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PROBLEM-SOLVING TRAINING FOR COUPLES

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There are few areas in life that require skillful social problem solving as consistently as marriage. Differences between partners and the resulting friction are part of the natural fabric of marriage, and how successfully partners cope with those inevitable relationship problems determines how healthy their marriage will be. Marital therapy was among the first to adopt the social problem-solving model as a basis for treatment (e.g., Jacobson & Margolin, 1979).

The evolution of behavioral couple interventions has followed from its roots in social problem solving to include emphases on both acceptance and motivation to change. The goal of this chapter is to present the evolution of couple interventions in the service of expanding the social problem-solving model to include an emphasis on acceptance and motivation to change.

RELATIONSHIP DISTRESS

Ninety percent of adults will marry at least once (Norton & Moorman, 1987) and almost all marriages begin with happy partners. Despite the initial

promise, it has been estimated that 20% of all couples are experiencing significant relationship distress (Beach, Arias, & O'Leary, 1987) and approximately half of all first marriages end in divorce (see Sayers & Cordova, 2001).

Relationship distress is associated with a number of other problems, including risk of depression (Whisman, 2001), substance abuse (Maisto, O'Farrell, Connors, McKay, & Pelcovits, 1988), domestic violence (Holtzworth-Munroe, Smutzler, Bates, & Sandin, 1997), diminished immune system functioning (Newton, Kiecolt-Glaser, Glaser, & Malarkey, 1995), and poorer adherence to medical treatment (Schmaling & Sher, 1997). In addition, marital distress is associated with child difficulties such as diminished mental health, increased problem behavior, and poorer school performance (e.g., Amato, 2001).

Destructive communication and ineffective conflict are among the biggest contributors to marital distress (e.g., Gottman, 1994). Distressed partners tend to ignore relationship problems, have difficulty generating viable solutions, and physically withdraw in response to conflict (Christensen & Shenk, 1991). Dissatisfied partners are less likely to engage in active listening and more likely to criticize and blame each other (Weiss & Heyman, 1997). Thus, it appears that poor social problem solving plays a substantial role in marital deterioration. Given the amount of suffering resulting from relationship deterioration, developing effective treatments for couple distress is essential to the health and welfare of the population as a whole. It is toward this end that the social problem-solving model was first applied as a treatment for marital deterioration.

THE SOCIAL PROBLEM-SOLVING MODEL

D'Zurilla and Goldfried (1971) first defined social problem-solving as the process by which an individual attempts to identify, discover, or invent effective coping responses to everyday problems. They proposed a model consisting of two components: (a) problem orientation and (b) problem-solving skills.

A problem orientation is the response set brought to a problem based on past experience (D'Zurilla & Sheedy, 1992). It comprises the specific ways in which a person perceives and appraises a new problem. It involves motivation to address a problem, as well as a person's general awareness of problems, assessment of problem-solving competence, and effectiveness expectations (Reinecke, DuBois, & Schultz, 2001). A person's problem orientation affects the quality of problem solving by influencing when problem solving begins, the amount of time and effort expended, the emotions generated, and the efficiency of the solution.

Partners develop their unique relationship problem orientations over their lifetimes, from early childhood experiences with family and peers through later adult experiences with romantic partners. These histories shape how well prepared a person is to identify and respond to relationship issues. For example, there is evidence that individuals with anxious–ambivalent attachment styles (compared to those with more secure styles) may be hyperattuned to fluctuations in relationship quality, leaving them uniquely vulnerable to depressive symptoms when relationship quality declines (Scott & Cordova, 2002).

A set of four skills makes up the second component of the social problem-solving model. The first skill is problem definition and formulation, or the ability to obtain relevant, factual information about a problem, clarify the nature of the problem, and delineate a set of realistic goals. The second skill involves the ability to identify, discover, or create a range of solutions. The third skill is decision making, which involves comparing and choosing the best solution for the situation. The fourth skill is solution implementation and verification, or evaluating the actual outcome of the solution. Training in these four skills was incorporated into behavioral couple therapy as the principal means of improving failing marriages.

