

## BEHAVIOR ANALYSIS AND THE SCIENTIFIC STUDY OF COUPLES

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Behavior analysis has recently contributed a great deal to the study of couples. The current paper reviews several of those contributions. First, the contributions of behavior analysis to the development of Integrative Behavioral Couple Therapy (ICT) are discussed. It is concluded that behavior analysis has guided ICT to be more flexible, more thoroughly contextual, and more attentive to naturally occurring contingencies for change. Second, a behavior analytic exploration of acceptance is discussed, highlighting the what, when, and how of acceptance in therapy. Third, a behavioral conceptualization of intimacy is reviewed, highlighting the contributions that behavior analytic principals make to our understanding of the intimacy process. Finally, the contributions of behavior analysis to the study and treatment of depression are briefly reviewed, with an emphasis on conceptualizing depression in context.

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Behavior analysis has recently contributed a great deal to the study of couples. Although the study of couples has a long history of using behavioral observation as a key method, a great deal of the work has been either consciously pre-theoretical (in an inductive sense; e.g., Gottman, 1994) or inspired by common-sense theory. Recently, however, those in the field are rediscovering the theoretical and practical utility of behavior analysis.

### A Behavior Analytic Approach to Couple Therapy

An excellent example of this process of rediscovery can be found in the evolution of traditional behavioral marital therapy (Jacobson & Margolin, 1979) into its current manifestation as integrative couple therapy (Christensen & Jacobson, 1991; Jacobson & Christensen, 1998). Traditionally, behavioral marital therapy was rooted in social learning and behavior exchange theories. As such it was primarily focused on identifying relationship skill deficits as the etiology of relationship distress and addressing those skill deficits through systematic skills training. In addition to being focused on observable interpersonal skills, traditional behavioral marital therapy was inspired by the results of nomothetic research that highlighted the differences between groups of distressed couples versus groups of non-distressed couples. In other words, the targets of intervention were those things that had been found through nomothetic research to distinguish distressed from non-distressed couples. For example, distressed couples appeared to communicate more poorly, to have more difficulty solving even small problems, and to engage in fewer exchanges of positive behaviors than non-distressed couples. From a social learning theory

perspective, these group differences were interpreted as skill deficits and interventions were formulated to teach partners the skills that would allow them to communicate and solve problems more effectively, and exchange positive behaviors more frequently.

Unfortunately, these topographical group differences in many instances may have been simple reflections of other problems having little to do with literal skill deficits. For example, what appeared to be poor problem-solving skills may have been in fact the end result of partners being too emotionally upset with each other to cooperate effectively. In their daily lives, the partners in these couples tend to have no difficulty communicating and problem solving with others. It is only in the context of an emotionally strained marriage that these "deficits" materialize. In addition to seeing skill deficits where no such deficits actually existed, outcome studies of traditional behavioral marital therapy were finding that only approximately half of those couples presenting for therapy eventually improved their marital satisfaction and remained improved over time (Jacobson & Follette, 1985; Jacobson, Schmalings, & Holtzworth-Munroe, 1987). Although a 50% success rate is admirable, it remained the case that a great many couples were not benefiting as much as would be ultimately desirable. Further investigation suggested that those couples who did not do well in traditional marital therapy were those likely to be the least collaborative in working together to learn new skills (e.g., couples too emotionally polarized or in very traditional relationships; Jacobson, Follette, & Pagel, 1986).

