

Integrative Behavioral Couple Therapy: An Acceptance-Based, Promising New Treatment for Couple Discord

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Although traditional behavioral couple therapy (TBCT) has garnered the most empirical support of any marital treatment, concerns have been raised about both its durability and clinical significance. Integrative behavioral couple therapy (IBCT) was designed to address some of these limitations by combining strategies for fostering emotional acceptance with the change-oriented strategies of TBCT. Results of a preliminary clinical trial, in which 21 couples were randomly assigned to TBCT or IBCT, indicated that therapists could keep the 2 treatments distinct, that both husbands and wives receiving IBCT evidenced greater increases in marital satisfaction than couples receiving TBCT, and that IBCT resulted in a greater percentage of couples who either improved or recovered on the basis of clinical significance data. Although preliminary, these findings suggest that IBCT is a promising new treatment for couple discord.

Traditional behavioral couple therapy (TBCT; also known as behavioral marital therapy) has been the most widely studied approach to treating marital distress, and its efficacy has been repeatedly demonstrated in over 20 randomized clinical trials (Baucom, Shoham, Meuser, Daiuto, & Stickle, 1998; Christensen & Heavey, 1999; Jacobson & Addis, 1993). Several of these clinical trials were conducted by Jacobson and colleagues using the version of TBCT summarized by Jacobson and Margolin (1979). In an analysis of the clinical significance of various treatment approaches, Jacobson's version of TBCT yielded higher rates of success than the others examined (Jacobson et al., 1984). This is not to say that TBCT is the only effective approach to couple therapy. In fact, as Baucom et al. (1998) have documented, other treatments, such as emotionally focused couple therapy (Greenberg & Johnson, 1988), have shown promise. But TBCT is the only couple therapy to receive the highest designation as an

"efficacious and specific intervention" (Baucom et al., 1998, p. 58).

At the same time, these studies have also revealed significant limitations in both the clinical significance and the durability of TBCT. First, at least one third of the couples studied in randomized clinical trials of TBCT are clear-cut treatment failures, remaining in the maritally distressed range at the conclusion of therapy (Jacobson & Addis, 1993). Second, even among those couples who improve, many do not maintain their improvement over a 2-year period (Jacobson, Schmaling, & Holtzworth-Munroe, 1987).

The purpose of the present study was to provide preliminary data on a new approach to treating marital distress, integrative behavioral couple therapy (IBCT), which was developed by Andrew Christensen and Neil S. Jacobson (Christensen, Jacobson, & Babcock, 1995; Jacobson & Christensen, 1996). Whereas TBCT focuses on helping spouses "change" in light of their partners' complaints and requires active collaboration and compromise between partners, IBCT includes strategies to help spouses accept aspects of their partners that were previously considered unacceptable. However, despite the label, the purpose of "acceptance work" is not to promote resignation to the relationship as it is or mere acceptance. Rather, it is designed to help couples use their unsolvable problems as vehicles to establish greater closeness and intimacy. For couples who have difficulty changing their behavior, acceptance provides a viable alternative for building a closer relationship. For couples who do benefit from the traditional approach, IBCT can facilitate further progress by providing an alternative way to establish a closer relationship, given that there are problems in every relationship that are impervious to change. Paradoxically, acceptance interventions are also predicted to produce change in addition to acceptance, often more efficiently than the direct change inducing strategies that constitute TBCT, be-

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After the completion of this article, but prior to its revision, Neil S. Jacobson died suddenly and unexpectedly. His untimely departure is a major loss not only for his family and friends but also for the field of marital therapy, to which he contributed so much.

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Table 1
Pretreatment Demographic Variables

Variable	IBCT (n = 10)								TBCT (n = 11)							
	Husbands				Wives				Husbands				Wives			
	M	SD	n	%	M	SD	n	%	M	SD	n	%	M	SD	n	%
Age (years)	44.00	10.34			41.20	8.98			41.09	8.95			39.00	11.86		
Education																
High school graduate			2	20			2	20			4	36			4	36
College graduate			3	30			5	50			5	45			3	27
Postcollege			4	40			2	20			0	0			2	18
Unknown			1	10			1	10			2	18			2	18
No. of previous marriages	0.22	0.67			0.44	0.88			0.27	0.47			0.36	0.67		
Length of marriage (years)				13.60	12.28							5.91	4.21			
No. of children				1.40	1.84							1.82	1.17			

Note. IBCT = integrative behavioral couple therapy; TBCT = traditional behavioral couple therapy.

cause at times the pressure to change may be the very factor that prevents it from occurring.

