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Research on Couples and Couple Therapy
What Do We Know? Where Are We Going?

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ABSTRACT

This article discusses the outcome and process research on couple therapy and integrates the articles special section "Couples and Couple Therapy" into the discussion. All tested couple treatments show statistically significant effects relative to control groups, but there are no reliable differences between different theoretical models. Moreover, all tested approaches leave substantial numbers of couples unimproved or at least still somewhat distressed. A discussion of the strengths and weaknesses of various designs concludes that within-model comparisons have been more productive in producing knowledge than between-model comparisons. Recommendations for future research include developing a technology that would make possible matching studies focusing on Aptitude × Treatment interactions. Also, there needs to be greater emphasis on basic research and prevention.

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The articles in this special section are diverse and therefore hard to subsume under one theme. The section includes one outcome study (Halford, Sanders, & Behrens, 1993), one process study (Greenberg, Ford, Alden, & Johnson, 1993), one study on the predictors of outcome (Snyder, Mangrum, & Wills, 1993), one study on prevention (Markman, Renick, Floyd, Stanley, & Clements, 1993), two studies on the dynamics of domestic violence (Babcock, Waltz, Jacobson, & Gottman, 1993 ; Burman, Margolin, & John, 1993), and two examples of basic research on couple interaction (Gottman, 1993 ; Heavey, Layne, & Christensen, 1993). All of these articles represent components of the knowledge base that contribute to what investigators know about couple therapy. In fact, we would argue that these areas comprise the multiple fronts on which work must continue if knowledge about how couples change is to accumulate: research on therapy outcome, therapy process, prevention of relationship problems, and basic research on couple interaction generally, with particular attention to domestic violence.

Our purpose in this commentary is to place the special section in the context of a more general

examination of what is known about couple therapy: which treatments work, how they work, and what factors predict outcome. From what we know about couple therapy, we discuss the pros and cons of various research strategies from the standpoint of their potential future payoff.

What Is Known About Couple Therapy?

Which Treatments Work?

Most of the outcome research has focused on behavioral couple therapy (BCT). There have been over two dozen publsihed studies in at least four countries demonstrating the superiority of various versions of BCT to control groups (Hahlweg & Markman, 1988). Thus, it can be said that BCT is the closest thing that couple therapy has to an established treatment. It can also be said that the demonstration of an effect, having been replicated so many times, is unequivocal.

Other approaches have received considerably less attention from investigators of treatment outcome. However, there now exist three trials supporting significant effects for *emotion-focused couple therapy* (EFT; Goldman, 1987 ; James, 1991 ; Johnson & Greenberg, 1985), which is an experiential treatment based on a blending of systemic and gestalt theoretical perspectives (Greenberg & Johnson, 1988). Although three studies are a lot fewer than two dozen, the two replications make the findings from the initial trial more convincing. More recently, one trial evaluating strategic couple therapy (Goldman, 1987) and one trial on insight-oriented couple therapy (IOCT; Snyder & Wills, 1989) have been published. Both trials yielded positive results, thus providng the beginnings of an empirical basis for recommending these two widely practiced treatments.

Although this is the extent to which major models of couple therapy have been evaluated, it is intriguing that in no published study has a tested model failed to outperform a control group. In virtually every instance in which a bona fide treatment has been tested against a control group, the treatment has shown reliable change.

The success that investigators have had establishing these effects for their preferred treatments is not as impressive as first thought. The improvement rate in the absence of treatment is so low that even small changes in an experimental treatment are likely to be statistically significant (Jacobson, et al., 1984). Quite often, couples' relationships deteriorate without treatment. Typically, they remain unchanged during the waiting period. When there is such minimal change without treatment, establishing a statistically significant effect is relatively easy, but it actually reveals little about the efficacy of any of these treatments.

