An outcome study of integrative couples therapy delivered in a group format

John David Wimberly

The University of Montana

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An Outcome Study of Integrative Couples Therapy

Delivered in a Group Format

by

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B.A., Middlebury College, 1985

M.A., The University of Montana, 1995

Presented in partial fulfillment of the requirements

for the degree of

Doctor of Philosophy

The University of Montana

1997

Approved by:

[Signatures and dates]

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Abstract

This study compared a group format of Integrative Couples Therapy (Jacobson & Christensen, 1996) with a wait-list control condition. Seventeen couples were solicited from a community sample and were matched across treatment conditions. The couples were assessed with: a clinical interview, the Dyadic Adjustment Scale, the Marital Satisfaction Inventory, the Relationship Issues Questionnaire, the Communication Patterns Questionnaire, the Conflict Tactics Scale, and the SCL-90-R. Couples were screened out for current substance abuse, major thought disorder, significant personality difficulties, and domestic violence. Eight couples completed 2 ICT groups and nine couples were in the wait-list control group.

Results from this study show that Integrative Couples therapy delivered in a group format produced statistically improved scores on both the Dyadic Adjustment Scale and the global distress scale of the Marital Satisfaction Inventory as compared with the wait-list control couples. Tests of clinical significance were also performed and 100% of the couples in the group ICT treatment improved and 75% were alleviated on the DAS. Seventy-five percent of the ICT group couples improved and 60% were alleviated on the global distress scale. These results are consistent with other outcome studies on couples groups (e.g. Wilson, Bornstein & Wilson, 1988; Montag & Wilson, 1992) and give further evidence for the efficacy of couples groups.
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Introduction

Approximately 20% of all married couples are experiencing relationship discord at any given time (Beach, Arias, & O’Leary, 1987) and roughly 50% of all first time marriages will end in divorce (Glick, 1984). These statistics are especially meaningful given that the physiological and mental health consequences of relationship discord and relationship disruption can be significant. Relationship discord and disruption are correlated with a number of physical and mental health disorders for spouses (Beach & Nelson, 1990; Kiecolt-Glaser, Fisher, Ogrocki, Stout, Speicher, & Glaser, 1987), and with mental health problems for children (Emery, 1988).

Couples therapy seeks to improve a couple’s relationship along many relationship dimensions (i.e. intimacy, communication, sexual satisfaction, distribution of labor, problem solving, and child-rearing practices). A common secondary goal of couples therapy is to promote the growth in one or both of the individuals in the relationship. The third principal area of couples therapy can be to assist couples in determining whether their relationship is viable for them or not.

Traditional Behavioral Couples Therapy (TBCT) is an approach to couples therapy based upon social learning principles (Jacobson & Margolin, 1979). Traditional behavioral couples therapy was initiated in the late 1960’s when Stuart (1969) presented the first published paper applying behavior therapy to relationship problems. The theoretical underpinnings of behavior therapy as a strategy for treating couples were originally based on behavior exchange theory (Jacobson & Margolin,
1979). Jacobson has since enlarged his theoretical base to include social learning theory (Jacobson, 1981). Social learning theory includes the principles of learning derived from the laboratories of experimental psychology and contributions from both developmental and cognitive psychology (Jacobson, 1981). Experimental psychology has led to the development of learning theory and in particular to the understanding of reinforcement and its influence on behavior. TBCT rest solidly on this empirical base and this is evident in its emphasis on behavioral analysis (determining what the controlling reinforcers are in a behavioral sequence) and in its promotion of behavioral exchange (i.e. the increasing of reinforcers by one partner to the other). The influence of the environment is emphasized; however, the contributions of cognitive psychology are evidenced in the importance given to the role played by private events (i.e. thoughts and feelings). Thoughts and feelings (which are also considered behaviors) are also regarded as important in the understanding and modification of behavior in human beings (Jacobson, 1981).

In TBCT, each partner is assumed to bring into her/his relationship a unique reinforcement history, as well as unique goals for the long-term relationship. The social learning model presumes a largely idiosyncratic stance towards each couple's attempts to form and maintain a mutually satisfying relationship. Given the idiosyncratic nature of relationships, TBCT is reluctant to describe a "successful" relationship. Instead, it has emphasized training in the skills which couples are thought to need in order to maintain a satisfying relationship over time. Thus, relationships are considered satisfying to the extent to which partners provide each
other with benefits and that the benefits of the relationship generally outweigh the inherent costs (Jacobson, 1981).

From a behavioral perspective, satisfaction and continuity in a relationship are dependent upon maintaining a high ratio of the rewards to the relative "costs" of being in a relationship. Perhaps the most common cost in a relationship is a result of having conflict (or differences) about some issue. It is assumed that in time, all couples will experience conflict (i.e. they will disagree about child rearing practices, their sex life, how to manage their finances, etc.). Other costs in relationships include: doing things for the other person, doing things that one doesn't want to do, and compromising. Social learning models have suggested that critical skills needed in developing a successful relationship are communication and conflict resolution skills (Jacobson & Margolin, 1979). Since many behaviors are learned through people's reinforcement histories and interactions with the environment, behaviorists believe that people learn communication and conflict resolution skills initially from their family of origin. If the family had any difficulties in effectively using communication and conflict resolution skills, it becomes more likely that the individual may have some difficulties with these essential relationship skills. Couples in our society are generally ill prepared to handle conflict in their relationships (Jacobson, 1981). From the behavioral perspective it is not the existence of conflict per se that is detrimental to relationships, but rather, it is the inability to successfully negotiate the inevitability of conflict that causes problems in relationships (Jacobson, 1981).
With the foregoing in mind, TBCT has designed a set of communication and problem solving skills which are intended to teach couples how to successfully navigate conflict or problem resolution. These interventions will be discussed below.

Based on the above theoretical and empirical foundation, TBCT developed a structured approach to couples therapy. The first step of this approach is for the therapist and clients to gain an understanding of the contingencies which are currently maintaining the unwanted behaviors. This is labeled the behavioral analysis. Once the contingencies are understood, the therapist and clients can proceed with behavioral exchange (increasing the desired behaviors by each partner), communication skills training and problem-solving training.

The first major intervention strategy of TBCT involves helping the couple develop a collaborative set together. A collaborative set includes the ability for each partner to assume some responsibility for a problem, rather than seeing the problem as "caused by" or inherent in the other. This is considered essential in that most couples enter couples therapy at the height of their relationship dissatisfaction and focused on wanting their partners to change. The therapist provides a conceptualization of the couples problem that emphasizes reciprocal causality and mutual responsibility for the current problem. In this fashion, neither partner is identified as the cause of the relationship difficulties; rather, each is considered mutually accountable. The second major strategy for enhancing a couple's collaborative set involves obtaining their specific commitment to looking at their own contribution to the problem. Finally, the treatment sessions are graduated with respect to the difficulty of the assigned tasks.
Initial improvements will usually enhance collaboration and increase the chances of success for the more demanding aspects of therapy.

Distressed couples engage in more punishing exchanges and fewer rewarding exchanges than non-distressed couples. These differences are apparent in both their communication patterns (Gottman, Markman, and Notarius, 1977) and in the exchange of non-verbal reinforcers (Robinson and Price, 1980).

The second intervention strategy employed by TBCT is the use of positive behavioral exchanges. Behavioral exchange refers to helping partners to increase the frequency of behaviors desired by the other. First, behaviors which are desirable are targeted (i.e. increasing the amount of pleasurable activities done together). Desirable behaviors are pinpointed with a thorough assessment of what behaviors are desired but are lacking in the relationship. There may also be behaviors which are present, which one or both partners may wish to increase. Second, partners commit to doing more of these identified behaviors during the week. Behavior exchange is a structured way for partners to increase the benefits they provide for one another. The simple act of increasing positive behaviors can often be a powerful therapeutic intervention because distressed couples often underutilize their repertoire of reinforcers (Jacobson, 1981).

Communication skill differentiates distressed from non-distressed couples more powerfully than any other class of relationship behaviors (Markman, 1979). Communication serves multiple functions in a marriage and thus is considered essential to a successful partnership. TBCT also emphasizes direct training in communication skills and problem-solving.
Initially, communication skills are presented didactically or are modeled by the therapist to the couple. The second stage in communication training involves having the couples engage in the practice themselves, i.e. behavioral rehearsal. The final step involves feedback from the therapist to the couple. Both positive and undesirable aspects of the communications are discussed. Usually the sequence of communication training is shaped, in that successive approximations towards effective communications are reinforced. As couples become more proficient with certain skills, they are then taught more difficult and sophisticated communication skills.

Problem-solving is often helpful for couples because distressed couples tend to exacerbate rather than resolve their conflicts by discussing them (Jacobson, 1981). Negotiations between dissatisfied couples are often experienced as battles to be won rather than presenting mutual problems to be solved. TBCT has structured problem-solving into two distinct phases: problem definition and problem solution. In the definitional stage, the task of the couple is to arrive at a mutually agreed upon definition of what the problem is. The definition has to be specific and not general in nature. The problem should also be defined in concrete behavioral terms (i.e. “The problem is that we have different views on discipline for our kids. I tend to be more strict with them and you prefer to be more lenient when they misbehave.”) Feeling expressions are encouraged in problem definitions, as well as having both partners acknowledge their roles in maintaining the problem. Finally, problem definitions are preferably brief in nature.
Once the couple has defined the problem, couples are then taught to brainstorm as many possible solutions to the problem as they can generate. Once a list of possible solutions has been created, the list is analyzed, with the advantages and disadvantages of each solution discussed. This process should lead to the couple being able to select one or a combination of the solutions. This selection should be characterized by mutuality and compromise. Finally, the solution is later evaluated to see if it has met the goals of the couple. If it has not, then they would initiate the problem solving process again.

TBCT focuses on the promotion of positive behavioral exchange, developing communication skills, and increasing couples' abilities to problem solve effectively (Jacobson & Margolin, 1979). To date, TBCT has been the most thoroughly researched approach to couples therapy (Holtzworth-Munroe & Jacobson, 1991); and TBCT has consistently been found to be superior to no treatment (Hahlweg & Markman, 1988). Based on analysis of results across over two dozen controlled outcome studies, TBCT appears to substantially improve couples' relationships in about two thirds of couples who participate in therapy (Jacobson & Follette, 1985). Of the two thirds who improve, approximately one half of these couples recover to the point at which they can be described as in the happily married range on measures of relationship satisfaction (Jacobson, 1989).

With respect to the question of longer term follow-up results, empirical evidence has found an increasing chance of couples returning to pre-therapy types of interactions and behaviors (i.e. "relapse") (Jacobson & Addis, 1993). One study
found that 30% of the couples who recovered during treatment had relapsed by the 2 year follow-up (Jacobson, Schmaling, & Holtzworth-Munroe, 1987). Snyder, Wills, & Grady-Fletcher (1991a) found in a 4 year follow-up study that 38% of couples who had received TBCT treatment had divorced. Thus at least two studies have found substantial relapse among TBCT recipients. Research also shows that the majority of couples' relationship satisfaction is not significantly higher than pretreatment levels at 4 or 5 year follow-up (Snyder, Wills, & Grady-Fletcher, 1991a).

Research on what types of couples benefit from TBCT has shown that couples who were not helped by TBCT were: 1) more emotionally disengaged (Hahlweg, Schindler, Revenstorf, & Bregelmann, 1984); 2) more severely and chronically distressed (Baucom & Hoffman, 1986); 3) older (Baucom & Hoffman, 1986); and 4) more polarized on issues (Jacobson, Follette, & Pagel, 1986). These findings suggest that the common element among couples who are having difficulty and are not responsive to TBCT lies within their ability to compromise and collaborate (Christensen, Jacobson, & Babcock, 1995). All of TBCT's change strategies presume the couple's ability to compromise and collaborate. Without these abilities, the skills taught to couples in TBCT are unlikely to be effectively used by the couples.

As the limitations of TBCT have become recognized, two general suggestions have been given to improve the therapeutic modality. First, a number of authors have suggested that the scope of TBCT must be broadened to include cognitions and affective components (Baucom & Epstein, 1990; Beach, Sandeen, & O'Leary, 1990; Jacobson, 1991). Second, others have suggested that TBCT needs to concern itself
with behaviors which are contingently reinforcing rather than prescribing a set of rule-governed behaviors. This means that the behavioral prescriptions of the therapists which are given to the couple must be reinforcing in and of themselves (i.e. that the couple engage in the therapist's behavioral recommendations because doing so is reinforcing in some intrinsic way, rather than being reinforcing for having been compliant with the therapist). The implicit criticism in this suggestion is that TBCT may not adequately generalize to the couple's lives outside of the therapy office (Behrens, Sanders, & Halford, 1990; Halford, Gravestock, Lowe, & Scheldt, 1992).

Attempts have been made to enhance the TBCT approach by adding treatment components; however, these additions do not seem to have increased the effectiveness of TBCT (Baucom & Lester, 1986). Cognitive couples treatments do modify maladaptive relationship beliefs and improve relationship satisfaction (Emmelkamp, van Linden van den Heuvel, Ruphan, Sanderman, Scholing, & Stroink, 1988). However, the addition of cognitive components to TBCT does not seem to significantly increase relationship satisfaction relative to TBCT (Baucom & Lester, 1986; Baucom, Sayers, & Sher, 1990).

At least four recent approaches to modifying the expression of affect related to within couples relationships have recently been described: emotional expressiveness training (Baucom & Epstein, 1990; Baucom & Lester, 1990); emotionally focused therapy (Greenberg & Johnson, 1988); exploration and expression of emotionally charged interpersonal material (Christensen, Jacobson, & Babcock, 1995); and insight-oriented exploration of emotional processes (Snyder & Wills, 1989).
The aspect which is common to these various strategies designed to facilitate the expression of affect is the encouragement of the individuals to focus on their subjective experience of emotion. Clients are usually directed to verbalize their experience of their emotions as well as their sense of the meanings associated with these feelings. There is currently some dispute as to how and whether the techniques of the various theoretical approaches are appreciably different from each other (Jacobson, 1991; Snyder, Wills, & Grady-Fletcher, 1991b).

Two studies have reported that affectively based couples therapies produce better long-term improvement in relationship satisfaction than TBCT (Johnson & Greenberg, 1985; Snyder et al., 1991a). Emotionally Focused Therapy (EFT) is an integrated affective systemic approach to couples therapy (Greenberg & Johnson, 1986) and is based on the experiential and systemic traditions of psychotherapy. Experiential psychotherapy emphasizes the role of affect and intrapsychic experience in promoting change. The systemic tradition emphasizes the role of communication and interactional styles in the maintenance of problem states (Watzlawick, Beavin, & Jackson, 1967). In the EFT model, clients are viewed as active perceivers constructing meanings on the basis of their current emotional state and experiential organization and are seen as having healthy needs and wants that can emerge in the safety of the therapeutic environment. It is not the partner's feelings and wants that are considered the problem, but rather the disowning, or disallowing of these experiences that leads to ineffective communication and escalating interactional cycles. EFT suggests that increases in the degree of emotional exploration and expressiveness
that result in new levels of self-disclosure lead to a changed perception of self and the other and to more affiliative behavior on the part of the partner. As spouses become more emotionally accessible to each other, they are able to be more responsive, which then promotes the growth of trust, new affiliative behaviors, and new positive interactional cycles. Jacobson (1991) has argued that the current practice of TBCT incorporates many of the procedures labeled as affect focused.

Integrative Couples Therapy (ICT) is both a continuation and a departure from Traditional Behavioral Couples Therapy (TBCT) (Christensen, Jacobson, & Babcock, 1995). ICT is an attempt to improve traditional behavioral couples therapy by incorporating an emphasis on promoting emotional acceptance into the traditional emphasis on behavioral change. ICT is a dialectical approach which seeks to use both acceptance and change work in promoting relationship satisfaction. Earlier approaches to behavioral couples therapy emphasized change rather than acceptance; ICT is more concerned with having acceptance and change implemented in a balanced fashion (Jacobson & Christensen, 1996). Neither is used to the exclusion of the other, and either will be implemented depending on characteristics of the couple (i.e. to what degree they can engage in a collaborative set). ICT asserts that fostering emotional acceptance is an essential step toward improving a couple's relationship. Acceptance is often used more frequently in the beginning stages of therapy, as this has been found to promote both collaboration and compromise, which are necessary for change strategies to be effective.
The primary assumption which distinguishes ICT from TBCT is the belief, based upon clinical experience and empirical evidence, that not all couples are amenable to change, as it has traditionally been defined. ICT asserts that this inability to change is founded within couples not being able to work collaboratively or to compromise (although, it may also be due to the extent of mismatch or difference in the couple). ICT works to increase each partner's abilities to collaborate and compromise and seeks to promote intimacy within a relationship by increasing the couple's ability to understand more fully and accept aspects of their partner or their relationship. Generally, promoting acceptance assists couples in identifying and accepting the aspects of their relationship or their partner which are unlikely to change and encourages them to come to terms with these problem areas. The goal of acceptance work, then, is not to alter the behavior itself, but rather, to alter the experience of this behavior by one or both of the partners. Emotional acceptance requires that the experience of the behavior be shifted from being unacceptable, offensive, or blameworthy to being tolerable, desirable, or even appreciated (Christensen, Jacobson, & Babcock, 1995). Emotional acceptance allows for the actions of the partner to exist without an active fight to change or alter the particular behavior.

A primary technique used in ICT to promote acceptance within a relationship is that of facilitating the expression of "soft" emotions, as distinguished from "hard" emotions. Hard emotions are those such as anger, resentment, frustration, and intolerance. The expression of hard emotions generally puts the listener in a defensive
position. Soft emotions, however, express feelings which are thought to underlie those of the harder emotions. Soft emotions include: hurt, fear, insecurity, vulnerability, pain, caring, love, disappointment, sadness, worry, anxiousness, fear of the partner leaving, and feeling bad about oneself. Soft emotions generally convey a sense of vulnerability within the speaker, and the listener is less likely to become defensive in hearing the expression of softer emotions versus hard emotions.

ICT asserts that it is through the promotion of intimacy that relationship impasses can be worked through, or at the least that they can be accepted with minimal discomfort. The expression of soft emotions allows for intimacy within a relationship, and it is this intimacy that can create a safe environment where partners can feel close to each other despite some significant differences between them. ICT also maintains that as each partner has increased contact with the softer emotions of the other and has decreased exposure to anger and hostility, then the negative interactions between the partners will begin to decrease and softer emotional expression will increase. For example, Cynthia had received a call from a male co-worker asking her if she wanted to go to see a movie. This made her husband, Jim, very jealous and he became quite angry and began to express anger at Cynthia. Initially, Cynthia responded by defending herself and became angry at Jim because of his accusations. This cycle of attacking and defending would have continued except that Cynthia remembered that a former girlfriend of Jim’s had cheated on him and she asked if he was feeling scared or vulnerable in their relationship. Jim was able to pause and come to see that underneath his jealousy and anger was the feeling that he
was frightened that their relationship might not be secure and that he was very scared about this. Jim’s ability to shift to expressing these softer emotions altered the trajectory of this situation and allowed both Cynthia and himself to more fully understand what was affecting his reaction to this phone call.

A second major component of the ICT approach is to assist partners in creating some emotional distance from their problems. Most distressed couples blame their partners and believe that their partners are responsible for many of the problems which exist in their relationship. People tend to believe that if only her or his partner would somehow change, then the problem would vanish. ICT attempts to alter this view of the problem from that of having the problem reside in the other to being able to view the problem as a result of having a mismatch in values, beliefs, or wants. Thus, ICT seeks to have the partners come to be able to view the problem as a problem within the relationship, rather than within the partner. For example, Susan was raised to value saving money for a rainy day. David was also raised in a household that did not have very much surplus money. However, he enjoys spending the money that he works very hard to earn, as he was never able to have many of the things that he wanted as a child and young adult. This has caused a great deal of friction between Susan and David. She feels that he is irresponsible with their money, and he feels that he cannot spend any of their money without a big fight with Susan. Both are very displeased with this situation. ICT seeks to change their views of the problem from "you spend too much money" (Susan) and "you are a miser" (David) to "the problem is that we have different feelings and beliefs about how to manage our
money, we together, have this problem." This will allow for an ontological shift in how this problem area shows up for this couple. ICT strives to foster this ability to shift the problem area from being experienced as residing in the other, to seeing the problem as residing within the relationship (i.e. in the interactional dynamics of the couple).

This ontological shift also helps to create emotional distance from the problem. This emotional distance is arrived at through a technique called "detachment". Detachment refers to the process of helping the couple learn how to discuss a problem from a collaborative stance, rather than engaging in the problem directly. This technique involves having the couple identify the problem as an entity which exists separately from their partner (i.e. "we, together, have this problem of having differing values regarding money"). This position allows the couple to gain some distance from the problem and thus to have more room with which to work through the problem. That is, the problem can be experienced as something apart from the couple (i.e. it is believed that the cause of the problem does not somehow reside solely in the partner); and this is thought to foster the couple's ability to experience the problem as something that they both can work on. In this manner, detachment fosters a collaborative set within a couple.

A third important element of ICT is that of theme identification. In TBCT, couples are taught skills with which they solve various specific problems in their relationship and, hopefully, these skills will generalize to other problem-solving situations. In ICT, couples are taught to view their problems as instances of recurring
themes in their relationship. ICT maintains that the ability to view a specific instance of a problem as a manifestation of a recurrent kind of interpersonal interaction will increase the ability of the couple to work more effectively from a collaborative stance with respect to that particular relationship difficulty. This is asserted with the assumption that the ability to see a particular problem as an instance of a relationship theme will help the partners to be able to more fully understand their respective parts in the interaction and therefore to be less invested in maintaining their conviction of the other's culpability with respect to that problem. Theme identification also fosters the generalization of behaviors, so that couples can recognize similar themes across differing contexts. For example, Steve was very close to his two brothers while growing up. He was the middle child of the three and they were very close in age. They played lots of sports together, and he came to rely on their friendship and support. Through these relationships with his brothers, he came to value very close relationships in which he spent most of his free time with his family and friends.

Sarah, on the other hand, also had brothers and sisters, but she was the oldest child and was three years older than her nearest sibling. Thus, she came to value solo activities and developed a love for her independence. Understanding these historical factors was very important in helping Sarah and Steve understand their current pattern of approach/avoid. Steve would approach Sarah wanting to do something with her, which sometimes would have Sarah feel that her independence was being threatened. If Steve believed that Sarah was pulling away from him because of not valuing time spent with him, he had a tendency to question whether she still loved him and this
would often make him anxious. He would attempt to initiate even more shared activities the more anxious he became. This only served to have Sarah feel that she had to be even more adamant about preserving her independent time, which further exacerbated their cycle. This same approach/avoid cycle was evident in Steve's feeling abandoned when Sarah wanted to spend time with her friends; Sarah's feeling pressured by Steve when he sought to increase their intimacy and closeness through sex or spending quality time together; and their difficulty in problem-solving when Steve would approach Sarah with something that he wanted to improve and she would want to avoid this, telling him he should make his own decisions. Having both Steve and Sarah be able to clearly see the various manifestations of this theme as it played out in very diverse ways in their relationship allowed them to be able to cope more effectively with the many ways in which this interactional pattern manifested itself. They could then recognize the pattern for what it was and could avoid having to fight about the individual instances of the approach/avoid interaction.

ICT also seeks to identify and reframe negative interaction patterns in terms of their positive features, especially with respect to historical features in the relationship. For example, with Steve and Sarah, one of the things which initially attracted Sarah to Steve was his closeness with his family and with friends in general. Steve was attracted to Sarah's independence and how she was able to make so many important decisions by herself. By reminding Sarah and Steve of how these differences were initially aspects of the other that were very attractive to each other, the differences in affiliation style became more tolerable and acceptable and even appreciated by each of
them, rather than something which had to be worked against. ICT also prepares
couples for slip-ups or the inevitability of conflict in their relationship, and seeks to
promote individual self-care (Jacobson & Christensen, 1996).

Research on ICT

Since ICT is a new approach to the treatment of couples' difficulties, there has
been little research on it: however, one pilot study has been completed. Cordova,
Jacobson, Christensen (1995) compared 6 couples who received ICT with 6 couples
who received TBCT. This study specifically examined the changes in couples in-
session communication processes over the course of the two different treatments. The
couples in the two treatments behaved differently in several of the ways predicted.
ICT couples expressed more soft emotions and non-blaming descriptions of mutual
problems than TBCT couples during middle and late phases of therapy. ICT couples
significantly decreased their expressions of hard emotions and problematic
communications over the course of therapy, whereas TBCT couples did not. There
was also a trend for couples in the ICT group to have greater relationship satisfaction,
as measured by the Dyadic Adjustment Scale (Spanier, 1976), as compared with the
TBCT group.

Although preliminary and needing replication, these results are encouraging in
that ICT has demonstrated that it does in fact produce differential results along the
dimensions that it targets (an increase in softer emotional expression and a decrease in
the expression of hard emotions). If the expression of softer emotions reflects greater
acceptance, then ICT does appear to promote acceptance between partners more effectively than TBCT. The hope is that the promotion of acceptance by ICT will ultimately lead to more effective couples therapy. These results are also encouraging in that ICT produced comparable, and perhaps more effective results in improving relationship satisfaction than TBCT. This is noteworthy in that TBCT has been the "standard" treatment for couples therapy and has definitely been the subject of the most research on couples therapy to date.