Given this set of circumstances, Jacobson and Christensen (1998) set out to

formulate a more powerful form of couple therapy capable of successfully treating those couples who were difficult to treat with the original form of therapy. They called this new approach Integrative Couple Therapy (ICT) to denote the integration of traditional skills-based change strategies with the newer emphasis on promoting acceptance. This is where an appeal to behavior analytic principals was found to be most useful. For example, in ICT a greater emphasis is placed on issues of context and functional analyses. Thus, rather than assuming that distressed couples have communication skill deficits, ICT focuses on developing an individualized case conceptualization based on a functional analysis of the couples' complaints in context. Thus, one couple may fight about money because they have very little and it is a cause of genuine deprivation, whereas another couple may fight about money because, although they have enough to live comfortably on, they both have very different styles of managing it. How an ICT therapist effectively addresses these arguments over money is likely to be quite different for these two couples if considered contextually. Thus, rather than focus on the apparent communication problem (which Christensen and Jacobson would call a derivative problem) and intervene by training both of these couples in "better" communication techniques, the ICT therapist would first work to understand the functional context of the issue for each set of partners. For the first couple, the principal source of suffering is limited access to necessary resources. In this case, the therapist can help the partners to work as a team to manage available resources and to actively seek assistance in the community. For the second couple, the principal source of suffering is framing their differences as something aversive, located within each of them, that must be defeated. In this case, the therapist can help by fostering empathic understanding. For example, the therapist might guide the partners toward discovering that one partner, having experienced genuine deprivation in the past, now feels genuine fearfulness when she does not feel like they are saving enough money to protect them in an emergency, whereas the other partner, having suffered genuine loss, wants to use money to enjoy life before it is too late. Through processes described later, the new stories about their differences foster greater acceptance, deeper

intimacy, and more compassionate understanding.

In short, attention to the behavior analytic emphasis on context and functional analyses allows an approach to couple therapy that is more flexible and thus capable of dealing with the variety of issues that couples bring to therapy. Where traditional behavioral marital therapy was blinded by the topography of the couple's problem, ICT, with its roots in behavior analysis, is more conscientious about pursuing the meaning of the problem in context.

Another example from the development of ICT involves greater attention to naturally occurring versus arbitrary reinforcers. For example, it was often found that even those couples who initially did very well learning the communication and problem-solving techniques taught in traditional marital therapy, did not necessarily use those skills at home. Upon reflection, the absence of generalization could be explained by the arbitrary nature of the reinforcers for those behaviors. The reinforcement for learning and using the communication skills, such as active listening, came primarily from the therapist through active coaching, correcting, and assigning homework. When the therapist was no longer around to deliver consequents, the behavior failed to emerge, because salient consequents in the natural environment of the relationship were missing. Alternatively, ICT helps partners make contact with naturally occurring contingencies by drawing their attention to those destructive patterns they engage in with each other and by helping partners to discover their own strategies for addressing their major issues. For example, if two partners tend to have their biggest fights around issues of closeness and distance, then recognizing that pattern as something normal and non-blameworthy allows them to better accept those individual differences. In other words, changing the meaning of their different needs for closeness sets the stage for different behavior, and that different behavior in turn is shaped and maintained by its effects in the relationship.

Another example was a couple we worked with who had particularly dismal communication skills. They snapped at each other constantly, fought often, were prone to

serious miscommunication, and tended to infer malicious intent to the other's behavior. The therapeutic goals for this couple included decreasing the frequency and destructiveness of the partners' arguments, improving the level of understanding between them, and diminishing their negative attributions. These goals would likely be the same in both traditional behavioral marital therapy and ICT. Within the traditional approach, the therapist would reinforce compliance with the rules of communication and problem solving in the hopes that that behavior would (1) be reinforced by beneficial effects on the partners and, thus (2) replace the targeted destructive behavior. Unfortunately, what was reinforced was compliance with the therapist's rules, rather than effective communication and problem-solving behavior, so couples would learn to look like they were communicating and problem solving when the therapist was salient, but would not engage in similar behavior under the control of their actual daily problems.

