

## ACCEPTANCE VERSUS CHANGE INTERVENTIONS IN BEHAVIORAL COUPLE THERAPY: IMPACT ON COUPLES' IN-SESSION COMMUNICATION

James V. Cordova  
*University of Illinois at Urbana-Champaign*

Neil S. Jacobson  
*University of Washington*

Andrew Christensen  
*University of California, Los Angeles*

*Integrative Behavioral Couple Therapy (IBCT) attempts to improve Traditional Behavioral Couple Therapy (TBCT) by incorporating an emphasis on promoting acceptance into TBCT's emphasis on behavioral change. This study examined changes in couples' communication over the course of IBCT and TBCT. Early, middle, and late sessions were coded to measure couples' communication of acceptance. Results showed that IBCT couples expressed more nonblaming descriptions of problems and more soft emotions than TBCT couples during late stages of therapy. IBCT couples significantly increased their nonblaming description of problems and significantly decreased their expressions of hard emotions and their problematic communication over time. Results support the hypothesis that structural differences between the therapies affect initial levels of emotional expression in session. Increases in nonblaming descriptions of problems were significantly correlated with increases in marital satisfaction.*

Integrative Behavioral Couple Therapy, developed by Andrew Christensen and Neil S. Jacobson (Christensen & Jacobson, 1991; Christensen, Jacobson, & Babcock, 1995; Jacobson, 1992; Jacobson & Christensen, 1996), represents an attempt to improve Traditional Behavioral Couple Therapy (TBCT; Jacobson & Margolin, 1979) by incorporating an emphasis on promoting acceptance into the traditional emphasis on overt behav-

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James V. Cordova, Department of Psychology, University of Washington (now at the Department of Psychology, University of Illinois at Urbana-Champaign); Neil S. Jacobson, Department of Psychology, University of Washington; Andrew Christensen, Department of Psychology, University of California, Los Angeles.

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Correspondence concerning this article should be addressed to James V. Cordova, Department of Psychology, 603 East Daniel Street, University of Illinois at Urbana-Champaign, Champaign, IL 61820. E-mail jcordova@s.psych.uiuc.edu.

ioral change. The resulting therapies, however, operate from two very different theories of change. IBCT suggests that fostering acceptance is an essential step toward improving couples' relationships. TBCT suggests that effective skill building is not only necessary but sufficient for ameliorating distress. In this pilot study, 12 maritally distressed couples were randomly assigned to either IBCT or TBCT. Given that we are developing a new set of interventions within IBCT, we deemed it prudent that this initial pilot investigation be limited to a fairly small sample size. The purpose of the current pilot study was to investigate whether these two different approaches to couple therapy lead to theoretically predictable differences in couples' in-session communication processes. Given that TBCT emphasizes change through skills training and IBCT emphasizes change through acceptance, couples' in-session communication processes should differ in specifiable ways.

### THE EVOLUTION OF IBCT

TBCT (Jacobson & Margolin, 1979) has consistently been shown to be one of the most effective couple therapies currently available (Baucom & Hoffman, 1986; Gurman, Kniskern, & Pinsof, 1986; Hahlweg & Markman, 1988; Jacobson, 1978, 1984). TBCT is primarily a skill-building approach to treatment. It is designed to quickly and effectively teach distressed couples the skills thought to be necessary for improving the relationship and maintaining those improvements over time. The version of TBCT employed in this study was based on Jacobson and Margolin's (1979) treatment manual and consisted primarily of training in behavior exchange skills and communication and problem-solving skills. Behavior exchange focuses on teaching partners to identify those things they do that are pleasing to each other and instructs couples in the utilization of those behaviors as a means of improving the quality of the relationship. Communication and problem-solving training focus on teaching partners specific techniques useful in facilitating effective communication and problem definition and resolution. Communication training teaches partners the effective use of *I* messages and active listening as well as the clear distinction between the speaker's role and the listener's role. Problem-solving training teaches specific steps to be followed in the process of solving a problem, including problem definition, brainstorming solutions, selecting workable solutions, solution contracting, and solution testing. Although various additions to and adaptations of these basic techniques have been constructed and investigated (Addis & Jacobson, 1991; Baucom, Epstein, & Rankin, 1995; Baucom, Sayers, & Sher, 1990; Beach, Whisman, & O'Leary, 1994; Halford, Sanders, & Behrens, 1993; McCrady, Epstein, & Hirsch, 1996), these core techniques were considered the principal components of behavioral marital therapy (Jacobson, Schmaling, & Holtzworth-Munroe, 1987) and were the focus of TBCT as utilized in the present research. Research has shown that this version of TBCT effectively improves the relationship quality of approximately two thirds of couples presenting for therapy (Jacobson & Follette, 1985). In addition to its proven effectiveness, TBCT is also straightforward in its implementation and easy to teach to beginning marital therapists.

Despite its success, TBCT has not been effective for everyone. Prior research has demonstrated that approximately one third of all couples presenting for therapy did not improve (Jacobson & Follette, 1985), and that of those improved, approximately 30% relapsed within a two-year period (Jacobson et al., 1987). These difficult couples tended to be (1) more severely and chronically distressed (Baucom & Hoffman, 1986), (2) older

(Baucom & Hoffman, 1986), (3) more emotionally disengaged (Hahlweg, Schindler, Revenstorf, & Brengelmann, 1984), and (4) more polarized on basic issues (Jacobson, Follette, & Pagel, 1986). What these factors appear to have in common is their negative effect on a couple's capacity to compromise and collaborate. Severely distressed couples, older couples who have engaged in their destructive patterns for years, couples who are emotionally disengaged, and couples who are incompatible are the very couples who find it most difficult to work together collaboratively. This difficulty may be at the heart of TBCT's failing, because TBCT's change strategies rely on the couple's capacity to collaborate and compromise. Without the willingness to collaborate necessary to implement TBCT's change strategies, a couple is unlikely to find any relief from therapy.

If difficult couples such as these were to be helped, TBCT had to evolve beyond an exclusive emphasis on change and find a way to reach those couples too polarized to work together collaboratively. This evolution led to a new emphasis on the utility of promoting acceptance and the birth of Integrative Behavioral Couple Therapy (Christensen & Jacobson, 1991; Christensen et al., 1995; Jacobson, 1992; Jacobson & Christensen, 1996). Initially acceptance strategies were developed to address the polarization of difficult couples. However, as the effectiveness of these strategies became apparent, it was realized that strategies for promoting acceptance could be helpful to any distressed couple seeking therapy. IBCT emerged from this realization, as a treatment broad enough potentially to be effective with most types of distressed couples.

#### ACCEPTANCE IN IBCT

IBCT restructures the traditional approach to behavioral couple therapy around the idea that not all aspects of a couple's relationship are amenable to negotiated change. Promoting acceptance in this context means promoting closeness despite unresolvable problems. In general, promoting acceptance helps couples identify those aspects of their relationship that are unlikely to change and coaches them in ways of coming to terms with those problems.