**Couples Groups**

Given the current health care climate, clinicians are faced with the substantial problem of delivering proven psychological services in an efficacious as well as cost-effective manner. Clinicians often seek to provide quality services to the greatest number of consumers. This has led to the natural increase in the use and delivery of group approaches to psychotherapy. Couples group therapy is a natural therapeutic extension of delivering skilled psychotherapeutic services to appropriate couples in a cost effective and productive manner.

There are several additional important advantages inherent in couples group therapy. The group format allows for couples to actively observe other couples working on problems. In this manner, they are able to experience other couples' interactional and communication styles that they might wish to actively model as well as to consciously avoid. Also through the process of observing others, couples may be able to more easily notice interactional and historical patterns in the other group
members than they might be able to discern similar patterns within their own relationship. This objective view into another's relationship can allow for couples to more effectively be able to come to witness and understand their own relationship patterns and interactional styles. Thus, the observational process allows couples to compare their relationship as similar to as well as different from other relationships in an intimate and informative fashion. This process should facilitate insight into a couple's own relationship dynamics in what could be a more efficacious manner than more traditional conjoint couples therapy.

Group work with couples may also facilitate the normalization of many couples difficulties. Through the process of couples observing and listening to other couples in conflict and experiencing relationship difficulties, couples can begin to see conflict and other problems as a natural part of relating and then as something to be worked through effectively, rather than avoided at all costs. In this manner, the process of universalization would be very beneficial to many couples. As Yalom (1985) stated:

In the therapy group, especially in the early stages, the disconfirmation of a patient's feelings of uniqueness is a powerful source of relief. After hearing other members disclose concerns similar to their own, patients report feeling more in touch with the world and describe the process as a 'welcome to the human race' experience. (pp. 8).
Thus, the universalization process which Yalom describes may also serve to reduce any stigmas associated with having relationship difficulties.

Several other therapeutic factors in group therapy are likely to affect group members and these include: the instillation of hope, imparting of information, altruism, the corrective recapitulation of the primary family group, development of interpersonal techniques, and modeling others’ behaviors (Yalom, 1985).

Judith Coche has worked with many couples in couples group therapy and she states:

As I reflect on 6 years of experience with over 75 couples in couples group psychotherapy, couples have expressed to me the benefits that they have received from the group. Advantages that have come from the group include a sense of universality, that is, a sense that a couple gets of other couples’ experiencing some of the same difficulties they do, and that every couple is working on issues all of the time. A second benefit from the intensive working phase of the group is a sense of community that is developed from the high level of trust, which provides the foundation for the exceptional self-disclosure about each couple’s marriage in particular, and about what marriage is about in general. A third benefit from the working climate in the group is that the group offers enough solid support that couples are able to counteract their own resistance to change in order to move forward in areas that are exceptionally painful. The rousing support offered when a couple makes changes provides the enthusiasm and the energy needed to help couples make decisions that would be too painful to make without this level of support. (Coche, 1995, pp. 207-208)

Couples groups developed in the early 1960’s as a natural synthesis of group therapy and family systems approaches. Both of these approaches conceptualized the individual within a complex network of multiple transactions, acting upon and reacting
to others. It was a natural step to integrate systems thinking into the formulation of treatments for the couple dyad, particularly when the results of couples seeking individual therapy (vs. conjoint) more often than not ended up in greater dissatisfaction with the marriage. Framo (1973), began to run couples groups for married couples as a result of wanting to maximize the therapist's ability to impact the couples. He had found in conducting conjoint couples psychotherapy that the couples often would triangulate against the therapist and attempt to place her/him in a position of having to play the role of the referee for the couple.

In 1962, van Emde Boas (1962) suggested that long-term groups with fixed memberships be formed for couples whose marriages were felt to have a poor prognosis (the so called "hopeless couples groups"). Leichter (1962) centered her efforts on using group therapy to help couples with problems of separation and individuation. Framo (1973) asserted that couples groups were the treatment of choice for relationship problems. His technique de-emphasized cross-relationship and intragroup issues and concentrated instead on the marital relationship. Low and Low (1975) wrote one of the first detailed papers describing their particular group approach to couples.

There was considerable resistance to the couples group movement in the early 1960's primarily coming from the psychoanalytic schools of psychotherapy. In a review of the literature, Gottlieb and Pattison (1966) found that most of the objections to the treatment of married couples, within or outside a group setting, stemmed from an unnecessarily narrow commitment to psychoanalytic theory, rather than from
pragmatic and outcome oriented considerations. The more operational concerns of those with a transactional approach - that such group treatments would result in the inhibition of group process by defensive pairing of the couple in an anxious attempt to defend against the exploration of their neurotic interaction - was not born out in clinical practice.

Outside of the analytic perspective other concerns were voiced about group approaches to couples therapy. Some asserted that the use of couples-group therapy would be more likely to damage marriages than to repair them by such actions as releasing hostile feelings towards one's spouse in the presence of the entire group, by stimulation of extra-marital affairs, and by tampering with the fragile neurotic ties that bonded some couples together (Spitz, 1979). Additional concerns included the question of whether a therapeutic group climate could be achieved and that a spouse might use the group to engage the other members in support against their spouse (Spitz, 1979).

Clinical experience has shown that these fears are not justified. Some of these phenomena do occur, of course, but usually in an encapsulated form. These phenomena can be used therapeutically by skilled group leaders to assist couples in moving past difficult areas. As in all groups, the group leader must be wary for these and other pitfalls which could potentially derail a group's progress. Once these concerns were adequately addressed and the advocates of couples groups were satisfied that they were on solid theoretical and clinical ground, couples-group work proceeded at an accelerated pace (Spitz, 1979).
Research Findings on Couples Groups

Research on couples groups has found that this modality is as effective as individual, conjoint, or group formats where only one member of the couple is present (non-spouse groups) (Marett, 1988). Couples groups in diverse settings have included the treatment of alcoholism (Cardogin, 1973; O'Farrell & Cutter, 1984); communication problems (Clarke, 1970; Revenstorf, Schindler, & Hahlweg, 1983); divorce-crisis interventions (Kagan & Zaks, 1972; Wallerstein, 1991); as an adjunct for lithium therapy for Bipolar disorder (Davenport, Ebert, Adland, & Goodwin, 1977); agoraphobia (Barlow, O'Brien, & Last, 1984); preparation for remarriage after divorce (Messinger, Walker, & Freeman, 1978); sexual dysfunction (Metz & Weiss, 1992); stress in medical students (Ziegler, 1976); dialysis patients, problems with substance abuse, gambling, and families with child related problems such as Down's syndrome (Spitz, 1979); and brief psychotherapy (Papp, 1976).

Outcome research on couples groups has been sparse to date. Marett (1988) found five outcome studies which compared couples groups to control groups. These studies include a couples group treatment for agoraphobia (Barlow, O'Brien, & Last, 1984); a group treatment for patients on lithium and their spouses (Davenport et al., 1977); treatment for chronic pain patients and their spouses (Moore & Chaney, 1985); treatment for male alcoholics and their spouses (O'Farrell & Cutter, 1984); and behavioral marital therapy for distressed couples (Revenstorf, Schindler, & Hahlweg, 1983). At least two outcome studies have been performed since Marett's review. Wilson, Bornstein, & Wilson (1988) evaluated group TBCT with distressed couples.
Montag & Wilson (1992) compared a TBCT group therapy approach with TBCT enhanced with cognitive approaches and with a wait-list control.

All of the six studies which used a non-treatment control group (Davenport et al., 1977; Montag & Wilson, 1992; Moore & Chaney, 1985; O'Farrell & Cutter, 1984; Revenstorf et al., 1983; Wilson, Bornstein, & Wilson, 1988) found that the couples group to be more effective than the no-treatment control groups. Barlow et al. (1984) did not include a no-treatment control group, but did find that the couples group was superior to non-spouse groups in the treatment of agoraphobia. Of particular note for the current study was the fact that Revenstorf et al. (1983) found that the TBCT couples group therapy to be equally effective as TBCT conjoint marital therapy in the treatment of relationship discord.

Wilson, Bornstein, & Wilson (1988) randomly assigned 15 couples into either group, conjoint, or a wait-list control. These authors used TBCT in both the group and conjoint modalities. Results revealed that couples in both the conjoint and the group conditions exhibited significant improvement in relationship satisfaction as compared to the wait-list control group. Treatment gains were maintained in both the therapy conditions at six month follow-up. Minimal differences were detected between the treatment conditions. Couples in the conjoint condition did report greater improved affective communication and relationship harmony, compared with the couples group. Group therapy couples demonstrated greater improvement in child-rearing practices, sexual satisfaction, and positive verbal interactions.
In a more recent study of TBCT group approaches to couples therapy, Montag & Wilson (1992) compared TBCT and TBCT enhanced with a cognitive component to a wait-list control condition. This study replicated the Wilson, Bornstein, and Wilson (1988) findings: the TBCT couples group achieved significant improvements in relationship satisfaction compared to the wait-list control group. Both the TBCT group and the enhanced TBCT group improved on relationship satisfaction. The relative differences in effectiveness between TBCT and enhanced TBCT groups were minimal. TBCT couples showed significantly greater improvement in relationship adjustment as measured by the DAS (Spanier, 1976). The TBCT group enhanced with a cognitive component produced greater relationship happiness than the TBCT only group on the Marital Happiness Scale (Bornstein, Wilson, Bornstein, Balleweg, Weisser, Andre, Smith, Woody, Laughna, McLellarn, Kirby, & Hocker, 1985). These results are consistent with those found by Baucom & Lester (1986), who found that behavioral and cognitive-behavioral couples treatments are generally equal in effectiveness.

Thus, the research to date suggests that couples groups are as effective as conjoint therapy. TBCT has been the most highly researched conjoint approach and has consistently demonstrated the ability to improve relationship satisfaction for many couples. Currently, there are some questions about the ability of conjoint TBCT to maintain treatment gains over time. Research on couples groups using TBCT has shown that this approach is as effective as conjoint couples therapy. Follow-up studies are greatly needed in both the research of conjoint couples and in couples group
therapy. ICT is both an extension and departure from TBCT. It has been developed
to be more effective with couples who might not as readily benefit from TBCT. It is
also hoped that treatment gains from ICT will be more resistant to relapse than TBCT
has shown to be.

Hypothesis

This study investigated the treatment efficacy of ICT delivered in a couples
group format. The couples receiving the ICT group were compared to a wait-list
control group to assess its efficacy in increasing relationship satisfaction as measured
by the Dyadic Adjustment Scale (Spanier, 1976) and by the Global Distress Scale on
the Marital Satisfaction Inventory (Snyder, 1981). It was hypothesized that the ICT
couples would evidence significantly improved scores in the DAS. These couples
were also expected to improve in the Global Distress Scale of the Marital Satisfaction
Inventory. It was also predicted that several additional scales of the MSI would show
improvement and these were expected to be: Problem Solving Skills, Time Together,
and Affective Communication. We did not expect to see any improvement on the MSI
subscales of History of Family Distress or Role Orientation.
Methods

Subjects

Recruitment

Couples were recruited from the community of Madison, Wisconsin through the use of newspaper advertisements and flyers placed in community settings (e.g. bookstores and grocery stores). Advertisements describing the group and the research project (Appendix E) were run in two newspapers (The Madison State Journal and The Isthmus) in approximately 10 issues. Each newspaper advertisement resulted in roughly 3-8 inquiries about the group. The principal investigator answered couples' questions about the group on the phone. If the couple remained interested in participating in the groups, an intake evaluation was scheduled. All of the intake screenings were conducted by the principal investigator.

Description of Subjects

Couples who participated in this research ranged in age from 21 - 61, with an average age of 39.8. Participants had a mean educational level of 15.7 years. On average, approximately one half (0.55) of the individuals had been in a previous marriage (range of 0-4 previous marriages). The couples had been in their relationships for an average of 7.98 years (range from 2-25 years). Relationship satisfaction measures indicated that on average these couples were moderately distressed (DAS: mean = 90.00, range = 65.00-109.00, and S.D. = 11.04; GDS: mean = 61.65, range = 49.00-77.50, and S.D. = 8.91). Lower scores indicate more
distress or dissatisfaction on the DAS and higher scores indicate more distress or
dissatisfaction on the GDS. Four of the couples fell in the satisfied range on both
relationship satisfaction measures (i.e. DAS > 98; GDS < 59) and two couples' scores fell in the severely distressed range (i.e. DAS < 70; GDS > 65). Please see Table 1 for these descriptive values.

The couples in this study were predominantly Caucasian, middle class Americans. There was one Asian woman, three Hispanic persons, and one Native American man in the sample. Although the sample could perhaps best be described as "middle class", most of the couples were interested in this group because it provided an affordable means of working on their issues.
### Table 1

Case Summaries and Descriptives for Control and Treatment Couples

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Initial Screening Process and Subject Selection

A total of 24 couples were interviewed for the ICT groups. Couples were interviewed on a first come basis until 11 appropriate couples were found for each of the two phases of the research. Five couples were recruited for the ICT group and six couples for the wait-list control. Six couples were recruited for the control group in order to better protect against attrition during the 12-16 week period in which the ICT group received treatment and the control group was waiting for the weekend seminar. When the first ICT group and weekend seminar were nearing completion, another group of couples was screened until 11 appropriate couples were found. In order to find twenty-two appropriate couples, twenty-four couples were initially screened with two couples being screened out.

The intake process took three hours for each couple. First, the principal investigator answered any questions that the couple had about the couples research project. Next, the Consent Form (Appendix D) was read verbatim to the couple so that they would fully understand what the research program entailed. This consent form gave a detailed account of: what the ICT group and the weekend seminar would consist of, what couples' issues would be addressed in the groups, what risks were involved in couples group work, the information that they would be randomly assigned to either an ICT group or a weekend seminar group, the procedures involved in the research, information about confidentiality in the group setting and in what situations member's confidentiality would ethically and legally need to be broken, information
about the audiotaping and/or videotaping of the sessions, and information about the voluntary nature of this research and the couple's rights to withdraw from the project at any time. Couples were encouraged to ask questions as the principal investigator discussed this material. After all of the couple's questions had been answered, the principal investigator asked if the couple would be willing to sign the informed consent document. All couples who participated in the project did so.

During the informed consent process, the issue of the couple's fee was discussed. Couple's fees were based upon a sliding fee scale (see Appendix F) and the fee was negotiated at that time. Some of the couples (N=2) were able to bill their insurance carrier directly, the remaining couples paid out of pocket. The range of the fees for the ICT group was from $10 to $45 per two hour session per couple. The range of the negotiated fees for the weekend seminar (wait-list control group's treatment) was from $150 to $360 for the entire weekend (14 total hours) per couple. These fees were paid to the University of Wisconsin Medical Hospital.

The remainder of the intake procedure consisted of two parts. The principal investigator interviewed one member of the couple, while the other member completed the questionnaires which were part of the screening and assessment process. The clinical interview took approximately one hour and covered typical couples intake questions such as: individual history, family history, couple's history, other relationship history, psychiatric history, drug and alcohol history, and what each member hoped to achieve as a result of being in the group or weekend seminar. The clinical interview was standardized in that each and all of the question areas were
covered with all participants.

After the interview with the first partner was completed, this person was given time to complete the questionnaires and the principal investigator interviewed the second partner. At the end of this process, most couples were told that the principal investigator believed that they were appropriate for this project. With three of the couples, the principal investigator told the couple that he wished to have a chance to look at their questionnaires to ensure that the group format was in their best interest.

**Screening Criteria**

Couples were excluded from this study according to the following criteria. Couples were eliminated when there was current: substance abuse difficulties (assessed by clinical interview and the individual and partner's reports about current behaviors); relationship or domestic violence - assessed by spousal report and the Conflict Tactics Scale (Straus, 1990); significant thought disorder (assessed by clinical interview); significant interpersonal difficulties (i.e. Personality disorder characteristics which might be disruptive to the group - assessed through the clinical interview); having an insufficient level of commitment to the relationship (i.e. currently proceeding with divorce actions as assessed by clinical interview); and having been in relationship with their current partner for less than 1 year. To reduce group heterogeneity, same sex couples were also excluded from this project. Couples were told that they would be dropped from the group if they missed three (25%) of the weekly sessions.
Two of the initial 24 interested couples were referred for couples therapy outside of this project. The husband in the first excluded couple exhibited signs of having interpersonal difficulties that were believed to be potentially disruptive to the group. He was considered to be quite guarded during the intake interview, was evasive and dismissing about some legal charges of farm animal abuse, and was suspicious about others in his interactions with them (his SCL90-R scores also support these observations: Paranoid Ideation = 44%, Interpersonal Sensitivity = 34%, Somatization = 59%, OCD = 48%, and Positive Distress Level = 96%). A second couple was also referred to an outside couples therapist when one member exhibited interpersonal deficits. The husband was thought to be extremely perfectionistic and rigid in his thinking, hyper-critical in his evaluations of others, interpersonally demanding, stubborn, and controlling.

Subject Attrition in the ICT Group

Of the remaining 22 couples, 10 couples participated in the ICT group. Two of these couples did not complete the ICT group. One couple said that the husband's work schedule had changed and that they could no longer make the scheduled time. They had attended 2 sessions and had missed two sessions prior to dropping out. This couple was younger than the rest of this group. Her age was 21 and the average age for women in this group was 40.0. His age was 23 and the average age for men in this group was 40.6. Although they stated to the principal investigator that they believed that they were benefitting from the group, the age differential between this
couple and the other group members may have been a factor in their decision not to continue.

The second couple who did not finish the ICT group missed three sessions and so were asked to leave the group after they missed session number 11. They attributed some of their attendance difficulties to their having trouble with finding adequate child care. This couple was made aware of the guidelines for being able to continue with the group both during the intake procedures and when they were having difficulty with attendance early in the group. They had recently moved back to this country from living in Chile for 14 years and were having to make a number of cultural, personal, professional, living, and family adjustments.

Subject Attrition in the Wait-List Control Group

Twelve couples were initially assigned to the wait-list control group. Six couples were able to complete the weekend long seminar (2 couples in the first weekend seminar and 4 couples in the second). Three couples said that they preferred not to participate in the weekend seminar. They stated that they had wanted to be in the weekly ICT group (although the experimental design of matched assignment had been clearly discussed with them during the intake). Thus, they seemed to have agreed to matched assignment with the hope that they would be placed in the ICT group. Of the three other couples who were not able to participate in the weekend seminar; one couple moved out of the area, a second wanted to participate but stated that business concerns prevented them from attending, and the final couple had ended
their relationship in the period between the intake and the delivery of the weekend seminar.

Six couples participated in the weekend seminar. All six couples were required to complete the DAS and the MSI before the weekend seminar. Three couples who did not participate in the weekend seminar (for the above stated reasons) were willing to fill out the questionnaires after the 12-16 week waiting period. One couple who did not wish to participate in the weekend seminar refused to come in and fill out the time 2 questionnaires for unknown reasons. A second couple precipitously moved from the area and so were not available to fill out the measures a second time. The remaining couple who did not fill out the time 2 questionnaires was the couple who had ended their relationship subsequent to the time of their intake.

A total of 9 wait-list control couples completed the DAS and MSI at intake and then completed these measures a second time prior to the weekend seminar. These measures were used to control for the possibility that couples' scores might improve with the passage of time or perhaps for some of the non-specific effects of therapeutic contact during the intake procedure (i.e. being able to start to address their concerns as a couple and feel that they were starting a change process).

Measures

Couples spent approximately two hours responding to a number of paper and pencil questionnaires in the initial screening. These measures included: the Dyadic Adjustment Scale (DAS) (Spanier, 1976), the Marital Satisfaction Inventory (MSI)
(Snyder, 1981), the Conflict Tactics Scale (Straus, 1990), the Relationship Issues Questionnaire (Christensen, 1984), the Communication Patterns Questionnaire (Christensen & Sullaway, 1984), and the SCL-90-R (Derogatis, 1977). The ICT group was again assessed using the DAS and the MSI shortly after the completion of treatment (within 3-14 days of the completion of therapy). During the 12 weeks that the ICT group was receiving treatment, the control group waited for the start of the weekend seminar. The wait-list control group was assessed on the DAS and the MSI prior to the weekend seminar group (12-16 weeks after the initial intake screening). This sequence occurred for both of the two phases of this research.

**Principal Measures**

The Dyadic Adjustment Scale (Spanier, 1976) and the Marital Satisfaction Inventory (Snyder, 1981) are the two principal measures in this outcome study. The Global Distress subscale of the Marital Satisfaction Inventory was used along with the DAS to measure couples' satisfaction and relationship distress before and after the interventions or waiting periods.

The DAS is a 32-item self-report inventory that has subjects rate various aspects of their relationships. For example, it asks partners to rate the extent to which they agree/disagree about areas such as recreation, time together, finances, sex, etc.; how often they confide in each other; and how they rate their relationship (from extremely unhappy to perfect).

Scores on the DAS have been normed and a cut-off value for distressed and
non-distressed couples has been determined to be 97 (Jacobson, Follette, Revenstorf, Baucom, Hahlweg, & Margolin, 1984). Couples scoring 97 and below are considered to be distressed and those scoring 98 or above are considered to be non-distressed. Scores from 90 - 70 are thought to indicate moderate distress or dissatisfaction and scores below 70 indicate severe distress or dissatisfaction.

The DAS has been analyzed in order to determine content validity, construct validity, criterion validity, and reliability (Spanier, 1976) and was found to have excellent psychometric properties, with a Cronbach's alpha reliability coefficient of .96.

The Marital Satisfaction Inventory (MSI) (Snyder, 1981) is a multidimensional self-report measure that identifies separately for each partner the nature and extent of relationship distress along several key dimensions of relationship. The partners report their subjective experiences and appraisals of the marriage by answering true or false to each of the 280 MSI items. The individual’s responses are scored on the 11 scales of the inventory which are: a validity scale, a global distress scale, a global affective communication scale, a problem-solving communication scale, a time together scale, a disagreement about finances scale, a sexual dissatisfaction scale, a role orientation scale, a family history of distress scale, a dissatisfaction with children scale, and a conflict over childrearing scale, (Snyder, 1981).

A brief description of the 11 MSI scales follows. The Global Distress scale (GDS) contains items which measure an individual’s overall dissatisfaction with the relationship. The Affective Communication scale (AFC) assesses individuals'
dissatisfaction with the amount of affection and understanding expressed by their partner. The Problem-Solving Communication scale (PSC) is composed of items assessing the couple's general ineffectiveness in resolving differences. The Time Together scale (TTO) reflects a lack of common interests and dissatisfactions with the quality and quantity of leisure time together. The Disagreement About Finances scale (FIN) measures relationship discord regarding the management of family finances. The Sexual Dissatisfaction scale (SEX) is concerned with dissatisfaction with the frequency and quality of intercourse and other sexual activity. The Role Orientation scale (ROR) reflects the adoption of a traditional versus nontraditional orientation toward relationship and parental sex roles. The Family History of Distress scale (FAM) is comprised of items reflecting an unhappy childhood and disharmony in the marriage(s) of the respondent's parents. The Dissatisfaction With Children scale (DSC) assesses parental dissatisfaction or disappointment with children. The Conflict Over Childrearing Scale (CCR) is concerned with the extent of conflict between partners regarding childrearing practices. The Conventionalization scale (CNV) assesses individuals' tendencies to distort the appraisal of their relationship in a socially desirable direction (Snyder, 1981). A primary strength of the MSI is its ability to identify particular sources of relationship distress and strengths. It is often used as an assessment instrument with couples who are beginning couples therapy. As a research instrument, the MSI provides an objective, multifaceted criterion of relationship functioning. The MSI has been used to investigate the effectiveness of various couples treatment methods (Snyder, 1981).
The reliability and validity of the MSI have been assessed (Scheer & Snyder, 1983; Snyder & Regts, 1982; Snyder, Wills, & Keiser, 1981). Cronbach's alpha coefficients of internal consistency were calculated for each of the scales. The coefficients confirmed high internal consistency and ranged from .80 (DSC) to .97 (GDS) with a mean coefficient of .88 (Snyder, 1981). Test re-test reliability coefficients demonstrate a high temporal stability of individual scales, ranging from .84 (AFC) to .94 (FAM) with a mean correlation of .89 (Snyder, 1981).

The MSI has been found to satisfactorily distinguish couples entering therapy from non-clinical samples. Scores equal to or greater than 59 on a T scale, classifies subjects as maritally distressed. This cutoff of 59T was empirically derived as the score that optimally distinguishes clinic from non-clinic couples (Jacobson & Truax, 1991). The MSI scales were constructed so that scores from 50 - 65 indicate moderate distress or dissatisfaction and scores above 65 indicate extreme distress or dissatisfaction.

