COGNITIVE-BEHAVIORAL MARITAL THERAPY: A COGNITIVE-BEHAVIORAL APPROACH FOR MARITAL DISTRESS

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INTRODUCTION

Marriage therapy was initially developed in the United States in the 1930s. It was originally born by psychoanalysis, with the first report on psychoanalysis of married couples was presented in 1931 (Nichols & Schwartz, 1998). In recent years, there have been many other approaches being applied for marital problems, including classic approaches such as experiential, insight-oriented, and behavioral approaches, and more contemporary approaches such as solution-building and cognitive-behavioral approaches.

Behavioral treatment approach to marital distress was introduced in the last 1960s. Since the last two decades, the approach has been collaborated with cognitive approach. This collaboration emerges in the new cognitive-behavioral marital therapy (CBMT) [1]. While the new approach looks sophisticated, research findings unfortunately show that it does not have more power compared to the original behavioral marital therapy.

This article is intended to give more details about the cognitive-behavioral marital therapy, and to analyze how the cognitive approach addition to the behavioral therapy for marital distress does not increase the efficacy. The development and theoretical ideology of CBMT will be described at first, followed by a glance of its current effectiveness status. The analysis and suggestions for future direction will be the last part of this essay.

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[1] *The term cognitive-behavioral marital therapy and CBMT will be used interchangeably in this text.*

THE DEVELOPMENT OF COGNITIVE-BEHAVIORAL MARITAL THERAPY: FROM BMT TO CBMT

Cognitive-behavioral intervention for marriage roots in the pure behavioral approach for marital distress, which is known as behavioral marital therapy (BMT) [2] or later referred too as behavioral couple therapy (BCT). The behavioral formulation for marital distress arose in the late 1960s. This formulation laid mostly on two behavioral theories: social learning theory and social exchange theory (Baucom, Eipstein, Rankin, & Burnett, 1996).

Social learning theory believes in operant conditioning, in which social behavior is governed mostly by its consequences. There are antecedent discriminative stimuli signaling that particular reinforcement contingencies. It is behavioral marital therapists' task to understand how a particular couple extinguished or punished certain adaptive behaviors necessary for their functioning and how maladaptive behaviors were perhaps unconsciously reinforced.

The social exchange theory views social relationships as economic relationships. Each person in the relationship is involved in the exchange of goods, and one's satisfaction with the relationship is a function of ratio of benefits received from the relationship relative to costs incurred. Rewards and punishments, or benefits and costs, is an emphasis of this theory. Researches have been conducted to prove the accuracy of this assumption on marital relationships. They found that distressed couples reported more displeasing behaviors and fewer pleasing behaviors from their partners, compared to non distressed couples. Other studies found that daily fluctuations in marital happiness are related to changes in the frequency of positive and negative behaviors of partner.

It is also postulated by social exchange theory that the exchange of goods between partners in a continuous relationship is reciprocal, meaning that the level of reinforcement and punishment provided by one partner is influenced by the rewards and punishments of the other. Over time, this process results in a relatively equitable exchange of goods between the two partners. However, reciprocity does not necessarily imply symmetry or equality. Balance in a marital partnership is when the exchange is perceived as fair or acceptable by the two partners. For instance, in a particular couple the wife perhaps contribute more than the husband, but she established a sense of balance that she viewed as gratifying. Therefore, therapists do

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[2] *The term behavioral marital therapy will be used interchangeably with BMT.*

not need to ensure that all contributions to the marriage are "equal", rather, they have to make sure that the couple function in a manner that both partners find gratifying and acceptable (Baucom *et al.*, 1996).

Based on two theories above, marital satisfaction is defined as the prevalence of positive interactions between spouses. Initial behavioral interventions are aimed to replace negative interactions with positive ones by increasing positive behaviors (Schmaling, Fruzzetti, & Jacobson, 1989). Some of the common methods that are widely used by behavioral marital therapists are communication training to improve positive communication skills of partners, problem solving training to improve effective problem solving skills, and contracting to increase the positive behavioral exchange.

Focusing on behavioral changes does not mean that BMT disregard cognition and affect as important aspects that determine marital functioning. However, BMT placed the focus of treatment on behavioral changes, based on the logic that because behavior, cognition, and affect are interrelated, changes in behavior should result in subsequent changes in cognition and affect (Baucom *et al.*, 1996). Thus the original BMT was heavily oriented toward dealing with instrumental behaviors that could be negotiated (Baucom & Eipstein, 1991).

Early research findings showed that while BMT is of benefit to many couples, many other couples end treatment without moving into better, non distressed marital conditions. Bennun (in Baucom & Eipstein, 1991), for example, found that BMT was effective in helping couples resolve task-related or instrumental aspects of relationships such as chores and finances, but was not very effective in resolving the issues that involved ways of demonstrating care and concern for spouse. Iverson & Baucom (in Baucom *et al.*, 1996) concluded that there are many instances in which behavioral change does not lead to the important cognitive and affective changes needed to assist couples.

BMT scientists and clinicians then agreed that couples need more than the ability to negotiate resolutions to instrumental aspects of their relationship. In the late 1980s, BMT practices were broadened by adding cognitive approaches. This new cognitive-behavioral marital therapy (CBMT), as BMT, holds the principle that behavioral, cognitive, and affective components of marital interaction are interrelated, and changes in one area may elicit changes in the other two. In addition, it also admits that changes in three areas may occur independently and thus may require different (although overlapping) sets of treatment (Baucom *et al.*, 1996).

