouses. However, although more recent outcome studies have demonstrated that these cognitive interventions combined with TBCT can indeed change cognitions
in distressed couples, this combined treatment has not been more effective than TBCT alone (Baucom & Lester, 1986; Baucom, Sayers, & Sher, 1990; see Alexander, Holtzworth-Munroe, & Jameson, 1994, for a review of these studies). Further, the addition of these cognitive components to TBCT has not increased the generalization of treatment effects from the therapy session to the home beyond the generalization produced by TBCT alone (Behrens, Sanders, & Halford, 1990).

More recently, Halford and his colleagues have introduced the notion of self-regulation to TBCT (Halford, Sanders, & Behrens, 1994). These researchers believe the limitations of TBCT are due to its heavy emphasis on the dyad, which often focuses distressed clients on changing their partner. As discussed elsewhere, this emphasis on change can be counterproductive when partners are unable or unwilling to make the changes their partners request (Eldridge, Christensen, & Jacobson, in press; Jacobson & Christensen, 1996). Further, requests for change often result in greater resistance to change (Jacobson & Christensen, 1996). Instead, Halford and his colleagues recommend that therapists focus primarily on self-change. For each component of behavioral and cognitive-behavioral couples therapy, Self-Regulatory Cognitive-Behavioral Couples Therapy provides an alternate strategy that encompasses the concept of self-regulation. For example, instead of the therapist or partner defining the goals and performance standards for the other partner in behavior exchange or communication training, the partner sets his/her own standards and goals. Further, standard assessment instruments such as the Spouse Observation Checklist can be used in relation to the self instead of the partner by converting the measure into a “self” observation checklist (Halford et al., 1994). Although the notion of self-regulation is a promising one, it has yet to be investigated empirically for its additive impact on TBCT.

In sum, researchers have begun to develop alternative strategies to enhance the effectiveness of TBCT. Following this trend, we will suggest strategies to enhance TBCT based on a consideration of individual factors and dyadic developmental issues. We begin with a discussion of the underlying assumptions of TBCT that may contribute to its limited efficacy rates.

Assumptions in TBCT

Three underlying assumptions of TBCT are relevant to understanding how individual factors and marital development may impact the success of TBCT. The first assumption is that behavior change is the key to relationship satisfaction for distressed couples. In other words, induce positive behavioral changes in distressed couples and their satisfaction will increase. However, this strong emphasis on behavioral change and skills-training may be too challenging for some couples. Many partners presenting for treatment have developed so much anger and resentment toward each other that they are not emotionally ready to make positive changes in their behavior and they cannot work collaboratively.

As a result of their strong feelings, partners often know what behaviors they should increase to foster relationship satisfaction and already possess effective communication and problem-solving skills, but are simply unable or unwilling to perform these behaviors because of their anger or resentment (Jacobson & Christensen, 1996). Marital discord may therefore be associated with a lack of motivation rather than deficits in behavioral skills. Consequently, behavior exchange and communication/problem-solving training might be premature or unnecessary with these couples. The anger and resentment, rather than the inability to perform behaviors, are the obstacles to relationship satisfaction; these emotions cause partners to be unmotivated to imple-
ment positive behaviors. For couples who have developed strong negative emotions, TBCT may not effectively address these feelings or the factors that contribute to them, and therefore may be unsuccessful at producing meaningful changes in behavior and subsequent relationship satisfaction. We will argue that, by incorporating a focus of individual factors and marital development into couples therapy, we might be better able to address a couple’s degree of anger or their inability to collaborate.

The second implicit assumption underlying TBCT is that these hallmark interventions of behavior exchange and communication/problem-solving training can be utilized in all content areas. Consequently, they are uniformly applied to couples seeking treatment, regardless of the couple’s particular characteristics. Instead of addressing the content of conflicts, the approach is focused on teaching the process of effective communication and problem-solving to resolve whatever conflicts arise. In short, TBCT is process-oriented, not content-oriented. What the couple argues about is not a primary consideration; how the partners behave around the argument is considered to be of paramount importance.

Theoretically, the advantage of this approach is that couples can learn to communicate about and solve all of the problems that arise in their relationship, regardless of the content of those problems. The skills couples learn can be generalized and applied to a broad range of conflicts. However, the content of couples’ issues is likely to change depending on their stage in the marital life cycle, and giving process the highest priority means that the unique characteristics of each couple and their conflicts may be overlooked (Bradbury, Johnson, Lawrence, & Rogge, in press). Thus, incorporating a focus on individual factors and marital development may foster greater awareness of the content of couples’ conflicts, not just the process. In turn, strategies for specific content issues can be developed and explored for efficacy.

Additionally, because of this emphasis on process rather than content in TBCT, little attention has been paid to addressing diverse content issues (Beach & O’Leary, 1986). Indeed, the limited outcomes found with TBCT have led to a summons for both clinicians and researchers to identify issues associated with greater marital difficulties (Babcock & Jacobson, 1993). It is possible that TBCT is equally effective with subgroups of couples distinguished by their primary content issues such as trust, sex, closeness, or depression. However, research has not yet addressed this question, and TBCT may currently be limited in the extent to which it is effective with couples experiencing conflict in different topic areas.