Alternatively, ICT helped the couple examine the pattern of their interactions in the search for how those interactions emerged naturally from their daily lives. Over the course of therapy, this couple found that they became more contemptuous, more dismissive, and more easily moved to anger when the pressures of daily life interfered with the amount of time they spent talking and enjoying each other's company (possibly because their salience as sources of positive reinforcement diminished in relation to their salience as sources of frustration and annoyance). Recognizing this pattern increased the salience of the circumstances contributing to their distress, thus allowing those circumstances to gain control over healthier behavior. As a result, the partners developed, on their own, ways of spending more quality time together that, in turn, had dramatically positive effects on the quality of their interactions. In addition, when they found themselves slipping into bickering again, that bickering itself set the stage for renewed efforts to increase the amount of shared quality time. Finally, these new opportunities for spending time together developed outside of therapy and were well maintained, theoretically because they resulted from naturally occurring circumstances rather than arbitrary circumstances arranged in therapy. Thus, greater attention to behavior analytic principals has aided in the development of

therapeutic strategies that are more likely to lead to change maintained by the circumstances in partners' daily lives rather than by the arbitrary attentions of the therapist.

There are several other examples of the influence of behavior analytic principals on the development of ICT (Christensen & Jacobson, 1991; Cordova, Jacobson, & Christensen, 1998; Jacobson & Christensen, 1998; Jacobson, Christensen, Prince, Cordova, & Eldridge, 2000). Perhaps most important of the developments has been the greater focus on promoting acceptance, itself a movement within the behavior therapy community that has been heavily influenced by behavior analysis.

#### **A Behavior Analytic Conceptualization of Acceptance**

Although acceptance as a therapeutic goal has received widespread attention within the behavior therapy community (e.g., Hayes, Jacobson, Follette, & Dougher, 1994), the conceptualization of what acceptance is remains somewhat murky. As with most such terms, the field was initially quite comfortable with the common understanding of its meaning, and in most circumstances, that common, fuzzy meaning was perfectly adequate. However, progress in the conceptualization and empirical study of the phenomenon itself is greatly hindered to the degree that the referent phenomenon is inadequately specified. Some preliminary conceptual work has been done defining acceptance as "a change in the behavior evoked by a stimulus from that functioning to avoid, escape, or destroy to behavior functioning to maintain or pursue contact (Cordova, 2001)." The benefit of this conceptualization is that it defines acceptance as an observable change in an individual's behavior in relation to a given stimulus, thus potentially facilitating the observational study of acceptance in the transaction of organism and environment. In addition, behavior analytic principals provide a framework for addressing how and when to facilitate acceptance. We have argued that techniques for facilitating a change from aversion to acceptance of a given stimulus can be targeted at any of the three components of the three-term contingency.

Acceptance can be promoted by directly targeting the function of an aversive stimulus

(the Sd). An aversive stimulus, such as a partner's "tightfistedness," can be discussed in therapy in relation to a related but more "attractive" stimulus in an attempt to promote a transfer of function through derived bidirectional relating. In ICT, one technique for promoting acceptance involves uncovering the "understandable reasons" for a partner's aversive behavior. In this example, a partner's tightfistedness might be discussed in terms of his or her need to actively save money in order to feel safe and comfortable in the world. The partner's stinginess can be related to his or her fearfulness of financial insecurity stemming from a childhood in which lack of money was a significant emotional hardship. In the couple therapy literature, this kind of intervention, in which understandable reasons are uncovered and sympathy-eliciting emotions are disclosed, is presented as the type of intervention likely to promote increases in acceptance of one partner's frugality by the other partner. The behavioral processes by which this type of technique works are not specified, but attention to the behavior analytic literature suggests reasonable candidates for the processes at work. For example, vocal discussion of the partner's tightfistedness involves utterances that have acquired some of the stimulus functions of events in which the partner actually engaged in tightfisted behavior. Similarly, discussion of the associated fearfulness involves utterances that have acquired some of the stimulus functions of experienced fearfulness. Pairing these two classes of stimuli in talk therapy theoretically allows for the transfer of function from the more sympathy-eliciting "fearfulness" to the more aversion-eliciting "tightfistedness." Then through the process of derived bidirectional relating, it is theoretically possible for actual instances of tightfistedness occurring outside of the therapy session to take on some of the stimulus function of experienced fearfulness. If such a transfer of function does successfully take place, then future instances of tightfistedness should elicit less aversion and more sympathy. In other words, the stimulus function involving expressions of tightfistedness are transformed toward stimulus functions involving expressions of fearfulness. Note that this change fits our definition of acceptance in that the topography of tightfistedness does not necessarily change, but its stimulus function for the other partner does change from one that elicits attack,

avoidance, or withdrawal to one that elicits a relationship-healthy tendency to approach and offer comfort. Thus these two fairly well documented behavioral phenomena (the transfer of stimulus function and derived bidirectional relating) allow for an effective and actionable explanation of the therapeutic phenomenon.