Method

Participating Couples and Therapists

Participants in this study were 21 couples requesting therapy for marital distress. To be eligible for the study, couples had to be legally married and living together and both spouses had to be between 21 and 60 years old. In addition, each was required to score above 58 on the Global Distress Scale (GDS) of the Marital Satisfaction Inventory (MSI; Snyder, 1979), indicating clinically significant levels of marital distress. Couples were excluded if either spouse was in some concurrent form of psychotherapy ($n = 8$), taking psychotropic medication ($n = 8$), alcohol dependent ($n = 2$), engaging in moderate to severe domestic violence within the past year ($n = 2$, using criteria from Jacobson, Gottman, Waltz, Babcock, & Holtzworth-Munroe, 1994), or if the sole presenting complaint was sexual dysfunction ($n = 2$). We were also prepared to exclude couples if either spouse met the criteria for schizophrenia (current episode), drug dependence, or mania, although no such couples were encountered.

After qualifying for the study, couples were randomly assigned to either TBCT or IBCT. Table 1 presents a summary of pretreatment demographic variables for each spouse (age, education, duration of marriage, number of previous marriages, and number of children) as a function of treatment condition. None of the demographic variables were significantly different in the two treatment conditions.

Cases were assigned to one of five therapists as the therapist was available and as needed to ensure that therapists saw cases in both conditions. Each therapist saw a total of two to six cases and, with the exception of one therapist who saw an extra TBCT case, saw equal numbers of cases in each condition. The five therapists, who included four licensed psychologists and one master's-level marriage and family therapist, were trained by first attending a didactic workshop presented by Neil S. Jacobson. They were then asked to read both the IBCT (Christensen et al., 1995) and TBCT (Jacobson & Margolin, 1979) treatment manuals. Once they began seeing cases, half were supervised by Andrew Christensen and half were supervised by Neil S. Jacobson, who both supervised cases in each treatment condition. All of the treatment sessions were audio- or videotaped and mailed to supervisors, and each therapist had weekly 30-min telephone conversations with each supervisor during which the supervisor provided feedback and answered questions regarding the therapist's current cases. In

addition to these weekly phone contacts, Andrew Christensen and Neil S. Jacobson met monthly with therapists in Year 1 and bimonthly in Year 2. During these meetings, taped segments illustrating both treatments were viewed, difficult cases were discussed, and any violations of treatment protocol observed by the adherence raters were reviewed. These strategies were successful in preventing drift across supervisors and in revising the IBCT treatment manual so that versions could be published for therapists (Jacobson & Christensen, 1996) and for clients (Christensen & Jacobson, 2000).

Treatment Conditions

TBCT. The version of TBCT used in the present study was an adaptation of the one used by Jacobson and Margolin (1979), as specified in a companion manual.¹

IBCT (Christensen et al., 1995; Jacobson & Christensen, 1996). This approach includes three interventions designed to promote acceptance between partners: empathic joining, unified detachment, and tolerance building. In IBCT, these acceptance strategies are integrated with the change-oriented strategies of TBCT. The relative emphasis on acceptance versus change depends to some extent on the individual characteristics and needs of the couple.

IBCT treatment began as clinically indicated for each couple in the study on the basis of the case formulation developed during the initial assessment sessions but usually began with acceptance interventions. Subsequently, change techniques were integrated with acceptance strategies as needed.

Treatment length. All of the couples in both treatment conditions were allowed up to 26 sessions (which included 2 individual sessions during an evaluation phase) and, in fact, received between 13 and 26 sessions. The mean number of sessions for TBCT couples was 20.72 ($SD = 3.55$), whereas the mean number of sessions for IBCT couples was 21.00 ($SD = 4.15$); the difference between groups was not significant. Of the 11 couples assigned to TBCT, 1 couple experienced substantial improvement early in treatment and, in agreement with their therapist, terminated after the 14th session. Of the 10 couples assigned to IBCT, 1 couple did not complete treatment, deciding to divorce after 13 sessions.