BEHAVIORAL MARITAL THERAPY

Social learning theorists proposed that marital discord results from poor communication and problem-solving skills, leading to decreases in positive interactions and increases in aversive interactions (Jacobson & Margolin, 1979). Behavioral Marital Therapy (BMT) was grounded on the principle that improving partners' problem-solving skills would improve relationship quality. BMT consists of three strategies: (a) increasing partners' exchange of positive behaviors, (b) increasing consistent and effective communication, and (c) teaching effective problem solving.

The first BMT strategy, Behavior Exchange (BE), is designed to increase the number of positive interactions between partners. BE consists of two steps. First, partners identify things they could do to increase the other's relationship satisfaction but that do not require significant personal change. Next, each partner is assigned to do at least one thing from the list during the week and to observe the effect on the other partner. When BE works, the increased level of positivity provides a quick boost to partners' marital satisfaction.

Although BE provides a quick boost, communication and problem-solving training are the primary methods for improving relationship quality (Cordova & Jacobson, 1997). Communication training (CT) involves teaching principles of effective communication. The first principle is the inherent

difficulty of effective communication. Although in day-to-day conversation we generally understand each other well enough to get by, that understanding is usually less than completely accurate. What we hear of what others say to us is clouded by our preconceptions, lack of attention, and focus on our own thoughts. This clouding is usually not terribly disruptive; however, the more important or emotionally challenging the conversation, the greater the likelihood that it will result in destructive misunderstandings.

The next principle involves sharing thoughts and feelings during a conversation. Partners are taught to avoid mind reading, criticizing, and blaming because doing so often results in defensiveness and polarization. Partners are also taught to take turns talking, to avoid interrupting, and to keep each turn short so the other partner can hear and remember the message. Finally, partners are taught to paraphrase as a means of double-checking their initial understanding of what the other person said. Paraphrasing consists of (a) privately acknowledging that one's initial understanding of what the partner said may be wrong, (b) sharing one's initial understanding and, (c) asking if what one heard is what the partner meant to convey. Paraphrasing also allows the *speaker* to hear what the other partner is hearing and to clarify the message before misunderstandings derail effective communication.

Problem-solving training (PST) teaches couples concrete strategies for addressing relationship problems. PST closely follows D'Zurilla and Goldfried's (1971) steps for effective problem solving. The first step involves distinguishing between two phases of problem solving: (a) problem definition and (b) problem solution. This is an important distinction because problem solving can become bogged down if the problem is poorly understood. In addition, jumping back and forth between defining and attempting to solve a problem can easily derail partners. Partners begin the definition phase by expressing appreciation, understanding, and positive regard for each other. Because partners bring a history of hurt and anger to discussion of the problem, an initial demonstration of affection lays the foundation for improved collaboration. Couples next identify the specific circumstances and behaviors that define the problem. Thus, instead of the husband saying that the problem is that the wife does not care about him, he is guided to the specific statement that he feels ignored when his wife spends her evening talking on the phone with friends. The therapist also asks the partners to express their feelings about the problem. This allows each partner to develop a deeper understanding of the other's experience.

Following definition, couples begin the problem-solution phase. Brainstorming involves generating as many solutions as possible while refraining from evaluating their viability. Partners are instructed to be creative, offering both genuine and outlandish suggestions. The goal is to increase the probability that partners will discover the best available solution rather than settling

for the first solution that comes to mind. After generating a list of solutions, partners review each item and remove the ones that are impossible, silly, or inadequate.

Next, partners review the remaining items, discuss the pros and cons of each, and work together to make a decision about each item. The couple is asked to find solutions that do not impose too heavy a burden on either partner. Changes to items are explored until some compromise is worked out or the item is eliminated.

Next partners write a change agreement that details their solution. Partners anticipate obstacles that might interfere with implementation, and plans are made for dealing with those obstacles. Verification occurs over the following sessions. At the beginning of each session, partners review how the agreement is working and collaborate on any necessary changes.