Additional Measures

The remaining measures were used to gather important clinical information in order to assess for the appropriateness of treatment and to increase the therapists' understanding of important issues for each couple. The Communication Patterns Questionnaire (Christensen & Sullaway, 1984) assesses how the members of the couple verbally interact with each other. For example, the Communication Patterns Questionnaire asks to what degree couples blame each other, avoid issues, understand
issues, reconcile their differences, or withdraw from important verbal interactions. The Relationship Issues Questionnaire (Christensen, 1984) assesses differences between partners in their desire for closeness or autonomy. The Conflict Tactics Scale (Straus, 1990) is a measure used to assess the amount, frequency, and extent of verbal aggression and physical violence experienced in a relationship. Finally, the Symptom Checklist-90-R (Derogatis, 1977) is a 90 item inventory of common psychiatric difficulties. This instrument has subjects rate the intensity of various psychiatric symptoms on a scale from 0-4. These scores are then compared to normed groups (e.g. inpatient or outpatient populations). This is a widely used screening measure and has also been used as a research instrument. All of these measures (The Communication Patterns Questionnaire, The Relationship Issues Questionnaire, the Conflict Tactics Scale, and the SCL-90-R) were used to gain important information about the subjects to aid in both screening and in understanding the couples' issues. All of the measures used in the study are presented in Appendix H.

Procedures

**Matched Assignment to ICT Group or Wait-List Control**

When 11 couples had been screened and determined to be appropriate for the study, the couples were assigned to either the wait-list control group or to the ICT group. Five couples were assigned to the ICT group and six couples were assigned to the wait-list control group. Assignments were made by the principal investigator using a matched samples design. These couples were matched along several variables which
are considered to be important predictors of couples treatment response: age, length of the relationship, number of previous marriages, education, DAS scores, and GDS Scores. After the couples were matched, they were randomly assigned to either the ICT group or the wait-list control group. When these groups were originally matched and then assigned to either the ICT group or the wait-list control group, there were no significant differences between the groups on any of these variables (age, educational level, years in relationship, previous marriages, DAS, or GDS). However, since some of the subjects did not complete either the weekend seminar or the ICT group, the difference in educational level between the two groups approached significance (p=.072, mean wait-list control = 15.00 and mean ICT group = 16.38). Please see Table 2 for these results.
Table 2
Independent Samples T-Test For Control Group vs. ICT Treatment Group

<table>
<thead>
<tr>
<th>Variable</th>
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<td></td>
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<td></td>
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<td>Years Together</td>
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Chronology of the Assessment Administrations and Delivery of Groups

Group 1

1) December 1st, 1996 - Newspaper solicitation for couples began

2) December 7th - January 15th - couples were screened

3) January 22nd - April 16th - ICT group administered (met from 6p.m. until 8p.m. once each week)

4) April 19th - April 27th - ICT couples complete post testing on the DAS and MSI

5) April 21st - April 25th - Control group couples were readministered the DAS and MSI prior to receiving the weekend long seminar

6) April 26th and April 27th - Control group couples participate in weekend long seminar (met from 9a.m. - 5 p.m. on both days)

Group 2

1) March 10th, 1997 - Newspaper solicitation for couples began

2) March 17th - April 18th - couples were screened

3) April 23rd - July 9th - ICT group administered (met from 6p.m. until 8p.m. once each week)

4) June 21st - June 26th - Control group couples were readministered the DAS and GDS prior to receiving the weekend long seminar

5) June 28th - June 29th - Control group couples participate in weekend long seminar

6) July 11th - July 23rd - ICT couples complete post testing on DAS and MSI
Group Format

Each group session consisted of several specifically pre-determined interventions (please refer to the group manuals in Appendix A and Appendix C). After the first session, all sessions began with a discussion of the homework assigned to the couples from the previous session. Typically, the first half of each group session was spent in discussing the homework. The second half of each session involved the presentation of new material, group discussions, and exercises designed to facilitate experiential learning.

Each homework assignment was designed to allow for the behavioral practicing of specific relationship skills (i.e. promoting intimacy, practicing communication skills, and engaging in enjoyable couple's activities), to have the participants continue to develop their understanding of a particular theme or issue from the previous group, and/or to enhance the ability of the couples to participate meaningfully and insightfully in the next group. Homework was designed to foster the couples' ability to integrate and make use of ICT in their relationship by having them think through such questions and directives as "What gets in the way of your expressing more soft emotions? What is your reaction to your partner when he or she expresses soft (as opposed to hard) emotions?" "This week you and your partner are to set aside two times when you can practice problem solving. Decide what problems you would like to work on. It would be easier if you were to work on some of the simpler problems in your relationship first. Use the problem solving worksheet to assist you in this process."

The homework assignments for all sessions are presented in Appendix B.
The format of the weekend seminar was very similar to that of the ICT group. The weekend seminars also followed a manual (please see Appendix C). The manual for the weekend seminars was entirely based upon the treatment manual for the ICT group and was a condensed form of the ICT group manual. The main difference between the two formats was the lack of homework for the weekend seminar and the absence of the discussions pertaining to the skills practiced between sessions in the ICT group. It was also necessary to reduce the number of group discussion and practice exercises to fit within the time limitations of the weekend.

The weekend seminar was presented in fourteen total hours on a consecutive Saturday and Sunday. Couples were given breaks every 1.5 to two hours and had a one hour lunch break.

Treatment Adherence Issues

An important aspect of the design of this outcome study was to insure that the co-therapists were following the treatment protocol. There were essentially two issues to be addressed here. The first was the question of whether the group treatment as designed by Wimberly and Waltz was in fact representative of Integrative Couples Therapy. The second question is whether the co-therapists adhered to the treatment manual. To address the first question feedback on a draft of the ICT group manual was solicited from Andy Christensen Ph.D. (one of the developers of ICT). Dr. Christensen believed that the manual did an adequate job of operationalizing ICT in a group format. He suggested an additional intervention which he found to be effective
(having couples parody their typical fighting behaviors). This intervention was added into the first ICT group; however, many of the couples complained about this intervention and so it was not included in the second ICT group.

In order to promote adherence to the treatment protocol, the entire ICT group and the weekend seminar group were manualized. The manuals describe what is to be accomplished in each session and direct the co-therapists to deliver particular interventions. Specifically, these manuals direct the co-therapists in how topics are to be addressed, how interventions are performed, and in what order each aspect of the groups is to be delivered. These manuals are presented in their entireties in Appendices A & C. The ICT group treatment manual also prescribes specific homework assignments to be done by each couple between the sessions (Appendix B).

To address the treatment adherence issue, all sessions were videotaped. As of this date, these videotapes have not been rated by trained observers to determine treatment adherence. For this research endeavor, treatment adherence is considered to be of lesser importance than the question of couples group efficacy in general.

It is interesting to note that the principal investigator found it easy to follow the manuals in running the groups because of their specificity and detail. In the opinion of the principal investigator in almost all of the sessions the planned interventions, discussions, and exercises were carried out in accordance with the manual. There were two or three occasions when an intervention or discussion point was intentionally left out of a particular session in order to insure that other material would not have to be foregone, as a result of the time limitations of the group.
Treatment Manuals

The treatment manuals were developed by Wimberly and Waltz (unpublished manual) to promote the implementation of ICT in a group format. The authors relied heavily upon the ICT treatment manual as written by Christensen, Jacobson, and Babcock (1995) to guide their design of the group. They also used Jacobson and Christensen's book *Integrative Couples Therapy: Promoting Acceptance and Change*, (1996) when it became available (Fall, 1996). Direct training in the therapy model also informed development of the group format of the therapy.

Therapists for the Groups

The co-therapists for the two ICT groups and the two weekend seminars were Christine Costanzo, M.D., Sarah Chisholm-Stockard, M.A., and John Wimberly, M.A. Wimberly had trained with Jennifer A. Waltz, Ph.D. at the University of Montana for two semesters in the ICT model. He also participated in a weekend long workshop on ICT with Jacobson in the Spring of 1996. Chisholm-Stockard was a Clinical Psychology Intern from Kent State University who was completing her Internship year at the University of Wisconsin’s Department of Psychiatry and Psychology. Chisholm-Stockard had minimal training in couples work (i.e. had done co-therapy with three couples with Wimberly) prior to the group. Costanzo was finishing her fourth year of Residency Training in Psychiatry at the University of Wisconsin's Medical School Department of Psychiatry when she participated in this project. She had no couples and little group experience prior to her participation as a
co-therapist. Both Chisholm-Stockard and Costanzo were considered competent clinicians in the delivery of individual psychotherapy and their previous limitations in training in couples and group work have been noted. Each was a co-therapist for one ICT group and one weekend seminar. Wimberly co-led all ICT groups and all weekend seminars.

Prior to each session, the co-therapists met for approximately one hour in order to ensure that both co-therapists were prepared and in agreement about how to run the upcoming session. Areas of co-therapists’ preparation included: discussing theoretical aspects of ICT and how to implement these in the session; discussion of the histories, dynamics and interactional patterns of couples in the group; feedback to each other about how the group was running; and planning who would be responsible for each segment of the next session.

Follow-up Assessments

Subsequent follow-up questionnaires (e.g. the DAS & MSI) will be mailed to the participants with self addressed stamped envelopes at six months, one year, and two years subsequent to the end of treatment. All participants had the follow-up procedures explained to them both at the initial intake session and again when the treatment was coming to a close. All participants have agreed to participate in follow-up testing.
Results

Background Assumptions

Before presenting the results and a detailed discussion of the analysis, it is necessary to briefly discuss an important issue involved in analyzing data gathered from couples. The essence of this debate is concerned with the question of whether to view the couples' scores as individual and independent scores (e.g. Baucom, 1983; Baucom & Mehlman, 1984) or as fundamentally interrelated measures. Baucom (1983) and Baucom & Mehlman (1984) argue that to use the composite couple's scores (i.e. averaging the partners scores for the DAS, GDS, etc. to obtain a couple's score) risks losing sensitivity to differences in responses to treatment either individually or across gender. This is a coherent argument and suggests that more research needs to be done in order to determine if there is a differential response to treatment across gender or individuals.

An alternative view is that the scores from the members of a couple on measures such as relationship satisfaction are intimately linked with each other. If one member of the relationship is dissatisfied with some aspect(s) of the relationship, this dissatisfaction cannot help but influence and affect how the other experiences and evaluates the relationship. Although there may be gender related differential responses to treatment in some studies (there were not any statistical difference in treatment response across gender in this study - DAS: \( p = .489 \); GDS: \( p = .753 \) - see Table 3), one can argue that couples' scores of relationship satisfaction are essentially
interrelated variables and that they are not independent of each other. If one partner is very unhappy in a relationship, it is entirely possible that the other might be fairly happy. However, it is argued that the "happy" partner would likely be even more satisfied with the relationship if their partner was also content or pleased with the relationship. To treat each of the partners as independent agents neglects the fact that they are intimately linked in their relationship and that their relationship scores are likely to be highly correlated.

In this small sample, three out of four of these measurements were highly correlated across partners. The partners' score on the GDS at time 1 was significantly correlated ($r = .513, p = .010$), and at time 2 was significantly correlated ($r = .684, p = .002$). The partner's scores on the DAS were correlated at time 1 ($r = .233, p = .273$), and significantly correlated at time 2 ($r = .635, p = .006$) - please see Table 4. Since the partner's scores were so highly correlated in this sample, it makes statistical sense to use the composite scores across the DAS, GDS, and other relationship variables.
### T-Test

#### Group Statistics for Comparing Differential Response by Gender

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<thead>
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<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
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#### Independent Samples Test Across Gender For ICT Group and Walt-List Controls

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<td>GDS1 - GDS2</td>
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<td>Pre Treatment GDS</td>
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</table>
Testing for Differences Between Wait-List Control and ICT Groups

To test whether the ICT group and the wait-list control group were similar on the variables of age, educational level, years in current relationship, number of previous marriages, Dyadic Adjustment Scale and the Global Distress Scale of the MSI, the groups were compared at pre-testing using an Independent t test. At the time of assignment to groups, no significant differences were found between the wait-list control groups and the ICT groups on these variables. Two couples from the ICT group and three couples from the wait-list control group were lost to attrition (as described in the Methods section). After attrition, the two sets of groups were collapsed into one data pool - 8 couples who completed the ICT group and 9 couples who participated as wait-list controls. These two groups showed no significant differences on couples' DAS (p = .384, t[15, -.896]); couples' GDS (p = .307, t[15, 1.058]); age (p = .376, t[32, -.898]); educational level (p = .072, t[32, 1.86]); previous marriages (p = .193, t[32, -1.330]); and length of their current relationship (p = .341, t[32, .966]) (see Table 5 and Table 6 for these figures and other descriptors).
<table>
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**Group Statistics For Wait-List Control vs. ICT Treatment Subjects**

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Independent Samples T-Test For Control Group vs. ICT Treatment Group

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Analysis of Pre- and Post-Treatment ICT Group Data

Treatment data were analyzed using two methods: 1) analyses to determine statistically significant changes due to the effects of the ICT group intervention and 2) an analysis of clinical significance (Jacobson, Follette, & Revenstorf, 1984; Christensen & Mendoza, 1986).

Two primary dependent variables were used in this study, the DAS and GDS. Pre and Post tests scores were analyzed using a repeated measures MANOVA. The MANOVA showed a significant main effect for Time, Wilks' Lambda = .344, F(2, 14) = 13.349, p = .001. The Time X Treatment interaction was also significant, Wilks' Lambda = .628, F(2, 14) = 4.154, p = .038. These data are presented in Tables 7 & 8. Subsequent to the MANOVA, a Univariate test was used to test for significance on the DAS and the GDS. The change in DAS scores was significant for the interaction of Time and Treatment (p = .010, F[1, 15] = 8.772). The change in GDS scores was significant for the interaction of Time and Treatment (p = .038, F[1,15] = 5.170), please see Table 9. The main effect of Time was significant for DAS and GDS but is not discussed in light of the significant interaction of Time and Treatment. Table 10 depicts the interaction of Time X Treatment for the DAS. Table 11 portrays the interaction of Time X Treatment for the GDS.

The Time X Treatment interaction eta squared statistic is also important for this analyses. The eta squared statistic is the proportion of variance in the dependent variables that is explained by differences among groups. The Wilks' Lambda
produces an eta squared value of .372. Effect sizes of greater than .25 are considered to be "large" effect sizes (Cohen, 1977). Thus, this is evidence that the ICT group is producing a large effect size as compared to the wait-list control group. This suggests that the ICT treatment is indeed producing the results (i.e. changes in relationship satisfaction) that were intended. Please see Table 8 for the eta squared values.
Table 7

Descriptive Statistics

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### Table 8

Repealed Measures MANOVA

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a. Computed using alpha = .05

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Table 10

Couples' Pre and Post Treatment

DAS Means

TIME

Treatment Groups
- Wait-List Group
- ICT Group
Table 11

<table>
<thead>
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<th>Couples' Pre and Post Treatment GDS Means</th>
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<tr>
<td>ICT Group</td>
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Analyses of Additional MSI Scales

In addition to the main predictions regarding changes in relationship adjustment, satisfaction, and distress, several other hypotheses were made with regard to expected changes in some of the subscales of the MSI. ICT specifically targets increasing partner's understanding of the other, effective emotional communication (i.e. using "soft emotions"), and increasing the quality and amount of time spent together. In addition, it focuses on improving problem solving skills, understanding of common individual and interactional themes that may be operating in a relationship, and effective request making. Since ICT targets these specific areas, it was hypothesized that there would be significant changes in the subscales of the MSI that assess these relationship dimensions. It was predicted that the Problem-Solving Communication (PSC), Time Together (TTO) and Affective Communication (AFC) subscales would show significant changes from pre to post treatment. It was also expected that the subscales for Family History of Distress (FAM) and Role Orientation (ROR) would not show any changes. No specific predictions were made for the remaining scales of: Sexual Dissatisfaction (SEX), Financial Disagreements (FIN), Dissatisfaction with Children (DSC), Conflict Over Childrearing (CCR), or Conventionalization (CNV).

The results for the Problem Solving scale, Time Together scale, and the Affective Communication scale are as follows. A repeated measures MANOVA showed a significant main effect for Time: Wilks' Lambda = .359, \( F(3, 13) = 7.731 \),
\( p = .003 \). The Time X Treatment interaction was significant, Wilks' Lambda = .556, \( F(3, 13) = 3.458, p = .048 \) - please see Tables 12 & 13. Subsequent univariate analyses on these subscales showed that for the interaction of Time and Treatment PSC was significant with \( p = .006 \), TTO was significant with \( p = .034 \), and AFC was not significant with \( p = .079 \) - please see Table 14. The main effect for Time was significant for all of these subscales but is not discussed in light of the significant interaction of Time and Treatment. Tables 15, 16, and 17 portray the interactions of Time X Treatment for PSC, TTO, and AFC respectively.
Table 12

Descriptive Statistics

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Table 13

Repeated Measures MANOVA

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<td>.444</td>
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</table>

a. Computed using alpha = .05
b. Exact statistic
c. Design: Intercept*TRMT
Within Subjects Design: TIME

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Table 14

Univariate Tests

Sphericity Assumed

<table>
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<tr>
<th>Source</th>
<th>Measure</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig</th>
<th>Eta Squared</th>
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<tbody>
<tr>
<td>TIME</td>
<td>PSC</td>
<td>419.187</td>
<td>1</td>
<td>419.187</td>
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<td>.482</td>
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<tr>
<td></td>
<td>TTO</td>
<td>277.359</td>
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<td>23.163</td>
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<td>.607</td>
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<td>AFC</td>
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<td>1</td>
<td>446.089</td>
<td>16.476</td>
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<td>.523</td>
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<tr>
<td>TIME *</td>
<td>PSC</td>
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<td>314.187</td>
<td>10.472</td>
<td>.006</td>
<td>.411</td>
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<td>TRMT</td>
<td>TTO</td>
<td>65.359</td>
<td>1</td>
<td>65.359</td>
<td>5.458</td>
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<td>AFC</td>
<td>96.089</td>
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<td>96.089</td>
<td>3.549</td>
<td>.079</td>
<td>.191</td>
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<td>PSC</td>
<td>450.049</td>
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<td>TTO</td>
<td>179.611</td>
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</table>

a. Computed using alpha = .05

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Table 15

Couples’ Pre and Post Treatment

Problem Solving Communication

<table>
<thead>
<tr>
<th></th>
<th>Treatment Group</th>
<th>Control Group</th>
<th>Therapy Group</th>
</tr>
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<tbody>
<tr>
<td>Pre</td>
<td>64</td>
<td>62</td>
<td>60</td>
</tr>
<tr>
<td>Post</td>
<td>58</td>
<td>58</td>
<td>58</td>
</tr>
</tbody>
</table>
Table 16

Couples' Pre and Post Treatment

Time Together Means

Couples' TTO Means

TIME

Treatment Group
Control Group
Therapy Group

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Table 17

Couples' Pre and Post Treatment

Affective Communication

![Graph showing Couples' Pre and Post Treatment Affective Communication]
A third repeated measures MANOVA was done on the History of Family Distress (FAM) and Role Orientation (ROR) subscales. There was no significant difference for the main effect of Time, Wilks' Lambda = .937, F(2, 14) = .469, p = .635. As predicted, there was no significant interaction of Time X Treatment, Wilks' Lambda = .836, F(2, 14) = 1.374, p = .285. As would be expected based upon the omnibus test, univariate tests were not significant for the Time X Treatment interaction for either FAM (p = .385) or ROR (p = .206) - please see Tables 18, 19, 20, 21, & 22.
Table 18

Descriptive Statistics

<table>
<thead>
<tr>
<th>Treatment Group</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Couple's ROR1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control Group</td>
<td>61.6667</td>
<td>5.6954</td>
<td>9</td>
</tr>
<tr>
<td>Therapy Group</td>
<td>62.8125</td>
<td>3.5450</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>62.2059</td>
<td>4.6973</td>
<td>17</td>
</tr>
<tr>
<td>Couple's ROR2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control Group</td>
<td>60.8889</td>
<td>4.9798</td>
<td>9</td>
</tr>
<tr>
<td>Therapy Group</td>
<td>63.2500</td>
<td>2.8031</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>62.0000</td>
<td>4.1608</td>
<td>17</td>
</tr>
<tr>
<td>Couple's FAM1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control Group</td>
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<td>6.9462</td>
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</tr>
<tr>
<td>Therapy Group</td>
<td>55.7500</td>
<td>8.5482</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>56.3235</td>
<td>7.5103</td>
<td>17</td>
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<tr>
<td>Couple's FAM2</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Control Group</td>
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<td>9</td>
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<tr>
<td>Therapy Group</td>
<td>54.4375</td>
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<tr>
<td>Total</td>
<td>55.6765</td>
<td>7.1062</td>
<td>17</td>
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### Table 19

Repeated Measures MANOVA

<table>
<thead>
<tr>
<th>Effect</th>
<th>Type</th>
<th>Pillai's Trace</th>
<th>Wilks' Lambda</th>
<th>Hotelling's Trace</th>
<th>Roy's Largest Root</th>
<th>Sig.</th>
<th>Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Subjects</td>
<td>Intercept</td>
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<td>.996</td>
<td>.996</td>
<td>.996</td>
<td></td>
<td>.996</td>
</tr>
<tr>
<td></td>
<td>Wilks' Trace</td>
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<td>.004</td>
<td>.004</td>
<td>.004</td>
<td></td>
<td>.996</td>
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<tr>
<td></td>
<td>Hotelling's Trace</td>
<td>2.000</td>
<td>14.000</td>
<td>.000</td>
<td>.996</td>
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<td></td>
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<tr>
<td></td>
<td>Roy's Largest Root</td>
<td>2.000</td>
<td>14.000</td>
<td>.000</td>
<td>.996</td>
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<td><strong>TRMT</strong></td>
<td>Pillai's Trace</td>
<td>.071</td>
<td>.538</td>
<td>.095</td>
<td>.071</td>
<td></td>
<td>.071</td>
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<tr>
<td></td>
<td>Wilks' Lambda</td>
<td>.929</td>
<td>.538</td>
<td>.095</td>
<td>.071</td>
<td></td>
<td>.071</td>
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<tr>
<td></td>
<td>Hotelling's Trace</td>
<td>.077</td>
<td>.538</td>
<td>.095</td>
<td>.071</td>
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<tr>
<td></td>
<td>Roy's Largest Root</td>
<td>.077</td>
<td>.538</td>
<td>.095</td>
<td>.071</td>
<td></td>
<td></td>
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<tr>
<td><strong>Within Subjects</strong></td>
<td><strong>TIME</strong></td>
<td>.063</td>
<td>.469</td>
<td>.635</td>
<td>.063</td>
<td></td>
<td>.063</td>
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<tr>
<td></td>
<td>Wilks' Lambda</td>
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<td>.635</td>
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<tr>
<td></td>
<td>Hotelling's Trace</td>
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<td>.469</td>
<td>.635</td>
<td>.063</td>
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<tr>
<td></td>
<td>Roy's Largest Root</td>
<td>.067</td>
<td>.469</td>
<td>.635</td>
<td>.063</td>
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<tr>
<td></td>
<td><strong>TIME * TRMT</strong></td>
<td>.164</td>
<td>1.374</td>
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<td>1.374</td>
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<td></td>
<td>Hotelling's Trace</td>
<td>.196</td>
<td>1.374</td>
<td>.285</td>
<td>.164</td>
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<td></td>
<td>Roy's Largest Root</td>
<td>.196</td>
<td>1.374</td>
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</table>

- Computed using alpha = .05
- Error statistic
- a. Design: Intercept*TRMT
  - Within Subjects Design: TIME

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### Table 20

**Univariate Tests**

Sphericity Assumed

<table>
<thead>
<tr>
<th>Source</th>
<th>Measure</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
<th>Eta Squared</th>
</tr>
</thead>
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<tr>
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<td>.245</td>
<td>.137</td>
<td>.717</td>
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<td>4.173</td>
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</table>

*a. Computed using alpha = .05*
Table 21

Couples' Pre and Post Treatment

History of Family Distress

<table>
<thead>
<tr>
<th>Couples' FAM Means</th>
<th>Treatment Group</th>
<th>Control Group</th>
<th>Therapy Group</th>
</tr>
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<tr>
<td>75.0</td>
<td>70.0</td>
<td>A</td>
<td>&lt;65.0</td>
</tr>
<tr>
<td>65.0</td>
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<td>55.0</td>
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<td>&lt;45.0</td>
</tr>
<tr>
<td>45.0</td>
<td></td>
<td>A</td>
<td></td>
</tr>
</tbody>
</table>

TIME
Table 22

Couples' Pre and Post Treatment
Role Orientation Means

TIME

Couples' ROR Means

Treatment Group
△ Control Group
□ Therapy Group

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**Paired Samples T Tests for the Wait-List Controls**

Additional statistical analyses were performed on the wait-list control group's data to determine if any of the observed changes on the measures were significant. Paired Samples t tests were used to determine if there were any significant changes from time 1 until time 2 testing on the wait-list control group's scores. The Paired Samples t test is a more sensitive test than the Independent Samples t test and so was used to increase sensitivity to detect any differences pre and post should they exist. Results for the wait-list control group show that they did not improve significantly on the DAS (p = .138), the GDS (p = .178), or on the other subscales of the MSI (Problem Solving Skills: p = .605; Time Together: p = .105; Affective Communication: p = .061; History of Family Distress: p = .957; Disagreements about Finances: p = .820; Sexual Satisfaction: p = .291; Conventionalization: p = .068; or Role Orientation: p = .184). Please see Tables 23 and 24 for these results.
Table 23