Acceptance techniques have also been developed that target the aversion behavior itself (e.g., attacking, avoiding or withdrawing). One might target aversion behavior, for example, with techniques such as exposure and response prevention for compulsive hand washing (e.g., Abramowitz, 1997). This technique places the individual in contact with the aversive stimulus and then prevents him or her from engaging in the usual aversion behavior (e.g., hand washing). Such techniques have been found to be very effective treatments for a range of problems, including obsessive-compulsive behavior and post-traumatic stress disorder (Foa, Rothbaum, Riggs, & Murdock, 1991). The changes in behavior that result fit our definition of acceptance in that the stimulus remains topographically the same (e.g., unwashed hands), but the function changes from eliciting aversion (compulsive hand washing) to maintaining contact while pursuing a richer life.

One might also promote acceptance by targeting the consequences of aversion by, for example, differentially reinforcing behavior that results in greater interpersonal contact (e.g., increased eye contact, increased self-disclosure) in a client with a history of difficulty with intimate relationships (e.g., Kohlenberg & Tsai, 1991). In this instance, all approximations of the behavior class in question (making and maintaining interpersonal contact) are differentially reinforced by the therapist, shaping over time a change in the relationship between the client and other people from one in which the presence of others elicits withdrawal and avoidance to one in which the presence of others is more likely to elicit approach and engagement. A more detailed exploration of the application of behavior analytic principals to our understanding of acceptance can be found in Cordova (2001).

### A Behavior Analytic Conceptualization of Intimacy

The principals of behavior analysis have also influenced us (Cordova & Scott, 2001) in our understanding of the intimacy process. Our theory posits that intimacy is a process driven by the reinforcement of interpersonally vulnerable behavior. The theory defines interpersonally vulnerable behavior as any behavior occurring in an interpersonal context that has been associated with punishment by others in the past. In other words, a behavior is considered interpersonally vulnerable to the extent that a person has (1) been punished for it in the past, (2) seen others punished for it, or (3) been informed that it is subject to punishment. The process of intimacy is set in motion when one person engages in vulnerable behavior and another person reinforces it. This sequence of events is called an *intimate event* and results in an increase in the frequency of the first person's subsequent interpersonally vulnerable behavior in relation to the reinforcing partner. In other words, not only does the reinforcement of vulnerable behavior result in its increase, but it results in its increase specifically in relation to the person who reinforced it. This increase in behavioral frequency in relation to the context within which reinforcement occurs constitutes a gain in stimulus control, and in this context is the process of *intimate partnership formation*. Given the opportunity, this intimacy process will continue to result in more and more frequent displays of vulnerable behavior in relation to the intimate partner. Thus, the reinforcement of interpersonally vulnerable behavior is the engine that drives the process of intimacy.

Thus, if a person has a history of being punished for being loud and exuberant and then meets someone who consistently reinforces exuberance, the theory would predict that the first person will come to feel particularly close to the second person and will engage in a wider variety of vulnerable behaviors with that person than with most others. In a sense, intimate events release behavior that is at strength but that has been previously suppressed by others. That release is a fundamental aspect of the process of intimacy, leading to the frequent statement that people feel they can be "more themselves" with intimate others.