More empirical research has been conducted on BMT than on any other approach to couple therapy, and the results have been promising. Studies show that 72% of couples improve during treatment (58% scoring in the maritally satisfied range), and most couples maintain gains through six months (Jacobson, 1984). However, continued follow-up revealed that approximately 30% of recovered couples relapsed after two years (Jacobson, Schmaling, & Holtzworth-Munroe, 1987). Overall 50% of all couples treated with BMT achieve lasting benefits.

Social problem solving with couples, as originally implemented, required a lot of active collaboration between partners for the treatment to be successful. Partners had to collaborate to (a) increase positive exchanges; (b) learn, practice, and adhere to the CT guidelines; and (c) negotiate solutions to emotionally volatile problems. This expectation of collaboration is viable for many couples; however, for many others, anger, polarization, and problem embeddedness precluded partners' ability to work with each other to practice new skills. Research found that the couples least likely to benefit from BMT were older, more distressed, more emotionally disengaged, and more polarized in their disagreements (e.g., Jacobson, Follette, & Pagel, 1986), all characteristics likely to undermine partners' capacity for collaboration.

In addition, BMT also required partners to adhere to a well-defined rule structure. One difficulty with this is that during emotionally challenging interactions, partners find it difficult to follow rules. Some researchers have commented on the emotional gymnastics required to use rational skills in emotionally challenging contexts (Gottman, Coan, Carrere, & Swanson, 1998).

Another difficulty with teaching rules is that the initial contingencies for following them are imposed by the teacher, who praises or corrects partners' adherence. Reinforcement does not stem naturally from the transaction between the individual and the out-of-session environment. Rules

are only beneficial in the long run if the behavior they elicit eventually comes under the direct control of naturally occurring contingencies. Thus, partners may follow the rules of CT and PST in the presence of the therapist, but unless they make direct contact with the benefits of following those rules in their real-world relationship, they are unlikely to continue doing so outside of therapy. Research suggests that couples are unlikely to continue using BMT techniques after therapy, even if those couples remain maritally satisfied. Instructing couples to begin their discussion with a positive statement is an example of rule-governed behavior. The therapist reinforces the couple for compliance with the rule in the hope that natural contingencies will maintain the behavior. However, because the behavior is "following a rule," rather than genuinely praising or reassuring the partner, it feels forced and not genuine. In turn, a positive response from the partner is improbable and the behavior is unlikely to continue for lack of reinforcement. The implication is that the skills may never come to be controlled by naturally occurring contingencies. Therefore, they may not generalize outside therapy and they may be susceptible to quick extinction once therapy is over.

Thus, although a 50% success rate for BMT was laudable, there were empirical and theoretical reasons to suspect that the approach could be improved by attending to the underlying causes of noncollaboration and developing techniques using natural contingencies

INTEGRATIVE COUPLES THERAPY

Advances in couples' therapy in the 1990s consisted of integrating an approach to coping with problems that emphasized acceptance. Promoting acceptance can facilitate intimacy and reestablish effective problem solving. D'Zurilla's model anticipates this evolution toward addressing emotional climate. D'Zurilla (1990) stated that problem solving is conceived as a broad strategy whose goals are not limited to problem-focused goals but may include emotion-focused goals, depending on the nature of the problem and how it is defined and appraised. D'Zurilla (1990) defined a problem-focused goal as one that is aimed at managing situational demands and an emotion-focused goal as one that is aimed at managing emotions generated by the problem. He stated that when the problem is appraised as unchangeable or uncontrollable, an emotion-focused goal would be emphasized. On the other hand, if the situation were appraised as changeable or controllable, then a problem-focused goal would be appropriate, although an emotion-focused goal might be included to cope with emotional stress.