Paired Samples Statistics for the Wait-List Control Group

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>N</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>3) Couple's DAS1</td>
<td>92.2778</td>
<td>9</td>
<td>12.3620</td>
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<td>Couple's DAS2</td>
<td>97.3889</td>
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<td>10.3222</td>
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<td>59.5000</td>
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<td>7.7015</td>
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<td>Couple's GDS2</td>
<td>57.0556</td>
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<td>7.1783</td>
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<td>3) Couple's PSC1</td>
<td>59.2222</td>
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<td>Couple's PSC2</td>
<td>58.2778</td>
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<td>9.2504</td>
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<td>4) Couple's TTO1</td>
<td>58.0556</td>
<td>9</td>
<td>9.6516</td>
<td>3.2172</td>
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<tr>
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<td>Couple's TTO2</td>
<td>55.1111</td>
<td>9</td>
<td>7.5943</td>
</tr>
<tr>
<td>5) Couple's AFC1</td>
<td>60.2222</td>
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<td>6.5197</td>
<td>2.1732</td>
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<td>Couple's AFC2</td>
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<td>5.6789</td>
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<td>6) Couple's FAM1</td>
<td>56.8333</td>
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<td>6.9462</td>
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<td>Couple's FAM2</td>
<td>56.7778</td>
<td>9</td>
<td>6.2255</td>
</tr>
<tr>
<td>7) Couple's FIN1</td>
<td>54.5556</td>
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<td>Couple's FIN2</td>
<td>54.1667</td>
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<td>9.1822</td>
</tr>
<tr>
<td>8) Couple's SEX1</td>
<td>55.2778</td>
<td>9</td>
<td>10.4317</td>
<td>3.4772</td>
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<td>Couple's SEX2</td>
<td>53.1111</td>
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<td>10.6207</td>
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<td>9) Couple's CNV1</td>
<td>40.9444</td>
<td>9</td>
<td>2.2001</td>
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<td>Couple's CNV2</td>
<td>43.7222</td>
<td>9</td>
<td>4.8613</td>
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<td>10) Couple's ROR1</td>
<td>61.6667</td>
<td>9</td>
<td>5.6954</td>
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<td>Couple's ROR2</td>
<td>60.8889</td>
<td>9</td>
<td>4.9798</td>
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</table>
Table 24

Paired Samples Test For Wait-List Control Group

<table>
<thead>
<tr>
<th>Paired Differences</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
<th>Lower</th>
<th>Upper</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Couple's DAS1 - Couple's DAS2</td>
<td>-5.1111</td>
<td>9.3132</td>
<td>3.1044</td>
<td>-12.2699</td>
<td>2.0477</td>
<td>-1.646</td>
<td>8</td>
<td>.138</td>
</tr>
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<td>2) Couple's GDS1 - Couple's GDS2</td>
<td>2.4444</td>
<td>4.9714</td>
<td>1.6571</td>
<td>-1.3769</td>
<td>6.2658</td>
<td>1.475</td>
<td>8</td>
<td>.178</td>
</tr>
<tr>
<td>3) Couple's PSC1 - Couple's PSC2</td>
<td>9444</td>
<td>5.2586</td>
<td>1.7529</td>
<td>-3.0977</td>
<td>4.9866</td>
<td>.539</td>
<td>8</td>
<td>.605</td>
</tr>
<tr>
<td>4) Couple's TTO1 - Couple's TTO2</td>
<td>2.9444</td>
<td>4.8376</td>
<td>1.6125</td>
<td>-.7741</td>
<td>6.6630</td>
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<td>.105</td>
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<tr>
<td>5) Couple's APC1 - Couple's APC2</td>
<td>3.8889</td>
<td>5.3431</td>
<td>1.7810</td>
<td>-2.182</td>
<td>7.9960</td>
<td>2.184</td>
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<td>.061</td>
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<tr>
<td>6) Couple's FAM1 - Couple's FAM2</td>
<td>5.356E-02</td>
<td>2.9942</td>
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<td>.957</td>
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<td>8) Couple's SEX1 - Couple's SEX2</td>
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<td>6.5865</td>
<td>1.130</td>
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<td>.291</td>
</tr>
<tr>
<td>9) Couple's CNV1 - Couple's CNV2</td>
<td>-2.7778</td>
<td>3.9458</td>
<td>1.3153</td>
<td>-5.8108</td>
<td>.2552</td>
<td>-2.112</td>
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<td>.068</td>
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<tr>
<td>10) Couple's ROR1 - Couple's ROR2</td>
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<td>1.6029</td>
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<td>2.0099</td>
<td>1.456</td>
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<td>.184</td>
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</tbody>
</table>
Tests of Clinical Significance

An important challenge in conducting psychotherapy outcome research involves being able to quantify whether "statistically significant" results have any "subjective or experiential significance" with the subjects who are being studied. It is therefore important to consider the question of clinical significance, or the degree to which the changes found are clinically meaningful.

Jacobson, Follette, & Revenstorf (1984) recommend that each individual client be categorized as "improved" if the amount of change for that individual on a given measure exceeds chance expectations. A statistic called the Reliable Change Index, which is based on the standard error of measurement (S.E.), can be used for this purpose. A change that exceeds 1.96 is unlikely to be merely a function of measurement error ($p < .05$). In contrast to the typical inferential statistics used to evaluate the effectiveness of psychotherapy, the Reliable Change Index leads to a psychometrically sound method of categorizing subjects on whether they have improved during the course of therapy with respect to the variables being studied (Jacobson, Follette, Revenstorf, Baucom, Hahlweg, & Margolin, 1984).

The Reliable Change Index (RCI) is equivalent to the difference score divided by the standard error of the difference scores:

$$ RCI = \frac{(X_2 - X_1)}{\text{S.E. Difference score}} $$

$X_2$ is the post-test score and $X_1$ is the pre-test score. S.E. Difference Score is the standard error of the difference between test scores. If the RCI is greater than -1.96 and less than 1.96 (-1.96 < RCI < 1.96), then it is unlikely ($p < .05$) that any
change has occurred. If the RCI is greater than 1.96 or less than -1.96, then it is likely \( (p < .05) \) that reliable change has occurred. Any RCI greater than 1.96 is labelled "improvement" - the couple has made a significant change in the more functional direction. If the RCI is less than -1.96, then this is labelled "worsened" - the couple has made a significant change in the more distressed direction. If the RCI is between -1.96 and 1.96, then the relationship is labelled "unchanged". Thus, it is quite possible to have changes in the overall scores that are statistically significant, but the RCI for any individual in that study might not be significantly changed.

A second (and related) measure of clinical significance is suggested by Jacobson, Follette, Revenstorf, Baucom, Hahlweg, & Margolin (1984). They suggest that for many clinical populations, clinical significance should refer to the movement from a dysfunctional population to a functional population with respect to the variables being measured. In other words, a change in scores is considered to be clinically significant when the post-test score places the individual in the functional population (Jacobson et al., 1984). Empirically derived cut-off scores are used to determine whether a score on relationship satisfaction places an individual or a couple in the clinically dysfunctional or functional range. This statistic combines the Reliable Change Index with whether the couple has moved from the distressed range of relationship functioning (i.e. dysfunctional) to a non-distressed (i.e. satisfied, happy, or functional) relationship. This second method has two criteria: Is the change reliable and has the couple moved out of the distressed range? If so, then the distress of the couple’s relationship is said to have been "alleviated". This method will also
characterize couples' scores as "deteriorated" if their score has reliably worsened and has moved from the functional range to the dysfunctional range.

The term dysfunctional or functional is applied to scores that fall below or above (respectively) the cut-off scores for relational distress. Cut-off scores were empirically derived by determining the mid-point between the overlap of the distributions between couples in the clinically distressed range (i.e. were presenting for couples therapy or proceeding with divorce actions) and couples reporting that their relationships were satisfactory and non-distressing. The cut-off score for non-distressed couples on the DAS is 98 and above (Jacobson et al., 1984). The cut-off score for non-distressed couples on the GDS is 59 and below (Jacobson & Truax, 1991). Alleviation employs the criteria that a couple must have improved (as measured by the RCI) as well as moved from the dysfunctional to the functional range of couples' scores.

In the ICT group, 8 out of 8 couples (100%) improved on DAS scores and 6 out of 8 couples (75%) improved on the GDS. All of the ICT couples were in the dysfunctional range for the DAS at pre-testing. Six of the 8 ICT couples (75%) scored in the non-dysfunctional range for the DAS after the ICT group. Five of the ICT couples scored in the dysfunctional range on the GDS at pre-testing. Of these five couples, three scored (60%) in the non-dysfunctional range on the GDS at post-testing. The same two couples in the ICT group did not meet criteria for being functional on either the DAS or the GDS at either time period. None of the ICT couples deteriorated on either measure. Tables 25, 26, & 27 present the data on the
RCI - whether couples in the two groups were worse, unchanged, improved, deteriorated, or alleviated.

Six of the 8 ICT couples (75%) met criteria for alleviation on the DAS (i.e. they improved reliably and moved from the distressed range to the non-distressed range). Of the five ICT couples who scored in the dysfunctional range at pre-testing on the GDS, three couples (60%) met criteria for alleviation on the GDS. The two couples who did not meet criteria for alleviation on the DAS were the same two couples who did not meet criteria for alleviation on the GDS. Please see Table 27 for this data.

For the wait-list control group, five out of nine couples (55%) reliably improved on the DAS and two out of nine couples (22%) reliably improved on the GDS. For the wait-list control group, six couples met criteria for being dysfunctional on the DAS at pre-testing. Of these 6 couples, 3 couples (50%) scored in the functional range at post-testing on the DAS. Five couples scored in the dysfunctional range of scores on the GDS at pre-testing. Of these five couples, one couple (20%) scored in the functional range for the GDS at post-testing. One of the wait-list control couples deteriorated on their DAS score. None of the couples deteriorated on the GDS. Please see Tables 25, 26, & 27 for this data.

In the wait-list control group, 5 couples were initially in the dysfunctional range on the DAS. Out of these 5 couples, 3 couples (60%) met criteria for alleviation on the DAS. Five couples in the wait-list control group were initially in the dysfunctional range for the GDS out of which only 1 couple (20%) met criteria for...
alleviation on the GDS. Please see Table 27 for these results.
## Table 25

<table>
<thead>
<tr>
<th>Treatment Group</th>
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<th>Couple's DAS1</th>
<th>Couple's DAS2</th>
<th>Couple's DAS Difference Score (DAS2 - DAS1)</th>
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*a. Limited to first 100 cases.*

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Table 26

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<tr>
<th>Treatment Group</th>
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<th>DAS Change Classification</th>
<th>GDS Change Classification</th>
<th>Improvement on DAS &amp; GDS</th>
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| Therapy Group   |               |                           |                           |                         |
|                 |               | Improved                  | Improved                  | Both Improved           |
| 1               |               | Improved                  | Improved                  | Both Improved           |
| 2               |               | Improved                  | Improved                  | Both Improved           |
| 3               |               | Improved                  | Improved                  | Both Improved           |
| 4               |               | Improved                  | Improved                  | Both Improved           |
| 5               |               | Improved                  | Unchanged                 | Mixed Change            |
| 6               |               | Improved                  | Improved                  | Both Improved           |
| 7               |               | Improved                  | Improved                  | Both Improved           |
| 8               |               | Improved                  | Unchanged                 | Mixed Change            |
| Total           | N             | 8                         | 8                         | 8                       |

Total N | 17 | 17 | 17 |
Table 27

Scores of Clinical Significance at Post-Testing

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<td>0 (0%)</td>
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Discussion

Evidence for the Efficacy of ICT Groups

The results of this study give solid initial support for the efficacy of ICT presented in a group format. Statistically significant differences comparing the scores of the ICT group to the wait-list control were found on both the DAS and the GDS. In addition to affecting these more global measures of relationship satisfaction, ICT also improved other targeted areas of couples' interactions including Problem-Solving Communication, which measures general ineffectiveness at resolving differences, and Time Together, which reflects feelings about the quantity and quality of leisure time spent together. There was a trend toward change in Affective Communication, which assesses dissatisfaction with the amount of affection and understanding provided by a partner.

Tests of clinical significance also provided strong evidence that the group format of ICT is effective. These measures showed that eight of eight couples (100%) in the ICT group showed improvement (Reliable Change Index $> 1.96$) on the DAS. This is an important finding as it shows that the couples are not merely changing in a statistically significant manner but also in a subjectively meaningful way (i.e. they experience their relationship as having improved). Perhaps more important than the fact that 100% of couples showed clinical improvement on the DAS, is the fact that 6 out of 8 (75%) were "alleviated" on the DAS by the end of the twelve ICT group sessions. The criteria for alleviation are that the couple has reliably improved and that
they have moved from a clinically distressed range into the non-distressed range. Thus, these 6 couples have not only reliably improved, but their responses to the DAS placed them in the satisfied or very satisfied range of scores. This is a noteworthy finding in that not only are these couples moving in the right direction, they were also able to make substantial enough changes in their relationships so that their relationship scores are now categorized as falling in the non-distressed, functional, or satisfied ranges of couples' scores.

The findings for the ICT group were not as strong on the GDS; however, this is in part an artifact of the pre-treatment scores of the couples who were recruited for this study. Six of the eight (75%) couples in the ICT groups improved on the GDS. Three of the eight couples were already below the cut-off score of 59 for being distressed at pre-treatment. This means that they could not move from a clinically distressed range into a clinically less distressed range on the GDS. Thus, of the five couples who were eligible to achieve alleviation on the GDS, three out of five (60%) met the criterion. It should be noted that the average post-therapy score for these three couples was 45.5, which indicates that these couples were reporting that their relationships were very satisfying after the ICT group.

Six of the eight ICT group couples scored in the functional or non-distressed range at follow-up for both the DAS and the GDS. The same two couples were in the dysfunctional or distressed range for both the DAS and the GDS at follow-up. Each of these two couples had been at a major relationship impasse for many years. One of
these couples had been living in separate houses for the last 5 years and the other
couple had been at a relationship standstill for approximately 6 years.

As expected, the control group did not statistically improve during the waiting
period on the DAS, the GDS, or on the other subscales of the MSI (Problem Solving
Skills, Time Together, Sexual Satisfaction, Affective Communication, Disagreements
about Finances, History of Family Distress, Dissatisfaction with Children, Role
Orientation, Conflicts over Child Rearing, or Conventionalization).

Benefits of the ICT Group Format

Although it is not possible to decipher which specific effects of being in a
group format helped to promote change and acceptance in the couples - a number of
aspects of the group process are thought to be beneficial: the observation and
modelling of other couples, desensitization to having relationship difficulties,
normalization of couples' problems, group cohesion, trust, having a structured
environment within which to practice relationship enhancing behaviors, and a lowering
of the need to be defensive.

As was anticipated, the opportunity to observe other couples interact was cited
by many of the group members (in feedback given to the co-therapists at the end of
the group) as an essential ingredient in the group's effectiveness. Couples seemed to
enjoy and were intrigued by being able to watch and observe other couples in action.
Couples stated that they were able to learn new skills and means of interacting by both
observing other couples interacting effectively as well as observing when other couples
would behave in a less than effective manner. Other couples' positive interactions served as models to be striven for and their negative interactions served as models to be avoided.

Couples often identified with other couples, seeing difficulties similar to their own playing themselves out within others. This seemed to allow for a greater feeling of objectivity with respect to some common couples' problems. The opportunity to observe other couples in action seemed to promote a desensitization process to having relationship problems. The couples learned that they could more effectively tolerate their difficulties, and so bring more resources to bear upon the resolution of their problems.

In addition to the benefit of being able to model other couples, they also could learn that relationship difficulties are a natural part of being in relationship. The couples in the group were faced with having to come to terms with the fact that being in relationship means having to resolve serious differences on many different issues. The realization that having substantial differences in a relationship is normal seemed to allow couples to feel that they had more breathing room within which to work on and resolve their difficulties. The couples then did not seem to have to spend their relationship resources in denying, avoiding, defending, or attacking their differences. Rather, they could accept their differences as a natural part of being in relationship and were then able to move forward towards some kind of resolution or acceptance of their differences. Coche (1995) stated that couples working in groups can learn that the norm for couples is "working on issues all of the time".
When the groups were working well, couples would often anticipate other couples’ problems and help them to see them from different vantage points. It seemed that the opportunity to recognize dysfunctional patterns in other couples and to offer solutions contributed to the couples’ abilities to recognize, understand, and then resolve their own difficulties.

The intense working environment of the group also seemed to allow for a sense of trust in which couples could begin to address very important and sensitive issues in their relationship. One way in which trust was promoted in the group was a result of the tendency of each member to be on his or her good behavior in the public setting of the group. Avoiding, denying, sarcasm, antagonism, minimizing, counter-attacking, and bringing in other issues were minimized as a result of couples working within the group format. Group members came to trust that their partners would behave in accordance with the implicit and explicit expectations of the group. The group members or co-therapists would usually stop any of the above negative behaviors by pointing them out to the couple and assisting the couple in getting back on track towards effective interacting. Thus, the group members found that they could trust that their partners would behave respectfully, conscientiously, and productively in the group.

A second means to increasing trust in the group was a result of group members taking risks in sharing about important and sometimes very sensitive topics that required group members to be quite vulnerable. Discussions about topics such as fearing that a partner might leave or feeling insecure about one’s sexuality or physical
attractiveness greatly added to the sense of trust in the groups. Group members found that not only could they bring up very sensitive and difficult topics, but that they gained respect and validation from other group members for doing so. Once sufficient trust was built in the group, difficult topics could more easily be worked on within the group environment.

Group cohesion and trust also allowed for the couples to feel supported in changing or accepting aspects of themselves, their partner, or their relationship. The support and trust offered by other group members seemed to promote couples’ abilities to act authentically and respectfully with their partners. For example, one woman began to address the previously taboo subject of her partner’s gambling and unemployment more openly in the group. The honesty, respectfulness, and effectiveness with which this couple started to address these emotionally loaded issues seemed to open the door for other couples to be able to do work of similar importance on their own issues.

The group format also seemed to contribute to a reduction in defensiveness. The opportunity to hear other group member discuss how they felt that they could sometimes be petty, hostile, unnecessarily sarcastic, or defensive created an environment in which other members could then begin to address their own issues with less defensiveness. This clearly led to more productive problem resolution as well as increasing each person’s ability to use soft emotions and to be empathic and understanding with their partner. One man began to openly discuss how he used his anger "to bully" his wife into not bringing up difficult issues. Subsequent to his
beginning to be responsible for the impact of his behavior on his partner, this couple found it considerably easier to bring up important issues with each other. Interestingly, shortly after this work by this couple, other group members were more likely to talk about their responsibility for the impact of their own behaviors on their partners and families.

The structure of the group sessions was also thought to be beneficial. Each session involved a discussion of the homework, the introduction of new topics, and in most sessions some time was devoted to the practicing of new skills or an exercise designed to improve relationship functioning. The structure of the group required that each couple start to address their difficulties and hopefully begin to learn how to interact more successfully with each other.

Another benefit of the couples group approach is what Marett (1988) has termed the therapist/couple ratio. The couples group format maximizes the number of people who can benefit from an hour of the therapist's time. In typical couples therapy, a therapist will see one couple per hour or have a 1:1 therapist/couple ratio. In this ICT group, 2 therapists saw an average of 4 couples per hour. This produces a 1:2 therapist/couple ratio. Perhaps more experienced ICT or couples therapists could run the group without a co-therapist, producing a therapist/couple ratio of 1:4 or 1:5. This is considered to be advantageous because with group ICT more services can be provided to more couples. This form of psychotherapy is therefore more cost and time effective than individual couple therapy (as long as equivalent results are
maintained). This is an important consideration in the era of session limitations, cost containment, managed care, and HMO's.

*Couples Who did not Benefit from the ICT Group*

It is important to consider why some couples did not benefit from the ICT group. Research has consistently found that couples who are more distressed are less likely to score in the ranges of the happily married after therapy than couples who are less distressed to begin with (Snyder, Mangrum, & Wills, 1993). This finding has been reproduced by many investigators using various self-report instruments which measure relationship satisfaction (Jacobson & Addis, 1993). Emotional disengagement has also been shown to be a bad prognostic sign for couples (Hahlweg, Schindler, Revenstorf & Brengelmann, 1984).

The same two couples did not evidence any alleviation on either the DAS or the GDS. One of these couples was clearly in the very distressed range of relationship adjustment and distress scores. This couple appeared to be extremely emotionally detached, as evidenced by the fact that they had been living separately for 5 years, had both had numerous affairs, and had a non-existent sex life. The second couple was also quite emotionally detached from each other. They described their marriage as having "been in the Cold War for the last several years". They had learned to live separate lives and were not to any degree emotionally involved with each other. They would often report to the group that they had not been able to do the current homework and were "sort of" working on homework from previous sessions. Both of
these couples matched the profile of couples who are least likely to benefit from therapy; their level of distress and withdrawal from each other may have prohibited them from benefitting from the ICT group.

Donovan (1995) believes that some kind of relationship commitment and a previous track record of attempts to make the marriage work are essential to effective couples group therapy. He also states that some couples may minimize their difficulties in order to gain entrance into the group. Although both of the couples struggled with the group and their scores of relationship distress were not alleviated, they did report that they found the group helpful and that they thought that perhaps they could continue to work on their relationships. They also felt more hopeful about their chances as couples and were not so resigned to "living like roommates in the same house".

Both of these couples reported that the 12 session group format was not long enough for them to make the changes that they desired. Each also stated that they believed that they had started to make some improvements, but that they would need additional sessions with which to make the changes they needed. The length of the ICT group would seem to be an important element to consider as this line of research and treatment is developed. It is of course impossible to know whether extending the length of the group would in fact have benefitted these two couples or would benefit other severely distressed couples in the future.

*Considerations Regarding Group ICT and Conjoint ICT*
Integrative Couples Therapy was developed to assist couples who are emotionally disengaged and who often did not benefit from Traditional Behavioral Couples Therapy (Jacobson & Christensen, 1996). Emotional disengagement appears to be a bad prognostic sign for couples therapy (Hahlweg, Schindler, Revenstorf & Brengelmann, 1984). Emotional disengagement is generally used to describe couples in which affective communication is underutilized, the quality and quantity of emotional connection is poor, and the frequency of sexual intercourse is low.

Although one of the limitations of this study is its small number of subjects, it is still important to consider the ICT treatment failures and how they might best be served. At this point in time, it is difficult to compare the results of group ICT and conjoint ICT approaches. A pilot study for conjoint ICT (Cordova, Jacobson, & Christensen, 1995) compared ICT (6 couples) with Traditional Behavioral Couples Therapy (6 couples). Couples were given between 20 and 25 sessions of individual couples therapy. In the ICT couples group research conducted by Wimberly and Waltz, each group session was two hours in length and so the ICT group members received 24 hours of group therapy. Thus, the amount of time spent in a therapeutic environment was similar for these two studies. However, it might be argued that these times are not comparable due to the fact that in the group ICT the time of the group is divided amongst the 4 or 5 couples.

Preliminary results from the ICT pilot study found that 100% of the couples that were in the ICT treatment showed clinically significant improvement at post-testing and 83% (5/6) of the ICT couples maintained treatment gains at one year.
follow-up (Jacobson - personal communication, 1996). Although preliminary at best, these results are encouraging and suggest an improvement upon the typical findings with TBCT.

Comparisons of this pilot data with group ICT approaches also needs to be interpreted with caution as both of these studies have a small number of subjects and are preliminary in nature. However, the findings are encouraging in that both modalities are positively affecting between 80% (group ICT) and 100% (conjoint ICT) of couples who participate. Follow up data is not available for the group ICT couples at this point in time.

In light of the two couples whose relationship satisfaction did not change, it is necessary to begin an evaluation of what kinds of couples might most benefit from the group therapy format. Given that the most distressed couples are the least likely to benefit from individual couples therapy (Jacobson & Addis, 1993; Snyder, Mangrum & Wills, 1993) and that emotionally disengaged couples also benefit least from couples therapy (Hahlweg et al., 1984), it is possible that severely distressed and/or emotionally disengaged couples might also benefit least from a couples group format. One hypothesis is that conjoint ICT may be more effective than group ICT in assisting severely distressed couples in understanding their interactional dynamics, working collaboratively, promoting change, and creating an atmosphere of acceptance due to the greater amount of time and perhaps intensity that a therapist can work with an individual couple. If the more distressed and/or emotionally disengaged couples do not benefit as substantially from ICT groups as they might from conjoint ICT, then it
would be wise to screen them out and to offer them services that had a greater likelihood of benefitting them. Future research should seek to address these issues and determine whether conjoint ICT might be more effective with emotionally disengaged and severely distressed couples than group ICT. This should be studied by directly comparing group ICT with conjoint ICT and examining any differences in effect for mildly, moderately, and severely distressed couples.

*Tests of Clinical Significance for the Wait-List Control Group*

Two out of nine (22%) couples in the wait-list control group showed improvement on the GDS. One of five eligible wait-list control couples (20%) showed alleviation on the GDS. It is considered unusual that 5 out of 9 (55%) of the wait-list control couples showed improvement on their DAS scores. Three of the five eligible couples (60%) met criteria for alleviation on the DAS.