The third and final assumption of TBCT is that identical communication and problem-solving skills are relevant to all couples seeking therapy. Therefore, young and mature couples, homosexual and heterosexual couples, and same-race and mixed-race couples alike are taught these skills and reinforced for implementing them. Age, sexual orientation, ethnicity, and sociocultural background were not originally noted as factors that would differentially impact the effectiveness of behavioral interventions. Further, the developmental stage of the marriage (such as newlywed, family with young children, and empty nest) was not included as a crucial factor in the effectiveness of TBCT.

Controlled research on TBCT has examined some of these factors and their impact on treatment outcome. Interestingly, the sociocultural experience of the couple can limit the effectiveness of the intervention. For instance, research has identified couples with more traditional gender roles as less likely to have successful outcomes with TBCT than couples with more contemporary or “androgynous” gender roles (Jacobson, Follette, & Pagel, 1986). Specifically, couples who decide which partner will perform which tasks, that is, doing the dishes or taking out the trash, based on gender-role
stereotypes are less likely to be helped by TBCT than more egalitarian couples. Similarly, when the wife alone is responsible for the emotional well-being of family members and of the marriage, a gender-role stereotyped responsibility, outcomes are less successful (Jacobson & Christensen, 1996).

Further, older couples have been found to achieve less success with TBCT than younger couples, even after controlling for length of marriage (Jacobson et al., 1986). It is possible that the lack of success with older couples may be due to a cohort effect; for example, rather than simply age affecting the success of treatment, older couples may have experienced a sociocultural environment promoting more traditional gender roles. Therefore, it is hypothesized that these poorer outcomes are due to the inability of older and more traditional couples to collaborate with each other, to compromise, and to accommodate to each other (Jacobson, 1992). Consequently, these couples are unable to effectively communicate and problem-solve, regardless of how well the therapist teaches these skills to them. In short, they are unable to make the behavioral changes required of them for successful outcomes with TBCT.

In sum, although limited in scope, the existing research challenges the assumption that TBCT works equally well for all couples and for all types of content. We believe that an examination of individual factors and dyadic developmental issues can lead to alterations in TBCT that may enhance its efficacy.

Consideration of the Effects of Individual Factors and Dyadic Development on Marital Quality

Heavey, Shenk, and Christensen (1994) suggested that individual factors and relationship development affect marital satisfaction. Individual factors include personal qualities that would likely impact marital functioning, such as personality traits and attachment patterns. By referring to these variables as individual factors, Heavey et al. (1994) implied that the individual’s history apart from the marriage was primarily responsible for these qualities. However, the variables that each partner brings to a marriage do impact how a couple interacts and how satisfied both partners are with the relationship. In contrast, relationship development includes gradual changes in the relationship over time, such as changes in the levels of closeness and psychological distance between partners, and abrupt transitions in the relationship such as the transition to parenthood. By referring to these as dyadic developmental issues, Heavey et al. (1994) suggested that the couple as a unit experiences these changes and that the marital quality of both spouses is affected.

Understanding these factors is the first step toward tailoring existing interventions to meet the needs of a diverse population of distressed couples with a wide variety of problems. We will begin with a discussion of how examining individual factors could enhance the effectiveness of TBCT, with a specific focus on attachment patterns.

INDIVIDUAL FACTORS AND MARITAL QUALITY: ATTACHMENT PATTERNS

Researchers have identified a broad range of individual variables that are associated with marital distress, such as depression, neuroticism, and impulsivity (Beach & O’Leary, 1993; Kelly & Conley, 1987). Rather than attempt to incorporate this diverse and comprehensive literature, we have chosen one individual factor to illustrate the impact such variables can have on relationship satisfaction and to illustrate how couples therapy may be altered to account for those factors. Specifically, we will discuss
An Overview of Attachment Theory and Research

Bowlby (1969) developed attachment theory by observing infants’ behaviors in relation to their primary caregivers. Infants depend on their caregiver to satisfy all of their needs, and to fulfill those needs when the infant desires them. If the caregiver consistently responds to the infant’s needs, the infant becomes securely attached to the caregiver. Specifically, the infant comes to view him or herself as worthy of being loved and cared for and to view the caregiver as dependable and responsive to his or her needs. These beliefs ultimately become generalized to other relationships the child has. He or she develops internal working models of the self, such as whether the self is capable of and worthy of being loved, and working models of others, such as whether others can be depended on in times of distress. These working models provide the framework for the development of attachment patterns.