Therapist adherence and competence. We constructed an adherence scale that included eight items reflecting change-oriented interventions and

¹The TBCT manual can be obtained from Andrew Christensen by written request.

Table 2
Overall Adherence Ratings

Type of intervention	IBCT		TBCT		<i>t</i> (129)	<i>p</i> <
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Change	11.13	2.37	17.59	3.31	13.01	.001
Acceptance	14.08	2.57	9.47	0.77	13.27	.001

Note. IBCT = integrative behavioral couple therapy; TBCT = traditional behavioral couple therapy.

nine items reflecting acceptance interventions. Two senior graduate students served as coding trainers and calibrators, and three additional graduate students served as coders. Eight TBCT and eight IBCT cases were coded for adherence. Nine tapes were coded per case (three early, three middle, and three late sessions); within these constraints, the exact tapes to be coded were determined randomly. Twenty percent of the coded tapes were also coded by a calibrator. Coders were blind as to both treatment condition and which sessions were coded by the calibrator. They rated the degree to which each intervention was observed in that session on a 5-point scale ranging from 1 (*not at all*) to 5 (*extensively*). Reliabilities were calculated based on intraclass correlation coefficients and represent the agreement between each rater and the calibrator. Reliabilities for the three coders ranged from .87 to .95 for change ratings and from .74 to .88 for the acceptance ratings.

In addition, we conducted a second, completely independent manipulation check to ensure that our ratings of adherence were not influenced by rater bias. The adherence ratings described above were conducted by clinical graduate students familiar with TBCT and IBCT and who therefore were often able to discern the treatment condition. Thus, we created a second, simpler system using global codes and trained undergraduate raters who had no previous knowledge of TBCT and IBCT to use this global coding system. This system included a code for "instigate change," which consisted of any of the change interventions defined in the earlier system, and "acceptance," which consisted of any of the acceptance activities defined in the earlier system. After watching an entire session, coders rated the extent to which therapists engaged in these activities on a 9-point scale. Six sessions from each of the 21 cases (two sessions each from the early, middle, and late phases of therapy) were rated by four teams of three or four undergraduate observers who were trained in the global coding system but who were uninformed about TBCT, IBCT, and the nature of the study. In fact, they were not told that two kinds of therapy were being compared but rather that we were examining the correlates of different types of therapist activities. Ratings on these two global scales were reliable (average alpha was .86 for change and .80 for acceptance).

Finally, to document that TBCT received a fair test in the present study, we had 120 TBCT tapes coded for competence by Donald H. Baucom, a recognized expert in TBCT. These manipulation checks and their results are described in greater detail below.

Outcome Measures

We measured pre- to posttreatment changes in marital satisfaction using the GDS of the MSI (Snyder, 1979) and the Dyadic Adjustment Scale (DAS; Spanier, 1976). Both are well-validated instruments for assessing satisfaction in marriage.

Results

Adherence to Treatment Protocols

Table 2 compares the overall change and acceptance ratings for

TBCT versus IBCT on our molecular Adherence scale. The table shows that change-oriented interventions were significantly more likely to be used in TBCT than in IBCT, whereas acceptance interventions were significantly more likely to be used in IBCT than in TBCT. The means reported in Table 2 represent the sum of the ratings for each item in that subscale. Thus, the range for the Change subscale (eight items) is 8 to 40, and the range for the Acceptance subscale (nine items) is 9 to 45. Of particular note is that the mean for Acceptance items in TBCT is very close to the minimum, indicating that there was very little acceptance work going on in TBCT and thus very few protocol violations. On the other hand, because IBCT includes the change-oriented strategies of TBCT, some change work is appropriate. As expected, there were a moderate number of change interventions observed in IBCT, but not as many as in TBCT.