The downside of the intimacy process is that as vulnerable behavior becomes more and more frequent in the presence of the intimate partner, the probability of punishment also increases. In other words, more and more opportunities for the reinforcement of vulnerable behavior are also more and more opportunities for the punishment of interpersonally vulnerable behavior. We refer to the punishment of interpersonally vulnerable behavior as the occurrence of a *suppressive event*, because such sequences continue to suppress the occurrence of that vulnerable behavior. For example, the same partner who reinforces loud exuberance, may also contingently punish loud displays of anger. Suppressive events become inevitable given the process set in motion by intimate events. As the intimacy process unfolds, the individual will eventually engage in some form of vulnerable behavior that is actually aversive to the other person. In response, that other person will respond punitively and thus, the behavior will be contingently punished. These are thought of as interpersonal boundary conditions and are posited to be part and parcel of all developing partnerships. Over time, partners learn to effectively discriminate between those vulnerable behaviors that will be reinforced by the partner and those that will be punished. They also learn to effectively discriminate between those *times* when the partner is more and less likely to reinforce vulnerable behavior. In addition to the contingent punishment of vulnerable behavior, increased frequencies of vulnerable behavior also increase the probability of non-contingent punishment. In other words, suppressive events are also likely to occur by accident. For example, an intimate partner might inadvertently punish a vulnerable attempt to talk about a touchy subject by being distracted or by responding with irritation spilling over from work stress. In short, the process of intimate partnership development necessarily includes both intimate and suppressive events, and thus, theoretically, all developing intimate partnerships can at any point be characterized by their accumulated ratio of intimate to suppressive events.

If the ratio of intimate to suppressive events favors intimate events, then people will develop a sense that they are generally safe behaving vulnerably with that partner. We refer

to this developing feeling of safety behaving vulnerably as a person's experienced level of *intimate safety*. The more the ratio favors intimate events, the more intimately safe the person will feel. The more the ratio favors suppressive events, the less intimately safe the person will feel. It is this feeling of intimate safety that I posit is the principal feeling emerging from the intimacy process.

In summary, intimacy theory posits that intimate events necessarily set in motion a process that, given the opportunity, becomes the process of intimate partnership formation and generates feelings of intimate safety that reflect the ratio of intimate to suppressive events accumulated over the course of the partnership. A behavioral conceptualization of intimacy also throws light on the emotional and social complexity of intimacy. For example, it highlights that the process of intimate partnership development necessarily involves the emotional pain associated with the occasional punishment of vulnerable behavior. One simply cannot engage in a genuine intimate partnership without accepting one's own vulnerability in that relationship. Vulnerability is a necessary component of intimacy, and the frequency of vulnerable behavior will be highest (and therefore most susceptible to punishment) within intimate partnerships. Many other conceptualizations describe intimacy in wholly positive terms and specifically exclude the negative products of the process (e.g., Prager, 1995). Such exclusions blind us to aspects of the intimacy process that are vital to our understanding of the phenomenon. In addition, a behavioral conceptualization allows that intimate partnerships can develop that reinforce topographically destructive behavior, such as drug usage or other criminal activity (e.g., gang membership). A behavioral conceptualization implies that some types of destructive behavior may be maintained through the same processes that develop within and maintain other, more socially accepted forms of intimacy.

#### **Behavior Analysis and Couples Therapy for Depression**

Behavior analysis has contributed to thinking about the etiology and treatment of depression in general (e.g., Ferster, 1973), and more specifically, to addressing depressive