Christensen and Jacobson (e.g., 1998) developed Integrative Couples Therapy (ICT) emphasizing a similar distinction between controllable versus uncontrollable situations. The wise application of acceptance came to be

seen as an adaptive repertoire for coping with relationship problems that do not lend themselves to negotiated change. When partners find themselves stuck struggling to change the unchangeable, bitterness, resentment, anger, and polarization can begin to define the relationship's emotional climate. In fact, it is impossible to assess for true problem-solving deficits before the emotional climate is healthy. If the emotional climate is clouded by anger and bitterness, even partners with excellent problem-solving abilities may not use those abilities to help their relationship. A couple's problems are not always solvable through negotiated change because two individuals will naturally have differences such as spending habits or intimacy needs. Techniques for promoting acceptance were developed to help partners cope more gracefully with the unchangeable aspects of their relationship while preserving the best parts of the relationship as a whole. Promoting acceptance is intended to help partners escape unwinnable battles, freeing up the time and energy spent fighting for relationship-healthy practices. Acceptance strategies foster intimacy and compassionate understanding, thus fostering the type of emotional climate in which partners genuinely want to behave lovingly and are willing to negotiate with each other toward instrumental change.

ICT begins by assessing each partner's experience of the problems that have led them to seek treatment. One goal of assessment is to determine the emphasis to place on change versus acceptance. Assessing partners' problem orientations allows the therapist to determine whether partners are defining solvable problems in unsolvable ways or whether they are defining unsolvable differences as solvable problems. A partner's likes and dislikes—whether she is a morning person or evening person; whether he is exuberant or neurotic, shy or gregarious, a spender or a saver, neat or messy—are unlikely to be bargained away. Although unchangeable differences can be a source of significant friction in a relationship, ICT proposes that gracefully accepting such differences is the key to long-term adaptive coping. Alternatively, framing such natural differences as problems that can be solved is often the root of chronic, corrosive conflict. The assessment phase consists of a conjoint interview followed by individual interviews with each spouse and a final conjoint feedback session. In the conjoint session, the therapist asks each partner what has brought him or her into therapy. It is often the case that partners' views of their problems differ in important ways. As partners describe their issues, the therapist models active listening and judicious paraphrasing. Paraphrasing provides a means for the therapist to understand each person's perspective and it communicates acceptance and validation of each partner. When done well, those initial sessions build rapport with each individual partner and helps partners to gain a deeper and more compassionate understanding of each other. Because they are not talking to each other but are instead listening to the other

partner talk to the therapist, it is often easier for partners to hear each other without the filtering of self-defensiveness. Next, the therapist describes the framework of therapy, explaining that assessment consists of the conjoint interview, the two individual interviews, and a final feedback session. Partners are told that they will decide whether to continue with therapy at the feedback session. Letting partners know early that they will be asked to decide whether to continue therapy helps them to recognize that engaging in therapy remains their choice and that they are free to choose otherwise at any time.

The individual sessions explore each partner's unique take on relationship issues without fear of hurting the other partner. It also allows the therapist to safely assess for domestic violence, secret affairs, and private thoughts of divorce. Finally, it allows the therapist to assess for individual issues such as depression, substance use, and individual stressors.

Six areas are assessed during the initial phase. The first is the couple's level of relationship distress. The more severe and chronic the distress, the more likely the therapist will begin by fostering acceptance. The second area assessed is relationship commitment. The less committed partners are, the more the therapist will focus initially on uncovering the couple's strengths and the positive aspects of the relationship.

Third, the therapist assesses the major issues in the relationship. Issues that are unlikely to change, such as those centered around private experiences (e.g., different desires for physical affection) are likely targets for acceptance, whereas issues concerning more instrumental behaviors (e.g., household tasks) are likely targets for problem-solving training.

The next area addressed is how the couple is currently dealing with their problems. Identifying the couple's patterns forms the basis for much of the following acceptance work, because it is often not the issues themselves but how the couple deals with these issues that determines their current level of distress. The final area assessed is the couple's strengths, because it is their strengths that motivate them to work on the relationship.