One of the main acceptance techniques within IBCT involves encouraging partners to express the soft emotions underlying expressions of hard emotions. This technique is one of the principal means of promoting "Empathic Joining" (Jacobson & Christensen, 1996) and is designed to promote compassion, understanding, and intimacy. Hard emotional expressions are regarded as those that are accusatory and that communicate hostile anger, contempt, and intolerance. Such hard emotional expressions most frequently lead the other partner to either respond defensively or retaliate. Soft emotions, on the other hand, express feelings such as hurt, loneliness, insecurity, fear, desire, and love. They reveal personal vulnerability and are more likely to evoke empathy and emotional closeness. Soft emotional expressions promote intimacy and create a nonhostile environment in which partners can feel close to each other despite their problems. It is theorized that as long as couples remain angry and polarized, they will remain more motivated to fight than to learn useful relationship skills (Cordova & Jacobson, 1993). Therefore, IBCT asserts that promoting acceptance through soft disclosures is an essential aspect of successful couple therapy.

IBCT also utilizes acceptance techniques designed to help partners gain a degree of emotional distance from their problems. Known as "Unified Detachment," this technique

helps couples learn to talk *about* their problems rather than engage in those problems directly. Couples are taught to recognize and describe common destructive patterns within their relationship as a means to decrease the destructive power of those patterns. In other words, Unified Detachment promotes a shift in perspective that allows active communication about problems that may be unresolvable and encourages them to join together around such irresolvable problems without blaming each other and without pushing each other to change. Promoting such emotional detachment from unresolvable problems is hypothesized to lead to greater acceptance and less direct problem engagement.

It should be noted that although our integration of acceptance techniques with skills training is a unique approach to behavioral couple therapy, the concept of acceptance has been acknowledged as an important ingredient in other approaches to couple therapy (e.g., Greenberg, 1996; Greenberg & Johnson, 1988; Johnson & Greenberg, 1994); and previous process research has explored such concepts as hard emotions and softening (Greenberg, Ford, Alden, & Johnson, 1993; Greenberg, James, & Conry, 1988; Johnson & Greenberg, 1988).

### HYPOTHESES

Does IBCT lead to predictably different types of communication processes over the course of treatment from TBCT? Given that TBCT emphasizes change through skills training and IBCT emphasizes change through acceptance, the process through which couples change in therapy should differ between the two treatments. Because we have cast IBCT as the next evolutionary step in behavioral couple therapy, our hypotheses focus, for the most part, on client changes that should be unique to IBCT. The following are several types of change that we hypothesize will differentiate IBCT from TBCT.

*H1.* As noted, one of the primary goals of IBCT is to help partners create some emotional distance from their problems rather than to engage in those problems in blaming and destructive ways. This change in the way partners relate to each other should manifest in the session as nonblaming discussions about mutual problems *without an emphasis on changing either partner*. Thus, given problems that are not amenable to negotiated change, IBCT promotes a willingness to talk about such a problem in a nonblaming way without struggling to change the unchangeable. Therefore, we hypothesize that IBCT couples will significantly increase their capacity to engage in nonblaming discussions of mutual problems over the course of therapy, and that TBCT couples will not. Furthermore, we hypothesize that this differential increase will result in IBCT couples engaging in significantly more nonblaming discussions of mutual problems during late sessions than TBCT couples.

*H2.* Given the IBCT assumption that promoting acceptance through soft disclosures is an essential aspect of effective couple therapy, we hypothesize that IBCT couples will increase their capacity to express soft emotions within the therapy session over the course of treatment more than TBCT couples. Specifically, we hypothesize that IBCT couples will significantly increase their expression of soft emotions from early to late sessions and that TBCT couples will not. Furthermore, we hypothesize that this will result in IBCT couples expressing significantly more soft emotions during late sessions than TBCT couples.

*H3.* IBCT is a much less structured form of therapy than TBCT. Because TBCT emphasizes change through skills building, therapy sessions tend to be quite didactic and consist primarily of the presentation, practice, and refinement of various skills. This is

especially true during the early stages of therapy. During later stages of therapy, however, TBCT therapists fade their influence, allowing couples to develop more naturalistic means of using the developed skills. In contrast, IBCT, from very early in therapy, helps couples confront and attempt to come to terms with their most difficult issues. Couples are encouraged to talk about these issues openly and honestly, and it is these discussions that are used as the vehicles for encouraging soft emotional expression and Unified Detachment. Theoretically, this approach promotes more contingency-shaped and natural change leading to greater generalization outside of therapy and greater resistance to extinction following therapy (Cordova & Jacobson, 1993). Given these differences in structure, we would expect a crossover effect in which expressions of hard emotions diminish significantly more in IBCT than in TBCT. Specifically, we hypothesize that couples receiving IBCT will express significantly more hard emotions during early sessions than couples receiving TBCT. Furthermore, we hypothesize that couples receiving IBCT will significantly decrease their expressions of hard emotions from early to late sessions and that couples receiving TBCT will either significantly increase their expression of hard emotions from early to late sessions as therapist control abates or will demonstrate no significant change. Finally, we hypothesize that IBCT couples will be expressing significantly fewer hard emotions during late sessions than TBCT couples. In short, we hypothesize that IBCT couples will start therapy expressing more hard emotions and end therapy expressing fewer hard emotions than TBCT couples.

*H4.* Because IBCT works to help couples deal with unchangeable problems in a non-blaming way, actually engaging in destructive relationship patterns should decrease. However, distressed couples frequently engage in problematic behavior without necessarily expressing hard emotions. Therefore, we will measure engaging in the problem separately from hard expressions to more accurately reflect the type of behavior we believe should decrease in response to Detachment interventions. We considered problematic such things as destructive arguing, blaming, demanding, criticizing, withdrawing, and defending. As above, given the differences in structure between IBCT and TBCT, we again hypothesize a crossover effect in which IBCT couples engage in more problematic behavior during early sessions and less of it during late sessions than TBCT couples. Couples within TBCT may increase their problem engagement over the course of therapy as therapist control abates or may demonstrate no overall change.

*H5. Correlations between process and outcome.* Finally, we hypothesize that the in-session changes outlined above will be related to changes in couples' marital satisfaction from pre- to post-therapy. Specifically, we hypothesize that increases in soft expression and nonblaming discussions of mutual problems will be substantially correlated with decreases in marital distress. Furthermore, we hypothesize that decreases in hard expressions and problem engagement will also be substantially correlated with decreases in marital distress.