symptoms within the context of an intimate relationship (Cordova & Gee, 2001; Cordova & Jacobson, 1997). Research has repeatedly demonstrated that depression both affects and is affected by intimate relationships (e.g., Beach, Whisman, & O'Leary, 1994). A substantial body of evidence suggests that relationship difficulties often set the stage for depressive symptoms (e.g., Beach & Cassidy, 1991). In addition, a great deal of research suggests that the onset and presence of depressive symptoms has predictable negative effects on relationship quality (e.g., Billings, Cronkite, & Moos, 1983), because most depressed people will experience symptoms within the context of the primary intimate relationship. Behavior analysts present a unique way of thinking about depression, emphasizing both the *context* in which depressive symptoms emerge and the *function* of the symptoms (or the associated lack of reinforced behavior) in those contexts. For example, according to Martell, Addis, and Jacobson (2001), a contextualist conceptualization of depression does not posit a "defect model," but instead conceptualizes depression as "a set of behaviors in context" that are "understandable and predictable given a person's life history and current context (p. xxv)." In addition, Ferster (1973) noted that the most striking thing about depression is what the person is *not* doing rather than what the positive symptoms look like. In fact, depression can be conceptualized as a marked deterioration in the active pursuit of positive consequences (Cordova & Jacobson, 1997). Ferster also noted that most of the behavior that depressed people actually do engage in primarily serves primitive escape and avoidance functions (i.e., aversion).

Ferster (1973) identified three characteristics of a person's repertoire that might predispose him or her to depression. The first is a rigid repertoire that does not adapt well to changing circumstances. Although such a repertoire may function well within appropriate domains, it predisposes a person toward depression because, as the Buddhists put it, the nature of life is change, so successful living requires adaptability. The second is a repertoire that ineffectively avoids aversive situations. It is simply the case that some means of addressing aversive circumstances are more effective than others at removing those aversive circumstances. A person with an aggressive or avoidant

repertoire for coping with aversive circumstances may be more prone to depression because efforts to cope with aversive situations are more likely to result in either greater negative consequences or diminished positive engagement. Finally, the third depression-prone repertoire is one that is minimally exploratory or that inhibits the normal exploration of the environment. The less exploratory a person is, (1) the less he or she learns how to behave effectively in the world, (2) the smaller their effective repertoire, and (3) the more aversive circumstances he or she accumulates. In short, behavior analysis contributes to the study and treatment of depression by providing a useful conceptualization of depression that is contextualized and pragmatic. Couples therapy for depression (Cordova & Gee, 2001; Cordova & Jacobson, 1997) is informed by behavior analysis in that its goal is to address the depression-prone repertoire as a deficit in effective behavior.

For example, rigid repertoires are particularly problematic in intimate relationships because such relationships continually change as they develop. Those who have difficulty adapting to changing circumstances may be particularly prone to relationship deterioration and depression. The key to addressing a rigid repertoire is to promote flexibility by helping partners accept a degree of unpredictability in the intimate relationship while promoting more effective ways of adapting to changing interpersonal circumstances.

For example, consider Steve and Tina's relationship. Steve reported experiencing a return of his depression following the birth of their one-year-old son. Over the course of therapy, it became increasingly clear to both Steve and Tina that they did not spend as much time together as they use to because of their new focus on parenting. Although they both reported feeling the strain on their relationship, Steve found himself feeling more and more depressed about the loss of intimacy with Tina. He was stuck without a viable repertoire for maintaining emotional closeness with her. Essentially, they had failed to develop new ways of attending to the quality of their relationship. Targeting this aspect of the depression involved coaching them toward a new, shared repertoire for maintaining intimacy, including strengthening their social

support network, scheduling regular time alone together, and checking in with each other throughout the day to maintain their sense of connectedness. In short, the therapist helped them develop a more flexible repertoire to address that aspect of the depression stemming from their failure to adapt together in the transition to parenthood.

The second repertoire, characterized by avoidance or aggression, can be depressogenic because of the resentment that builds when a partner copes with problems through avoidance or emotional withdrawal. The depressive symptoms develop as the relationship deteriorates and intimacy decreases. Couples therapy for depression within such a relationship helps partners learn how to cope both with the class of problems that lend themselves to instrumental problem solving and with the problems that lend themselves more to acceptance. For the solvable problems, partners can be taught how to break them down into manageable units and to work together toward a solution. For unsolvable problems, partners can be guided toward a healthy acceptance, opening up an entire category of effective strategies for managing relationship difficulties.