Following assessment, the therapist designs a treatment plan that is presented at the feedback session. Depending on the particular needs of the couple, the therapist will propose a combination of acceptance and change strategies. The goal of feedback is to move the couple toward a shared understanding of their difficulties and increase their compassion for each other. The therapist also begins constructing a theme that captures the main problematic pattern in the relationship. The theme reframes problems as arising out of understandable reactions to fundamental differences. The theme is formulated in a way that diminishes partners' blaming of each other, instead moving the blame onto the theme. The theme is described as a pattern that emerges naturally out of understandable differences between partners. Thus, rather than tell the story of the

couple's problems in terms of individuals in conflict injuring and being injured by each other, the therapist constructs a story about a union that, like any individual, has weaknesses that are blameless and that can be compensated for.

After feedback, the therapist begins the intervention stage. Intervention involves three general strategies for promoting acceptance: (a) empathic joining around the problem, (b) unified detachment from the conflict, and (c) tolerance building. The goal of empathic joining is to increase partners' compassionate understanding and to promote greater intimacy. The technique involves facilitating discovery of the soft emotions associated with partners' biggest area of conflict. Partners are encouraged to describe their experience of hurt, vulnerability, sadness, fear, and love. Soft emotions such as these tend to elicit empathy, compassion, and closeness. Hard emotions, such as hostility, naturally elicit defensiveness and counterattack. When soft emotions are emphasized over blame and recrimination, then each partner is better able to see the other's distress without the distorting cloud of accusation and is less likely to view the other as an enemy to be condemned but as a fellow sufferer who deserves compassion. For example, when one partner is angry because her partner neglects her, the therapist might lead her to reveal any feelings of loneliness and fear underlying the anger. By associating her anger with underlying feelings of loneliness and fear, the therapist hopes to make that anger more understandable and thus more acceptable. This process also occasionally results in partners spontaneously changing behavior (e.g., providing more attention), such that emotional acceptance and behavior change are both achieved. Thus change and acceptance are not mutually exclusive terms. Acceptance itself is positive change and in addition can help partners achieve negotiated changes previously unavailable to them.

Unified detachment reframes partners' problem as an "it" versus something that each partner does maliciously. The problem is reframed such that it is no longer "that thing my partner did to me" but becomes instead "that thing that happens to us sometimes." The therapist helps the couple describe their typical negative interactions to help them see the underlying pattern. As the couple begins to discern the pattern, it becomes the source of their shared pain and something that the partners can cope with together. For example, it is simply neither partner's fault that they have different needs for closeness. Although that difference may be a friction point, the partners will never solve it by pushing for change. At the same time, that friction point does not have to be corrosive. Partners can learn to acknowledge their different needs without judgment. Partners are then in a better position to give up the unwinnable struggle to change each other in fundamental ways and to instead use that energy to cope with their mutual difficulty as partners (Cordova & Jacobson, 1997).

Another way to facilitate acceptance is to increase tolerance for partner behavior. Tolerance is a point on the continuum from aversion to attraction (Cordova, 2001). When therapy starts, partners perceive the complained about situation as wholly aversive and struggle to avoid, escape, or destroy it. The difficulty with this strategy is that more often than not it means avoiding, escaping, or destroying the relationship as a whole. If one's partner is a tad neurotic, one cannot simply avoid or destroy that single aspect of his or her character. One can either tolerate and embrace it as part of the complex and lovable whole, or one can complain, attack, reject, belittle, and generally fight to diminish that person in the service of pursuing an imaginary partner that is "better" than the real one.

Acceptance strategies are designed to change the stimulus function of the unchangeable things that partners struggle against such that they are no longer wholly aversive but instead take on some of the positive qualities of the person and relationship as a whole (Cordova, 2001). When these strategies work exceptionally well, those things that were wholly aversive become attractive and embraceable. For example, as a person comes to associate exercise with its benefits, then, despite its initially aversive qualities, that person will come to embrace the feelings of strenuous exercise that were initially wholly aversive. Although this type of outcome is rare in couples therapy, it is the ideal toward which ICT therapists strive.