Treatment efficacy refers to the clinical significance of these treatment effects: How often is this approach effective? Are the effects clinically meaningful? Does the treatment have a substantial impact on the likelihood of divorce? These are the questions in which clinicians are interested (Jacobson & Traux, 1991). When examined under the microscope of clinical significance, the results are generally less impressive than the comparisons with control groups would lead us to believe. When we ask the question, What percentage of treated couples are happily married by the end of treatment? Most tested treatments report no better than 50% success. There is remarkable uniformity both across studies and across different treatment modalities in the success rate. Thus, it appears that all treatments are helping some couples, all treatments are leaving substantial numbers of couples unchanged or still distressed by the end of therapy, and all tested treatments appear to have about the same success rates.

Thus far, we have spoken only of the immediate effects of couple therapy. What about the long-term outcomes? Little is known about these long-term effects, because few researchers have followed their

couples beyond a few months after treatment termination. The BCT literature has produced evidence regarding the course of relationship functioning after therapy. One 2-year follow-up found that about 30% of those couples who recovered during the course of therapy had relapsed (Jacobson, Schmaling, & Holtzworth-Munroe, 1987). In another study, a 4-year follow-up revealed a 38% divorce rate, which was based on the entire sample of couples who received treatment (Snyder, Wills, & Grady-Fletcher, 1991). Thus, at least two studies have found substantial relapse in BCT at the time of a long-term follow-up. A third study on BCT (Hahlweg, Schindler, & Revenstorf, 1982) also hints at such deterioration.

The Snyder et al. (1991) study also reported a 4-year follow-up of couples treated with IOCT, and the divorce rate was a remarkably low 3%. This suggests not only that there was little deterioration in the relationships of couples who responded positively to begin with, but also that couples who initially failed to improve stayed together. The findings suggest promise for IOCT are a couple treatment that might be particularly effective at fostering long-term couple stability. However, it was only one study, and any set of findings, no matter how promising, should be considered preliminary until they are replicated. Nevertheless, in the light of the somewhat disappointing long-term outcomes of BCT, the low divorce rates of IOCT are provocative.

A number of studies have directly compared two or more "schools" of couple therapy (e.g., behavioral vs. insight oriented). Most comparative studies have not yielded statistically significant differences among treatments, either in terms of immediate or long-term outcomes (Baucom & Hoffman, 1986). In virtually every instance in which there has been a significant difference favoring one treatment over another, the difference favored the treatment that was consistent with the theoretical orientation or the expertise of the investigators. The finding of an allegiance effect in couple therapy research is consistent with the general outcomes of psychotherapy research: When one covaries out the principal investigator's allegiance to one treatment over another, significant differences between treatments in comparative research are generally eliminated (Smith, Glass, & Miller, 1980).

Another trend in this literature is that familiarity appears to breed contempt: Effect sizes appear to be largest when the treatment first appears and then drop as the studies are replicated and extended (Goldman, 1987 ; Hahlweg & Markman, 1988 ; James, 1991 ; Johnson & Greenberg, 1985). Thus, it is hazardous to form conclusions about a treatment that is based on the first investigation or two: One would likely overestimate efficacy if one were to make a guess on the basis of these early inquiries. The primary implication is that a treatment has to be around for a while and tested repeatedly before its effects can be evaluated with confidence.

Finally, promising results have emerged from the literature on marital enrichment and prevention. Two examples illustrate this promise. The relationship enhancement approach developed by Guerney (1976) has had a powerful impact on the communication of happy couples seeking an enrichment experience (Ely, Guerney, & Stover, 1973 ; Jesse & Guerney, 1981 ; Ridley & Bain, 1983 ; Ridley, Jorgensen, Morgan, & Avery, 1982). When the active listening and expressive communication skills that comprise relationship enhancement are presented to distressed couples seeking therapy, they appear to achieve the same success as achieved with other approaches (Emmelkamp, van der Helm, MacGillavary, & van Zanten, 1984 ; Hahlweg et al., 1982 ; Turkewitz & O'Leary, 1981).