Attachment patterns are most readily detected when children become distressed or anxious and are expected to turn to the caregiver for support. Ainsworth, Blehar, Waters, and Wall (1978) developed the strange situation paradigm to assess attachment in toddlers by exposing these young children to the stress of separation from, and then reunion with, their primary caregiver. Based on the different behaviors exhibited by children and caregivers, Ainsworth and colleagues classified children into three types of attachment patterns: secure, avoidant, and anxious/ambivalent. Secure children show behavioral signs of missing the caregiver when he or she is out of sight. The child believes the caregiver would respond if sought out and approximately half of them cry. When reunited with the caregiver, the child seeks interaction and physical contact. When the caregiver provides this contact and interacts with the child, the child becomes calm and begins exploring his or her surroundings and playing again. In contrast, avoidant children do not react when separated from their caregiver; their behavior seems to indicate that they are indifferent to the separation. When the child is reunited with the caregiver, the child avoids meeting the caregiver’s gaze and avoids interacting with the caregiver. Finally, anxious/ambivalent children almost always cry and exhibit other signs of distress when separated from their caregiver. They also suppress their level of play. Upon reunion, the child may either look at the caregiver and cry or approach without effectively establishing contact. If the caregiver picks the child up during the reunion, the child remains passive, struggles to be released, or behaves as if he or she is angry. In general, close contact with the caregiver does not readily comfort the anxious/ambivalent child (Ainsworth et al., 1978).

Hazan and Shaver (1987; Shaver, Hazan, & Bradshaw, 1988) noticed similarities between how young children behaved in the strange situation and how adults behaved in romantic relationships. They applied Bowlby’s theories to these adult relationships and concluded that adults have similar attachment systems and that similar behaviors can be activated when individuals are either physically separated from, or perceive themselves to be psychologically separated from, their romantic partner. However, they noted that adult romantic relationships are different in two important ways from child-caregiver relationships. First, adults are able to play the dual roles of needing support and providing support to their partner; this reciprocity cannot exist between...
caregivers and infants or young children. Second, sexuality is an important component to adult romantic relationships that is not considered to be a factor in child-caregiver relationships.

In two studies examining how adults classified their own attachment patterns (as summarized in Shaver et al., 1988), Shaver and colleagues adapted Ainsworth’s descriptions of attachment patterns to adult romantic relationships. They had participants endorse one of the three categories below:

Securely Attached Adults:

I find it relatively easy to get close to others and am comfortable depending on them and having them depend on me. I don’t often worry about being abandoned or about someone getting too close to me.

Avoidantly Attached Adults:

I am somewhat uncomfortable being close to others; I find it difficult to trust them completely, difficult to allow myself to depend on them. I am nervous when anyone gets too close, and often, love partners want me to be more intimate than I feel comfortable being.

Anxiously/Ambivalently Attached Adults:

I find that others are reluctant to get as close as I would like. I often worry that my partner doesn’t really love me or won’t want to stay with me. I want to merge completely with another person, and this desire sometimes scares people away. (Shaver et al., 1988, p. 80)

Based on these self-reports, they found that approximately 50% of adults were securely attached, 25% were avoidant, and 25% were anxious/ambivalent, a breakdown that mirrored the percent of infants that fell into these categories in Ainsworth’s study.

These researchers also began to examine the association between attachment patterns and relationship quality and stability. Shaver et al. (1988) asked 620 adults to describe their “most important love relationship” (p. 79), which included both dating and marital relationships. They found that:

Secure lovers described love as especially happy, friendly, and trusting, and emphasized being able to accept and support their partner despite the partner’s faults. Moreover, their relationships tended to endure longer (10.02 years, on the average, compared with 4.86 years for the anxious/ambivalent and 5.97 years for the avoidant lovers), even though all three groups were the same age, on the average (36 years). Avoidant lovers were characterized by fear of intimacy, emotional highs and lows, and jealousy. They never produced the highest mean on a positive (desirable) feature of love. The anxious/ambivalent lovers experienced love as involving obsession, desire for reciprocation and union, emotional highs and lows, and extreme sexual attraction and jealousy. (p. 79)

In sum, based on self-reports, secure, avoidant, and anxious/ambivalent adults differed in their levels of intimacy, degree of relationship satisfaction, and relationship stability.

Because of the differences in marital quality among spouses with different attachment patterns, interventions will be discussed in terms of attachment patterns of individual spouses.
ment patterns, researchers have begun to investigate the factors that mediate the association between attachment patterns and relationship quality. Simpson, Rholes, and Nelligan (1992) categorized 83 women and their male romantic partners based on the three types of attachment patterns. They created an adult situation that paralleled Ainsworth’s strange situation paradigm for children in order to determine whether adults exhibited the same types of support-seeking and support-giving behaviors that children and caregivers demonstrated, respectively. The experimenters performed a series of tasks to induce anxiety in the women (telling them that subjects often feel anxious during the course of the study, showing them a room filled with psychophysiological equipment). The women then waited for five minutes with their partners, and their expressions of anxiety and support-seeking behaviors were coded. Further, the partners’ support-providing behaviors were coded. From these observations, Simpson et al. (1992) found that secure women, when anxious, were more likely to seek physical and emotional support from their partner than avoidant women. Similarly, secure men were more likely to provide support for their partner than avoidant men.

However, the degree of anxiety moderated the association between attachment patterns and support-seeking and support-providing behaviors. Specifically, of the women who were only moderately anxious, the avoidant women were more likely than secure women to seek support, and avoidant men were more likely than secure men to offer support. However, of the women who were highly anxious, the secure women sought more support, and the secure men offered more support than avoidant individuals.