## METHOD

### *Participants*

Participants were 12 maritally distressed couples randomly assigned to either IBCT or TBCT. Couples were recruited through public service announcements placed in local community newspapers. To qualify for the study subjects were required to be married, living together, and between 21 and 60 years old. Subjects were screened out of the study

**TABLE 1**  
**Rating Codes and Their Definitions**

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Soft Expression (SE)	Client expressed "soft" emotions or thoughts such as sadness.
Detachment (DT)	Wife or husband or both engaged in a nonblaming discussion about a mutual problem without engaging in the problem, blaming the other partner for the problem, or urging the other partner to change.
Hard Expression (HE)	Clients expressed "hard" emotions or thoughts such as anger directly or indirectly aimed at their partner.
Engaging in the Problem (EP)	Clients engaged in a type of interaction that is problematic for their relationship.

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if they suffered from bipolar disorder, psychotic symptoms, current alcohol or drug problems, or if they met criteria for battering (Jacobson et al., 1994). All subjects were required to score above 59 on the Global Distress Scale of the Marital Satisfaction Inventory (MSI; Snyder, 1979), thus indicating clinically significant levels of marital distress in both spouses. Participant couples were all caucasian and middle income.

#### *Measures*

Marital distress was measured using the Global Distress Scale of the Marital Satisfaction Inventory (MSI; Snyder, 1979). The MSI is a multidimensional questionnaire that generates scores reflecting global marital distress and distress in a number of specific subcategories, such as problem-solving communication, disagreements about sex, and disagreements about finances. The reliability and validity of the MSI have been demonstrated (Snyder, Wills, & Keiser-Thomas, 1981; Scheer & Snyder, 1984).

#### *Rating scales*

Selected sessions were rated on four 5-point scales designed to measure Soft Expressions (SE), Detachment (DT), Hard Expressions (HE), and Engaging in the Problem (EP). Each of these scales was designed specifically to address one of the stated hypotheses (see Table 1). A coding manual was devised describing each code in detail and providing examples of the types of responses to be coded. The descriptions of each scale and the examples used were primarily cued to the participant's verbal, as opposed to non-verbal, behavior to equalize the utility of audio- and videotaped material. It should also be noted that the various psychometric properties of these scales have not been thoroughly evaluated. The manual can be obtained from the first author.

The SE scale was designed to measure the degree to which the client expressed soft emotions during the therapy session. A soft expression is any statement or action by a client expressing such feelings as hurt, loneliness, insecurity, fear, sadness, shame, guilt, desire, love, caring, pleasure, empathy, tenderness, or other emotion revealing the client's

vulnerability within the relationship. The DT scale was designed to measure the degree to which partners actively engaged in nonblaming discussions about a mutual problem without a specific emphasis on overt change. In other words, this scale was designed to measure the degree to which couples actively talked about a relationship problem without blaming each other and without urging each other to change. The HE scale was designed to measure expressions of anger, contempt, and intolerance delivered in a blaming, hostile, or contemptuous manner and directly or indirectly aimed at the partner. The EP scale was designed to measure the degree to which each partner engaged in destructive interaction patterns, such as destructive arguing, cross-blaming, or demand-withdraw.

### *Procedures*

Couples were informed that the purpose of the study was to compare two different methods of treating marital problems: one that focused on accommodation, compromise, and collaboration; and one that added an emphasis on learning to accept your partner. They were told that both approaches were effective in increasing couples' marital satisfaction and that the purpose of the study was to compare the ways in which these two approaches help couples to improve their marriages, while helping therapists learn to distinguish clearly between the two approaches. Prior to therapy, couples were screened on the above exclusion criteria.

All couples received between 20 and 25 sessions of therapy. The first two TBCT and the first two IBCT couples received free therapy. The remaining 8 couples paid \$25 per session. Two couples in the IBCT sample received 25 sessions; all other couples received 20 sessions. All sessions were either audiotaped or videotaped. Treatment was performed by five experienced marital therapists, all licensed psychologists, under the training and supervision of the second and third author. Each treatment session was reviewed in its entirety by either the second or the third author prior to one-on-one supervision with the treating clinician. In addition, monthly group supervision meetings were held to assure supervisory agreement. Each therapist conducted an equal number of IBCT and TBCT cases. Therapists were monitored for adherence to each treatment protocol.

**TBCT.** TBCT is an approach to couple therapy based on social learning principles (Jacobson & Margolin, 1979) and primarily focused on inducing change in couples' behavior through skills training. Therapy consists primarily of instruction in Behavior Exchange (BE), Communication Training (CT), and Problem-Solving Training (PS). These modules teach the skills involved in increasing the exchange of positive reinforcers, improving communication skills, and effectively addressing and solving problems in the relationship, respectively. The three techniques were the primary components of the form of TBCT used in this study. Jacobson and Margolin (1979) was the principal TBCT treatment manual used in this study.

In order to assure that TBCT was conducted competently, randomly chosen sessions were independently rated by an internationally recognized expert in TBCT, Donald H. Baucom of the University of North Carolina. A competency rating system was devised and the TBCT conducted in this study was judged to be state-of-the-art.

**IBCT.** IBCT (Christensen & Jacobson, 1991; Christensen, Jacobson, & Babcock, 1995; Cordova & Jacobson, 1993, 1997; Jacobson, 1992; Jacobson & Christensen, 1996), is an approach to couple therapy that integrates techniques designed to promote acceptance with the change techniques of TBCT. Acceptance techniques include the promotion of

**TABLE 2**  
**Means and Standard Deviations for Demographic Variables**

Variable	IBCT		TBCT	
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
Wife's age	44.66	8.62	38.33	16.08
Husband's age	46.66	8.64	38.00	9.38
Years married	19.50 <sup>a</sup>	12.58	4.83 <sup>b</sup>	4.31
Children	2.00	2.09	1.83	1.47
Wife's MSI	64.66	5.75	70.50	5.32
Husband's MSI	63.66	11.18	73.33	8.95

*Note.* Groups with different subscripts are significantly different ( $p < .05$ ). MSI = Marital Satisfaction Inventory (Snyder, 1979).

soft emotional expression, the promotion of emotional detachment from unresolvable problems, recognition of the positive features of negative behavior, preparation for slipups and lapses, and the promotion of self-care. Christensen, Jacobson, and Babcock's (1995) chapter was the principal IBCT treatment manual used in this study. Promoting soft emotional expression is an approach to developing an empathic joining between partners that relies on the assumption that expressions of emotions such as anger often mask feelings such as hurt, loneliness, or fear. Unlike Communication Training, this technique does not advocate a structured form of communication but relies on the evocative nature of soft emotions to change the context within which a couple's problems occur. Similarly, Unified Detachment, unlike Communication or Problem-solving Training, does not promote use of a particular communication structure but instead relies on the effectiveness of self-observation to affect the perspective partners have on their problems. Again, self-observation is used as a means of changing the context of the problem in a way that facilitates acceptance.