Behavioral communication training techniques have been applied in a prevention format by Markman, Floyd, Stanley, and Lewis (1986) , with impressive results. With long-term follow-ups, a brief prevention program has yielded higher relationship satisfaction, higher sexual satisfaction, fewer relationship problems, and lower divorce rates (Markman, 1989) than was found for control couples not receiving this program. In the special section article by Markman et al. (1993) , there are some indications that the effect of the intervention may be attenuated as the follow-up period is extended more

than 4 years. Interpretation is complicated by the diminishing sample sizes, which suggest that there may be a statistical power problem rather than an attenuated effect.

Nevertheless, the success of these brief enrichment and prevention programs, combined with the somewhat equivocal results obtained from existing therapies for distressed couples, suggests that it may be easier to prevent relationship problems than to treat them once they emerge.

When Do They Work and Why?

The literature to be summarized in this section pertains to three critical questions in the evaluation of couple therapy: Who benefits from couple therapy? What are the active ingredients of successful couple therapy? What are the pertinent change processes? Whereas the previous section deals in an undifferentiated manner with questions related to efficacy, this section deals with questions of theoretical import, questions which help home in on when and why these treatments are successful.

What types of couples respond to couple therapy?

We look mostly to the BCT literature for information relevant to this question. Investigators know something about which couples are most likely to benefit from BCT. It was unclear before this special section whether these predictors would hold for other schools couple therapy. The Snyder et al. (1993) article constitutes the first published data on predictors of outcome and includes an approach other than BCT.

First, in past research, as Snyder et al. (1993) note, we have consistently found that couples more severely distressed are less likely to join the ranks of the happily married by the end of therapy. This finding has been replicated by numerous investigators on the basis of various paper-and-pencil questionnaires known to be correlated with marital satisfaction (Baucom & Hoffman, 1986).

Second, various studies have found an inverse relationship between age and outcome (Baucom & Hoffman, 1986). Treating older couples appears to be harder than treating younger couples.

Third, emotional disengagement appears to be a bad prognostic sign (Hahlweg, Schindler, Revenstorf, & Brengelmann, 1984). Researchers use this construct to unite a diverse set of findings that show that outcome is less likely to be positive when frequency of sexual intercourse is low, when affective communication is relatively underemphasized, and when the quality of emotional affection is poor. This literature reminds us of Gottman and Krokoff's (1989) recent work on conflict avoidance, which indicates that conflict engagement is predictive of longitudinal increases in marital satisfaction, whereas conflict avoidance leads to decreases.

Fourth, research has shown that couples who are polarized with respect to gender role preferences are less likely to benefit from BCT (Jacobson, Follette, & Pagel, 1986). Specifically, when highly affiliative wives are paired with highly autonomous husbands, couple therapy is less likely to be successful. This suggests that couples whose relationships are rigidly organized according to traditional gender roles are relatively poor risks for BCT.

How do the findings of Snyder et al. (1993) supplement the findings just outlined? For one thing, they confirm that it is harder to treat more severely distressed than less severely distressed couples; thus, it is not just BCT where less distressed couples have a better prognosis. However, the Snyder et al. findings combined with previous research suggest that long-term outcomes are better predicted by couple communication process than by global relationship sentiment. Another interesting finding by the Snyder

et al. group concerns the paradox that problem-solving during a conflict resolution exercise is predictive of higher marital instability longitudinally: As the authors note, these findings converge with others suggesting that clinicians' notions of constructive communication may not have much to do with what is really good for couples in the long run. In particular, they suggest that problem solving in a 10- to 15-min conversation may be counterproductive, a sign that couples are skirting issues in a superficial manner; they also support the findings of Gottman and Krokoff (1989) that conflict engagement is an important part of the process of conflict resolution. This means that arguing, attempts to persuade, and the like are not to be stamped out, but rather to be encouraged as long as couples eventually return to the task of resolution.