This finding seems counterintuitive. Avoidant people are often thought of as “cold, distant, or aloof” (Simpson et al., 1992, p. 442). However, Simpson and colleagues speculated that, despite their behavior, avoidant individuals want to be physically and emotionally close to their partners but are afraid of this intimacy. They theorized that, at lower levels of distress and anxiety, avoidant people are able to demonstrate behaviors toward achieving greater intimacy and greater relationship satisfaction. Indeed, they are more likely to seek or offer support than secure individuals. Possibly, secure adults have less of a need to overtly exhibit these behaviors because they are more secure with the relationship. However, as levels of anxiety and distress increase, avoidant individuals presumably become unable to tolerate, and fearful of, such intimacy. Consequently, avoidant adults may be unable or unwilling to turn to their partner for support, or to provide support, when stress levels become too high (Simpson et al., 1992).

Another factor which may mediate the association between attachment patterns and marital quality is cognitive style. Kobak, Ruckdeschel, and Hazan (1994) suggested that individuals with “insecure” attachment patterns (avoidant or anxious/ambivalent) may not have the skills necessary to objectively evaluate their partner’s behavior. Therefore, they will typically rely on pre-existing schemas to interpret the behavior. In contrast, secure spouses may be able to evaluate their partner’s behavior more objectively and therefore alter their schemas to include new information. Kobak et al. (1994) concluded:

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2 The Simpson, Rholes, and Nelligan (1992) study was conducted on college students and thus cannot be generalized to distressed married couples. Nevertheless, given the fact that attachment patterns are considered relatively stable throughout one’s life, the behaviors reported seem to provide useful information about how married individuals with different attachment patterns might behave toward each other during times of moderate or high anxiety.

3 Findings for anxious/ambivalent men and women were not significant and thus discussed only minimally.
When processing ambiguous signals, an individual with an insecure model is more likely to jump to conclusions that may negatively distort the meaning of the partner’s behavior. For instance, insecure models may lead an individual to incorrectly perceive rejection when a partner is occupied with other matters, or to mistakenly assume anger or lack of concern when a spouse is tense or anxious. (p. 60)

Kobak et al. (1994) theory suggests that the attributions of avoidant and anxious/ambivalent adults are both maladaptive and different from the attributions made by secure individuals. However, even if both types of insecurely attached individuals make similar attributions, the behavior they exhibit as a consequence of these attributions often differs dramatically. For example, avoidant spouses might make attributions that support the theory that their partner is rejecting. In turn, the avoidant spouse would likely withdraw to prevent him or herself from getting hurt. Anxious/ambivalent spouses might also make attributions supporting the notion that their partner is unresponsive or uncaring. However, prior research on attachment patterns suggests that they would likely react with anger. In sum, a spouse’s attachment pattern may be associated with the types of attributions they make and behaviors they exhibit in reaction to their partner’s behavior.

**Couples Therapy and Attachment Patterns**

Researchers have begun to theorize that attachment patterns may be altered based on the quality of a current romantic relationship. Kobak and Hazan (1991) found that spouses’ levels of attachment security were altered based on their partner’s behavior. For example, when wives were more rejecting during problem-solving interactions, their husbands subsequently reported feeling less secure compared to their feelings of security before the interaction. Further, although husbands’ problem-solving behavior was not associated with wives’ subsequent reports of attachment security, their husbands’ listening behavior was associated with wives’ subsequent levels of security (Kobak & Hazan, 1991).

Attachment patterns have been found to be stable in 70% of individuals and unstable in 30% of adults (Baldwin & Fehr, 1995; Fuller & Fincham, 1995; Scharfe & Bartholomew, 1994). Therefore, the 30% who change their attachment patterns may be doing so as a result of a romantic relationship. By extension, it is possible that couples therapy might also facilitate a shift in attachment patterns as a result of improving couples’ intimacy and relationship satisfaction. We propose that attachment patterns, rather than being fixed, might be able to be changed from avoidant or anxious/ambivalent to secure through couples therapy. Consequently, therapists could employ techniques to alter partners’ dysfunctional attachment patterns which might subsequently increase both partners’ relationship quality.

Efforts such as these have begun to be implemented and empirically tested. Emotionally Focused Marital Therapy (EFT; Greenberg & Johnson, 1988; Johnson & Greenberg, 1995), loosely based on attachment theory, focuses on emotion, not behavioral change, to improve marital quality. EFT therapists conceptualize marital distress as the result of an insecure attachment relationship with one’s spouse. Specifically, discordant spouses do not view their partner as a secure base and are believed to be either avoidantly or anxiously/ambivalently attached. According to EFT theory, these spouses experience primary emotions such as a fear of abandonment when their partner shows interest in others, or sadness when they are separated from their partner. Rather than expressing these primary emotions, however, they express what are called
secondary emotions. Secondary emotions are defined as the protective affect expressed by insecurely attached spouses such as withdrawal, defensiveness, and anger. Although the insecurely attached spouse expresses these secondary emotions with the goal of protecting him or herself from rejection, these actions typically elicit rejecting behavior from the partner. For example, when avoidant spouses begin to experience primary emotions such as a fear that their partner will be rejecting, they may feel anxious or sad, but they will typically express secondary emotions instead, such as withdrawal or indifference. Although this is done in an effort to protect themselves from the anticipated rejection, the partner usually will not respond to this behavior by being emotionally supportive or engaged. Rather, the partner typically reacts in an equally negative way. Consequently, avoidant spouses may create self-fulfilling prophecies in which they experience the very rejection they are trying to prevent. Similarly, when anxious/ambivalent spouses experience primary emotions such as anxiety that their partner will abandon them, they often express secondary emotions such as anger or defensiveness. Consequently, their partner often responds with negative affect such as anger, and the anxious/ambivalent spouse has created the very negative interaction they wanted to circumvent (Johnson & Greenberg, 1995).