*Session rating.* Two early, 2 middle, and 2 late sessions were chosen for rating. Both IBCT and TBCT begin with an assessment stage consisting of an initial conjoint session, an individual session for each person, and a conjoint feedback session. The 2 early sessions consisted of the 2 sessions immediately following the feedback session. The 2 middle sessions were chosen from the midpoint of therapy: sessions 11 and 12 for the 20-session therapies and sessions 14 and 15 for 25-session therapies. Late sessions consisted of the 2 sessions just prior to the final therapy session.

Ratings were conducted by four raters trained in the use of the rating system. The raters practiced rating sample tapes under the supervision of the first author until they consistently obtained reliability scores as measured by intraclass correlation approaching or above  $r = .70$  as calibrated against the first author's rating of the session. This method was chosen to assure that all raters were referencing the same source and that that source was the individual with the greatest expertise in the rating system. Once reliability was established, raters were assigned to two teams and rated the selected therapy sessions. Each



member of a team rated tapes independently, and both members worked together to develop a consensus rating. Coding teams were subject to random reliability checks, and weekly calibration meetings were held to maintain consistency. Raters were kept blind to the nature of the two treatments and to the group status of each couple. Reliability between both team's consensus ratings and the first author's ratings was calculated for approximately 25% of the sample using intraclass correlation. Intraclass correlations for the 4 scales were as follows: SE,  $r = .71$ ; DT,  $r = .76$ , HE,  $r = .72$ , and EP,  $r = .71$ .

## RESULTS

Group means, standard deviations, and results of post hoc between-group comparisons for demographic and marital satisfaction variables are depicted in Table 2, including age, length of marriage, number of children, and pretreatment MSI scores. The analysis of variance (ANOVA) uncovered a significant difference between groups for years married only:  $F(1,10) = 7.30$ ,  $p < .05$ . No significant differences were detected for any of the other demographic variables. Separate correlations between years married and the dependent variables revealed no significant correlations; thus there was no need to use years married as a covariate.

Although not statistically significant, pretreatment MSI scores were lower for IBCT couples than for TBCT couples, indicating somewhat greater marital satisfaction for IBCT couples prior to treatment. Although not significant, these differences could contribute to the differences found between groups on the dependent measures. Separate correlations between pretreatment MSI scores and all dependent variables revealed no significant correlations. No correlation with the dependent variables was above  $r = 0.20$ .

All four rating scales were tested separately for the hypothesized differences between groups and across time. For each, a repeated measures  $2 \times 2 \times 3$  (Group  $\times$  Gender  $\times$  Therapy Stage) ANOVA was calculated, with the last two factors repeated measures. ANOVAs were followed by planned one-tailed  $t$  tests between groups at each stage of therapy. Planned one-tailed  $t$  tests were also conducted within each group for differences between early, middle, and late sessions. Effect sizes for the  $t$  test ( $d$ ) were calculated using Cohen's (1988) formula and definition of small (.20), medium (.50), and large (.80) effect sizes.

Means and standard deviations for each group during each therapy stage, as well as between-group effect sizes and results of within-group  $t$  tests, are shown for all codes in Table 3.

### *Detachment*

Results of the repeated measures ANOVA for DT revealed significant effects for Group,  $F(1,10) = 5.03$ ,  $p < .05$ ; Therapy Stage,  $F(2,20) = 3.83$ ,  $p < .05$ ; and Group  $\times$  Therapy Stage,  $F(2,20) = 4.27$ ,  $p < .05$ . No significant effects were shown for Gender,  $F(1,10) = 0.82$ , *ns*; Group  $\times$  Gender,  $F(2,20) = 2.27$ , *ns*; Group  $\times$  Gender  $\times$  Therapy Stage,  $F(2,20) = 0.27$ , *ns*; or Gender  $\times$  Therapy Stage,  $F(2,20) = 0.04$ , *ns*.

$T$  tests reveal that groups did not differ during the early stages of therapy,  $t(10) = 0.69$ , *ns*, with a medium effect size,  $d = 0.68$ . IBCT couples were significantly higher on DT during middle,  $t(10) = 1.75$ ,  $p = .05$ , and late sessions,  $t(10) = 2.83$ ,  $p = .01$ , than were TBCT couples. Effect sizes were large,  $d = 1.02$  and  $d = 1.83$ , respectively.

**TABLE 3**  
**Mean Ratings for Each Rating Scale During Early, Middle, and Late Sessions**

Variable	IBCT		TBCT		Effect Size
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>ds</i>
Soft Expression					
Early	2.08	0.52	1.91	0.56	0.30
Middle	2.38	0.65	1.71	0.94	0.84
Late	2.42	0.85	1.54	0.70	1.13*
Detachment					
Early	1.29 <sup>a</sup>	0.40	1.58 <sup>ab</sup>	0.96	0.68
Middle	1.63 <sup>a</sup>	0.49	1.17 <sup>b</sup>	0.41	1.02*
Late	2.71 <sup>c</sup>	1.07	1.42 <sup>a</sup>	0.34	1.83**
Hard Expression					
Early	2.42 <sup>a</sup>	0.86	1.58	0.85	0.98
Middle	1.75 <sup>ab</sup>	0.63	1.88	1.17	0.14
Late	1.33 <sup>b</sup>	0.38	1.50	0.76	0.29
Engaging in the Problem					
Early	4.17 <sup>a</sup>	0.86	1.63 <sup>a</sup>	0.83	3.00***
Middle	3.04 <sup>b</sup>	0.75	3.46 <sup>b</sup>	1.12	0.45
Late	2.46 <sup>b</sup>	0.93	2.75 <sup>b</sup>	0.65	0.37

*Note.* \* =  $p < .05$ . \*\* =  $p < .01$ . \*\*\* =  $p < .001$ . Within each group, means not sharing common subscripts are significantly different.

Within IBCT,  $t$  tests revealed no change in DT from early to middle sessions,  $t(5) = -1.11$ ,  $p = .16$ , with a medium effect size,  $d = 0.74$ . A significant increase from middle to late sessions was detected,  $t(5) = -3.45$ ,  $p < .01$ , with a large effect size,  $d = 1.39$ . Finally, an overall increase in DT from early to late sessions was revealed,  $t(5) = -2.52$ ,  $p < .05$ , with a large effect size,  $d = 1.83$ .

Within TBCT,  $t$  tests revealed no change in DT from early to middle sessions,  $t(5) = 0.93$ ,  $p = .20$ , with a medium effect size,  $d = 0.61$ , and a significant increase from middle to late sessions,  $t(5) = -2.74$ ,  $p < .05$ , with a medium effect size,  $d = 0.66$ . No significant change from early to late sessions was detected,  $t(5) = .37$ ,  $ns$ , with a small effect size,  $d = 0.26$ .