In order to better understand these results, it is necessary to closely examine what happened with the wait-list control couples whose DAS and GDS scores were alleviated. In two of the three couples whose DAS scores were alleviated, a methodological problem was introduced. These two couples were allowed to respond to the questionnaires at home rather than in the clinic. This introduces some different demand characteristics into their responses. Interestingly, in both couples it was only one of the partner's scores which increased to any significant degree. The other partner's scores did not increase significantly on either the DAS or GDS.
Many of the couples remarked about how the intake process itself was helpful to them. They stated that they found it helpful to be able to come in and talk with a trained interviewer and begin to identify the problem areas in their relationships, to start to address some of the important issues that may have been long ignored, and that the intake procedures allowed them to begin to have some hope that their issues could and perhaps would be addressed. This can be quite a powerful experience for some couples. It is possible that the intake process could account for some of improvement seen in the wait-list control subjects.

In general, the tests of clinical significance show that the ICT group is effective and produces clinically meaningful results for many of the couples who participated in the ICT group. The tests of clinical significance are perhaps harder to interpret for the control group. There was more improvement and alleviation evidenced here than would usually be expected from a group which did not receive any interventions (excepting the three hour intake). It is hypothesized that some of this unexpected improvement may be in part due to allowing two couples to respond to the questionnaires at home and to the effects of the intake process as an intervention. In the three couples who showed the most change, it was primarily one member whose scores improved greatly, while the other partner's scores rose minorly or not at all. Perhaps these findings are evidence in favor of Baucom (1983) and Baucom & Mehlman's (1984) position that relationship scores are independent in nature. These issues are unclear at this point. Another issue seems to be that the unexpected improvements were found primarily in the change in DAS scores and not the GDS
scores. This is hard to interpret at this point, it may be that the DAS is more susceptible to being influenced by a couple's hopeful expectations than the GDS.

**Differences Between the ICT Groups**

There were some interesting differences between the two ICT groups that were run. First, two couples from the second ICT group did not finish that group, whereas all of the members of the first group completed it. The reasons for this attrition were described in the Methods section (one couple said that his work schedule changed and the other couples did not complete the group because they missed three sessions).

Drop-outs in groups in general, and in couples groups specifically, are quite common. Donovan (1995) describes how in the short-term couples groups he runs that he requires all couples to attend a pre-group meeting which provides the couples with a sense of how the group will function. One reason he finds this helpful is to reduce the drop-out rate once the group has begun working in earnest. He believes that the pre-group meeting gives the couples an idea of what is involved in the group so couples who determine that couples work and/or the group format is not something they are interested in can terminate before the beginning of the actual group. He states that as many as 25% of the couples decide not to go forward with the group after this initial meeting (Donovan, 1995). He also reports that even with the pre-group meeting, his couples groups have about a 10% drop-out rate (Donovan, 1995). This would make his reported drop-out rate approximately one-third of couples who
attend the pre-group meetings and start the groups. This study had a drop-out rate of 20%, which therefore seems within normal limits given Donovan's (1995) findings.

Since the ICT couples group is brief in nature, any pair that drops out once the group has started can cause a major disruption in cohesion (Budman & Gurman, 1988). In the second ICT group, the drop-out of one couple after 3 sessions was likely to have been fairly disruptive to the remaining group members and in fact the group members voiced some concerns about this issue.

From the co-therapists standpoint, the two groups were also very different. The first group built a sense of trust and cohesion rapidly. By the middle of the second session they were disclosing at an impressive depth and the couples seemed very comfortable with each other. In the second group, it was not until the seventh session that a sense of cohesion was more evident to the co-therapists. Attendance was generally more sporadic and there was greater heterogeneity in the second group, which may have interfered with the development of cohesion.

Two other very relevant factors are thought to have affected the second ICT group. The second group was significantly older with an average age of 46, as compared to 37 for the first group. The second group had also been in their relationships longer than the first group (16 years vs. 6 years). The literature suggests that couples' outcome in therapy is inversely related to age (i.e. the older one is the less likely that person is to have a favorable outcome in couples therapy) (Baucom & Hoffman, 1986; Jacobson & Addis, 1993). These factors might well account for how different these two groups felt to the co-therapists, the perceived difference in
cohesion levels, and for some of the attrition that occurred in the second group. It should be noted that the ICT groups did not differ significantly from their matched controls and the ICT groups were only compared to each other after the interventions were complete in order to better understand any differences between these groups.

Group homogeneity is also likely to be important for the optimal functioning of ICT couples groups. Budman, Simeone, Reilly & Demby (1994) emphasize the need for high therapist activity, homogenous patient selection, and the need for a rapid establishment of a working interpersonal focus for short term groups if they are to be effective. The second group was more heterogeneous in terms of ethnicity and type of relationship (one couple was in a long-term non-married relationship). The second group also had more previous marriages than the first. It is possible these several important factors (age of group members, drop-outs, length of relationship, number of previous marriages, and group heterogeneity) may have been involved in the co-therapists' sense that the second group did not seem to run as effectively as the first.

Other Outcome Studies in Couples Group Therapy

This study not only provides evidence for the efficacy of ICT in a group format, it adds and builds upon the small body of outcome literature that empirically supports couples group work. It is an important finding that the this study has replicated the findings of Wilson, Bornstein, & Wilson (1988) and Montag & Wilson (1992) which both found that couples group therapy is clinically effective for couples and is statistically better than no-treatment for couples. This study begins to address
the issue of generalizability for a couples group format. This is an important issue in psychotherapy research as it is often the case that one site cannot replicate the findings of another site and so the effectiveness of specific forms of interventions seem dependent on the persons delivering these forms of treatments. Thus, it is encouraging for couples group work that the results of Wilson and colleagues' studies have been replicated by this study.

At this time, it is not possible to determine with much assurance if the ICT group is in fact an improvement over TBCT groups because there are too many uncontrolled variables to be able to make any direct inferences about these comparisons. Some of the confounding variables include: these studies were done at different sites, the therapists were different in each study, and the two approaches were not compared directly with each other.

With the above mentioned cautions in mind, a few comments can be made. The results of this study appear to be fairly equivalent to what Montag & Wilson (1992) reported. These researchers had five couples in the TBCT group and five couples in a wait-list control group. They found that 100% of the couples in the TBCT group improved and 80% met the criteria for alleviation on the DAS. The data from this study also found a 100% improvement rate and had 75% of the couples meet criteria for alleviation on the DAS. Interestingly, Montag and Wilson also had 40% of the control couples improve and 40% met criteria for alleviation on the DAS. This study found that 55% of the control couples improved and 60% met criteria for alleviation on the DAS. In the Montag & Wilson (1992) study, the mean DAS score
at pre-treatment was 89.3 and at post-treatment was 101.7. Thus, TBCT as delivered by Montag and Wilson produced an average DAS change score of 12.4. This study produced an average DAS change score of 17.8. Based upon these data, the ICT group produced results that are at least equivalent with the TBCT groups and may perhaps suggest a slight or modest improvement over the TBCT groups.

Perhaps an even more important test of whether group ICT is more effective than group TBCT will be whether ICT can decrease the relapse rate at follow-up. Hopefully, some of the encouraging preliminary findings by Jacobson and his colleagues concerning the more robust effectiveness of ICT in reducing the relapse rate in conjoint couples therapy will also manifest in a group format of ICT. This will need to be assessed in follow-up work with the current and future samples.

**Generalizability of These Findings**

The issue of generalizability is an important one in all forms of psychotherapy research. The current research was done in Madison, Wisconsin which is a fairly diverse small city with an interesting mix of midwestern European-American population, an African-American population, an Asian-American population, some Native Americans, and a substantial population of Hispanics. In this research sample, the predominant culture was middle class peoples with European-American descent who were heterosexual. One of the group members was Native American, three were Hispanic, and one was Asian. This research needs to be replicated in more diverse
kinds of settings in order to determine if this approach is effective in other cultural and ethnic settings.

With respect to the generalizability issue, it is considered a strength of this research that only two couples were referred to individual couples psychotherapy. With the exception of couples in which significant personality difficulties were evident in one member, this study accepted all couples interested in participating. Although there was most certainly a selection factor at work with the couples who responded to the newspaper advertisements, there is also a selection factor at work with which couples present for traditional conjoint couples therapy. It may be that this research actually solicited for couples who would not otherwise have successfully sought couples therapy, as this approach offered a relatively inexpensive form of couples psychotherapy. Individual and couples psychotherapies can be very expensive. There are an increasing number of people whose health insurance plans will pay only limited amounts of mental health benefits, have plans that will not currently pay for couples work, or who do not have any form of health insurance. Thus, the couples in this study may have been couples who could not afford to obtain traditional couples psychotherapy because of the costs (this was commented on by a number of the group members). In this respect, these couples are similar to couples who might present to a community mental health center. There is another sense in which the issue of generalizability of the results of this study need to be discussed and that is the issue of therapist generalizability. The fact that two of the three co-therapists were very inexperienced couples and group therapists, suggests that this approach may be
effective as delivered by many mental health professionals. The other co-therapist was one of the authors of the treatment manuals and of the research design, but, as a doctoral candidate, also had not had extensive experience doing couples therapy. This would imply that other therapists with limited training could effectively use this approach with couples, as none of the co-therapists in this study had had much time in developing their expertise in the ICT approach. This would seem to speak well of the strengths of this approach. The fact that the ICT group has been manualized will allow for further testing of the generalizability of this approach as delivered by other therapists.

There is a well documented effect in psychotherapy research known as the "allegiance effect". This is the finding that an originator of a particular approach to therapy is often able to demonstrate the effectiveness of that approach, whereas other researchers may have difficulty in being able to replicate the original findings. This research falls prey to some of these potential difficulties. This study was not done by the originators of ICT. This should attenuate the allegiance effect; however, one of the principal investigators and co-authors of the treatment manual was a co-therapist for all of the groups and weekend seminars. This reintroduces some of the difficulties of an allegiance effect. Although the authors of this study are not the creators of Integrative Couples Therapy, they clearly have some investment in this approach. One of the next steps in the development of this line of research will be to use clinicians who are not equivalent to (Marett, 1988) the researchers in a particular study.
The issue of treatment adherence has to do with the question of whether the specified treatment was implemented in a fashion that faithfully represented it (i.e. did the co-therapists deliver ICT in a reliable fashion?). Hopefully, the fact that the treatment was manualized and that each session was clearly and precisely articulated, allowed for a faithful (i.e. representative) implementation of ICT as the authors of the manuals intended. The sessions were all videotaped and so in the future raters can be trained to assess whether the ICT group was adhered to by the co-therapists. As stated previously, testing for co-therapists' adherence to the ICT manual was considered beyond the scope of this doctoral dissertation and will be done in the future.

Methodological Critique

Methodological concerns in couples therapy research present specific issues which need to be addressed (Whisman, Jacobson, Fruzzetti, & Waltz, 1989). Gurman (1971) presented a methodological critique of couples group research which remains apropos to the current research in this area. Marett (1988) proposed that couples group therapy research needs to concern itself with the following methodological issues: the comparison format (the treatment modality as contrasted against an alternative format), sample size, how assignments to groups are made, standardization of treatment, pre and post measures of change, follow-up, multiple vantage points in measuring outcome (observational measures as well as self-report), individual change measures, therapist-investigator non-equivalence, and therapist/couple ratio. In
reference to these methodological concerns, the strengths of this study are: the use of a wait-list control group; matched couples across the ICT group and the wait-list control group; standardization of the treatment; pre and post measures that have excellent psychometric properties and are widely used in the field; and having a therapist/couple ratio of 1:2. The shortcomings of this study are: a relatively small sample size (N=17); follow-up has not yet been accomplished; the use of only self-report data (i.e. no observational data); no use of individual change measures (i.e. assessing individual functioning in areas other than relationship satisfaction); and not having therapist-investigator non-equivalence.

Summary

Integrative Couples Therapy has successfully been adapted to a group format. This research empirically supports ICT as an effective form of couples group therapy. 100% of couples in the ICT group improved on the DAS and 75% improved on the GDS. 75% of ICT couples were alleviated (improved and in the non-distressed range of scores) by the end of the group on the DAS. Sixty percent of eligible couples in the ICT group showed alleviation on the GDS. The ICT couples showed statistically significant improvement in their post-testing scores on the DAS (p < .010) and on the GDS (p < .038), as compared to the wait-list controls. The wait-list control subjects did not show any statistically significant differences between time 1 and time 2 testing. This group followed a manual developed by Wimberly and Waltz and was delivered by relatively inexperienced therapists. This suggests that this treatment might be
successfully given by a range of competent mental health professionals. The results of this research are similar in effect size to what other outcome studies have demonstrated (e.g. Wilson, Bornstein, & Wilson, 1988; Montag & Wilson, 1992) and so provides further evidence for the efficacy of couples group therapy.
References


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Introduction

Couples groups have been a focus for therapeutic interventions since the early 1960's. This manual will describe a group intervention for couples based upon Integrative Couples Therapy (Jacobson & Christensen, 1996). ICT is an extension and reconceptualization of Behavioral Marital Therapy (BMT), which has been recently labeled as Traditional Behavioral Couples Therapy (TBCT). TBCT has been researched more than any other couples therapy approach and has consistently been demonstrated to increase the relationship satisfaction of approximately 50% of couples who participate in this therapeutic modality. However, TBCT is not helpful for a significant proportion of couples. ICT incorporates several distinct therapeutic approaches to couples therapy designed specifically to help the couples who were not able to improve their relationship satisfaction as a result of TBCT.

Integrative Couples Therapy (ICT) is both a continuation and a departure from Traditional Behavioral Couples Therapy (TBCT) (Christensen, Jacobson, & Babcock, 1995). ICT is an attempt to improve traditional behavioral couples therapy by incorporating an emphasis on promoting emotional acceptance into the traditional emphasis on behavioral change. ICT is a dialectical approach which seeks to use both acceptance and change work in promoting relationship satisfaction. Earlier approaches to behavioral couple therapy emphasized change rather than acceptance, ICT is more concerned with having acceptance and change implemented in a balanced fashion (Christensen et al., 1995). Neither is used to the exclusion of the other and either will
be implemented depending on characteristics of the couple (i.e. to what degree can they engage in a collaborative set). ICT asserts that fostering emotional acceptance is an essential step toward improving a couple’s relationship. Acceptance is often used more frequently in the beginning stages of therapy, as this has been found to promote both collaboration and compromise, which are necessary for change strategies to be effective.

The primary assumption which distinguishes ICT from TBCT is the belief, based upon clinical experience and empirical evidence, that not all couples are amenable to change, as it has traditionally been defined. ICT asserts that this inability to change is founded within couples not being able to work collaboratively or to compromise (although, it may also be due to the extent of mismatch or difference in the couple). ICT works to increase each partner’s abilities to collaborate and compromise and seeks to promote intimacy within a relationship by increasing a couple’s ability to more fully understand and accept aspects of their partner or their relationship. Generally, promoting acceptance assists couples in identifying and accepting the aspects of their relationship or their partner which are unlikely to change and encourages them to come to terms with these problem areas. The goal of acceptance work, then, is not to alter the behavior itself, but rather, to alter the experience of this behavior by one or both of the partners. Emotional acceptance requires that the experience of the behavior be shifted from being unacceptable, offensive, or blameworthy to that of being tolerable, desirable, or appreciated (Christensen, Jacobson, & Babcock, 1995). Emotional acceptance allows for the
actions of the partner to exist without an active fight to change or alter the particular behavior.

A primary technique used in ICT to promote acceptance within a relationship is that of facilitating the expression of "soft" emotions, as distinguished from "hard" emotions. Hard emotions are those such as anger, resentment, frustration, and intolerance. The expression of hard emotions generally puts the listener in a defensive position. Soft emotions, however, express feelings which are thought to underlie those of the harder emotions. Soft emotions include: hurt, fear, insecurity, vulnerability, pain, caring, love, disappointment, sadness, worry, anxiousness, fear of partner leaving, and feeling bad about oneself. Soft emotions generally convey a sense of vulnerability within the speaker, and the listener is less likely to become defensive in hearing the expression of softer emotions versus hard emotions.

ICT asserts that it is through the promotion of intimacy that relationship impasses can be worked through, or at the least that they can be accepted with minimal discomfort. The expression of soft emotions allows for intimacy within a relationship and it is this intimacy which can create a safe environment in which partners can feel close to each other despite some significant differences between them. ICT also maintains that as each partner has increased contact with the softer emotions of the other and has decreased exposure to anger and hostility, then the negative interactions between the partners will begin to decrease and softer emotional expression will increase. For example, Cynthia had received a call from a male co-worker asking her if she wanted to go to see a movie. This made her husband, Jim,
very jealous and he became quite angry and began to express anger at Cynthia. Initially, Cynthia responded by defending herself and became angry at Jim because of his accusations. This cycle of attacking and defending would have continued except that Cynthia remembered that a former girlfriend of Jim's had cheated on him and she asked if he was feeling scared or vulnerable in their relationship. Jim was able to pause and come to see that underneath his jealousy and anger was the feeling that he was frightened that their relationship might not be secure and that he was very scared about this. Jim's ability to shift to expressing these softer emotions altered the trajectory of this situation and allowed both Cynthia and himself to more fully understand what was affecting his reaction to this phone call.

A second major component of the ICT approach is to assist partners in creating some emotional distance from their problems. Most distressed couples blame their partners and believe that their partners are responsible for many of the problems which exist in their relationship. People tend to believe that if only her or his partner would somehow change, then the problem would vanish. ICT attempts to alter this view of the problem from that of having the problem reside in the other to being able to view the problem as a result of having a mismatch in values, beliefs, or wants. Thus, ICT seeks to have the partners come to be able to view the problem as a problem within the relationship, rather than within the partner. For example, Susan was raised to value saving money for a rainy day. David was also raised in a household that did not have very much surplus money. However, he enjoys spending the money that he works very hard to earn, as he was never able to have many of the
things that he wanted as a child and young adult. This has caused a great deal of
friction between Susan and David. She feels that he is irresponsible with their money
and he feels that he cannot spend any of their money without a big fight with Susan.
Both are very displeased with this situation. ICT seeks to change their views of the
problem from "you spend too much money" (Susan) and "you are a miser" (David) to
"the problem is that we have different feelings and beliefs about how to manage our
money, we together, have this problem". This will allow for an ontological shift in
how this problem area shows up for this couple. It is this ability to shift the problem
area from that residing in the other to that of being mutually held outside of the other
person which ICT strives for.

This ontological shift also helps to create emotional distance from the problem.
This emotional distance is arrived at through a technique called "detachment". Detachment
refers to the process of helping the couple learn how to discuss a problem
from a collaborative stance, rather than engaging in the problem directly. This
technique involves having the couple identify the problem as an entity which exists
separately from their partner (i.e. we have this problem of having differing values
regarding money). This position allows the couple to gain some distance from the
problem and thus to have more room with which to work through the problem. That
is, that the problem can be experienced as something apart from the couple (i.e. is
believed that the cause of the problem does not somehow reside solely in the partner)
and thus is thought to foster the couple's ability to experience the problem as
something that they both can work on. In this manner, detachment fosters a
collaborative set within a couple.

A third important element of ICT is that of theme identification. In TBCT, couples are taught skills with which they solve various specific problems in their relationship and, hopefully, these skills will generalize to other problem-solving situations. In ICT, couples are taught to view their problems as instances of recurring themes in their relationship. ICT maintains that the ability to view a specific instance of a problem as a manifestation of a recurrent kind of interpersonal interaction, will increase the couples' ability to more effectively work from a collaborative stance with respect to that particular relationship difficulty. This is asserted with the assumption that the ability to see a particular problem as an instance of a relationship theme will help the partners to be able to correctly understand their respective parts in the interaction and therefore to be less invested in maintaining their conviction of the other's culpability with respect to that problem. For example, Steve was very close to his two brothers while growing up. He was the middle child of the three and they were very close in age. They played lots of sports together and he came to rely on their friendship and support. Through these relationships with his brothers, he came to value very close relationships in which he spent most of his free time with his partners. Sarah, on the other hand, also had brothers and sisters, but she was the oldest child and was three years older than her nearest sibling. Thus, she came to value solo activities and developed a love for her independence. Understanding these historical factors was very important in helping Sarah and Steve understand their pattern of approach/avoid. Steve would approach Sarah wanting to do something with
her, which sometimes would have Sarah feel that her independence was being threatened. If Steve believed that Sarah was pulling away from him because of not valuing time spent with him, he had a tendency to question whether she still loved him. He would attempt to initiate even more shared activities the more anxious he became. This only served to have Sarah feel that she had to be even more adamant about preserving her independent time, which further exacerbated their cycle. This same approach/avoid cycle was evident in Steve’s feeling abandoned when Sarah wanted to spend time with her friends; Sarah’s feeling pressured by Steve when he sought to increase their intimacy and closeness through sex or spending quality time together; and their difficulty in problem-solving when Steve would approach Sarah with something that he wanted to improve and she would want to avoid, telling him he should make his own decisions. Having both Steve and Sarah be able to clearly see the various manifestations of this theme as it played out in very differing ways in their relationship, allowed for them to be able to more effectively cope with the many ways in which this pattern manifested itself. They could then recognize the pattern for what it was and could avoid having to fight about the individual instances of the approach/avoid interaction.

ICT also seeks to identify and reframe negative interaction patterns in terms of their positive features, especially with respect to historical features in the relationship. For example, with Steve and Sarah, one of the things which initially attracted Sarah to Steve was his closeness with his family and with friends in general. Steve was attracted to Sarah’s independence and how she was able to make so many important
decisions by herself. By being reminded of how these differences were initially aspects of the other that were very attractive to each other, then, when these differences would appear in their relationship, they became significantly more tolerable and able to be accepted and appreciated, rather than something which had to be worked against. ICT also prepares couples for slip-ups or the inevitability of conflict in their relationship, and seeks to promote individual self-care. (Christensen, Jacobson, & Babcock, 1995).

Group Design

This group is designed to be run with up to 4 or 5 couples per group. The couples will be screened and any couples who exhibit current problems with substance abuse, domestic violence, or thought disorder should be referred to appropriate treatments. The group is set up to run for 12 weeks. This group would probably run most optimally with the use of co-therapists, as they will role play and demonstrate many of the basic aspects of ICT. Also, because of the group format and the multiple layers of interactions which follow from a group format, co-therapists are considered to be more optimal than a single therapist in order to make therapeutic use of the various individual and group dynamics which take place.

The next section contains an outline of each of the 12 sessions. Therapists should use this outline as a detailed reference from which to guide the group interventions. Clearly, therapists must use their clinical judgement in deciding when
to explore a particular topic in greater depth than indicated as well as when to abbreviate a section in the best interest of the group.

Co-therapists are directed to role-play a number of skills and behaviors throughout the ICT group. In these role-plays, they should discuss prior to the session how they wish to illustrate the ideas and what specific issues they would like to portray. Co-therapists are encouraged to role-play issues which are germane to the couples in their group. For example, if the co-therapists are directed to role play a situation involving effective and non-effective communication skills they might choose the topic of one partner desiring more intimacy if they know that this is a difficult area for several of the couples.
Session # 1 - Basic Interactional Patterns

1) Introduce co-therapists

2) Have group members introduce themselves
   A) Name
   B) What attracted them to their partner?
   C) Talk about what they wish to accomplish from the group

3) Therapist present information on Group Structure
   A) Rationale for the group
      - Many couples have relationship difficulties
      - Couples often have skills deficits or dysfunctional interactional patterns
   B) How each session will be structured
      - discuss homework
      - group discussions
      - exercises
      - therapist presenting new information
      - role-plays by therapists
      - homework
   C) Guidelines for participation in the group
      - no physical, verbal, or emotional abuse will be allowed either in group or at home
      - be honest and candid
      - active participation
      - apply what you learn/do homework
      - all information about group members discussed in group is strictly confidential
      - should you or your partner have issues which you need to discuss with the group leaders, please do not hesitate to do so
4) Therapist present information on common interactional patterns and themes in relationships (with the intention of letting couples know that their needs will be met through this group, i.e. that this group will benefit the couple and that the therapist understand some of the problem areas of the participating couples)

A) Approach/Avoid
B) Approach/Approach
C) Avoid/Avoid

- give an example of Approach/Avoid with a particular couple

- Janet and Chris -

Chris has recently been unhappy about their sex life. He has brought this up for discussion on numerous occasions, but without any real change in the things that he is wanting. Janet is very embarrassed talking about their sex life and so reluctantly agrees with Chris so that she can avoid having to talk about sex any longer. The more that Chris brings this up, the more that Janet wants to avoid this topic. The more that Janet tries to avoid talking about their sex life, the more frustrated Chris feels and so he wants to work this out by talking about it. And the cycle continues to get worse. Chris has now become more upset, because he now believes that Janet is consciously trying to not do what he enjoys in bed to make him mad. Janet is aware of Chris's rising resentment, but is unable to address this issue any more directly. They continue down this path until both are very resentful at the other and the discussion almost never comes up anymore.

- clarify the day to day ways in which this pattern manifests itself (i.e. give other examples of Approach/Avoid)

- talking about any problem area
- intimacy/emotional expression
- communication

5) Presentation of video which portrays these different styles
   - Introduce Cynthia and Jim, the actors

6) Group discussion of the video
   - What style matches your relationship?
   - How does ___ pattern get Cynthia and Jim in trouble?
7) Therapists lead discussion about the inevitability of having differences in a relationship

A) start discussion about the inevitability of differences
B) debunk the myth that differences are "bad"
C) conflict as a natural product of differences in a relationship
D) differences cannot be avoided in a relationship
E) conflict does not mean failure in a relationship

Main Point - the question is not whether you will have differences in your relationships (you will), the question is really how you will choose to deal with and understand the differences that will inevitably show up in your relationship.