Finally, variables related to life stress and individual problems seem important things to consider when recommending couple therapy. Depression in particular seems to contribute to a poor prognosis for couple therapy. Although couple therapy can be and often is an effective treatment for depression (Jacobson, Dobson, Fruzzetti, Schamling, & Salusky, 1991 ; O'Leary & Beach, 1990), studies also indicate that only a minority of couples with a depressed partner recover from their marital problems after a relationship-focused treatment.

What are the active ingredients of couple therapy?

At least one study has shown that the effects of BCT cannot be accounted for by nonspecific factors common to all treatments (Jacobson, 1978): There appears to be something about the BCT technology that accounts for the effects that have emerged.

What is it about the technology that seems necessary and sufficient? A number of investigators have found it useful to distinguish between two primary aspects of BCT technology: *behavior exchange* (BE), which is oriented toward direct instigation of positive changes in the natural environment, and *communication problem-solving training* (CPT), which is process focused, oriented toward teaching couples to solve their own problems with new communication skills, and focused on long-term rather than immediate change (Baucom, 1982 ; Jacobson, 1984 ; O'Leary & Turkewitz, 1978). Although the components are relatively interchangeable in terms of their immediate effects, CPT has prophylactic effects when used alone or in combination with BE (Jacobson, 1984). Moreover, the two modules appear to work as they were expected to: BE produces change at home but has little impact on communication process (Jacobson, 1984); CPT produces improvement in communication process but has little immediate effect on positive interaction at home (Jacobson, 1984 ; Jacobson et al., 1985). Finally, both BE and CPT are necessary components for the treatment effect to last beyond a 1-year follow-up. Relapse is so extensive when either component is presented alone that by a 2-year follow-up, couples in the component controls are as distressed as they were before treatment (Jacobson et al., 1987).

What is known about the process of change in couple therapy?

Most of the work in the process domain has examined EFT. In one study, Johnson and Greenberg (1988) identified two characteristics of successfully treated couples that differentiate them from treatment failures. Successful couples showed "higher levels of experiencing"–that is, greater emotional involvement and self-description in the sessions–and more autonomous and affiliative actions–that is, more acceptance and less hostility and coercion. This study relied on direct observations of client behavior in the sessions. In a second study based on clients' retrospective accounts (Greenberg, James, & Conry, 1988), five significant change processes were described: one partners' feeling expression leading to a change in perception by the listener, learning to express needs, acquiring understanding, taking responsibility for one's own experiences, and receiving validation from the partner.

The contribution by Greenberg et al. (1993) in the special section adds to the list of relationship variables that seem to change as couples improve during the course of EFT. By now, investigators have identified several interaction factors that appear to be markers for change: That is, there are a number of interaction patterns that seem more prevalent later in therapy and among improved couples than they do earlier in therapy and among unimproved couples. Identifying these markers is an important first step in generating support for specific change processes.

Therapists still do not understand how change is produced in EFT. The methodology for studying change mechanisms exists, and much of its was developed by Greenberg and colleagues (e.g., Rice & Greenberg, 1984). However, it has not yet been applied to EFT. Moreover, there is a perennial problem in psychotherapy process research that continues to interfere with interpretation of most interesting empirical findings: It is the issue of interpreting the direction of the correlational relationships. Whenever a correlation is found between an outcome and a process variable, the possibility exists that the process variable is the result of improvement rather than a mediator of improvement. Thus, for example, when it is found that the tendency to communicate vulnerability rather than hostility is more likely to occur in improved couples later in therapy than in unimproved couples earlier in therapy, it is often implied that the communication of vulnerability mediates relationship enhancement. In fact, it is equally plausible that the communication of vulnerability is an outcome of an improved relationship that has in turn been mediated by other factors. Until this correlational relationship is disentangled, it will be difficult to distinguish process markers of change from process mediators of change.

In the only study on BCT to investigate change processes, Holtzworth-Munroe, Jacobson, DeKlyen, and Whisman (1989) asked therapists and clients to report, session by session, on their reactions to the session and their observations of participant behaviors. Client behaviors were much better predictors of outcome then were therapist behaviors: Specifically, client insession and out-of-session involvement showed up as the most robust factor associated with improvement.