#### *Soft Expression*

The repeated measures ANOVA revealed a trend toward group differences that approached significance:  $F(1,10) = 3.99$ ,  $p = .07$ . No significant effects were revealed for Gender:  $F(1, 10) = 1.49$ ,  $ns$ ; Group  $\times$  Gender,  $F(2,20) = 0.80$ ,  $ns$ ; Group  $\times$  Therapy Stage,  $F(2,20) = 0.96$ ,  $ns$ ; Therapy Stage,  $F(2,20) = 0.03$ ,  $ns$ ; Group  $\times$  Gender  $\times$  Therapy Stage,  $F(2,20) = 0.57$ ,  $ns$ ; or Gender  $\times$  Therapy Stage,  $F(2,20) = 1.70$ ,  $ns$ .

$T$  tests revealed a significant difference between groups during late sessions with IBCT

couples engaging in more SE:  $t(10) = 1.95$ ,  $p < .05$ , with a large effect size,  $d = 1.13$ . A trend toward group differences during middle sessions favoring IBCT was revealed:  $t(10) = 1.43$ ,  $p = .09$ , with a large effect size:  $d = 0.84$ . No differences were found between treatments in SE during early sessions,  $t(10) = 0.52$ , *ns*, and a small effect size,  $d = 0.30$ .

Within IBCT, a trend toward an increase in SE between early and middle sessions approaching significance was revealed:  $t(5) = -1.66$ ,  $p = .08$ , with a medium effect size,  $d = 0.50$ . No significant change was detected from middle to late sessions:  $t(5) = -0.09$ , *ns*, with a small effect size,  $d = 0.06$ . In addition, no significant change was detected between early and late sessions,  $t(5) = -0.71$ , *ns*, with a medium effect size,  $d = 0.49$ .

Within TBCT, no significant increase in SE was detected between early and middle sessions:  $t(5) = 0.45$ , *ns*, with a small effect size,  $d = 0.27$ . A trend toward a decrease in SE was detected between middle and late sessions:  $t(5) = 1.58$ ,  $p = 0.09$ , with a small effect size,  $d = 0.20$ . Finally, no significant change was detected between early and late sessions:  $t(5) = 0.97$ , *ns*, with a medium effect size,  $d = 0.58$ .

#### *Engaging in the Problem*

Results of the repeated measures ANOVA for EP revealed a significant effect for the Group  $\times$  Therapy Stage interaction:  $F(2,20) = 13.93$ ,  $p < .001$ . No significant effects were shown for Group:  $F(1, 10) = 2.87$ ,  $p = 0.12$ ; Gender,  $F(1, 10) = 0.20$ , *ns*; Group  $\times$  Gender,  $F(2,20) = 1.07$ , *ns*; Therapy Stage,  $F(2,20) = 2.40$ , *ns*; Group  $\times$  Gender  $\times$  Therapy Stage,  $F(2,20) = 0.52$ , *ns*; or Gender  $\times$  Therapy Stage,  $F(2,20) = 0.12$ , *ns*.

*T* tests revealed that IBCT couples engaged in significantly more EP during the early stages of therapy than did TBCT couples:  $t(10) = 5.20$ ,  $p < .001$ , with a large effect size,  $d = 3.00$ . No significant differences were found between groups at middle,  $t(10) = -0.76$ , *ns*, or late sessions,  $t(10) = -0.63$ , *ns*, with small effect sizes,  $d = 0.45$  and  $d = 0.37$ , respectively.

Within IBCT, a significant decrease in EP from early to middle sessions was detected:  $t(5) = 2.96$ ,  $p < .05$ , with a large effect size,  $d = 1.40$ , and a moderate trend toward decrease from middle to late sessions was detected:  $t(5) = 1.28$ ,  $p = .13$ , with a medium effect size,  $d = 0.70$ . Overall, there was a significant decrease in EP from early to late sessions:  $t(5) = 4.11$ ,  $p < .01$ , with a large effect size,  $d = 1.91$ .

Within TBCT, a significant increase in EP from early to middle sessions was detected:  $t(5) = -3.11$ ,  $p = .01$ , with a large effect size,  $d = 1.87$ ; and a moderate trend toward decrease was detected from middle to late sessions:  $t(5) = 1.44$ ,  $p = .11$ , with a large effect size,  $d = 0.80$ . Overall, a significant increase in EP from early to late sessions was detected:  $t(5) = -3.83$ ,  $p < .01$ , with a large effect size,  $d = 1.52$ .

#### *Hard Expression*

Results of the repeated measures ANOVA for HE revealed no significant main or interaction effects (Group,  $F(1, 10) = 0.29$ , *ns*; Gender,  $F(1, 10) = 0.28$ , *ns*; Group  $\times$  Gender,  $F(2,20) = 0.50$ , *ns*; Group  $\times$  Therapy Stage,  $F(2,20) = 1.63$ , *ns*; Therapy Stage,  $F(2, 20) = 1.95$ , *ns*; Group  $\times$  Gender  $\times$  Therapy Stage,  $F(2,20) = 1.48$ , *ns*; Gender  $\times$  Therapy Stage,  $F(2,20) = 1.59$ , *ns*).

*T* tests revealed a trend toward more HE in IBCT couples during the early stages of therapy than TBCT couples:  $t(10) = 1.69$ ,  $p = .06$ , with a large effect size,  $d = 0.98$ . No significant differences between groups were found during middle,  $t(10) = -0.23$ , *ns*, or late

**TABLE 4**  
**Correlations Between Raw Change Scores and Residualized Change Scores.**

	SERC	DTRC	HERC	EPRC	MSIRC
SECH	.79				
DTCH		.66			
HECH			.46		
EPCH				.46	
MSICH					.94

*Note.* Small effect size = .10. Medium effect size = .30. Large effect size = .50. RC = Residualized Change. CH = Raw Change. SE = Soft Expression. HE = Hard Expression. DT = Detachment. EP = Engaging in the Problem. MSI = Marital Satisfaction Inventory.

sessions,  $t(10) = 0.48$ , *ns*, with small effect sizes,  $d = 0.14$  and  $d = 0.29$ , respectively.

Within IBCT, *t* tests revealed a trend toward a decrease in HE from early to middle sessions:  $t(5) = 1.71$ ,  $p = .07$ , with a large effect size,  $d = 0.89$ , and a moderate trend toward a decrease in HE from middle to late sessions,  $t(5) = 1.30$ ,  $p = .13$ , with a large effect size,  $d = 0.83$ . Overall, there was a significant decrease in HE from early to late sessions:  $t(5) = 3.19$ ,  $p = .01$ , with a large effect size,  $d = 1.75$ .

Within TBCT, no significant decreases in HE were detected from early to middle,  $t(5) = -0.45$ , *ns*, from middle to late,  $t(5) = 0.87$ , *ns*, or from early to late sessions,  $t(5) = 0.16$ , *ns*. Effect sizes were all small:  $d = 0.29$ ,  $d = 0.39$ , and  $d = 0.10$ , respectively.