The goal of EFT is to teach couples to break this cycle of problematic attachment-related behaviors and to shift spouses toward the direct expression of primary emotions. Primary emotions are viewed as the true experiences of spouses, in contrast to secondary emotions which mask the actual experience. Spouses are encouraged to express primary emotions to their partner, such as anxiety or disappointment, rather than secondary emotions such as defensiveness or resentment. EFT therapists use this technique to help couples develop more secure attachments. When spouses express primary emotions, their partner is more likely to respond with compassion and support rather than defensiveness or withdrawal. Spouses expressing primary emotions are thus able to experience the emotional support from their partner that they anticipate they will not get; they learn to experience their partner in a new light. The interaction shifts from one of reciprocal negative affect to an expression of true underlying feelings and emotional support. The overall goal is for insecurely attached spouses, through these interactions, to develop more secure attachments to their partners.

There is some evidence that this EFT intervention creates greater increases in intimacy and marital satisfaction in mildly distressed couples who participate in EFT than in control groups of mildly distressed couples who do not receive treatment (e.g., Johnson & Greenberg, 1985). However, these increases in intimacy are often nonsignificant trends (James, 1991), may not significantly improve over the effects of problem-solving treatment on intimacy (Johnson & Greenberg, 1985), and may be stronger for women than men (Johnson & Greenberg, 1985). In sum, these findings highlight the challenging nature of treating marital discord, but suggest that focusing more on emotion as it relates to attachment patterns may be an important component in the enhancement of TBCT to achieve the goal of improving marital satisfaction.

DYADIC DEVELOPMENT AND MARITAL QUALITY

So far we have discussed how researchers and clinicians might consider individual factors in an effort to enhance the efficacy of TBCT. Specifically, we focused on attachment patterns and how they may be associated with spouses’ cognitions, affect, and behavior, all of which may ultimately impact marital quality. In this same vein, consid-
eration of dyadic development might also enhance the effectiveness of TBCT. First, we will discuss how gradual changes in marriage such as shifts in intimacy levels may impact marital quality. We will also summarize existing interventions that address couples’ intimacy problems specifically. Second, we will examine the possible importance of the stage of the marriage when choosing an intervention. For example, couples struggling with the impact of children on their marriage presumably differ greatly from couples who do not yet have children and may need interventions that consider those children. Third, we will discuss how the magnitude of the problem may determine what intervention would be effective. For example, the length of time a problem has been a marital issue may have several implications for couples therapy. In general, as we address each dyadic developmental issue, the main focus will be on existing and potential treatments that are relevant to these issues.

**Gradual Change: The Example of Intimacy**

Throughout the course of marriage, a couple’s level of intimacy changes, increasing and decreasing at various points in the marriage. During the early stages of marriage, relationships are typically characterized by frequent intimate contact and extreme happiness, which bodes well for future marital quality (Fischer & Sollie, 1993). Indeed, the first year of marriage is usually marked by high levels of romantic feelings and verbal intimacy (Swensen, Eskew, & Kohlhepp, 1981). Feelings of closeness might decline with the introduction of children into the marriage, however. During the transition to parenthood, spouses’ time and energy is often shifted to a focus on parenting responsibilities, which may result in a decline in attention to the marriage and a subsequent decline in marital quality (Cohen, 1992). This change seems to reflect spouses’ willingness to put their own intimacy needs aside temporarily and tolerate less intimate contact in order to meet their child’s needs (Ambert, 1992). In contrast, the middle stages of marriage (ages 40–55) are often marked by an increase in intimacy. During this time period, a couple’s children may leave the home and one or both partners may be preparing to retire. These changes often result in spouses shifting their primary focus back to each other and to the marriage. Consequently, they often report experiencing an increase in closeness and, subsequently, in marital satisfaction (Prager, 1995).

Some couples may enter their marriage with different desires for levels of closeness, and thus be incompatible from the onset of marriage. For other couples, spouses may agree on the levels of intimacy they desire early in their marriage, but as their relationship develops, they may become incompatible in the level of intimacy each desires. For example, a couple may be satisfied with the level of intimacy in their relationship for the first four years of marriage. However, when the husband gets a promotion and begins working longer hours, the amount of time he has to be close to his wife and his need for intimacy may decrease. In contrast, his wife may still want the level of closeness they had before his promotion. In this case, the couple was convergent on their desire for specific levels of intimacy when they married, but diverged due to life events that occurred during their marriage.