What Methods Have Proved Useful in Studying Couple Therapy?

In this section, we evaluate the prmary methods that have been used to study couple therapy and discuss their assets and liabilities.

Comparative clinical trials.

In these investigations, two or more distinct theoretical systems are compared, primarily on measures of efficacy. As we indicated in the previous section, all such studies have either found no differences between active treatments, or when differences have been found, they have in each case been in the direction of the allegiance and expertise of the investigators. In short, we have learned very little from these studies, especially given the time and expense that has gone into them.

We think that there are several reasons for the lack of substantive knowledge resulting from comparative trials. First, in their natural form there is considerable overlap among the major models of couple therapy. Theoretical models of therapy can be defined according to their observable operations, their goals, or the conceptual framework that gives rise to the technology. Comparative studies have tended to use observable operations as the criterion for distinguishing between treatments. These criteria are not necessarily better than the others, but they do facilitate internally valid comparisons. However, it appears that the more important distinctions between schools of couple therapy are their discrepant goals or conceptual frameworks and that at the level of therapist operations there is considerable overlap of treatments. This overlap makes scientifically sound comparisons of treatment models difficult, if not impossible. When protocols are altered to create artificial differences between treatments, internal

validity may be preserved, but the scientific integrity is severely compromised. Even though models can be discriminated by adherence rating scales (e.g., Wills, Faitler, & Snyder, 1987), the overlap may none-theless be considerable (Jacobson, 1991). To the extent that the common factors or areas of overlap account for change in both models, treatment integrity measures designed according to the discriminable components can yield misleading results (Waltz, Addis, Koerner, & Jacobson, in press).

Another constraint operating in comparative trials is that they are set up to identify main effects for treatment, and such effects may not exist in nature. That is, there may not be differences in efficacy of treatments that cut across the gamut of therapist and client variables. In contrast, there may well be interaction effects in nature, such as Aptitude × Treatment interactions (Shoham-Salomon & Hannah, 1991). Although very large sample sizes may be needed to detect such interaction effects, they may be the only ones that are of sufficient clinical significance to warrant detection.

The allegiance factor seems to be a particularly thorny problem throughout the psychotheapy research literature. Although no one knows exactly how to explain it, several factors probably contribute. Certainly, differential expertise often plays a role. The biases that underlie differential allegiance also probably play a role. Biases get communicated to therapists and can affect treatment process and outcome in various and sundry ways. Finally, the failure to maintain conditions of "blindness" also leaves room for allegiance to affect results. Although most studies attempt to enforce blindness on the part of those who implement assessment procedures, it is often quite difficult to maintain blindness in practice.

In some areas of psychotherapy research, attempts have been made to control for allegiance and expertise by conducting the studies at more than one site: One type of study includes a site with allegiance to Treatment A and another with allegiance to Treatment B, with both treatments conducted at both sites and experts and adherents doing all training and supervision for their favored treatment; a second type includes sites that are presumably neutral, with a centralized training and supervision process so that adherents and experts provide the training and supervision at both sites. These designs certainly constitute an improvement relative to those used thus far in couple therapy comparative trials. Unfortunately, such studies are quite expensive and complicated to administer. A less expensive alternative would be to conduct the study at one site, but to control for allegiance through collaborations in which each approach is represented by an adherent and expert.

Finally, there has been far too little attention paid to the evaluation of therapist competence in previous comparative investigations. Competence is not the same as adherence: The latter refers to whether the interventions were consistent with a treatment protocol; the former refers to the quality of the interventions. In a between-model comparison, competence must be equated across the two treatments to rule out the possibility that any differences that are found between them are confounded with differential competence. Competence cannot be assumed on the basis of the experience level of the therapist. The absence of a correlation between therapist experience and outcome is one of the best documented null findings in the psychotherapy research literature (Smith et al., 1980). To assess competence, it has to be operationalized in the treatment manual, and it has to be evaluated by disinterested experts.