In addition to the above, we conducted a second manipulation check using naive raters and global codes of instigate change and acceptance described earlier to ensure that our adherence data were not an artifact of the raters' biases. Primary analyses consisting of 2 (treatment group) \times 6 (session) repeated measures analyses of variance revealed significant main effects of treatment group. As predicted, average ratings of acceptance were much higher for IBCT therapists ($M = 6.47$) than for TBCT therapists ($M = 4.28$), $F(1, 17) = 35.61, p < .001$, whereas mean ratings for instigate change were much higher for TBCT therapists ($M = 6.08$) than for IBCT therapists ($M = 3.32$), $F(1, 17) = 33.45, p < .001$. Further, when we created a ratio of acceptance to instigate change, we found no overlap in the two distributions: The lowest ratio among IBCT cases was higher than the highest ratio among TBCT cases. In short, results indicate that these two systems for rating adherence were able to discriminate between TBCT and IBCT and, further, that therapists conducting both treatments were able to keep them distinct: They were successful in avoiding acceptance interventions in TBCT and in incorporating such interventions when conducting IBCT.

Therapist Competence in TBCT

One possible explanation for promising results when testing a new treatment approach is the effect of therapist allegiance: Perhaps the therapists' greater enthusiasm for the new treatment and/or their corresponding decreased confidence in the old treatment lead them to provide a less than optimal test of the latter. Therefore, it was important to ensure that TBCT was performed with a high degree of competence and that therapist bias toward IBCT did not influence our results. To this end, we had 120 TBCT tapes coded by an expert in TBCT, Donald H. Baucom from the University of North Carolina. Baucom had no other connection to the study beyond his role as a consultant who provided competence ratings of TBCT. In collaboration with Baucom, we designed a scale, called the Behavioral Couple Therapy Competence Rating Scale, which is designed to have a maximum score of 66. A score of 40, which indicates an average rating of "good," is considered the cutoff for competent performance of TBCT. Baucom rated up to 16 tapes per couple for 8 couples assigned to TBCT. The first 4 tapes (1st conjoint session, individual assessment sessions with both husband and wife, and feedback session) were viewed for case conceptualization purposes only; competence ratings were completed for Sessions 5-16. Results indicated that TBCT was

Table 3
Pre- to Posttreatment Improvement by Treatment Condition

Measure	IBCT				TBCT				ES
	Pretreatment		Posttreatment		Pretreatment		Posttreatment		
	M	SD	M	SD	M	SD	M	SD	
GDS									
Husbands	64.80	11.20	57.30	11.49	69.09	9.44	65.09	13.00	0.62
Wives	64.50	6.65	56.10	8.94	68.91	6.67	64.64	11.36	0.78
DAS									
Husbands	91.30	11.70	106.20	14.27	86.91	15.76	97.09	17.59	0.56
Wives	89.20	11.26	101.30	16.17	79.91	14.38	88.00	28.35	0.56

Note. IBCT = integrative behavioral couple therapy; TBCT = traditional behavioral couple therapy; ES = effect size; GDS = Global Distress Scale of the Marital Satisfaction Inventory; DAS = Dyadic Adjustment Scale.

conducted with a high level of competence. Ratings for individual sessions ranged from 43 to 66, with an overall mean rating of 61.1. These ratings consistently exceeded our established minimum standards of competence and indicated that the TBCT performed in this study was state of the art.

Treatment Outcome

Because of the small sample size and inadequate statistical power of the present study, we made a decision to confine our analyses to descriptive statistics reflecting both effect size and clinical significance of the group differences but not to use statistical analyses for hypotheses-testing purposes. Table 3 presents the results of our primary outcome analyses. The table shows pre- and posttest scores for husbands and wives on the GDS and the DAS, our two primary outcome measures. Results are presented for all 21 couples who participated in the study, including the 1 IBCT couple who did not complete treatment. For the latter couple, because we were unable to obtain posttest scores, their pretest scores on each outcome measure served as the termination score. As the table shows, both husbands and wives experienced greater improvements in their satisfaction following IBCT than they did following TBCT. The effect sizes indicate moderate (based on the DAS) to large (based on the GDS) group differences favoring IBCT.