When these differences emerge, either at the beginning of the marriage or over time, couples often begin to argue about their current level of intimacy. These kinds of conflict about the amount of closeness in the relationship are associated with greater marital discord (Christensen & Shenk, 1991). Typically, one partner desires more closeness and the other prefers more psychological distance (Christensen & Pasch, 1993).
Different desires for closeness may manifest themselves in a demand-withdraw pattern in which the partner desiring more closeness demands, pressures, criticizes, and complains and the partner desiring more distance withdraws or becomes defensive to preserve the status quo (Christensen, 1988). Interestingly, researchers have identified a gender difference characterizing this pattern, with women most often in the demanding role and men most often in the withdrawing role (Christensen, 1988). Often, couples are experiencing the consequences of their different desires for closeness when they seek therapy (Greenberg & Johnson, 1988).

TBCT therapists would use their standard tools—behavior exchange and communication/problem-solving training—to address problems of intimacy between partners. During behavior exchange, TBCT therapists would have partners discuss the behaviors they would like the other to exhibit, such as greater physical affection. They would then instruct them to display those behaviors. However, because the partners are called upon to display closeness behaviors such as physical affection rather than exhibiting them spontaneously, they may not feel comfortable or natural doing them. Further, the “receiving” partner may perceive them as insincere. As a result, neither partner may be reinforced by this “forced” display of closeness.

TBCT therapists would also use communication and problem-solving techniques to help partners negotiate their different levels of closeness. Although this problem-solving process is well-suited to many problems, such as decisions about finances, parenting, and in-laws, it is perhaps less applicable to issues such as intimacy. Often, a couple can come to an agreeable solution but have difficulty implementing it due to an emotional barrier. A couple may agree to spend an intimate evening together on Saturday night but find that when the night arrives, one or both is too angry to feel close to the other. The difficulty lies not in the problem-solving process, but in these emotional obstacles, such as defensiveness.

Thus, problems of intimacy may not be solved simply through current TBCT strategies. Additional strategies to supplement TBCT may be found in two existing treatments that are designed to promote intimacy in distressed couples, Integrative Couple Therapy (ICT; Christensen, Jacobson, & Babcock, 1995; Jacobson & Christensen, 1996) and Emotionally Focused Marital Therapy (EFT; Greenberg & Johnson, 1988; Johnson & Greenberg, 1995), which was summarized above.

Integrative Couple Therapy (ICT) clinicians encourage partners to talk more about their “soft” feelings, such as sadness, fear, and loneliness, and less about their “hard” emotions, such as anger and resentment. Whereas partners respond to statements of hard emotions with defensiveness, they tend to respond to expressions of vulnerability with empathy and compassion. If therapists foster soft disclosures and a partner responds with compassion, intimacy can be created rather than blame. Sometimes, this more vulnerable expression of emotion comes easily to partners and they automatically respond compassionately to the disclosing partner. However, therapists often need to suggest soft feelings partners may be experiencing, to encourage partners to elaborate on those feelings, and to prompt partners to reflect them back. Nevertheless, soft disclosures can be a powerful means of creating intimacy and closeness.

Initial research supports the premise that ICT increases soft disclosures. In a pilot study comparing ICT and TBCT, couples in the ICT condition expressed more soft emotions in the middle and end of therapy than couples in the TBCT condition (Cordova, Jacobson, & Christensen, 1995). Further, couples in the ICT condition had better outcomes in that they demonstrated greater increases in marital satisfaction and more acceptance of negative behaviors than couples in the TBCT condition (Jacobson & Christensen, 1996). These findings indicate that ICT techniques, which promote
soft disclosures, may truly increase acceptance and decrease distress in couples. Although we may presume that intimacy was increased as well, the direct effect of these interventions on levels of closeness has yet to be explored.

The ICT technique of encouraging couples to make soft disclosures is somewhat similar to the “softening” intervention described earlier that is utilized in EFT. However, there are two important differences between EFT and ICT. For example, soft disclosures in ICT consist of any vulnerable, painful feelings which, when expressed, lead to compassion and empathy in the partner. In contrast, EFT focuses primarily on attachment-related situations and emotions. Also, ICT consists of several strategies to promote intimacy, whereas EFT focuses solely on facilitating “softening” events. In sum, if couples therapists included a consideration of gradual changes in the marriage such as changes in intimacy, TBCT could be enhanced by adding interventions to promote intimacy through soft disclosures.

Marital Stages: The Example of Children

Different stages of the marital life cycle are associated with different conflict issues, and for certain topics, additional interventions may be necessary. Perhaps the most important stage of the marital life cycle that couples experience is the childrearing stage. From their arrival into the home until long after their departure, children affect the content and course of their parents’ marriage. The introduction of a child into the marriage has been associated with significant declines in spouses’ marital quality. Couples typically experience high levels of marital satisfaction during the last trimester of pregnancy. During the first few months after the child is born, however, marital satisfaction often declines markedly, although this decline is usually temporary. Between three and nine months postpartum, marital quality typically improves, albeit modestly (Belsky, Spanier, & Rovine, 1983). The impact of children on the marriage does not end at this point, however. As the children grow, couples often argue about issues such as the division of labor regarding child care, how to discipline the children, and different expectations for their children. If the child develops adjustment difficulties, these conflicts between parents are liable to increase.