For example, Michelle and Robert sought couple therapy, in part, because their frequent disagreements about family finances resulted in a chronic state of tension and emotional withdrawal. Robert worked as an independent contractor and, as a result, his monthly income varied considerably and was often less than they needed to stay out of serious debt. Robert managed his own finances and did not like to include Michelle because he felt criticized by her and because he felt that including her would not help improve their financial situation. Michelle, for her part, was anxious about their financial situation and wanted Robert either to find another line of work with more regular income or to become involved in the bookkeeping so she could try to improve the financial management of the business. Robert had developed depressive symptoms that he attributed to financial stress, marital stress, the failure of the business to thrive, and a general sense of being stuck in a situation with no way out. From the current perspective, Robert's repertoire was ineffectively avoidant in that he made frequent

contact with several sources of aversive stimulation for which he had no adequate response. His depressive symptoms had emerged as a result of that chronic, inescapable aversiveness. Therapy, therefore, focused on helping Robert and Michelle develop a greater degree of compassion for the pain that they both experienced. This served two relevant purposes. One was to improve the quality of their emotional relationship and thus to remove one source of chronic aversiveness (the tension between them). The second purpose was to facilitate their willingness to work together to confront their financial situation. As a result, Robert became more willing to include Michelle in the day-to-day finances of the business and Michelle became more accepting of the unpredictable nature of the work. In addition, as their willingness and ability to talk about their financial concerns without withdrawing improved, they were able to brainstorm viable and creative ways to resolve their debt load. Thus, through a combination of acceptance and change techniques, Michelle and Robert were both able to develop more effectively avoidant repertoires, which in turn helped to alleviate both their relationship distress and Robert's depressive symptoms.

The third depression-prone repertoire, limited exploratory, creates a vulnerability to relationship distress and depression because it stunts a couple's capacity for shared positive experiences, creating stagnation in the relationship. Couple therapy for depression addresses a limited exploratory repertoire by educating partners about the patterns that may be interfering with their exploration of the environment, and encourages them to view their surroundings together, within the context of a mutually satisfying relationship.

For example, Pamela's depression was embedded in her relationship with Phil and they had become almost completely withdrawn from each other after a series of misunderstandings and emotionally damaging arguments. In addition to a great deal of work in therapy to repair the couple's intimacy, the therapist also worked with them to discover new ways of finding time together and developing active curiosity about each other. After several months of therapy, Phil and Pamela started meeting for lunch once or twice a week to be alone and to

explore the shops and galleries in the neighborhood. This new context for their relationship had dramatically positive effects on the quality of their affection for each other, which appeared to contribute greatly to improvements in both their relationship and Pamela's depressive symptoms. Activating the couple to become more exploratory of their shared world increased the size and flexibility of their repertoires, in a sense displacing depressive symptoms with more effective behavior.

## CONCLUSION

In summary, I have provided a brief overview of how the principles of behavior analysis have influenced some of the current work in the study and treatment of couples. These theoretical and conceptual contributions have in turn inspired a good deal of empirical research. For example, work has been done evaluating the efficacy of ICT as intervention for relationship distress (Jacobson, Christensen, Prince, Cordova, & Eldridge, 2000) and studying the theoretical mechanisms of change, including increases in partner acceptance (Cordova, Jacobson, & Christensen, 1998). In addition, we are currently developing a system for studying the process of acceptance development over the course of couples therapy. We are also developing both observational (Dorian & Cordova, in press) and paper-and-pencil measures (Cordova, Gee, Warren, & McDonald, 2002) inspired by the behavioral conceptualization of intimacy, and preliminary studies have found these to be useful and informative. Finally, we are also beginning to study the efficacy of couple therapy for depression and continue to develop its applications (e.g., Cordova & Gee, 2001).

In conclusion, the study of couples has a great deal to gain from greater attention to the principals of behavior analysis. The most positive outcome of this interaction would be the benefits that behavior analysis brings to the scientific study of couples and the opportunity this work has to demonstrate the vitality of behavior analysis to mainstream clinical researchers.



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