8) Homework

A) hand out homework sheet
B) let the group know that we will be discussing this material in depth next week
C) empower group members to spend some time working on the Homework
D) you get what you put into this
Session # 2 - Soft and Hard Emotions

1) Group Discussion of the homework (themes/patterns that couples have noticed in their particular relationship)

   - make sure that each couple is as clear as possible of the patterns operating in their relationship

2) Discussion of noticing when these patterns are occurring

   A) Noticing the pattern is the first step in being able to change the pattern

   B) Want to notice as early in the interactional sequence as possible - so that can stop and do something different

   C) Noticing these patterns allows you to be able to step out of the pattern and then to do something new, and hopefully more successful

   D) Over the course of the group, we will help you to identify when these patterns are occurring, and what you can do instead that will allow you to have more satisfying relationships

3) Therapist present information on Soft vs. Hard Emotions

   A) Lack of awareness of our emotional state contributes to relationship difficulties

      - give an example

   B) Examples of hard/soft emotions

      **hard** - anger, resentment, frustration, intolerance, pissed off

      **soft** - hurt, fear, insecurity, vulnerability, pain, caring, love, afraid, disappointed, sad, worried, anxious, fear of partner leaving, feeling bad about oneself

   C) hard emotions put our partners on the defensive and soft emotions allow our partners to hear and understand why it is that we are reacting in a particular way
4) Present Role-Play - Soft and Hard Emotions

- instruct participants to look for how:

A) lack of awareness of emotions and expression of harder emotions (limited awareness of underlying emotions) and how this may promote misunderstanding

B) aware of own deeper/softer emotions (full range of emotions) and how this facilitates understanding and intimacy

5) Group Discussion

- Can any couples see some areas that they are expressing the harder emotions and have some awareness of there being softer/deeper emotions available?

6) Exercise

- Pass out Emotion Checklist to each member
- have each person share with the group some of the softer emotions that are particularly hard for them to express
- What kinds of patterns can they see?

7) Homework - hand out homework sheets

- notice what emotions you have during the next week
- which emotions are easier/harder to be with?
- which emotions come up most when you are communicating well with your partner?
- which emotions come up most when you are arguing/fighting with your partner?
- as usual, we will be discussing this homework at the beginning of our next session
- what would stop you from completing this Homework?
- have couples schedule the three nights that they are to discuss their feelings. Have them be very specific about when they will do this.
Session # 3 - Emotional Expression (continued)

Note: This session is a continuation of last session in wanting to develop couple's awareness and expression of soft/hard emotions

1) Discuss homework
   - Focus on times when softer emotions were expressed
   - What was this like for couples?

2) Therapist present information on modeling and family of origin issues.
   - The main point is to illustrate how we learn how to relate with others through what we learn in our families. Work on family of origin history and how this has affected emotional expression in couple's relationship

3) Therapists interview each other about the history of emotional expression in their family and in their current relationship.
   - How was emotion expressed in your family?
   - What emotions were ok/not ok to express?
   - How are you like your Mother/Father/Significant family member with respect to your emotional expression?
   - How did you decide to be different from your Mother/Father/significant family member with respect to your emotional expression?
   - How has emotional expression evolved in your relationship?
   - What hard emotions do you currently express?
   - What soft emotions do you currently express?
   - What soft emotions do you have that you need to be able to express more with your partner?

4) Exercise
   - Hand out Exercise sheet to group members
   - Have each partner interview the other partner using the exercise questions
   - Therapists should move around and assist the couples with this exercise.
5) Group Discussion - Cover the following topics

- What did group members get out of this exercise?
- What insights did people have about their emotional expression?
- What stops people from expressing their softer emotions?

6) Group Discussion

- lead discussion designed to increase each partner's understanding of how his/her partner experiences emotions and what is hard for them about emotional expression, especially expressing softer emotions

7) Hand out homework sheets
Exercise For Session #3

Directions

Each couple is to interview each other (or another couple) and ask each of the following questions. Make sure that each question is answered as fully as possible.

1) How was emotion expressed in your family?

2) What emotions were ok/not ok to express?

3) How are you like your Mother/Father/significant family member (choose the most important one) with respect to your emotional expression?

4) How did you decide to be different from your Mother/Father/significant family member with respect to your emotional expression?

5) How has emotional expression evolved in your current relationship?

6) What hard emotions do you currently express?

7) What soft emotions do you currently express?

8) What soft emotions do you have that you need to be able to express more with your partner?
Session # 4 - Communication Training

1) Homework Discussion

2) Therapist present information on Communication Skills

   A) "I statements"
   - not a sophisticated cover for blaming other (give example "I feel that you are jerk!")
   - importance of emotional expression for satisfying relationships

   B) Paraphrasing
   - active listening (not preparing rebuttals) so that you insure that you understood your partner

   C) Check with partner that understood correctly

3) Present role-play of effective/non-effective communication skills

4) Group Exercise with active coaching by therapists

   - have each couple practice communication skills with the therapists giving constructive feedback
   - topic - talk about your day

5) Group discussion of the exercise

   - What did you notice about your communication skills?
   - What worked/did not work for you in talking with your partner?
   - What was helpful to you about this exercise?

6) If have time, have couples pair with another couple and do the communication skills practicing again

   - Again, have the co-therapist consult with couples and offer advice about better communication

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7) Hand out Homework sheet

- set up a time in which you will practice communication skills at least twice this next week - decide on the times now
- communication skills are like a muscle, you must use them in order to make them stronger
- good communication skills are essential for a satisfying relationship
Session # 5 - Having Differences

Note: This session is also meant to continue having the group members practice and develop the communication skills.

1) Discuss homework

2) Therapist present information on the naturalness of having differences in our relationships

   A) differences will occur in all relationships
   B) the bottom line is how you will handle having differences, not whether or not they will occur (they will)

3) Therapists model a situation in which they have differences with each other

   A) first time, they are more angry at each other and disagreeing about the issue
   B) second time, therapists should model having more understanding and accepting of having differences

4) Group Discussion

   A) What are some of the differences which you have with your partner?

   B) Facilitate group members increasing their understanding of why they differ from their partners

       - How can these differences be better understood?
       - We have a difference in ______. How can I better understand this difference?
       - What kind of rationale or experiences would my partner have to have in order to believe/do this?
       - therapists can use the following to facilitate increasing the couple’s understandings

           - historical factors (learning history)
           - differing preferences
           - reframe in terms of what initially attracted one partner to the other
           - reframe difference in terms of difference is partner’s way of wanting to contribute to the relationship
5) Exercise

Note: There are 3 options for this exercise (based on what the therapist believes will be most effective)

A) have the therapists work with one couple while the other couples observe
B) have the couples pair up with another couple and one couple will observe the other
C) have each couple do this exercise by themselves

1) Each couple is to spend some time identifying some of their major differences which cause them problems.
2) After identifying these differences, each partner is to state their understanding of why their partner feels/believes differently about the issue.

• The partner doesn’t have to agree with the perspective of their partner, they only must understand it.

6) Group Discussion

A) What has this exercise opened up for individuals in the group?
   - How has your understanding of your differences with your partner shifted?
   - How does your changed understanding of differences allow for a different kind of interaction with your partner?

B) Will you and your partner have differences in the future?
   - Yes, obviously - the point is to accept this fully so that differences can be experienced as a normal part of relationships, rather than as an area of conflict.

7) Communication Exercise

- Have each couple practice their communication skills
- the topic can be talking about some interesting event that has happened in the past and how they felt about this event
8) Hand out homework sheet

- Are any couples having difficulty following through with the homeworks?
- Address this if necessary.
- Have couples schedule and agree on when they are going to do the homework.
Session # 6 - Problem Solving

Note: Continue having group members practice their communication skills.

1) Discuss homework

2) Group leaders present information on problem solving

   A) Have group members discuss the differences between:

   1) arguing
   2) problem solving

   B) Have group members brainstorm the steps to effective problem solving while co-therapist writes these on a black board or easel. Assist as necessary.

   Steps
   1) define the problem
   2) brainstorming
   3) choosing among solutions
   4) evaluate costs/benefits of each solution
   5) implementing the solution
   6) assessing the solution
   7) updating the solution

   C) Have group members brainstorm helpful guidelines for when they are problem-solving

   Guidelines
   - only one problem at a time
   - discuss only your own view
   - paraphrase your partner
   - avoid inferences about partner’s view
   - focus on finding a solution
   - be willing to collaborate and compromise (i.e. give some)
   - is not arguing
3) Presentation of Role-play on problems solving

- Therapist can stop the tape when Cynthia and Jim make problem solving pitfalls and have the group identify and discuss what just occurred and how that would interfere with effective problem solving

4) Group discussion - Ineffective problem solving

A) What gets in the way of your effective problem solving? Make sure that the group discusses the following pitfalls to communication/problem solving

- sidetracking
- bringing in old material or arguments
- blaming
- being defensive
- denying the problem
- bringing in other problems

5) Exercise

- Therapists should make sure to assist all of the couples with this exercise with coaching and feedback
- Have each couple problem solve an "easy" problem

6) Group Discussion

- What worked well with the problem solving skills?
- What did you have difficulty with in this exercise?

7) Hand out homework sheet

- Hand out problem solving easy reference sheet
- have each couple identify and agree on two problems that they will use to practice these skills on in the next week
- have each couple agree on what days and times that they will do this assignment (this can be a problem solving exercise)
Session # 7 - Negotiating/Accommodating Differences

1) Discuss Homework

2) Therapist present material about inevitability of conflict in relationships
   
   A) Who here would prefer that they not have any conflict in their relationship? (wait for response from group members)
   
   - Is this a realistic goal?
   - Is this actually possible?

   B) The inevitability of Conflict
   
   - Is conflict inevitable in relationships?

   C) Conflict as a normal part of relationships and a result of having natural differences

   D) As with differences, the question is not whether you will have conflict in your relationships (you will), but rather how you will handle the conflict that will arise in your relationship

3) Group Discussion

   A) What are some common themes that group members get into conflict about? (wait for group members to respond and make sure that they discuss all of the following areas)

   - closeness/independence
   - responsibility/authority to make decisions
   - child rearing/discipline practices
   - how to spend time together
   - recreation
   - intimacy
   - sex
   - money
B) What has to be done in order to work through conflict (wait for group response)?

- Answer - communicate with each other
- is essential for each of you to accommodate/negotiate with each other allows you to work through conflict without hurting each other

4) Therapist present information on Conflict

A) Conflict - 3 important aspects:

1) Content area

- what the conflict is about
- the topic
- i.e. sex, housework, time together, kids, money

2) Process in areas of conflict

- process as how you talk about the issue or content
- how there may be significant areas of conflict which reside "underneath" the content issue

3) Themes

- themes are patterns or core areas of conflict which cut across several differing content areas
- they may not be obvious in a specific content area
- they exist just "underneath" the surface content

B) Give examples of themes in conflicts

- needing to feel loved
- feeling like a good person
- feeling respected
- fear of abandonment
- fear of rejection
- differences in desired levels of intimacy
- needing to feel trust in the relationship

C) give an example of how the topic (content) may not match the underlying theme in the conflict
5) Present the role-play which illustrates some conflicts

Note: After each vignette, stop the role-play and discuss the following:

A) What was the content area of each scenario?
B) What was the underlying theme in each scenario?
C) How would you describe the process or manner of working through conflicts?

6) Hand out Homework sheet
Session # 8 - Acceptance vs. Change

1) Discuss homework

2) Present Role-play on Acceptance and Change

3) Therapist should be familiar with the following information on Acceptance vs. Change and be able to bring these ideas into the discussions about the role-play.

   A) We all want to change some aspects of our partners/relationship - this is natural

       1) We would prefer that he/she spends more time with us, does more of the housework, does sex differently/more/less frequently, was more independent, less talkative, more talkative, was more helpful doing _____, etc.

       2) after we have asked/begged/argued with our partners to change and they do not we often assume that:

           a) they don't care for me
           b) they don't love me
           c) the relationship isn't that important to them because they haven't hanged

   B) What if our partner/relationship hasn't changed despite our best efforts?

       1) one approach is to keep trying to change them
       2) we could give up and resign yourself to the situation
       3) or we could try to really understand the situation

   C) Understanding the situation/partner

       1) leads to increasing one's ability to accept what's so in a relationship
       2) often (paradoxically) leads to allowing the partner to change more easily

4) Discuss role-play bringing in information from 3) above as is helpful.
5) Exercise - Prepare group members for the difficulty involved with this exercise. Understanding and accepting are very difficult behaviors to do and so you’ll need some patience. Don’t expect too much initially.

- Therapists are to actively coach couples in this exercise.
- Have the couples pair up (or work singly, depending on the therapists’ sense of what will be more effective) and have one couple discuss an area in which one of the partners is wanting the other to change.

A) First, have one partner choose something that they need to gain more understanding about

B) Have this same person ask their partner questions in a way that helps them understand why their partner does what he/she does

C) The partner talks about their experiences and beliefs in order to increase the other's understanding

D) Have the first partner state their understanding and repeat this to their partner and check if it is "correct" with their partner, until they get it right

E) Have therapists give their observations and feedback

6) Group Discussion

A) Have the group process what this exercise was like for them

B) How have each of the group members wanted to change their relationships/partners?
7) Group discussion

A) What is acceptance? Therapists make sure that some kind of understanding of the below is had by the group members

- psychological acceptance involves experiencing events fully and without defense or judgement
- acceptance does not mean "approve of" or condone in any way
- acceptance is not just a tolerance or resignation to something
- acceptance - involves the deliberate abandonment of a change agenda in situations in which this agenda does not work
- involves emotional or social willingness - to be open to the experience of others or oneself

B) What is the best way to promote acceptance in your relationships?

Make sure that the group fully understands that understanding is the key to being able to accept difficult things about a relationship. Also that understanding is not liking or wanting it that way, it's just understanding what is so for their partner, given their history or beliefs about something

C) How would each actually accomplish accepting _____ in their partner?

D) What would accepting _____ mean to your partner?

8) Group Discussion

A) What to do instead of fixing/changing other?

- meet own needs in other ways

B) Have group members discuss what they can do to fulfill their own needs rather than insisting on change from their partner

9) Hand out homework sheet
Session # 9 - More on Acceptance

Note: This session is really a continuation of accepting vs. change. Direct the discussions and exercises with this in mind, working to continue to develop the ability to accept in the partners

1) Discuss homework

2) Group Discussion

A) Getting what we want from our partners

- How do you attempt to get what you want from your partner?
- What things do you do to get what you want?

- do these work?
- how does your partner react?

B) How does your partner attempt to get what he/she wants from you?

- What things does your partner do to get what they want from you?
- How do you react when your partner does these things?

C) How does your partner's wanting what they want from you make sense? Why would they want that from you?
3) Group Exercise

Note: As in previous exercises, the therapist can begin this exercise at any of the following three levels:

A) Therapists model the exercise.
B) Therapists work with one couple and models for the group
C) Couples do the exercise with active therapist coaching

1) Other ways to get your needs met

a) Couples are to work on how to ask directly for what they want.
b) Have each partner pick something not too threatening and practice:

1) Describing feelings around the behavior (i.e. “I would really feel good about it if you could help around the house more”)
2) Not a demand - have to be able to be ok with non-compliance
3) Express appreciation for approximations of the behavior (i.e. really appreciate your putting the kids to bed last night, that made me feel good. Could you also help me in getting them ready for school?)
4) Partner receiving request can also practice paraphrasing and responding responsibly and assertively (i.e. not agreeing to do things that they cannot follow through on).

c) Have group members discuss how they might get these needs met by other friends/family/or self if partner is unable or unwilling to comply with requests.
4) Group Discussion

A) How does today's session relate to the work we did on accepting vs. change last week?

B) Make sure that the couples have the tools to be able to ask directly for what they want, and when their partner is unwilling or unable to meet their needs, that couples can increase their understanding of the other so as to increase their ability to accept certain aspects of the other/relationship.

C) What changes have you noticed in the last week that may have to do with accepting in your relationship?

5) Hand out homework
Session # 10 - Intimacy

1) Discuss homework

2) Group Discussion - Intimacy

A) What is intimacy?
   - feeling close to our partner
   - feeling an emotional connection
   - importance of being vulnerable
   - importance of emotional expression and sharing

B) What makes you feel close/intimate with your partner? (Make sure that the group covers and discusses the following)
   1) self-disclosure/being vulnerable
   2) expressing emotions (softer)
   3) time together/shared experiences

C) What does being intimate require from each partner?

D) What is your biggest personal hurdle in being intimate?

E) What fears do you have around being intimate?

F) What is the cost of not having as much intimacy as you would like in your relationship?

3) Present role-play on intimacy
   - Therapists can stop the role-play during the vignettes and ask the group what is hindering/helping Jim and Cynthia being intimate.
4) Exercise - therapist should work with various couples, actively facilitating this exercise

- Have each couple practice being intimate (feeling close or connected) with each other.
- Each person is to discuss something personal about themselves which makes them feel vulnerable, or is currently stressful, or they are concerned about, or afraid of, or worried about, etc.
- Each person can disclose at a level they are comfortable with.

5) Group discussion of above exercise

A) What did this exercise bring up for people?

B) What was it like to be intimate?

C) What was it like to be with your partner when she/he was being intimate?

6) Hand out homework sheet

- Therapist have couples schedule their homework activities.
Session # 11 - Intimacy

1) Discuss homework
   - Spend considerable time in processing the couples attempts at being intimate this last week.
   - What worked for them?
   - What hindered them?

2) Exercise - same as in last session. Therapist should work with various couples in this exercise.
   - Have each couple practice being intimate (feeling close or connected) with each other.
   - Each person is to discuss something personal about themselves which makes them feel vulnerable, or is currently stressful, or they are concerned about, or afraid of, or worried about, etc.
   - Each person can disclose at a level they are comfortable with.

3) Group Discussion
   - Process the exercise
   - Continue to develop couples ability to be intimate with each other

4) Group discussion
   A) What kind of emotions (i.e. soft vs. hard) facilitate being intimate?
   B) Is wanting to change your partner helpful in promoting intimacy? Why not?
   C) How does having an accepting stance help/hinder intimacy?

5) Hand out homework
   - discuss termination issues (see homework)
Session # 12 - Consolidating Gains and Relapse Prevention

1) Group Discussion of termination issues
   (Therapists should insure that each member participates in this discussion.)
   
   A) What did you get out of this group?
   B) What was learned?
   C) What are the areas that you still need to work on?
   D) What improvements were made in your relationship?

2) Group discussion of couples issues
   (Therapist should insure that each member participates in this discussion.)
   
   A) How will you know when your relationship is going well?
   B) How will you know if you might need some help with your relationship? What would the signs be for you to do some more couples work?

3) Group discussion - How to improve the group
   
   A) What was most helpful to you about this group?
   B) What suggestions for improving this group do you have?
   C) What did you find in the group that was not helpful to you?
4) Group Discussion - Relapse Prevention

A) Do you expect that you will have relationship challenges in the future?
   - of course, the question is not really whether difficulties will come up, rather, it's how the couples will be able to handle them

B) Discuss "lapses" vs. "relapses" in relationship functioning.

C) What will help you to use the skills that you have developed in this group?

5) Exercise - Saying Goodbye

A) Have each member of the group (including the therapists) say what his/her hopes and concerns/fears are for each of the other couples.
Appendix B
ICT Group Homework
Homework for Session # 2

1) Which pattern(s) do you believe best describe(s) the interactions that you and your partner most fall into?

   - approach/avoid
   - approach/approach
   - avoid/avoid

2) Please give some examples of the times when you have found yourself in one of the above patterns.

3) When you and your partner are in one of the patterns:

   A) What are you feeling?

   B) What do you think your partner is feeling?
4) Notice times during this next week when you and your partner have an argument that reflects one of these patterns. Record at least 2 of the times in this table.

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<tr>
<th>Date</th>
<th>Pattern</th>
<th>Your Feelings</th>
<th>Partner Feelings</th>
</tr>
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Homework for Session # 3

1) How do you express anger or frustration at your partner?

2) Think of a recent time when you felt angry or frustrated, what other emotions were you feeling (for example: hurt, scared, sad, abandoned, fearful, vulnerable). Describe this time and the underlying emotions.

3) How do you feel when your partner is angry or frustrated at you?

4) How do you react or feel when your partner is sad, afraid, hurt, or being vulnerable?
5) Schedule with your partner **three nights** this week to discuss what feelings you had during the day with your partner. Each partner is to describe as many feelings as they felt that day to the other. Please be prepared to discuss how this went in the next group.
Homework For Session # 4

1) How was emotion expressed in your family? Who expressed it?

2) Did your family express hard emotions, soft emotions, both?

3) How has your history with your family of origin affected how you express your emotions and which emotions you do express?

4) How would you like to shift how you express emotions to your partner?
5) How would you like your partner to shift how she/he expresses her/his emotions to you?

6) This week, spend at least one time expressing at least one of the softer emotions which may be difficult for you. For example, you could talk to your partner about a time when you felt scared, or hurt, or sad, or worried, or vulnerable about something. Be ready to talk about this experience in the next group session.
Homework for Session # 5

1) Your assignment this week is to practice using the communication skills at least twice. Please actually schedule two times with your partner (for example Monday night at 9 p.m.). Of course you can use these skills any time during the week.

   A) The basic model is:

   1) Speaker speaks
      Listener listens

   2) Listener paraphrases back to Speaker

   3) Listener checks with the Speaker to make sure that the message was fully understood

   4) Speaker makes any subtractions or additions to the message that the Listener received

   B) Use "I" statements

      - I feel _____ when you do _____.

• You can discuss some neutral topics like areas that interest you, or you could talk about what you did that day.

• Use paraphrasing and check with the speaker that you understood the communication correctly, ask for clarification if you did not understand the communication.
Homework for Session # 6

1) At least 3 times this next week, describe what feelings you had during the day to your partner. Schedule these times in advance with your partner. Your partner is to listen carefully and say back to you what you said. Make sure that they understood correctly and gently correct any misunderstandings they might have. Be prepared to discuss this exercise in the next group.
Homework for Session # 7

1) This week you and your partner are to set aside two times when you can practice problem solving. Agree with your partner when you will do this. Decide what problems you would like to work on. It would be easier if you were to work on some of the easier problems in your relationship first.

2) What worked well about your problem solving strategies?

3) What could you improve about your problem solving?

4) Where did you and your partner get into trouble in using problem solving?

5) Be ready to discuss your experiences with the group.
**Problem Solving Worksheet**

**Guidelines**
- only one problem at a time
- discuss only your own view
- paraphrase your partner
- avoid inferences about partner’s view
- focus on finding a solution
- be willing to collaborate and compromise (i.e. give some)
- is not arguing

**Problem Solving**
1) define the problem
   - agree on what the problem is
   - be very specific
2) brainstorming
   - make a list of all possible solutions, no matter how far fetched they may seem
3) evaluate all of the solutions. Do a cost/benefit analysis on each solution.
4) choose one (or a combination) of the solutions
5) implement the solution
6) assess the solution
   - was it a satisfactory solution?
7) update the solution

**Things to avoid:**
- sidetracking - bringing in other issues
- bringing in lots of examples
- blaming
- being defensive
- denying the problem
- bringing in other problems
- making inferences (i.e. mindreading) about what your partner is thinking, believing, or feeling
Homework for Session # 8

1) This week you are to again practice the problem solving skills. This week you and your partner are to set aside two times (please actually schedule these times with your partner) when you can practice problem solving. Decide what problems you would like to work on. It would be easier if you were to work on some of the easier problems in your relationship first.

2) What worked well about your problem solving strategies?

3) What could you improve about your problem solving?

4) Where did you and your partner get into trouble in using problem solving?

5) What roles do hard and soft emotions play in your problem-solving?
6) What are your beliefs about conflict and what they mean about your relationship? For example, if you get in an argument with your partner do you ever think that that means that the relationship isn’t working well?
Homework for Session # 9

1) What things do you do to try and get your partner to change?

2) What effect does trying to change your partner have on him/her?

3) Schedule at least one opportunity this week to set down with your partner and try to more fully understand what you’d like to change about them. Don’t try to change this, just understand it better. Use your communication skills in this exercise.
Homework for Session # 10

1) Your homework this week is to schedule some time with your partner to do something that you both enjoy. This is to be some special time for you and your partner to spend together doing something that you both like.

2) Please be ready to discuss how your enjoyable activity went with your partner.
Homework for Session # 11

1) Schedule **two things** with your partner that have you feel close or connected with them, and share a little more than you might usually.
   
   - be ready to share your activities with the group

2) What was easy/hard about what you did to be close with your partner?

3) What gets in the way of being intimate in your relationship?
4) What fears do you have about being intimate?

5) How did your parents express intimacy and what did you learn about being intimate from watching them?
Homework for Session #12

1) Do 2 things that continue to promote intimacy with your partner this week. Be ready to discuss what you did in the next session.

2) What improvements have you noticed in your relationship?

3) What areas do you still need to work on?
4) How will you know if you might need some help with your relationship? What would the signs be for you to do some more couples work?