No one has examined the effectiveness of TBCT when conflicts over childrearing are the primary concern or when child adjustment problems coexist with marital problems. However, in their manual for TBCT, Jacobson and Margolin (1979) discuss the need to switch from TBCT techniques to parent-training strategies when child behavior problems exist concurrently with marital distress. They further recommend that the marital problems be treated first, followed by the parent-training strategies. By implementing the TBCT strategies to treat marital problems first, the spouses would become stronger as a unit, and therefore be better able to focus on their relationships with their children.

Parent-training strategies are widely used to treat child behavior problems, regardless of whether these problems occur simultaneously with marital discord. Clinicians that implement parent-training interventions focus on the child’s problematic behavior, and the main goal is to shape, that is, modify, the behavior. Together, the clinician and parent(s) target specific behaviors, typically negative ones, which the parents want the child to change. In addition to identifying negative behaviors to be changed, the clinician encourages the parents to generate alternative positive behaviors, because increasing an alternative positive behavior is more effective than simply suppressing a negative one.

Once the parents and therapist identify the target behaviors to be shaped, they
monitor the frequency of those behaviors and identify the antecedents and consequences of those behaviors to better understand their context. Next, the clinician trains the parents to reinforce systematically the child’s display of positive alternative behaviors and to ignore or punish the child’s negative behaviors. Reinforcers might consist of social approval or of concrete rewards, such as earning points toward the purchase of a toy. Punishment might consist of “time outs” or removal of points. The clinician and parents continue to monitor the frequency of the child’s behavior to be sure improvement is taking place.

Parent-training techniques such as the ones described above have consistently been shown to be effective in changing children’s problematic behavior (Chambless et al., 1996; Task Force on Promotion and Dissemination of Psychological Procedures, 1995). Thus, Jacobson and Margolin’s recommendation to add parent-training to TBCT seems valid. However, when marital conflict centers around a child and occurs when the child exhibits problems, an approach that integrates the two treatments rather than implementing them sequentially might be more effective. Indeed, researchers have made preliminary efforts to develop integrated treatments targeting the dual problems of marital distress and the child’s behavior. For example, Dadds (1992) discusses the impact of marital conflict, marital discord, and parent-child conflict on a child’s behavior. Because all of these problems may affect a child’s behavior, Dadds argues, we need to integrate marital interventions (i.e., treatments targeting marital communication, conflict, and problem-solving) and behavioral parenting-focused interventions in order to improve a child’s behavior. So far, Dadds and colleagues have conducted a few treatment outcome studies integrating these two types of treatments on small samples (n of 4 to 24; e.g., Dadds, Schwartz, & Sanders, 1987). However, they have found that, when couples presented for treatment with marital discord and child behavior problems, the integration of marital and child-focused interventions was more effective than parent-training alone in improving spousal interactions, parent-child interactions, and child behavior. This suggests that the integration of marital and child-focused interventions may be more effective than either focus alone in treating concurrent marital and child problems.

Another approach that is directly relevant to treating couples who have school-age children is family therapy. Although there are numerous variations, family therapists try to strengthen important alliances in the family, such as the marital alliance, and strengthen boundaries in the family, such as the hierarchical boundary between parents and children. The goals are to improve child behavior problems, parent-child relationships, and the marital relationship. Family therapists view marital conflict and discord as affecting each spouse’s ability to be an effective parent, which subsequently affects the children. Further, children’s behavior affects parents’ interactions with their children and with each other.

TBCT might be more beneficial with couples who have children if it incorporated a conceptualization at the level of the family. TBCT clinicians only consider interactions between spouses in their conceptualization of the problems leading to marital discord. If TBCT clinicians incorporated this more comprehensive perspective, TBCT would likely be more effective at treating marital distress in couples for whom their children are a primary focus of the relationship. For example, Gordon and Mariaχ express negative affect during marital conflict; Maria exhibits demanding behaviors and Gordon exhibits withdrawing behaviors. A TBCT therapist would assume this is due to a behavioral skills deficit and teach them the necessary skills to decrease their negative affect.

χ Spouses’ names have been changed to protect their anonymity.
However, by conceptualizing this interaction at the level of the family, we might see additional problematic interactions that contribute to the marital problems. Maria may be frustrated that Gordon is withdrawing when she wants to engage him in conversation, and may instead turn to her son Charles for emotional contact. Gordon may respond by feeling relatively distant from their son, and then withdraw further from his family. This may lead to Maria becoming overinvolved with Charles, and increase the marital problems between Maria and Gordon. To break the pattern of Gordon’s withdrawal, TBCT could be enhanced by including some sessions in which all family members attended. This might mean a temporary shift in therapy from the dyadic sessions already in place to a number of sessions incorporating Charles as well as Maria and Gordon to target family issues that impact marital quality. Once these issues have been addressed, the focus of therapy could return to the dyad.