Finally, we assessed the clinical significance of the observed group differences using the criteria for improvement and recovery derived by Jacobson and colleagues (e.g., Jacobson & Truax, 1991). Table 4 shows the number and proportion of couples whose increases in marital satisfaction were both statistically and clinically

significant using the GDS. Clinical significance referred to both spouses scoring in the nondistressed range at the conclusion of therapy, whereas improvement referred to scores that indicated increased marital satisfaction but were still in the distressed range for 1 or both spouses posttreatment. To ensure that the magnitude of change exceeded that which could reasonably be explained by measurement error, we also required that each partner's magnitude of change had to be statistically reliable on the basis of the modified reliable change index (Jacobson & Truax, 1991). As Table 4 indicates, 64% of the TBCT couples either improved or recovered by the end of therapy; in contrast, 80% of the IBCT couples either improved or recovered.

Discussion

The results of our treatment development study suggest that IBCT may be a promising alternative to TBCT. First, through our adherence ratings, we demonstrated that IBCT was a distinct treatment from TBCT. Second, we showed that the therapists in this study were able to successfully implement our independent variable by confining acceptance-focused interventions to IBCT and by providing an intensive, state-of-the-art test of change-oriented interventions in TBCT. Third, and most importantly, IBCT, performed by therapists with no prior experience with the treatment, obtained results that were impressive both in an absolute sense and relative to TBCT.

Besides these outcome results, there are several additional findings that support the future study of IBCT. Christensen and Jacobson (1996) reported that IBCT produced as much or more change in some areas of the relationship than TBCT, despite the emphasis on acceptance, rather than change, in IBCT. Consistent with the theory of change underlying IBCT (Jacobson & Christensen, 1996), the contextual shifts following successful acceptance work can be a more effective way of shifting the contingencies of reinforcement in a way that supports spontaneous change. Acceptance may not only be conducive to an improved relationship in its own right but may also at times be a more efficient way of producing behavior change than the direct attempts to induce it, which characterize TBCT.

Furthermore, evidence of differential processes occurring in the two treatments was found in an examination of couples' in-session verbal behavior (Cordova, Jacobson, & Christensen, 1998). Using

Table 4
Clinical Significance Data

Outcome	TBCT (n = 11)		IBCT (n = 10)	
	%	n	%	n
Nondistressed	55	6	70	7
Improved but still distressed	9	1	10	1
No change or worse	36	4	20	2

Note. TBCT = traditional behavioral couple therapy; IBCT = integrative behavioral couple therapy.

a system designed to rate husband-wife interaction, coders were trained to rate early, middle, and late therapy sessions on the occurrence of spouse behaviors expected to discriminate between the two treatments. Results indicated different kinds of interactional changes in the two treatments that were in accord with the theories of change underlying the two treatments. For example, two categories of spouse behavior, empathic joining and unified detachment, behaviors that are encouraged in IBCT but not in TBCT, were indeed more common in IBCT sessions, especially toward the end of therapy. This study provides further evidence that the types of interactional change targeted by the two treatments are actually reflected in couples' in-session behavior, especially in middle and later sessions.

Since we conducted this original trial, two additional unpublished studies, summarized by Christensen and Heavey (1999), have provided further preliminary evidence as to the scope of IBCT. Not only does it appear to be possible to successfully apply IBCT in a couples-group format, but the treatment may also be a viable alternative to individual therapy when depression in 1 spouse coexists with marital discord.

Although these results, taken together, warrant further exploration, they must be interpreted in the preliminary spirit in which the data were collected. The next step is a randomized clinical trial with sufficient statistical power to establish both the replicability and the reliability of group differences between IBCT and TBCT. In fact, we have begun such a trial at two sites—the University of California, Los Angeles, and the University of Washington—where 150 couples are being randomly assigned to IBCT or TBCT in what will be the largest study of marital therapy efficacy ever undertaken. Only after such a trial has been completed will we know if the early promise demonstrated in the present study can be confirmed. The study currently under way will also address a question that is crucial to the value of a marital treatment but beyond the scope of the present treatment development study: the durability of acceptance and change produced by the two treatments under study. Not only do we need to know about the immediate benefits of IBCT, but a major reason for its development was also the hope that an integrative treatment would lead to permanent improvement, a goal that has not yet been tested, even in a preliminary way.

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