Further back on the continuum lays tolerance. Tolerance is not enthusiastic embracing. It results from a mix of attractive and aversive elements such that the original source of aversion no longer sets off the same destructive relationship patterns. Although the target situation is still experienced as less than pleasant, there are enough positive things about it to make it tolerable (the person is not actively trying to destroy it). For example, partners may never be thrilled that their needs for intimacy do not match, but a more compassionate understanding of that mismatch may make it easier to tolerate and less likely to corrode the foundation of the relationship.

Emotional acceptance through tolerance building is promoted in several ways. For example, positive reemphasis is a strategy for increasing tolerance by uncovering the positive features of the partner's negative behavior. This strategy commonly frames the spouse's negative behavior as part of an otherwise attractive characteristic. For example, it may be that the constant need to have friends around that is currently driving the spouse crazy is an aspect of the gregariousness that he initially found compelling.

Highlighting complementary differences is another strategy for increasing tolerance. The point is that some differences create a well-rounded relationship, and without them the couple might experience more distress. For example, if one partner is a spender and the other is a saver, then the therapist can frame this difference as complementary in that if both were

savers, they would never enjoy the fruits of their work and if both were spenders they would have little saving to rely on for the future.

Preparing the couple for backsliding is another tolerance strategy. It is inevitable that couples will both make progress and backslide. Therefore, it is important that the therapist prepare the couple for the inevitability of slip-ups so that they do not misinterpret a lapse as utter defeat. This is especially important during the initial stage of therapy when a couple may believe that the changes they have made are impervious to relapse. Preparing partners builds tolerance for slip-ups and allows them to remain positive about the health of their relationship throughout the ups and downs of relating.

The implications of acceptance for the theory of social problem solving derive from the increased emphasis on the limits of framing all problems as solvable through instrumental change. Although D'Zurilla and colleagues did not limit social problem-solving theory to the pursuit of instrumental change over acceptance, the spirit of the times resulted in the bulk of the emphasis being on instrumental, manipulate the environment, change. This is, of course, a warranted emphasis in that most of the problems that we are confronted with are of the type that can be solved in the same way that puzzles are solved and machines are repaired. However, currently there is an appreciation that applying this one way of pursuing solutions to all perceived problems often results in more harm than good. Trying to solve the problem of unpleasant thoughts and feelings or trying to solve the problem of naturally occurring individual differences in the same way that one solves the problem of waking up on time for work is not simply foolhardy but actually dangerous. The theoretical lesson of ICT is that struggling to change the unchangeable in a relationship often destroys the very thing that the person is trying to save. Similarly, recent advances in thinking about the etiology of depression, anxiety, and substance abuse suggest that the struggle to solve the problem of unpleasant thoughts and feelings or simply the struggle to solve all discrepancies between what is and what should be is at the heart of a great deal of psychopathology (Hayes, 1994; Marlatt, 1994; Teasdale et al., 2002).

MOTIVATIONAL INTERVIEWING WITH COUPLES AND SOCIAL PROBLEM SOLVING

The first component of social problem solving is a person's problem orientation, including when he or she recognizes a problem exists and whether he or she is motivated to change. Both BMT and ICT assume that partners have recognized the existence of problems in their relationship and

that they are motivated to seek treatment and pursue change. However, it is likely that there exists in the population of couples a subset that are experiencing relationship-threatening problems but that do not yet recognize those problems or are ambivalent about what, if anything, to do about them. Although these at-risk couples may have perfectly adequate social problem-solving skills, those skills will remain unused if the partners do not recognize the problems or are ambivalent about change. Whereas couples seeking therapy and premarital education are motivated to pursue these interventions either by their distress or by their desire to start their married lives on the right foot, at-risk couples in established marriage are motivated by neither. These couples may be suspicious of therapy or may not think of it as a viable or desirable option for economic, time, or social reasons.

To reach these couples and to facilitate their natural problem-solving abilities, Cordova and his colleagues (Cordova, Warren, & Gee, 2001) designed an intervention called the Marriage Checkup (MC) to apply the techniques of motivational interviewing to couples that are at-risk of marital deterioration but that are not actively working to solve those problems. The MC is an assessment and feedback intervention using Miller and Rollnick's (1991) motivational interviewing (MI) strategies and Jacobson and Christensen's (1998) acceptance promotion strategies. The MC is intended to fill the niche between the inoculations against marital distress provided by prevention programs (e.g., PREP; Freedman, Low, Markman, & Stanley, 2002) and the intensive treatment of severe distress provided by couples therapy.