In sum, TBCT might be enhanced if couples therapists were to consider a couple’s marital stage and the particular content issues that might be associated with their particular conflict during that stage. For example, during the stage when couples have young children and the specific conflict surrounds child behavior problems, TBCT could be augmented by integrating a family or parent-training focus into the traditional dyadic focus.

**Problem Chronicity**

So far we have discussed how the effectiveness of TBCT might be enhanced by considering gradual dyadic changes, such as shifts in a couple’s level of intimacy, and by considering the stage of marriage, such as the advent of children. Another consideration is the magnitude of the problem in the marriage. There are three reasons why a serious marital difficulty might require different treatment than a less severe one. First, a serious marital difficulty often has a longer history than a less serious difficulty. A couple may have struggled with the problem for years and tried numerous unsuccessful strategies to solve the problem. Consequently, they are likely to have become rigid in their positions and less amenable to behavioral change.

Second, a severe problem is more likely than a less serious one to affect other aspects of the relationship, such as each partner’s level of distress, anger, intimacy, and commitment. A serious problem can hinder partners’ enjoyment of each other and diminish their motivation to work on the relationship. It can lead to emotional disengagement between partners. In the extreme, a serious problem can lead couples to consider separation or divorce. Because of this impact on enjoyment, motivation, emotional engagement, and commitment, a serious problem represents a challenge to treatment strategies. Indeed, TBCT is less effective with couples who are emotionally disengaged (Jacobson & Christensen, 1996).

Third, a serious problem is likely to lead to greater reactivity or sensitivity in partners than a relatively mild one (Christensen & Pasch, 1993). Partners may become so affected by a problem that any manifestation of it leads to distress. For example, a husband who has a major problem with his wife over her criticism of him may become sensitized to even slight indications of disapproval from her. Evidence for this process of reactivity comes from work by Jacobson, Follette, and McDonald (1982), who showed that the daily marital satisfaction of distressed couples was more affected by positive and negative daily events than the daily marital satisfaction of nondistressed couples. For example, if a relatively happy couple has a mild, short disagreement, they are more likely to let it pass and continue to feel positively toward each other. Conversely, a distressed couple is more likely to be upset by the disagreement and it may
affect their interactions and feelings toward each other for the rest of the day. This may then become a cycle in which negative affect leads to further distress, which leads to further negative affect. Over time, this process would lead to a decline in marital satisfaction.

The acceptance strategies of ICT may be a useful adjunct to TBCT when marital problems are especially serious and chronic. These acceptance strategies were designed for “unsolvable marital problems” which are not responsive to the direct strategies of negotiation and behavior change of TBCT. If couples are able to be more accepting of each other’s problematic behavior, they may be able to enjoy their relationship despite the problem. Further, one tenet of ICT is that the pressure to change is sometimes a major barrier to change. Resistance to change declines through acceptance, and some change in behavior may occur “spontaneously” (Christensen et al., 1995).

One strategy for promoting acceptance in ICT is “unified detachment.” With this strategy, ICT therapists try to help couples create some emotional distance from the problem. They engage the couple in a process of analyzing the conflict. For example, they look at the interaction sequence that surrounds the problem. They identify triggers for each partners’ emotional reactions and have the partners rate the intensity of those reactions. They compare different instances when the problem occurred, trying to determine why the problem was more intense on one occasion than on another. They may engage the couple in a search for an appropriate name or metaphor for the problem or the reactions it entails. With these strategies, the problem gradually becomes less of a “you” (“something you do to me”) and more of an “it” (“a problem that we share”).

Another strategy for promoting acceptance is “tolerance building.” Here, ICT therapists try to desensitize partners to each other’s negative behavior. For example, they may have the couple role-play negative behavior in the session, perhaps even exaggerating it, and then examine each partner’s reactions to the other’s negative behavior. Therapists may request that one member enact a negative behavior at home when “you are not really feeling it” in order to more objectively observe the other’s response to the negative behavior. This request is given in front of the partner with the explicit message that the other may do a “false” negative behavior. Knowing the negative behavior may be false, the partner may be less likely to give his or her “knee-jerk” response to it. These strategies and others may enable spouses to be more tolerant and less reactive to their partner’s behavior.

Neither of these strategies may solve a serious marital problem, but they may enable couples to live with the problem more comfortably. This may be the most realistic outcome for a serious, long-term marital problem.

CONCLUSION

Few published studies on couples therapies have considered the impact that individual factors and dyadic development have on relationship distress. Further, there has been little effort to develop couple therapies that view relationships from a content-relevant or developmental perspective. In this article we have called for a shift in thinking about marriage to include the roles that individual factors and dyadic development play in a couple’s level of marital quality. By changing our conceptual framework as a field, we will be able to examine the impact that both individual variables and relationship development have on communication and conflict and on subsequent satis-
faction and stability. Further, we have proposed utilizing TBCT as a starting point, as it is the couples therapy for which we have the most empirical information. Consequently, we have delineated ways in which a consideration of individual factors and dyadic development can guide the enhancement of TBCT with novel and improved techniques that will ultimately allow us to reach a wider range of couples than our current interventions allow.

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REFERENCES