#### *Correlations Between In-session Changes and Changes in Marital Satisfaction*

Given that the above data provide some suggestion that couples within IBCT are changing differently from couples within TBCT, the next question becomes, is there a relationship between these in-session changes and changes in couples' marital satisfaction over the course of therapy? The easiest way to answer this question given this data set is to compute the correlations between the raw change from early to late sessions for each of the process variables and the raw change in satisfaction from pre- to post-therapy. However, deviation from the regression line is often considered the real measure of change (in essence removing from the post-score the portion that could have been predicted from the prescore). Therefore, in addition to computing the raw change scores, we also computed the residualized change scores. Change scores were computed using the couple as the unit of analysis, accomplished by averaging the rating of the husband and wife of each couple on each of the dependent variables. Our preference is to limit our discussion to the raw change scores when possible because they are easier to interpret and because they represent the actual amount of change from pre to post. However, because results can change depending on whether one is looking at raw change or residualized change, we first examined the correlations between raw change and residualized change scores. Results demonstrated that these were all large correlations achieving 1-tailed significance for two variables and approaching significance for two variables. In addition, the correlation between raw and residualized change for the outcome variable

(MSI) was very large and highly significant (see Table 4). Therefore, following our inclination, we will report exclusively the correlations between raw change scores. Given the pilot nature of the study, we were particularly interested in correlations that met Cohen's (1988) definition of medium to large effects, given that our power to detect medium effects was low (see Table 5).

A large correlation was revealed between increases in couples' nonblaming discussions of mutual problems (DT) and decreases in marital distress ( $r = -.55, p = .03$ ). Analyses reveal a trend toward a moderate correlation between increases in Soft Expression (SE) and decreases in marital distress ( $r = -.42, p = .09$ ). There was also a trend toward a moderate correlation between increases in problem engagement (EP) and increases in marital distress ( $r = .38, p = .12$ ). Finally, there was only a nonsignificant correlation between hard expression (HE) and changes in marital distress ( $r = .16, p = .19$ ).

These results suggest moderate-to-large relationships between changes in couples' in-session behavior and changes in couples' reported levels of marital distress. Although correlation is not causation, these results do imply a link between an increase in nonblaming discussions of mutual problems (DT) and an increase in marital satisfaction. In addition, although nonsignificant, the results for SE and EP are encouraging in that they suggest a possible relationship between increases in soft emotions, decreases in problem engagement, and actual decreases in marital distress. These results provide some preliminary support for IBCT's hypothesis that promoting acceptance through these specific techniques increases marital satisfaction. A larger study should provide more definitive evidence concerning this hypothesis. It should also be noted that the direction of the relationship could possibly proceed from increases in marital satisfaction to increases in expressions of soft emotions, nonblaming discussions of mutual problems, and decreases in problem engagement. In other words, it may be increases in satisfaction that lead to changes in these communication patterns rather than vice versa.

## DISCUSSION

The results of the present study tend to support the general hypothesis that IBCT and TBCT lead to identifiably different types of change over the course of treatment, and that these changes may be related to changes in couples' satisfaction. As noted, however, the present sample is small and power to detect differences is low. In several instances this lack of power contributed to *t* test's revealing only trends or moderate trends toward differences even when effect sizes were relatively large. The data are, however, quite interesting. Those instances where only trends were detected despite large effect sizes should be considered suggestive and regarded cautiously.

### *Detachment*

One of the primary methods for promoting acceptance in IBCT is through helping distressed couples learn to relate to unsolvable problems in a nonblaming way without pushing each other for change, a technique referred to as Unified Detachment (Jacobson & Christensen, 1996). Our results strongly support our hypothesis that IBCT couples would engage in significantly more of these nonblaming discussions of mutual problems than would TBCT couples as therapy progressed. Our results demonstrate that compared to TBCT couples, IBCT couples are talking more about their unresolvable problems without

**TABLE 5**  
**Correlations Between Raw Change in Process Variables and Raw Change in Outcome With the Couple as the Unit of Analysis.**

	MSICH
SECH	-.42 ( $p = .09$ )
DTCH	-.55 ( $p = .03$ )
HECH	0.16 ( $p = .19$ )
EPCH	0.38 ( $p = .12$ )

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*Note.* Small effect size = .10. Medium effect size = .30. Large effect size = .50. CH = Raw Change. Correlation coefficients should be squared to obtain the proportion of shared variance. SE = Soft Expression. HE = Hard Expression. DT = Detachment. EP = Engaging in the Problem. MSI = Marital Satisfaction Inventory.

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blaming each other and without pushing for change during both middle *and* late therapy sessions. In addition, IBCT couples engaged in these discussions significantly more frequently as therapy progressed from the early stages of therapy to late stages of therapy. TBCT couples, on the other hand, demonstrated no overall change in DT from the beginning to the end of therapy.

IBCT interventions designed to promote nonblaming discussions of mutual problems appear, therefore, to be quite effective. Couples appear to learn that they can experience irresolvable problems within their relationship, and at the same time openly discuss those problems, outside the context of blame and the struggle to change each other. In other words, these couples are actually beginning to actively talk about their unresolvable problems, and they are doing so without blaming each other and without trying to change each other. In therapy, these discussions often occur in a context of increasing understanding and compassion, therefore building intimacy despite the problem at hand. On the other hand, TBCT couples, in the absence of such interventions, do not appear to be developing this capacity. Theoretically at least, TBCT couples may remain prone to engaging in fruitless and destructive struggles to change the unchangeable.

#### *Soft Expression*

Given the IBCT assumption that promoting acceptance through soft disclosures is an essential aspect of effective couples' therapy, we hypothesized that IBCT couples would increase their expressions of soft emotions significantly more than TBCT couples. Our results offer mixed support for this hypothesis. IBCT couples are clearly expressing more soft emotions than TBCT couples during late sessions. However, neither IBCT nor TBCT couples show any significant change in the expression of soft emotions over the course of therapy. Group means do increase within IBCT and decrease within TBCT from early to late sessions, and although nonsignificant, these trends most likely account for the between-groups difference found during the last stages of therapy. Thus, these data are somewhat encouraging in that they suggest that efforts to promote Empathic Joining may lead to increases in the expression of soft emotions over and above what may be achievable through traditional BCT techniques. The theoretical implication is that such increases may facilitate increased intimacy, understanding, and shared empathy.