The MC facilitates the motivational component of partners' problem orientation to elicit effective problem solving. Specifically, the MC facilitates couples' progress through the stages of change. Prochaska and DiClemente (1984) argued that people that achieve successful change pass through five distinct stages. The first is a precontemplative stage, in which partners suffering from problems do not recognize these areas as problematic or subject to change. The second is a contemplation stage in which partners recognize problems but are ambivalent about what to do. The third is a determination stage in which partners are determined to address their problems but may not know what to do. The fourth is an action stage, in which partners are taking specific steps to address their problems. At this stage, efforts to change may or may not be effective. The fifth stage is a maintenance stage, in which partners work to maintain positive changes. The sixth stage can be either a stage in which the problems are resolved or a stage in which the problems recur and the couple returns to one of the former stages.

MI moves people through the stages of change by helping them identify problems that interfere with important personal goals and values and to channel any motivation to change in productive directions. To attract couples that may be ambivalent about seeking help, the MC offers commu-

nity couples an opportunity to receive a thorough relationship health checkup followed by tailored feedback about the results. The service is advertised as informational only and it is made clear that partners are free to do with that information whatever they wish. This allows partners to remain ambivalent and still participate in the checkup.

As part of the checkup, partners complete a battery of questionnaires covering all areas of their relationship from satisfaction, stability, commitment to housework, decision-making, sex, and children. In addition, partners are interviewed about the early history of their relationship, because studies have found that how partners describe their early history is predictive of their future relationship health (Buehlman, Gottman, & Katz, 1992). Next, partners' problem-solving skills are assessed by asking them to identify two of the most pressing problems in their relationship and then asking them to spend 15 minutes trying to work toward some resolution of each problem. These 15-minute interactions are videotaped and analyzed for the presence of any behavior patterns that have been associated with relationship deterioration. The assessment session ends with an interview in which the therapist works to facilitate improved understanding between the partners using the techniques of ICT for highlighting softer emotions, promoting unified detachment, and developing improved tolerance.

Two weeks later, couples return for their feedback. Partners are given the results of the questionnaire battery, as well as feedback concerning how they talk about their early history and how they work with each other to solve problems. The results are presented simply as data for the partners to consider. Motivation is facilitated by juxtaposing problematic behavior with partners' valuing of the health of their relationship. The assumption is that when partners learn that certain behaviors such as criticism and withdrawal are predictive of relationship deterioration, they will be motivated by their desire to have a healthy marriage to work toward changing those destructive behaviors. In addition, the feedback provides the couple with ways of reframing any unchangeable differences so that those differences are less likely to wear away at the foundation of their relationship. The therapist also attempts to facilitate improved intimacy by highlighting each partner's vulnerability in relation to the other and by underscoring the role of vulnerability in sustaining and deepening intimacy (Cordova & Scott, 2001). Finally, to the degree that partners are motivated to pursue change, they are offered a number of alternative strategies for pursuing that change, including therapy.

The implication of the MC for social problem-solving theory is in its emphasis on eliciting partners' motivation to identify and work toward solving relationship problems. In addition, it assumes that most people have adequate problem-solving skills and will be able to effectively address their own problems given the proper motivation. MI contributes to the evolution of social problem solving by providing an effective means of actively eliciting

the motivation necessary for effectively coping with day-to-day relationship problems.

CONCLUSION

Social problem-solving theory has provided a framework for understanding the essential role of effective problem-solving skills in interpersonal settings. It contributed directly to early behavioral interventions for marital distress and continues to provide an important perspective on recent developments in the field of couple intervention. Recent developments have added to problem-solving skills training an emphasis on acceptance as an essential problem-solving tool, as well as tools for promoting the motivation necessary to begin the processes of effective coping.

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