5) Consider what feedback you would like to give to the other group members.
   - How have they been helpful to you?
   - What parting words would you like to give?
   - What are your concerns for the others?
   - What are your wishes for the other couples?
ICT Weekend Seminar Manual
Manual for the Weekend Seminar

Time framework for each day

9:00 - 10:45 session
10:45 - 11:00 break
11:00 - 12:30 session
12:30 - 1:30 lunch
1:30 - 3:15 session
3:15 - 3:30 break
3:30 - 5:00 session

Session # 1 - Basic Interactional Patterns

1) Introduce co-therapists

2) Have group members introduce themselves
   A) Name
   B) What attracted them to their partner?
   C) Talk about what they wish to accomplish from the group

3) Therapist present information on Group Structure
   A) Rationale for the group
      - many couples have relationship difficulties
      - often have skills deficits or dysfunctional interactional patterns
   B) How each session will be structured
      - group discussions
      - exercises
      - therapist presenting new information
      - role-play presentations
   C) Guidelines for participation in the group
      - no physical, verbal, or emotional abuse will be allowed either in group or at home
      - be honest and candid
      - active participation
      - apply what you learn
      - all information about group members discussed in group is strictly
confidential
- should you or your partner have issues which you need to discuss with the
group leaders, please do not hesitate to do so

4) Therapist present information on common interactional patterns and themes in
relationships (with the intention of letting couples know that their needs will be met
through this group, i.e. that this group will benefit the couple and that the therapist
understand some of the problem areas of the participating couples)

A) Approach/Avoid
B) Approach/Approach
C) Avoid/Avoid

- give an example of Approach/Avoid with a particular couple

- Janet and Chris -
  Chris has recently been unhappy about their sex life. He has brought this
up for discussion on numerous occasions, but without any real change in the
things that he is wanting. Janet is very embarrassed talking about their sex
life and so reluctantly agrees with Chris so that she can avoid having to talk
about sex any longer. The more that Chris brings this up, the more that
Janet wants to avoid this topic. The more that Janet tries to avoid talking
about their sex life, the more frustrated Chris feels and so he wants to work
this out by talking about it. And the cycle continues to get worse. Chris
has now become more upset, because he now believes that Janet is
consciously trying to not do what he enjoys in bed to make him mad. Janet
is aware of Chris's rising resentment, but is unable to address this issue any
more directly. They continue down this path until both are very resentful at
the other and the discussion almost never comes up anymore.

- clarify the day to day ways in which this pattern manifests itself (i.e. give other
examples of Approach/Avoid)
  - talking about any problem area
  - intimacy/emotional expression
  - communication

5) Presentation of video which portrays these different styles
  - Introduce Kristen and Bob, the actors

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6) Group discussion of the video
   - What style matches your relationship?
   - How does ____ pattern get Kristen and Bob in trouble?

7) Therapists lead discussion about the inevitability of having differences in a relationship

   A) start discussion about the inevitability of differences
   B) debunk the myth that differences are "bad"
   C) conflict as a natural product of differences in a relationship
   D) differences cannot be avoided in a relationship
   E) conflict does not mean failure in a relationship

**Main Point**- the question is not whether you will have differences in your relationships (you will), the question is really how you will choose to deal with and understand the differences that will inevitably show up in your relationship.
Session # 2 - Soft and Hard Emotions

2) Discussion of noticing when these patterns are occurring - How to Change the Patterns?

   A) Noticing the pattern is the first step in being able to change the pattern

   B) Want to notice as early in the interactional sequence as possible - so that can stop and do something different

   C) Noticing these patterns allows you to be able to step out of the pattern and then to do something new, and hopefully more successful

   D) Over the course of the group, we will help you to identify when these patterns are occurring, and what you can do instead that will allow you to have more satisfying relationships

3) Therapist present information on Soft vs. Hard Emotions

   A) Lack of awareness of our emotional state contributes to relationship difficulties - give an example

   B) Examples of hard/soft emotions

      hard - anger, resentment, frustration, intolerance, pissed off

      soft - hurt, fear, insecurity, vulnerability, pain, caring, love, afraid, disappointed, sad, worried, anxious, fear of partner leaving, feeling bad about oneself

   C) hard emotions put our partners on the defensive

      soft emotions allow our partners to hear and understand why it is that we are reacting in a particular way
4) Role Play - Soft and Hard Emotions

- instruct participants to look for how:

  A) lack of awareness of emotions and expression of harder emotions (limited awareness of underlying emotions) and how this may promote misunderstanding

  B) aware of own deeper/softer emotions (full range of emotions) and how this facilitates understanding and intimacy

5) Group Discussion

- What did the group notice about the role-play?

6) Exercise

- Pass out Emotion Checklist to each member
- have each person share with the group some of the softer emotions that are particularly hard for them to express
- What kinds of patterns can they see?
Session # 3 - Emotional Expression (continued)

Note: This session is a continuation of last session in wanting to develop couple’s awareness and expression of soft/hard emotions

1) Therapist present information on modelling and family of origin issues.

   A) the main point is to illustrate how we learn how to relate with others through what we learn in our families. Work on family of origin history and how this has affected emotional expression in couple’s relationship

2) Therapists interview a couple (or each other depending on how well they believe the group can accomplish this) about the history of emotional expression in their family and in their current relationship

   - How was emotion expressed in your family?
   - What emotions were ok/not ok to express?
   - How are you like your Mother/Father/Significant family member with respect to your emotional expression?
   - How did you decide to be different from your Mother/Father/significant family member with respect to your emotional expression?
   - How has emotional expression evolved in your relationship?

   - What hard emotions do you currently express?
   - What soft emotions do you currently express?
   - What soft emotions do you have that you need to be able to express more with your partner?

3) Exercise

   - Hand out Exercise sheet to group members
   - Have each partner interview the other partner and interview each other using the Exercise questions
4) Group Discussion - Cover the following topics

- What did group members get out of this exercise?
- What insights did people have about their emotional expression?
- What stops people from expressing their softer emotions?

LUNCH BREAK (12:30 - 1:30)
Exercise For Session #3

Directions

Each couple is to interview each other (or another couple) and ask each of the following questions. Make sure that each question is answered as fully as possible.

1) How was emotion expressed in your family?

2) What emotions were ok/not ok to express?

3) How are you like your Mother/Father/significant family member (choose the most important one) with respect to your emotional expression?

4) How did you decide to be different from your Mother/Father/significant family member with respect to your emotional expression?

5) How has emotional expression evolved in your current relationship?

6) What hard emotions do you currently express?

7) What soft emotions do you currently express?

8) What soft emotions do you have that you need to be able to express more with your partner?
Session # 4 - Communication Training

1) Homework Discussion

2) Therapist present information on Communication Skills

   A) I statements
      - not a sophisticated cover for blaming other (give example "I feel that you are a jerk!")
      - importance of emotional expression

   B) Paraphrasing
      - active listening (not preparing rebuttals) so that you insure that you understood your partner

   C) Check with partner that understood correctly

   D) Speaker "adds to" Listener's understanding

4) Group Exercise with active coaching by therapists

   - have each couple pair with another couple and practice communication skills with the therapists giving constructive feedback

   - topic - talk about your day

5) Group discussion of the exercise

   - What did you notice about your communication skills?
   - What worked/did not work for you in talking with your partner?
   - What was helpful to you about this exercise?
Session # 5 - Having Differences

Note: This session is also meant to continue having the group members practice and develop the communication skills.

2) Therapist present information on the naturalness of having differences in our relationships

   A) differences will occur in all relationships

   B) the bottom line is how you will handle having differences, not whether or not they will occur (they will)

3) Therapists role-play a situation in which they have differences with each other

   A) first time, they are more angry at each other and disagreeing about the issue

   B) second time, therapists should model having more understanding and accepting of having differences

4) Group Discussion

   A) What are some of the differences which you have with your partner?

   B) Facilitate group members increasing their understanding of why they differ from their partners

      - How can these differences be better understood?

      - We have a difference in ______. How can I better understand this difference?

      - What kind of rationale or experiences would my partner have to have in order to believe/do this?
- therapists can use the following to facilitate increasing the couple's understandings
  - historical factors (learning history)
  - differing preferences
  - reframe in terms of what initially attracted one partner to the other
  - reframe difference in terms of difference is partner's way of wanting to contribute to the relationship.

DONE BY 3:15

5) Exercise

- there are 3 options for this exercise (based on what the therapist believe will be most effective)

  A) have the therapists work with one couple while the other couples observe

  B) have the couples pair up with another couple and one couple will observe the other

  C) have each couple do this exercise by themselves (preferred option)

1) Each couple is to spend some time identifying some of their major differences which cause them problems.

2) After identifying these differences, each partner is to state their understanding of why their partner feels/believes differently about the issue.

   The partner doesn't have to agree with the perspective of their partner, they only must understand it.
6) Group Discussion

A) What has this discussion opened up for individuals in the group?
- How has your understanding of your differences with your partner shifted?
- How does your changed understanding of differences allow for a different kind of interaction with your partner?

B) Will you and your partner have differences in the future?
- Yes, obviously - the point is to accept this fully so that differences can be experienced as a normal part of relationships, rather than as an area of conflict.
Session # 6 - Problem Solving

Note: Continue having group members practice their communication skills.

1) Discuss homework

2) Group leaders present information on problem solving (Have the group brainstorm on how to effectively problem solve)

   A) Present information on the difference between:
      a) arguing
      b) problem solving

   B) Problem Solving

      Guidelines
      - only one problem at a time
      - discuss only your own view
      - paraphrase your partner
      - avoid inferences about partner’s view
      - focus on finding a solution
      - be willing to collaborate and compromise (i.e. give some)
      - is not arguing

      Steps

      1) define the problem
      2) brainstorming
      3) choosing among solutions
      4) evaluate costs/benefits of each solution
      5) implementing the solution
      6) assessing the solution
      7) updating the solution

3) Role Play on problem solving

4) Group discussion - Ineffective problem solving
A) What gets in the way of your effective problem solving? Make sure that the group discusses the following pitfalls to communication/problem solving

- sidetracking
- bringing in old material or arguments
- blaming
- being defensive
- denying the problem
- bringing in other problems

5) Exercise
- therapists should make sure to assist all of the couples with this exercise with coaching and feedback

- Have each couple problem solve an "easy" problem

6) Group Discussion

- What worked well with the problem solving skills?
- What did you have difficulty with in this exercise?

7) - Hand out homework sheet

- hand out problem solving easy reference sheet

8) Homework

HW is to do something fun together tonight

FINISHED BY END OF SATURDAY
Time framework

DAY TWO

9:00 - 10:45  session
10:45 - 11:00  break
11:00 - 12:30  session
12:30 - 1:30  lunch
1:30 - 3:15  session
3:15 - 3:30  break
3:30 - 5:00  session

Session # 7 - Negotiating/Accommodating Differences

2) Therapist present material about inevitability of conflict in relationships

A) Who here would prefer that they not have any conflict in their relationship? (wait for response from group members)
   - Is this a realistic goal?
   - Is this actually possible?

B) The inevitability of Conflict
   - Is conflict inevitable in relationships?

C) Conflict as a normal part of relationships and a result of having natural differences

D) As with differences, the question is not whether you will have conflict in your relationships (you will), but rather how you will handle the conflict that will arise in your relationship

3) Group Discussion

A) What are some common themes that group members get into conflict about? (wait for group members to respond and make sure that they discuss all of the following areas)
   - closeness/independence
   - responsibility/authority to make decisions
   - child rearing/discipline practices
   - how to spend time together
   - recreation
   - intimacy
   - sex
   - money
B) What has to be done in order to work through conflict (wait for group response)?

- Answer - communicate with each other
- Communication
  - is essential for each of you to accommodate/negotiate with each other
  - allows you to work through conflict without hurting each other

4) Therapist present information on Conflict

A) Conflict - 3 important aspects:

1) **Content area** - what the conflict is about - the topic
   - i.e. sex, housework, time together, kids, money

2) **Process** in areas of conflict
   - process as how you talk about the issue or content
   - how there may be significant areas of conflict which reside "underneath" the content issue

3) **Themes**
   - themes are patterns or core areas of conflict which cut across several differing content areas
   - they may not be obvious in a specific content area
   - they exist just "underneath" the surface content

4) Give examples of themes in conflicts
   - needing to feel loved
   - feeling like a good person
   - feeling respected
   - fear of abandonment
   - fear of rejection
   - differences in desired levels of intimacy
   - needing to feel trust in the relationship

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B) give an example of how the topic (content) may not match the underlying theme in the conflict

5) Group discussion about what themes are operating in the couples relationships

Session # 8 - Acceptance vs. Change

1) Therapist present information on Acceptance vs. Change

A) We all want to change some aspects of our partners/relationship - this is natural

1) We would prefer that he/she spends more time with us, does more of the housework, does sex differently/more/less frequently, was more independent, less talkative, more talkative, was more helpful doing _____, etc.

2) after we have asked/begged/argued with our partners to change and they do not we often assume that:

   a) they don't care for me
   b) they don't love me
   c) the relationship isn't that important to them because they haven't changed

B) What if our partner/relationship hasn't changed despite our best efforts?

1) one approach is to keep trying to change them

2) we could give up and resign ourself to the situation

3) or we could try to really understand the situation

C) Understanding the situation/partner

1) leads to increasing one's ability to accept what's so in a relationship
2) often (paradoxically) leads to allowing the partner to change more easily
D) Role Play - Therapists will role play an approach/avoid example in which the more one partner approaches about a particular topic, the more the other avoids that topic. Then have the approacher focus on trying to understand the situation, which would lead to the avoider not having to defend or distance around that problem, becoming more willing to work on the behavior or problem and thus, then being able to accommodate or negotiate with their partner.

4) Exercise - Prepare group members for the difficulty involved with this exercise. Understanding and accepting are very difficult behaviors to do and so you'll need some patience. Don't expect too much initially.

- Have the couples pair up and have one couple discuss an area in which one of the partners is wanting the other to change.

  A) First, have one partner choose something that they need to gain more understanding about

  B) Have this same person ask their partner questions in a way that helps them understand why their partner does what he/she does

  C) The partner talks about their experiences and beliefs in order to increase the other's understanding

  D) Have the first partner state their understanding and repeat this to their partner and check if it is "correct" with their partner, until they get it right

  E) Have therapists give their observations and feedback

5) Group Discussion

  A) Have the group process what this exercise was like for them

  B) How have each of the group members wanted to change their relationships/partners?
6) Therapist present information on Acceptance

A) There are many things in the world, which despite your best efforts, will never be changed.

**Examples**

- you will get rained on
- your partner will do things that you don't like
- your partner will forget to do things
- your partner will be insensitive to your needs
- your partner will not always be kind to you
- your partner will want more/less of some things than you do
- your partner will be different from you in many important areas

- All of these facts imply that in order to remain sane, that the ability to accept certain situations is absolutely necessary

7) Group discussion

A) What is acceptance? Therapist make sure that some kind of understanding of the below is had by the group members

- psychological acceptance involves experiencing events fully and without defense or judgement

- acceptance does not mean "approve of" or condone in any way
- acceptance is not just a tolerance or resignation to something

- acceptance - involves the deliberate abandonment of a change agenda in situations in which this agenda does not work

- involves emotional or social willingness - to be open to the experience of others or oneself

B) What is the best way to promote acceptance in your relationships?

Make sure that the group fully understands that understanding is the key to being able to accept difficult things about a relationship. Also that understanding is not liking or wanting it that way, it's just understanding what is so for their partner, given their history or beliefs about something
8) Group Discussion

A) Does accepting aspects of my partner facilitate the change process?
   - does change facilitate the acceptance process?

B) What would accepting the same behavior that they have wanted changed look like?

C) How would each actually accomplish accepting _____ in their partner?

D) What would accepting _____ mean to your partner?

9) Group Discussion

A) What to do instead of fixing/changing other?
   - meet own needs in other ways

B) Have group members discuss what they can do to fulfill their own needs rather than insisting on change from their partner
Session # 9 - Getting What You Want

Note: This session is really a continuation of accepting vs. change. Direct the discussions and exercises with this in mind, working to continue to develop the ability to accept in the partners.

2) Group Discussion

A) Getting what we want from our partners

- How do you attempt to get what you want from your partner?

- What are your techniques/strategies for getting what you want?

  - do these work?
  - how does your partner react?

B) How does your partner attempt to get what he/she wants from you?

- What strategies/techniques does she/he use on you?
- How do you react to your partner's techniques?

3) Exercise

A) In this exercise have each couple pair up with another couple and then have each group member parody how they have attempted to get their needs met from their partner. Encourage group members to really ham it up so that they fully understand on an experiential level how it is that they attempt to meet their needs through the other.

B) process this exercise with a group discussion
4) Group Discussion

A) Other ways to get your needs met

- ask directly for what you want
- self-care activities

5) Group Discussion

A) How does today’s session relate to the work we did on accepting vs. change last week

B) Make sure that the couples have the tools to be able to ask directly for what they want, and when their partner is unwilling or unable to meet their needs, that couples can increase their understanding of the other so as to increase their ability to accept certain aspects of the other/relationship

C) What changes have you noticed in the last week that may have to do with accepting in your relationship?
Session # 10 - Intimacy

1) Discuss homework

2) Group Discussion - Intimacy

A) What is intimacy?
   - feeling close to our partner
   - feeling an emotional connection
   - requires being vulnerable
   - requires emotional expression

B) What makes you feel close/intimate with your partner? (Make sure that the group covers and discusses the following)
   1) self-disclosure/being vulnerable
   2) expressing emotions (softer)
   3) time together/shared experiences

C) What has you feel less close with your partner?

D) What does being intimate require from each partner?

E) What is your biggest personal hurdle in allowing your partner to be intimate with you?

F) What fears do you have around being intimate?

G) What is the cost of not having as much intimacy as you would like in your relationship?

3) Present role-play on intimacy
   - therapists can stop the role-play during the vignettes and ask the group what is hindering/helping Bob and Kristen being intimate
4) Exercise - therapist should work with various couples, actively facilitating this exercise

Have each couple practice being intimate with each other.

- Each person is to discuss something personal about themselves which makes them feel vulnerable

5) Group discussion of above exercise

A) What did this exercise bring up for people?

B) What was it like to be intimate?

C) What was it like to be with your partner when she/he was being intimate?

Session #11 - Intimacy

1) Group discussion

A) What kind of emotions (i.e. soft vs. hard) facilitate being intimate?

B) Is wanting to change your partner helpful in promoting intimacy? Why not?

C) How does having an accepting stance help/hinder intimacy?
Session # 12 - Closing Session

1) Group Discussion of termination issues

(Therapist should insure that each and every member participates in this discussion.)

A) What did you get out of this group?
B) What was learned?
C) What are the areas that you still need to work on?
D) What improvements were made in your relationship?

2) Group discussion of couples issues

(Therapist should insure that each and every member participates in this discussion.)

A) How will you know when your relationship is going well?
B) How will you know if you might need some help with your relationship?
C) What would the signs be for you to do some more couples work?

3) Group discussion - How to improve the group

A) What was most helpful to you about this group?
B) What suggestions for improving this group do you have?
C) What did you find in the group that was not helpful to you?
4) Group Discussion - Relapse Prevention

A) Do you expect that you will have relationship challenges in the future?

- of course, the question is not really whether difficulties will come up, rather, it's how the couples will be able to handle them

B) What can you do when you're stuck?

C) How will you handle the challenges in your relationship?

D) What will help you to use the skills that you have developed in this group?

5) Exercise - Saying Goodbye

A) Have each member of the group (including the therapist) say what his/her hopes and concerns/fears are for each of the other couples.

B) Have each member (couple) say what they most appreciated about the other group members.
Consent Form

Evaluation of Couples Group Therapy

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Purpose

You are invited to participate in a research study being conducted at the UW Psychiatry Outpatient Couples Clinic. The investigators have developed a group approach to couples counseling, which they believe is very promising. Two modes of treatment will be compared: a group therapy format which will meet once per week for 12 weeks, and a weekend long seminar, which will meet for one weekend for approximately 8 hours on Saturday and Sunday. The purpose of this study is to determine how effective these new approaches are.

Procedures

In order to determine your appropriateness for this treatment program, you and your partner will be asked to come to the clinic for a pre-therapy evaluation, which will last approximately 3 hours. Upon arrival, you will meet with a trained clinical interviewer to review and sign your consent forms. You will then be asked to independently complete a packet of questionnaires which seek detailed information on your current marital functioning, including questions about areas of disagreement, violent relationship behavior, and sexuality. Examples of the most personal and sensitive kinds of questions include: "Has there ever been a time when your partner hit you or tried to hit you with something?", or "Approximately how many times have you initiated intercourse in the last week?" These questionnaires will take about 1 1/2 hours to complete. For us to decide on a suitable treatment plan for you, our information needs to be as complete as possible, so please try to answer all questions on the questionnaires. Nevertheless, at any time during your participation in this study, you are always free not to answer any questions you do not wish to answer.

Upon completion of the questionnaires, you and your partner will be interviewed with a trained interviewer. The interview will contain questions
regarding current and past marital functioning, past and present psychiatric history, physical health, and illegal drug use. Examples of some of the more personal and sensitive questions include: "Have you ever used street drugs?" and "Was there ever a time when your eating was out of control?"

At the end of this assessment, you and your partner will be informed about your acceptance or non-acceptance into the study. If you are not accepted into the study, or if you decide to discontinue, the assessment procedure will end and you will be referred to appropriate services in the community. If these treatments are not appropriate for you, or if you decide that you do not wish to participate in this study, all identifying information which has been gathered will be destroyed. If it is believed that treatment is appropriate and you are still interested in participating, we will ask you to join this project.

Couples who are eligible for our treatment program will be randomly assigned to one of the two treatment groups previously described (a group for couples lasting 12 weeks or a weekend long seminar for couples). If you are assigned to the weekend long seminar, you will be required to wait for a period of 12 weeks or so before this program will begin. We apologize for any inconvenience that this might cause. However, this is the only way that we can offer this seminar. Your chances would be one in two of being assigned to either the group or the seminar. Couples who are not eligible for this program, or who are not interested in random assignment to a treatment condition, will be assisted in finding the appropriate services elsewhere in the community.

The 12 week couples group will meet weekly for approximately 2 hours per night. Your therapy sessions may include some of the following: building skills which will enhance your relationship, communication and problem solving training, increasing your ability to be intimate with your partner, collaborating with your partner, and increasing acceptance and understanding. The weekend long seminar will meet on a Saturday and Sunday, from 9 a.m. until 6 p.m. This seminar will include the same procedures described above in the couples group: building skills which will enhance your relationship, communication and problem solving training, increasing your ability to be intimate with your partner, collaborating with your partner, and increasing acceptance and understanding. To ensure that you receive the best possible treatment, sessions may be audiotaped or videotaped. The primary purpose of taping is to enhance the supervision and training of the psychotherapist, although the tapes may be used for research training purposes.

At the conclusion of the treatment, you will be asked to come in for a post-therapy interview. During this time, you will be asked to fill out some of the questionnaires which you filled out before treatment was begun. In order to evaluate the long-term effectiveness of this program, we will ask you to fill out these questionnaires at 6 months, 1 year, and 2 years after you finish.
therapy. These questionnaires will be mailed to you at home and we will provide an addressed stamped envelope for your convenience.

Costs

There are no costs for the initial diagnostic assessment (which determines if you are eligible for this study). You or your insurance carrier will be billed for the psychotherapy. There is a reduced fee for these therapy sessions and this will be fully discussed with you when you decide that you would like to participate in this project.

Risks, Stress, and Discomfort

The content of all assessment and therapy sessions will always be treated with respect and as privileged communication, and your right to confidentiality will be protected. However, there are a few circumstances under which your therapist is ethically and legally bound to break this agreement of confidentiality. These are as follows:

1) If the therapist becomes aware that a child under 18 is or has been abused, that spouse abuse is occurring, or a developmentally disabled person or an elderly person is or has been abused, a report must be made to the appropriate authorities.

2) If a client threatens another person, the therapist must protect by warning the person at risk and reporting the danger to the appropriate authorities.

3) If a client poses a danger to self or others or is unable to take care of basic needs, the therapist will take appropriate actions to protect the client’s safety.

4) If the client discloses HIV infection, does not have a physician monitoring the condition, and has IV drug using or sexual partners, we may be obligated to report the identity of the partner(s) to the local public health officials. We will first consult with a health care officer, as there may be exceptions to this ruling.

Your participation in this study involves a risk that discussing problems in your relationship may upset you or make you angry with each other. Other risks which may result from your participation may include a breach of confidentiality or the experience of the invasion of privacy. The fact that the
therapy will take place in a group setting means that the authors and therapists cannot guarantee your confidentiality, although all efforts will be made to provide confidentiality. The reason that we cannot guarantee your confidentiality is that we cannot insure that other group members will not break confidentiality. Finally, there is the risk that you may not receive benefit from participating in this therapy program as the treatment is not necessarily effective for everyone who participates in it. Pilot data suggests that these therapy approaches are effective for 80% of couples who participate in standard couples therapy.

Will there be compensation for physical injury?
In the event that you are injured as a result of this research you should individually seek appropriate medical treatment. The University of Wisconsin does not automatically provide reimbursement for medical care or other compensation. If physical injury is suffered in the course of research, or for more information, please notify the investigator in charge. For more information on the rights of research subjects, you may contact the UW Hospital Patient Relations Representative at (608) 263-8009.