### *Engaging in the Problem*

We hypothesized that the differences in in-session structure between IBCT and TBCT would lead to a crossover effect. We expected IBCT couples to engage in more problematic behavior during the early stage of therapy than TBCT couples but by the late stage of therapy to in fact be engaging in significantly less problematic behavior than TBCT couples. Our results again partially support this hypothesis. The repeated measures ANOVA reveals a significant Group by Therapy Stage interaction. In addition, IBCT couples are clearly engaging in more problematic behavior during early sessions than TBCT couples. Furthermore, IBCT couples significantly decrease their in-session problematic behavior over the course of therapy, and TBCT couples significantly increase their in-session problematic behavior. However, our results did not support the hypothesized difference between groups during late stages of therapy. Results do seem to support the hypothesis that the highly structured nature of TBCT suppresses the expression of problematic behavior during the early stages of therapy, whereas IBCT, in keeping with its intent, appears to initially allow for significantly more emotional expression. This interpretation is also partially supported by the finding that TBCT couples significantly increase their problem engagement from early to middle sessions. Early sessions of TBCT are generally devoted to Behavior Exchange (BE), middle sessions to Communication Training (CT), and later sessions to Problem Solving (PS). BE is quite didactic, and the couple is given little opportunity to interact directly with each other. CT, on the other hand, requires the couples to interact directly and thus provides more opportunity for problem engagement. PS requires more structure than CT because couples must follow specific negotiation steps, including brainstorming lists of solutions, reviewing the pros and cons of each item on the list, and developing a behavioral contract. These differences in the overt structure of the session may explain the rebound in EP from early to middle sessions, followed by what may be either a subsequent suppression effect during later stages of therapy or genuine improvement in the couple's ability to deal with relationship problems. It could also be that in-session problem engagement is more generally suppressed by the highly structured nature of TBCT, and that it simply rebounds as therapist control of the session fades. In IBCT, because the therapist does not suppress the couples' natural behavior, couples follow the theoretically predicted course in which they argue more during the early stages of therapy and significantly less over time as the therapy works to improve their relationships. However, given the lack of difference between the two groups during late sessions, we currently have no evidence that IBCT couples have better outcomes with respect to this variable.

### *Hard Expression*

We again hypothesized a crossover effect in which IBCT couples compared to TBCT couples progressed from expressing more hard emotions during the early stage of therapy to expressing significantly fewer during the late stage of therapy. Our results again provide only partial support for this hypothesis. The data are suggestive of a difference between groups during the early stages of therapy, with IBCT couples engaging in more hard emotional expressions than TBCT couples. However, there was only a trend toward a significant group difference, and this result should be regarded cautiously. The only significant difference revealed was between early and late sessions within the IBCT group. These IBCT couples appear to be engaging in fewer expressions of hard emotions at the

end of therapy compared to the early stages of therapy. We also did not find the hypothesized crossover effect. Couples receiving TBCT did not significantly decrease their expressions of hard emotions from early to late sessions, and there was no significant difference between the groups during late sessions. Thus, although these results suggest that IBCT couples decrease their expression of hard emotions over the course of therapy, we cannot determine whether that improvement was greater than that experienced by TBCT couples.

#### *Correlations Between In-session Changes and Changes in Marital Satisfaction*

There appears to be some relationship between changes in couples' in-session communication and changes in their marital satisfaction from pre- to post-therapy. Specifically, increases in couples' nonblaming discussions of mutual problems were significantly associated with decreases in global distress. The relationship between increases in soft emotional expression and decreases in global distress only approached statistical significance and should be regarded cautiously. However, the results are at least suggestive of a genuine relationship. Similarly, a very moderate trend toward a significant relationship between decreases in problem engagement and decreases in global distress was revealed, and although by no means definitive, it is at least suggestive of a genuine relationship. Therefore, there is some encouraging evidence that in-session changes elicited by IBCT may be associated with improvements in marital satisfaction.

#### *Summary and Conclusion*

In summary, the results of this pilot study suggest that IBCT has different effects on couples' in-session communication than TBCT. That difference appears to be that IBCT leads to greater increases in the frequency with which couples talk about their irresolvable problems without blaming each other or pushing for change and greater decreases in destructive problem engagement. Additionally, these results also suggest that IBCT couples may finish therapy engaging in more open expression of soft emotion than TBCT couples and that IBCT couples may decrease their expressions of hard emotions over the course of therapy.

In addition, these data suggest that the highly structured nature of TBCT may suppress the emotional expression of couples seeking therapy and that IBCT may provide more room for genuine expressions of negative affect and demonstrations of problematic behavior in session. Although IBCT couples appear to be decreasing their problematic behavior over the course of therapy, we found no differences between groups at the end of therapy, suggesting that overall improvement may be equivalent. Whether this lack of differentiation is due to equivalent improvement or a general suppression of negativity within TBCT remains to be discovered. The question raised, however, is whether TBCT might simply be suppressing negativity rather than promoting genuine in-session improvement. One implication is that allowing couples to engage each other openly in therapy may aid therapists in judging whether or not negative behavior is indeed decreasing rather than simply being suppressed. In future studies this issue may be addressed by assessing couples' communication at home during the course of therapy and by conducting follow-up assessments.

These results suggest that changes in couples' in-session communication may be genuinely associated with changes in their reported global distress. Increases in couples' open



nonblaming discussions of mutual problems were associated with decreases in their global distress, and trends suggested that corresponding changes in soft emotional expression and problem engagement may also be associated with decreases in global distress. Although preliminary and only suggestive, these results suggest that future studies will demonstrate these associations more conclusively.

Finally, although we have attempted to be appropriately cautious in our interpretation of these results, it should once again be noted that the present study is limited by its small sample size and low power to detect differences. We consider these results preliminary but encouraging and urge that they be interpreted with appropriate caution. In addition, the significant difference between groups in years married, although not correlated with any of the dependent variables, may potentially confound some of the results, in that IBCT couples, having been married longer, may have been at a qualitatively different stage of their relationships from TBCT couples.