Intramodel comparisons.

In contrast to the comparative trial that generally asks which approach is better, intramodel comparisons contrast treatments all derived from the same theoretical model. Although these studies are also concerned with comparative outcome, they can and often do answer additional questions as well: What are the conditions under which a treatment effect is maximized? What are the active ingredients in a complex, multifaceted treatment? To what extent is the theory of change implicit in the treatment

confirmed or disconfirmed by the results? Thus, these designs answer theoretical as well as clinical questions, and they have the potential to tell clinicians and researchers when and why treatments work, in addition to how well they work.

When treatments are developed, the assumption is often made that each component affects a different process, and thus the combination of components is necessary to maximize treatment response. However, these assumptions about the additivity of treatment components and the mode specificity of component effects have generally not held up in the psychotherapy research literature (Imber et al., 1990). An example is the Halford et al. (1993) study in this special section. In the study, there was no more cognitive change in the enhanced cognitive treatment condition than there was in the traditional BCT condition. These failures to demonstrate mode specificity may reflect the insensitivity of the mode measures, or they could underscore the multiple, generalized effects of particular interventions, despite their discrete targets. Nevertheless, dismantling studies that measure the processes presumably affected by each component have the potential to shed light on multiple aspects of the clinical problem in addition to differential efficacy.

The Halford et al. (1993) study is an excellent example of a specific within-mode design: Often referred to as a *constructive treatment* design, the strategy involves examining whether a model works better when a new component is added to it. The Halford et al. study represents the latest effort to enhance the efficacy of BCT by adding a component that includes cognitive therapy and crisis management. As the findings indicate, there was no evidence that the enhanced component added anything to traditional BCT. This study by Halford et al. represents the third effort to enhance the efficacy of BCT by adding cognitive therapy to it; thus far, all efforts have been unsuccessful (Baucom & Lester, 1986 ; Baucom, Sayers, & Sher, 1990). Although it would be premature at this point to reject cognitive therapy as a treatment for couples, until now it has not shown much promise in adding to what is already done in BCT.

Thus, in contrast to comparative studies, intramodel comparisons have great potential for advancing knowledge. Given the technological overlap of major models of couple therapy, knowledge gained from one intramodel comparison is likely to have implications for other models as well. We would like to see further combinations of experimental and correlational designs, where specific treatment components are under experimental control, and the processes presumably affected by those components are measured separately from outcome. Not only do such designs test important theoretical hypotheses regarding change mechanisms, but they also often shed light on basic processes underlying couple conflict and distress. In terms of payoff and cost effectiveness, these types of designs seem to offer clear advantages relative to between-model comparisons.

Matching Studies and the Role of Basic Research

Although matching studies have not been tried in the couple therapy arena, they are receiving a great deal of attention in the psychotherapy research community. Recently, a miniseries in the *Journal of Consulting and Clinical Psychology* was devoted to designs for studying Aptitude × Treatment interactions (Shoham-Salomon, 1991). In virtually all of the published trials in the couple therapy arena, invariant treatments are applied to all couples in the sample. In contrast, practitioners alter their treatments depending on characteristics of the client. This factor probably contributes to the credibility gap between clinicians and researchers. Furthermore, it is hard to evaluate the potential of a treatment, let alone the role of specific processes and mechanisms, within a randomized trial because couples well suited for the treatment are combined with those for whom the treatment is contraindicated. Matching studies provide a partial solution to these problems by studying the efficacy of interventions for clients where there is some theoretical or clinical reason to believe that the intervention is indicated or contraindicated.

These matching studies can be purely correlational, or they can be under experimenter control. In the former case, matching variables are used to predict response to treatment, but the usefulness of matching is not directly tested. In the latter case, subjects are randomly assigned to either matched or mismatched conditions. This latter design provides an elegant test of whether selecting couples according to a particular characteristic actually pays off.