We believe that the benefits of this project outweigh the possible risks. Some of the benefits you might receive include: increasing the amount of satisfaction that you have in your relationship, increasing your communication and problem solving skills, being able to be more intimate with your partner, being more accepting of your partner, and being able to make the changes that both you and your partner wish for yourselves.
Other Information

Participation in this research project is completely voluntary. Even if you sign this consent form now, you are not permanently committing yourself. You are free to drop out at any time. If you choose not to participate in the program and still desire therapeutic assistance, we will help you find someone in the community.

Only the people directly involved in the research project will have access to the written and taped data which will be kept in a locked file in the investigator’s office and will not be released to any other persons or agency. Your name will not be written on any of the forms or tapes. Written data from all subjects who become involved in this study will be kept indefinitely to allow for proper analysis.

________________________________________
Signature of Investigator        Date

Subject's Statement

The study described above has been explained to me. I voluntarily consent to participate in this activity. I have had an opportunity to ask questions. I understand that future questions I may have about the research project or about my rights as a subject will be answered by the investigator listed above.

_________________________        Date
Signed                        

_________________________        Date
Signed                        

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Appendix E
Want To Improve Your Relationship?

The UW Department of Psychiatry is currently seeking couples interested in couples therapy. This group will address many couples' issues including: communication enhancement, increasing intimacy, problem solving, facilitating changes you would like to make, and increasing the amount of satisfaction you experience in your relationship. Eligible couples must have been in relationship for over 1 year, be committed to making their relationship work, and be willing to participate in a research project. Couples Psychotherapy will be provided and costs for the group therapy can be paid by your insurance carrier or will be offered at a negotiable rate for out of pocket payers.

If you are interested in this group, please contact:

John Wimberly, M.A. (608) 262-1914
### Sliding Fee Scale

<table>
<thead>
<tr>
<th>Annual Family Income</th>
<th>Cost per Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>under $10,000</td>
<td>5$ per session</td>
</tr>
<tr>
<td>10,000 - 15,000</td>
<td>10$</td>
</tr>
<tr>
<td>15,000 - 20,000</td>
<td>15$</td>
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<tr>
<td>20,000 - 25,000</td>
<td>20$</td>
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<tr>
<td>25,000 - 30,000</td>
<td>25$</td>
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<tr>
<td>30,000 - 35,000</td>
<td>30$</td>
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<tr>
<td>35,000 - 40,000</td>
<td>35$</td>
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<tr>
<td>40,000 - 45,000</td>
<td>40$</td>
</tr>
<tr>
<td>45,000 - 50,000</td>
<td>45$</td>
</tr>
<tr>
<td>above $50,000</td>
<td>50$</td>
</tr>
</tbody>
</table>
Guidelines for Group Participation

1) Be honest and candid. We cannot get the work done without honesty and respect.

2) Actively participate. You get what you put in.

3) Apply what you learn in the homework. Please do the homework, as this is where the main benefits of the group actually come into fruition. The group sessions are designed to assist you in being able to successfully do the homework, which is where the main benefits of the group will take place.

4) All information discussed in the group is strictly confidential. You are at liberty to share information about yourself with others, however, you are not at liberty to share information about others. If you share anything about what you have learned from other couples in the group, this must be done in a way so as not to give any hints as to their identities. We need an atmosphere of trust in order to get the work done we need to get done. Please be respectful of each other.

5) No physical, verbal, or emotional abuse will be allowed either in our sessions or at home with your partner.

6) Should you or your partner have any kinds of crises, you can contact either Christine or myself at:

   Christine Costanzo      263-6115
   John Wimberly           262-1914
Appendix H
Dyadic Adjustment Scale
Most people have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list.

<table>
<thead>
<tr>
<th></th>
<th>Always Agree</th>
<th>Almost Always Agree</th>
<th>Occasionally Disagree</th>
<th>Frequently Disagree</th>
<th>Almost Always Disagree</th>
<th>Always Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Handling family finances</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Matters of recreation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3. Religious matters</td>
<td></td>
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<tr>
<td>4. Demonstrations of affection</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>5. Friends</td>
<td></td>
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<td></td>
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<tr>
<td>6. Sex relations</td>
<td></td>
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<tr>
<td>7. Conventionality (correct or proper behavior)</td>
<td></td>
<td></td>
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<tr>
<td>8. Philosophy of life</td>
<td></td>
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</tr>
<tr>
<td>9. Ways of dealing with parents or in-laws</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Aims, goals, and things believed important</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>11. Amount of time spent together</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>12. Making major decisions</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>13. Household tasks</td>
<td></td>
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<td></td>
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</tbody>
</table>
### Leisure time interests and activities

<table>
<thead>
<tr>
<th></th>
<th>All the time</th>
<th>Most of the time</th>
<th>More often than not</th>
<th>Occasionally</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
</table>

### Career decisions

<table>
<thead>
<tr>
<th></th>
<th>All the time</th>
<th>Most of the time</th>
<th>More often than not</th>
<th>Occasionally</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
</table>

14. Leisure time interests and activities

15. Career decisions

16. How often do you discuss or have you considered divorce, separation or terminating your relationship?

17. How often do you or your mate leave the house after a fight?

18. In general, how often do you think that things between you and your partner are going well?

19. Do you confide in your mate?

20. Do you ever regret that you married (or live together)?

21. How often do you and your partner quarrel?

22. How often do you and your mate get on each other's nerves?
23. Do you kiss your mate?

- Every day
- Almost every day
- Occasionally
- Rarely
- Never

24. Do you and your mate engage in outside interests together?

- All of them
- Most of them
- Some of them
- Very few
- None

How often would you say the following events occur between you and your mate?

- Never
- Less than once a month
- Once/twice a month
- Once/twice a week
- Once a day
- More often

25. Have a stimulating exchange of ideas

26. Laugh together

27. Calmly discuss something

28. Work together on a project

These are things about which couples sometimes agree and sometimes disagree. Indicate if either item below caused differences of opinions or were problems in your relationship during the past few weeks. (Check yes or no)

- Yes
- No

29. Being too tired for sex

30. Not showing love

31. The dots on the following line represent different degrees of happiness in your relationship. The middle point, "happy", represents the degree of happiness of most relationships. Please circle the dot which best describes the degree of happiness, all things considered, of your relationship.

- Extremely unhappy
- Fairly unhappy
- A little unhappy
- Happy
- Very happy
- Extremely happy
- Perfect
32. Which of the following statements best describes how you feel about the future of your relationship?

_____ I want desperately for my relationship to succeed, and would go to about any length to see that it does.

_____ I want very much for my relationship to succeed, and will do all I can to see that it does.

_____ I want very much for my relationship to succeed, and will do my fair share to see that it does.

_____ It would be nice if my relationship succeeded, but I can't do much more than I am doing now to help it succeed.

_____ It would be nice if my relationship succeeded, but I refuse to do any more than I am doing now to keep the relationship going.

_____ My relationship can never succeed, and there is no more that I can do to keep the relationship going.
Marital Satisfaction Inventory
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Marital Satisfaction Inventory

UMI
SCL-90-R

Please provide the following information by first printing in the spaces at the tops of the grids and then marking the matching number below or to the side with a dark glossy mark. Use a number 2 pencil only. Note the examples below.

**EXAMPLES:**

- Correct: Yes = Yes
- Incorrect: Yes = No
- Correct: No = No
- Incorrect: No = Yes

**BELOW IS A LIST OF PROBLEMS AND COMPLAINTS THAT PEOPLE SOMETIMES HAVE. PLEASE READ EACH ONE CAREFULLY AFTER YOU HAVE DONE SO. PLEASE MARK ONE OF THE NUMBERED SPACES TO THE RIGHT THAT BEST DESCRIBES HOW MUCH DISCOMFORT THAT PROBLEM HAS CAUSED YOU DURING THE PAST 7 DAYS INCLUDING TODAY. MARK ONLY ONE NUMBERED SPACE FOR EACH PROBLEM AND DO NOT SKIP ANY ITEMS. MAKE YOUR MARKS CAREFULLY WITH A NUMBER 2 PENCIL. DO NOT USE A PENCIL NUMBERED HIGHER THAN 2B. BE SURE THAT YOUR MARKS ARE DARK AND GLOSSY AND FILL THE SPACE COMPLETELY. IF YOU CHANGE YOUR MIND, ERASE YOUR FIRST MARK COMPLETELY. PLEASE DO NOT MAKE ANY EXTRA MARKS ON THE SHEET.

**FOR THE LAST 7 DAYS HOW MUCH WERE YOU DISTRESSED BY**

1. Headaches
2. Nervousness or shakiness inside
3. Repeated unpleasant thoughts that won't leave your mind
4. Fainness or dizziness
5. Loss of sexual interest or pleasure
6. Feeling critical of others
7. The idea that someone else can control your thoughts
8. Feeling others are to blame for most of your troubles
9. Trouble remembering things
10. Worried about sloppiness or carelessness
11. Feeling easily annoyed or irritated
12. Pains in heart or chest
13. Feeling afraid in open spaces or on the streets
14. Feeling low in energy or slowed down
15. Thoughts of ending your life
16. Hearing voices that other people do not hear
17. Trembling
18. Feeling that most people cannot be trusted
19. Poor appetite
20. Crying easily
21. Feeling shy or uneasy with the opposite sex
22. Feeling of being trapped or caught
23. Suddenly scared for no reason
24. Temper outbursts that you could not control
25. Feeling afraid to go out of your house alone
26. Blaming yourself for things
27. Pains in lower back
28. Feeling blocked in getting things done
29. Feeling lonely

<table>
<thead>
<tr>
<th>MONTH</th>
<th>DAY</th>
<th>YEAR</th>
<th>MONTH</th>
<th>DAY</th>
<th>YEAR</th>
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<td>c15 JAN</td>
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<td>c16 FEB</td>
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<td>c16 FEB</td>
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<td>c19 MAY</td>
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<td>c22 AUG</td>
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<td>c24 OCT</td>
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<td>c25 NOV</td>
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<td>c25 NOV</td>
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<td>c26 DEC</td>
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<tr>
<td>c0a c1a c2a c3a c4a c5a c6a c7o</td>
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<tr>
<td>c0a c1a c2a c3a c4a c5a c6a c7o</td>
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</table>

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<table>
<thead>
<tr>
<th></th>
<th>FOR THE LAST 7 DAYS HOW MUCH WERE YOU DISTRESSED BY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>31.</td>
<td>Worrying too much about things</td>
</tr>
<tr>
<td>32.</td>
<td>Feeling no interest in things</td>
</tr>
<tr>
<td>33.</td>
<td>Feeling fearful</td>
</tr>
<tr>
<td>34.</td>
<td>Your feelings being easily hurt</td>
</tr>
<tr>
<td>35.</td>
<td>Other people being aware of your private thoughts</td>
</tr>
<tr>
<td>36.</td>
<td>Feeling others do not understand you or are unsympathetic</td>
</tr>
<tr>
<td>37.</td>
<td>Feeling that you are unfriendly or dislike you</td>
</tr>
<tr>
<td>38.</td>
<td>Having to do things very slowly to insure correctness</td>
</tr>
<tr>
<td>39.</td>
<td>Heart pounding or racing</td>
</tr>
<tr>
<td>40.</td>
<td>Nausea or upset stomach</td>
</tr>
<tr>
<td>41.</td>
<td>Feeling inferior to others</td>
</tr>
<tr>
<td>42.</td>
<td>Soreness of your muscles</td>
</tr>
<tr>
<td>43.</td>
<td>Feeling that you are watched or talked about by others</td>
</tr>
<tr>
<td>44.</td>
<td>Trouble falling asleep</td>
</tr>
<tr>
<td>45.</td>
<td>Having to check and double-check what you do</td>
</tr>
<tr>
<td>46.</td>
<td>Difficulty making decisions</td>
</tr>
<tr>
<td>47.</td>
<td>Feeling afraid to travel on buses, subways, or trains</td>
</tr>
<tr>
<td>48.</td>
<td>Trouble getting your breath</td>
</tr>
<tr>
<td>49.</td>
<td>Hot or cold spells</td>
</tr>
<tr>
<td>50.</td>
<td>Having to avoid certain things, places, or activities because they frighten you</td>
</tr>
<tr>
<td>51.</td>
<td>Your mind going blank</td>
</tr>
<tr>
<td>52.</td>
<td>Numbness or tingling in parts of your body</td>
</tr>
<tr>
<td>53.</td>
<td>A lump in your throat</td>
</tr>
<tr>
<td>54.</td>
<td>Feeling hopeless about the future</td>
</tr>
<tr>
<td>55.</td>
<td>Trouble concentrating</td>
</tr>
<tr>
<td>56.</td>
<td>Feeling weak in parts of your body</td>
</tr>
<tr>
<td>57.</td>
<td>Feeling tense or keyed up</td>
</tr>
<tr>
<td>58.</td>
<td>Heavy feelings in your arms or legs</td>
</tr>
<tr>
<td>59.</td>
<td>Thoughts of death or dying</td>
</tr>
<tr>
<td>60.</td>
<td>Overeating</td>
</tr>
<tr>
<td>61.</td>
<td>Feeling uneasy when people are watching or talking about you</td>
</tr>
<tr>
<td>62.</td>
<td>Having thoughts that are not your own</td>
</tr>
<tr>
<td>63.</td>
<td>Having urges to beat, injure, or harm someone</td>
</tr>
<tr>
<td>64.</td>
<td>Awakening in the early morning</td>
</tr>
<tr>
<td>65.</td>
<td>Having to repeat the same actions such as touching, counting, washing</td>
</tr>
<tr>
<td>66.</td>
<td>Sleep that is restless or disturbed</td>
</tr>
<tr>
<td>67.</td>
<td>Having urges to break or smash things</td>
</tr>
<tr>
<td>68.</td>
<td>Having ideas or beliefs that others do not share</td>
</tr>
<tr>
<td>69.</td>
<td>Feeling very self-conscious with others</td>
</tr>
<tr>
<td>70.</td>
<td>Feeling uneasy in crowds, such as shopping or at a movie</td>
</tr>
<tr>
<td>71.</td>
<td>Feeling everything is an effort</td>
</tr>
<tr>
<td>72.</td>
<td>Spells of terror or panic</td>
</tr>
<tr>
<td>73.</td>
<td>Feeling uncomfortable about eating or drinking in public</td>
</tr>
<tr>
<td>74.</td>
<td>Getting into frequent arguments</td>
</tr>
<tr>
<td>75.</td>
<td>Feeling nervous when you are left alone</td>
</tr>
<tr>
<td>76.</td>
<td>Others not giving you proper credit for your achievements</td>
</tr>
<tr>
<td>77.</td>
<td>Feeling lonely even when you are with people</td>
</tr>
<tr>
<td>78.</td>
<td>Feeling so restless you couldn't sit still</td>
</tr>
<tr>
<td>79.</td>
<td>Feelings of worthlessness</td>
</tr>
<tr>
<td>80.</td>
<td>Feeling that something bad is going to happen to you</td>
</tr>
<tr>
<td>81.</td>
<td>Shouting or throwing things</td>
</tr>
<tr>
<td>82.</td>
<td>Feeling afraid you will faint in public</td>
</tr>
<tr>
<td>83.</td>
<td>Feeling that people will take advantage of you if you let them</td>
</tr>
<tr>
<td>84.</td>
<td>Having thoughts about sex that bother you a lot</td>
</tr>
<tr>
<td>85.</td>
<td>The idea that you should be punished for your sins</td>
</tr>
<tr>
<td>86.</td>
<td>Thoughts and images of a frightening nature</td>
</tr>
<tr>
<td>87.</td>
<td>The idea that something serious is wrong with your body</td>
</tr>
<tr>
<td>88.</td>
<td>Never feeling close to another person</td>
</tr>
<tr>
<td>89.</td>
<td>Feelings of guilt</td>
</tr>
<tr>
<td>90.</td>
<td>THE END OF THE QUESTIONNAIRE</td>
</tr>
</tbody>
</table>

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Communication Patterns Questionnaire
COMMUNICATION PATTERNS QUESTIONNAIRE

Directions: We are interested in how you and your partner typically deal with problems in your relationship. Please rate each item on a scale of 1 (= very unlikely) to 9 (= very likely).

A. WHEN SOME PROBLEM IN THE RELATIONSHIP ARISES.

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Very Unlikely</th>
<th>Very Likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Mutual Avoidance. Both members avoid discussing the problem.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Mutual Discussion. Both members try to discuss the problem.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Discussion/Avoidance. Man tries to start a discussion while Woman tries to avoid a discussion.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
</tbody>
</table>

B. DURING A DISCUSSION OF A RELATIONSHIP PROBLEM.

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Very Unlikely</th>
<th>Very Likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Mutual Blame. Both members blame, accuse, and criticize each other.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Mutual Expression. Both members express their feelings to each other.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Mutual Threat. Both members threaten each other with negative consequences.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Mutual Negotiation. Both members suggest possible solutions and compromises.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Demand/Withdraw. Man naggs and demands while Woman withdraws, becomes silent, or refuses to discuss the matter further.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Criticize/Defend. Man criticizes while Woman defends herself.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
</tbody>
</table>
7. Pressure/Resist.
Man pressures Woman to take some action
or stop some action, while Woman resists.
Woman pressures Man to take some action
or stop some action, while Man resists.

8. Emotional/Logical.
Man expresses feelings while Woman
offers reasons and solutions.
Woman expresses feelings while Man
offers reasons and solutions.

Man threatens negative consequences
and Woman gives in or backs down.
Woman threatens negative consequences
and Man gives in or backs down.

10. Verbal Aggression.
Man calls Woman names, swears at her,
or attacks her character.
Woman calls Man names, swears at him,
or attacks his character.

11. Physical Aggression.
Man pushes, shoves, slaps, hits,
or kicks Woman.
Woman pushes, shoves, slaps, hits,
or kicks Man.

C. AFTER A DISCUSSION OF A RELATIONSHIP PROBLEM,
1. Mutual Understanding. Both feel each
other has understood his/her position.
2. Mutual Withdrawal. Both withdraw from
each other after the discussion.
3. Mutual Resolution. Both feel that the
problem has been solved.
4. Mutual Withholding. Neither partner is
giving to the other after the discussion.
5. Mutual Reconciliation. After the
discussion, both try to be
especially nice to each other.
   Man feels guilty for what he said or did while Woman feels hurt.
   Woman feels guilty for what she said or did while Man feels hurt.

7. Reconcile/Withdraw.
   Man tries to be especially nice, acts as if things are back to normal, while Woman acts distant.
   Woman tries to be especially nice, acts as if things are back to normal, while Man acts distant.

8. Pressure/Resist.
   Man pressures Woman to apologize or promise to do better, while Woman resists.
   Woman pressures Man to apologize or promise to do better, while Man resists.

   Man seeks support from others (parent, friend, children)
   Woman seeks support from others (parent, friend, children)
Conflict Tactics Scale
No matter how well a couple gets along, there are times when they disagree on major decisions, get annoyed about something the other person does, or have spats or fights because they're in a bad mood or for some other reason. A couple may also use many different ways to settle their differences. Listed below are some things that you or your spouse may have done when you had a dispute. First rate how many times you have done any of these things in the last year. Second, rate how many times your spouse has done any of these things in the last year. Then rate whether you or your spouse has ever done any of these things.

<table>
<thead>
<tr>
<th></th>
<th>YOU IN THE PAST YEAR</th>
<th>SPouse IN PAST YEAR</th>
<th>EVER HAPPENED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NEVER</td>
<td>ONCE</td>
<td>TWICE</td>
</tr>
<tr>
<td>a. Discussed the issue calmly</td>
<td>0 1 2 3 4 5 6 x</td>
<td>0 1 2 3 4 5 6 x</td>
<td>0 1 2 3 4 5 6 x</td>
</tr>
<tr>
<td>b. Got information to back up (your/his or her) side of things</td>
<td>0 1 2 3 4 5 6 x</td>
<td>0 1 2 3 4 5 6 x</td>
<td>0 1 2 3 4 5 6 x</td>
</tr>
<tr>
<td>c. Brought in or tried to bring in help to settle things</td>
<td>0 1 2 3 4 5 6 x</td>
<td>0 1 2 3 4 5 6 x</td>
<td>0 1 2 3 4 5 6 x</td>
</tr>
<tr>
<td>d. Insulted or swore at the other one</td>
<td>0 1 2 3 4 5 6 x</td>
<td>0 1 2 3 4 5 6 x</td>
<td>0 1 2 3 4 5 6 x</td>
</tr>
<tr>
<td>e. Sulked and/or refused to talk about it</td>
<td>0 1 2 3 4 5 6 x</td>
<td>0 1 2 3 4 5 6 x</td>
<td>0 1 2 3 4 5 6 x</td>
</tr>
<tr>
<td>f. Stamped out of the room or house (or yard)</td>
<td>0 1 2 3 4 5 6 x</td>
<td>0 1 2 3 4 5 6 x</td>
<td>0 1 2 3 4 5 6 x</td>
</tr>
<tr>
<td>g. Cried</td>
<td>0 1 2 3 4 5 6 x</td>
<td>0 1 2 3 4 5 6 x</td>
<td>0 1 2 3 4 5 6 x</td>
</tr>
<tr>
<td>h. Did or said something to spite the other one</td>
<td>0 1 2 3 4 5 6 x</td>
<td>0 1 2 3 4 5 6 x</td>
<td>0 1 2 3 4 5 6 x</td>
</tr>
<tr>
<td>YOU IN THE PAST YEAR</td>
<td>NEVER</td>
<td>ONCE</td>
<td>TWICE</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-------</td>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>Threatened to hit or throw methng at the other one</td>
<td>0 1 2 3 4 5 6 X</td>
<td>0 1 2 3 4 5 6 X</td>
<td>1 2 X</td>
</tr>
<tr>
<td>Threw or smashed or hit or kicked something</td>
<td>0 1 2 3 4 5 6 X</td>
<td>0 1 2 3 4 5 6 X</td>
<td>1 2 X</td>
</tr>
<tr>
<td>Threw something at the other one</td>
<td>0 1 2 3 4 5 6 X</td>
<td>0 1 2 3 4 5 6 X</td>
<td>1 2 X</td>
</tr>
<tr>
<td>Pushed, grabbed or shoved the other one</td>
<td>0 1 2 3 4 5 6 X</td>
<td>0 1 2 3 4 5 6 X</td>
<td>1 2 X</td>
</tr>
<tr>
<td>Slapped the other one</td>
<td>0 1 2 3 4 5 6 X</td>
<td>0 1 2 3 4 5 6 X</td>
<td>1 2 X</td>
</tr>
<tr>
<td>Kicked, bit, or hit with a fist</td>
<td>0 1 2 3 4 5 6 X</td>
<td>0 1 2 3 4 5 6 X</td>
<td>1 2 X</td>
</tr>
<tr>
<td>Hit or tried to hit with something</td>
<td>0 1 2 3 4 5 6 X</td>
<td>0 1 2 3 4 5 6 X</td>
<td>1 2 X</td>
</tr>
<tr>
<td>Beat up the other one</td>
<td>0 1 2 3 4 5 6 X</td>
<td>0 1 2 3 4 5 6 X</td>
<td>1 2 X</td>
</tr>
<tr>
<td>Threatened with a knife or gun</td>
<td>0 1 2 3 4 5 6 X</td>
<td>0 1 2 3 4 5 6 X</td>
<td>1 2 X</td>
</tr>
<tr>
<td>Used a knife or gun</td>
<td>0 1 2 3 4 5 6 X</td>
<td>0 1 2 3 4 5 6 X</td>
<td>1 2 X</td>
</tr>
<tr>
<td>Other</td>
<td>0 1 2 3 4 5 6 X</td>
<td>0 1 2 3 4 5 6 X</td>
<td>1 2 X</td>
</tr>
</tbody>
</table>
Relationship Issues Questionnaire
RELATIONSHIP ISSUES QUESTIONNAIRE

Directions: Please read each of the following items carefully, and answer the questions which follow each item by circling the number on the scales which best apply. Please answer each question.

1. Often one member (A) of a couple wants a closer relationship while the other member (B) wants more independence. For example, A may want more attention, more time together, more joint activities, more sharing of feelings, and more expressions of affection and closeness; B may want more time for independent activities, more time alone, and more personal privacy.

Does this difference characterize your relationship?

Not at all 1 2 3 4 5 6 7 8 9

A closer relationship 1 2 3 4 5 6 7 8 9

More independence 1 2 3 4 5 6 7 8 9

Man wants

Woman wants

2. Often one member (A) of a couple wants more contact with friends while the other member (B) wants a more exclusive relationship. For example, A may want to spend more time with friends, either alone or as a couple, while B prefers spending more time together, just A and B.

Does this difference characterize your relationship?

Not at all 1 2 3 4 5 6 7 8 9

More contact with friends 1 2 3 4 5 6 7 8 9

More exclusivity 1 2 3 4 5 6 7 8 9

Man wants

Woman wants

3. Often one member (A) of a couple wants more privacy within a relationship while the other member (B) wants more openness and sharing with others. For example, A may like to be open with others and reveal personal information about A's and B's relationship to others. B may want more privacy and less personal disclosure to others.

Does this difference characterize your relationship?

Not at all 1 2 3 4 5 6 7 8 9

More Privacy 1 2 3 4 5 6 7 8 9

More Sharing 1 2 3 4 5 6 7 8 9

Man wants

Woman wants