## REFERENCES

- Addis, M. E., & Jacobson, N. S. (1991). Integration of cognitive therapy and behavioral marital therapy for depression. *Journal of Psychotherapy Integration*, 1, 249-264.
- Baucom, D. H., Epstein, N., & Rankin, L. A. (1995). Cognitive aspects of cognitive-behavioral marital therapy. In N. S. Jacobson & A. S. Gurman (Eds.), *Clinical handbook of couple therapy* (pp. 65-90). New York: Guilford Press.
- Baucom, D. H., & Hoffman, J. A. (1986). The effectiveness of marital therapy: Current status and applications to the clinical setting. In N. S. Jacobson & A. S. Gurman (Eds.), *Clinical handbook of marital therapy* (pp. 597-620). New York: Guilford Press.
- Baucom, D. H., Sayers, S. L., & Sher, T. G. (1990). Supplementing behavioral marital therapy with cognitive restructuring and emotional expressiveness training: An outcome investigation. *Journal of Consulting & Clinical Psychology*, 58, 636-645.
- Beach, S. R. H., Whisman, M. A., & O'Leary, K. D. (1994). Marital therapy for depression: Theoretical foundation, current status, and future directions. *Behavior Therapy*, 25, 345-371.
- Christensen, A., & Jacobson, N. S. (1991). *Integrative behavioral couples therapy*. Unpublished treatment manual.
- Christensen, A., Jacobson, N. S., & Babcock, J. C. (1995). Integrative behavioral couples therapy. In N. S. Jacobson & A. S. Gurman (Eds.), *Clinical handbook of marital therapy* (2nd ed.). New York: Guilford Press.
- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, New Jersey: Lawrence Erlbaum Associates.
- Cordova, J. V., & Jacobson, N. S. (1993). Couple distress. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders* (2nd ed.) (pp. 481-512).
- Cordova, J. V., & Jacobson, N. S. (1997). Acceptance in couples therapy: Implications for the treatment and prevention of depression. In R. J. Sternberg & M. Hojjat (Eds.), *Satisfaction in close relationships*. New York: Guilford Press.
- Greenberg, L. S. (1996). Allowing and accepting of emotional experience. In R. D. Kavanaugh, B. Zimmerberg, and S. Fein (Eds.), *Emotion: Interdisciplinary Perspectives* pp. 315-336. Mahwah, New Jersey: Lawrence Erlbaum Associates.
- Greenberg, L. S., Ford, C. L., Alden, L. S., & Johnson, S. M. (1993). In-session change in emotionally focused therapy. *Journal of Consulting & Clinical Psychology*, 61, 78-84.
- Greenberg, L. S., James, P. S., & Conry, R. F. (1988). Perceived change processes in emotionally focused couples therapy. *Journal of Family Psychology*, 2, 5-23.
- Greenberg, L. S., & Johnson, S. M. (1988). *Emotionally focused therapy for couples*. New York: Guilford Press.

- Gurman, A. S., Kniskern, D. P., & Pinsof, W. M. (1986). Research on the process and outcome of marital and family therapy. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed.). New York: Wiley.
- Hahlweg, K., & Markman, H. J. (1988). Effectiveness of behavioral marital therapy: Empirical status of behavioral techniques in preventing and alleviating marital distress. *Journal of Consulting and Clinical Psychology, 56*, 440-447.
- Hahlweg, K., Schindler, L., Revenstorf, D., & Brengelmann, J. C. (1984). The Munich marital therapy study. In K. Hahlweg & N. S. Jacobson (Eds.), *Marital interaction: Analysis and modification* (pp. 3-26). New York: Guilford Press.
- Halford, W. K., Sanders, M. R., & Behrens, B. C. (1993). A comparison of the generalization of behavioral marital therapy and enhanced behavioral marital therapy. *Journal of Consulting and Clinical Psychology, 61*, 51-60.
- Hayes, S. C. (1989). *Rule-governed behavior: Cognition, contingencies, and instructional control*. New York: Plenum Press.
- Jacobson, N. S. (1978). A review of the research on the effectiveness of marital therapy. In T. J. Paolino & B. S. McCrady (Eds.), *Marriage and marital therapy: Psychoanalytic, behavioral, and systems theory perspectives*. New York: Brunner/Mazel.
- Jacobson, N. S. (1984). A component analysis of behavioral marital therapy: The relative effectiveness of behavior exchange and problem solving training. *Journal of Consulting and Clinical Psychology, 52*, 295-305.
- Jacobson, N. S. (1992). Behavioral couple therapy: A new beginning. *Behavior Therapy, 23*, 493-506.
- Jacobson, N.S., & Christensen, A. (in press). *Couple therapy: An integrative approach*. New York: Norton.
- Jacobson, N. S., & Christensen, A. (1996). *Integrative couple therapy: Promoting acceptance and change*. New York: Norton.
- Jacobson, N. S., and Follette, W. C. (1985). Clinical significance of improvement resulting from two behavioral marital therapy components. *Behavior Therapy, 16*, 249-262.
- Jacobson, N. S., Follette, W. C., & Pagel, M. (1986). Predicting who will benefit from behavioral marital therapy. *Journal of Consulting and Clinical Psychology, 54*, 518-522.
- Jacobson, N. S., Gottman, J.M., Waltz, J., Rushe, R., Babcock, J., & Holtzworth-Munroe. (1994). Affect, verbal content, and psychophysiology in the arguments of couples with a violent husband. *Journal of Consulting and Clinical Psychology, 62*, 982-988.
- Jacobson, N. S. & Margolin, G. (1979). *Marital therapy: Strategies based on social learning and behavior exchange principles*. New York: Brunner/Mazel.
- Jacobson, N.S., Schmaling, K.B., & Holtzworth-Munroe, A. (1987). Component analysis of behavioral marital therapy: Two-year follow-up and prediction of relapse. *Journal of Marital and Family Therapy, 13*, 187-195.
- Johnson, S. M., & Greenberg, L. S. (1988). Relating process to outcome in marital therapy. *Journal of Marital & Family Therapy, 14*, 175-183.
- Johnson, S. M., & Greenberg, L. S. (1994). Emotion in intimate relationships: Theory and implications for therapy. In S. M. Johnson and L. S. Greenberg (Eds.), *The heart of the matter: Perspectives on emotion in marital therapy*. New York: Brunner/Mazel.
- Johnson, S. M., & Greenberg, L. S. (1995). The emotionally focused approach to problems in adult attachment. In N. S. Jacobson & A. S. Gurman (Eds.), *Clinical handbook of couple therapy*. New York: Guilford Press.
- Margolin, G., Talovic, S., & Weinstein, C. D. (1983). Areas of change questionnaire: A practical approach to marital assessment. *Journal of Consulting and Clinical Psychology, 51*, 920-931.
- McCrady, B. S., Epstein, E. E., & Hirsch, L. S. (1996). Issues in the implementation of a randomized clinical trial that includes Alcoholics Anonymous: Studying AA-related behaviors during treatment. *Journal of Studies on Alcohol, 57*, 604-612.
- Scheer, N. S., & Snyder, D. K. (1984). Empirical validation of the marital satisfaction inventory in a nonclinical sample. *Journal of Consulting and Clinical Psychology, 52*, 88-96.
- Skinner, B. F. (1974). *About behaviorism*. New York: Vintage.

- Snyder, D. K. (1979). Multidimensional assessment of marital satisfaction. *Journal of Marriage and the Family*, 41, 813-823.
- Snyder, D. K., Wills, R. M., & Keiser-Thomas, W. (1981). Empirical validation of the marital satisfaction inventory: An actuarial approach. *Journal of Consulting and Clinical Psychology*, 49, 262-268.
- Spanier, G. B. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and the Family*, 38, 15-28.
- Spanier, G. B., & Thompson, L. (1982). A confirmatory analysis of the dyadic adjustment scale. *Journal of Marriage and the Family*, 44, 731-738.