If one were to design matching studies to examine couple therapy, it is unclear at present what the appropriate matching variables would be. There is little empirical basis at present for predicting what kinds of couple characteristics should interact with type of treatment. Partly for this reason, the top priority for improving the quality of couple therapy research may be to conduct basic research on couple interaction processes. The presumed relevance of basic couple interaction research for couple therapy is the rationale for including four articles in the special section that have nothing to do with treatment. Gottman (1993) provides a typology of marriage in the special section. These types might very well constitute a good starting place for matching variables. An avoidant couple and a volatile couple might respond to very different treatments. There is evidence that emotionally disengaged couples (i.e., avoidant couples) are less responsive to BCT than are other couples.

Studies of Therapy Process and Further Treatment Development

These types of studies are also directed at understanding change, but they generally address questions that are more fine-grained than those that serve as the focus for intramodel comparisons. Process studies generally look microscopically at the process of change as it unfolds in specific transactions between therapist and client. Although various methods have been used to study change processes, the task-analytic method proposed by Rice and Greenberg (1984) has been the most influential among investigators of individual psychotherapy. This method involves empirically identifying important segments of therapy sessions, generating hypotheses regarding what processes operate during these segments, developing a method for coding these processes, and then confirming or disconfirming the resultant model of change by coding the transactions and testing the viability of particular hypotheses. One advantage of this focus on therapy process is that the results could be of great interest to clinicians. Whereas it is difficult to use the results from clinical trials in work with particular clients, the results of process studies could be directly applicable and accessible to clinicians. A second virtue of process research is that it develops and later tests theories of change, and it thereby contributes to the knowledge base regarding how change occurs. A third advantage is practical. Models of change can be generated with individual subjects, and thus process studies can be done on small numbers.

At this point, however, the potential of process research for identifying the processes that mediate change remains a promissory note. We have already alluded to the major problem that all such research has, which is the lack of control that the experimenter has over the variable of interest. Only time will tell whether the promissory note is redeemed in the couple therapy arena. Nevertheless, if couple therapy research is to contribute to the development of more effective treatments rather than simply evaluate existing ones, discovery-oriented and hypothesis-generating research must remain a high priority.

Although process research paradigms provide a useful framework for using research to develop rather than merely test treatments, treatment development occurs at all phases of a clinical research program. In the couple therapy literature, we need an orderly progression from research findings, systematic analysis of treatment failures, treatment development and modification, and empirical testing of new modules. In our laboratory we are trying to practice what we preach. On the basis of our analysis of treatment failures, we have recently concluded that traditional BCT was excessively focused on change and paid insufficient attention to promoting acceptance. Jacobson, Christensen, and Babcock (in press) and Jacobson (1992) have reported on a module to promote acceptance. If this module were presented to

couples in conjunction with traditional BCT, would it enhance the efficacy of BCT? Would it succeed in promoting acceptance, independent of its impact on overall success? To answer these questions, adequate and well-differentiated measures of change and acceptance are required. Thus, adequate treatment development research includes (a) identifying reasons for treatment failure, (b) hypothesizing and piloting strategies for more effectively modifying the dysfunctional processes accounting for treatment failure, (c) producing instruments to measure those processes, and then (d) testing at both the outcome and process levels whether these treatment development endeavors have been successful.

Increased Attention to Prevention

Given the promising findings from the enrichment and prevention literatures, it seems clear that such efforts should be encouraged. Given what researchers know about the predictors of success and failure for BCT, it makes sense that the problems would be easier to prevent than to modify after the fact: Newlyweds or couples in a premarried state are much more amenable to change-oriented programs, in part because they are younger, happier, and emotionally engaged.

We think that prevention efforts should be expanded. Efforts to intervene at periods of the life cycle known to be high risk for couple discord provide excellent opportunities to do prevention work. The best example we can think of involves working with couples during pregnancy, to help them cope with the impending birth of their child (Cowan & Cowan, 1992). Because there is a predictable decline in couple satisfaction that occurs after the birth of children, this seems to be an ideal time to intervene.

Other Priorities for Basic Research on Couples

We have already alluded to the role of basic research in helping to determine how couple characteristics may interact with particular treatments. In addition to this important role, there are several ways that basic research could inform treatment development. We mention two of these because there are contributions in these areas for the special section.

Research on gender issues.

There have already been numerous contributions from research on gender differences in relationships that have played a role in the development of couple therapy techniques. The research program by Christensen and colleagues is an excellent example, and the Heavy et al. (1993) article in the special section represents an extension of their work on demand—withdraw communication. This work reminds us that although men and women tend to play different roles in typical dysfunctional interaction patterns, these roles are sensitive to context and can be altered under certain conditions. This work also highlights demand—withdraw interaction as an important target for intervention in couple therapy.

In the past 2 decades, researchers have learned a great deal about the different roles that men and women play in marital conflict (Baucom et al., 1990). The study by Heavy et al. (1993) converges with other recent evidence showing that women typically enter therapy wanting change, whereas men more often have the agenda of preserving the status quo (Jacobson, 1989). In addition to reinforcing the importance of examining gender differences, these findings remind us that a positive outcome for one partner is not necessarily a positive outcome for the other. Because partners often enter therapy with discrepant goals, there is often a great deal of ambiguity in defining success and failure. This ambiguity complicates the task for clinicians treating couples, and it creates numerous problems for researchers: The between-groups paradigm that is the gold standard for our field requires that success be defined the same way for all subjects in the study.

The ambiguity regarding success and failure relates to an even thornier problem that has never been adequately addressed by couple therapy researchers: how to define treatment success flexibly without being self-serving. For some couples, divorce is a desirable outcome; when working with such couples, increasing marital satisfaction or fostering harmonious communication is an unrealistic goal, and in some cases, it is counterproductive. Research has forced uniform outcome criteria on clinicians, but no couple therapist treats couples so uniformly. Yet, when one therapist tries before the fact to separate couples who should focus on improvement from those who should disengage, a host of methodological, moral, and ethical issues arise. From a methodological standpoint, it is equally problematic to make such decisions after treatment is over, because the criterion for success and failure would be post hoc and undoubtedly self-serving. Until the field grapples with this issue, the current outcome measures will remain insensitive to the clinical reality that for every couple there are two viable options: relationship enhancement and dissolution. Who is to say which is indicated?

Domestic violence.

Domestic violence has been ignored by couple interaction researchers until recently. Yet, at least in its milder forms it appears to be quite common in couples seeking therapy (O'Leary, Vivian, & Malone, 1991), even though it is often missed in the typical pretreatment assessment. Many couples in which the husband batters are not good candidates for couple therapy (Hastings & Hamberger, 1988). Nonetheless, couples with less severe violence are being given couple therapy whether therapists like it or not, and therefore the treatment should be informed by an understanding of the relationship dynamics of couples in which there is violence. The study by Babcock et al. (1993) in this special section examines power and its relationship to violence. The findings illustrate the dangers of trusting clinical intuition without careful investigation of hypothesized phenomena under controlled conditions. Similarly, the article by Burman et al. (1993) points to some features of interaction patterns in domestic violence that have important clinical implications.

Basic research on domestic violence has clinical implications for a variety of reasons. O'Leary et al.'s (1991) work has shown that therapists are all treating violence in many couples without realizing it. Some of our unaccounted-for outcome variances may pertain to these insensitive assessments. It may turn out that an identifiable subset of couples with domestic violence are treatable by couple therapy. Studies on the interaction patterns in these couples may help to determine how to make those decisions.

Conclusion

The special section presents a variety of empirical contributions from basic and applied research on couples and couple therapy. This commentary has attempted to place this work in a broader context. It is our belief that the continued interplay between basic and applied research maximizes the likelihood that the couple treatments will improve and that our understanding of relationships will grow.

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