COGNITIVE-BEHAVIORAL EXPLANATION ON MARITAL DISTRESS

While still be based on the behavioral model of marital relationship, CBMT expands its attention to the cognitions involved in marriage. Cognitive-behavioural model of marriage acknowledges that behavioral aspects together with cognitive aspects of marriage determine marital functioning.

In terms of behavioral aspects, researches have proven that happy and unhappy couples differ in their communication behaviors, interaction patterns, and ways of handling conflict. Craighead, Craighead, Kazdin, and Mahoney (1994), summarizing some research findings, wrote that compared to non distressed couples, distressed couples communicate each other more negatively, both verbally and nonverbally. More negative behaviors such as put-downs, criticisms, disapproval, and disagreeing statements appeared in unhappy couples' communication. Positive behaviors such as supportive behaviors, responsiveness to partners in the form of paraphrasing, agreeing, or acknowledging, and "reconciling acts" such as using humor were less showed by distressed couples. Nonverbally, members of distressed partners smile less, keep more distance between each other, and have more closed body posture.

Happy and unhappy couples also differ in their typical patterns of interaction. People in distressed partnerships tend to reciprocate with negativity, i.e. when one partner showed negative behavior, the other partner would respond with another negative behavior. Subsequently, distressed partners seem to be more reactive to negative events than happy partners. This tendency increases the likelihood of each partner feeling negatively about the relationship as a whole.

The ways of handling conflicts also appear as determinant of marital satisfaction. From previous findings Craighead concluded that to be satisfactory, a marital relationship need not to show positive verbal behavior and compliance all the time, rather, it need to have some amount of conflict and the ability to express anger without withdrawal. Defensiveness, stubbornness, and withdrawal from interaction are all harmful for the relationship.

Added to those behavioral aspects of marital distress, some cognitive factors have been acknowledged as playing important roles in marital functioning. Baucom & Eipstein (1990) established a formulation of cognitive factors that work in marriage and underlie the development and maintenance of marital dysfunction. According to them, there are five major categories of cognition that play important role in marital functioning: *perception, attributions, expectancies, assumptions, and standards.*

Perception is the cognitive process about *what* events occur (Baucom & Eipstein 1990). In marital relationships there is a phenomenon called *selective attention*, in which partners selectively attend to, or idiosyncratically notice, certain aspects of an interaction or an event. This tendency of selectively attending either positive or negative aspects of the relationship while ignoring other important behaviors can lead to distorted experiences of the partner, oneself, or the relationship occur (Eipstein & Baucom, 2002). Often, for example, one partner complaint that the other partner seems to notice him or her doing wrong more easily than to notice him or her doing right.

Attribution is about *why* events occur (Baucom & Eipstein 1990). Once an individual notices certain behavior, he or she might make inferences to explain the behavior. Numerous studies indicate that attributions in distressed and non distressed couples are different. Distressed partners tend to blame each others from problems, and they also attribute each other's negative actions to broad and unchangeable traits. On the other hand, distressed couples are less likely than non distressed ones to attribute each other's positive behavior to trait like characteristics (Eipstein & Baucom, 2002). For example, a wife might say "He did this because he is selfish", when her husband makes a mistake, whereas at other time when the husband does something right she says "He did that just because he did not want to argue with me". According to Eipstein & Baucom, such attributions foster a sense of hopelessness and pessimism about positive change. Negative attributions for relationship problems also lead couples to have ineffective problem solving discussions and to behave more negatively toward each other.

Expectancies are predictions about what *will* occur (Baucom & Eipstein 1990). One's expectancy affects his or her emotions and subsequent behavior. Negative expectancies are commonly found to be part of relationship distress. For instance, one might say, "I know that she is never going to listen to me when I am upset about something, so why bother telling her anything?" Expectancies are integrally related with attributions (Eipstein & Baucom, 2002).

Assumptions that spouses hold about the characteristics of individuals and intimate relationships also contribute in marital functioning. Each person usually develops an image of the partner (e.g. who he/she is, how he/she behaves, what he/she likes and dislikes). Attributions are made on the basis of assumptions. Disruption of assumptions will affect one's attention, attributions, expectancies, emotional responses, and behavior toward the partner. For example, an extramarital affair is overwhelming for the partner, largely because it disrupts the previous assumption that

the partner is honest, trustworthy, and committed (Baucom *et al.*, 1996, Eipstein & Baucom, 2002).

Standards involve personal beliefs about the characteristics that an intimate relationship and the members "should" have. Standards are different from assumptions in that assumptions involve how things "actually" are. Standards are used to evaluate whether each person's behavior is acceptable and appropriate (Eipstein & Baucom, 2002). Baucom *et al.* (1996) noted that marital conflict and distress arise when spouses are aware that their marital interactions do not match the ideal characteristics of intimate relationships or their standards. This happens perhaps because a spouse holds standard that is extreme and therefore unlikely to be met in the relationship, or perhaps the standard is not extreme but he or she is not satisfied with the degree to which it is met in the current relationship. Another possible cause is that the two partners hold incompatible standards.

All the cognitions described above contribute in maintaining distressed spouses' negative automatic reciprocities in the marriage. As all cognitive behavioral therapies, an essential of CBMT lies in the correction of automatic processes associated with maladaptive behaviors, including automatic thoughts, avoidance responses, pessimistic perspectives, misattributions, and other faulty but well-learned automatic behavior sequences. Combined with behavioral skill trainings such as communication training, effective problem solving training, and behavior contracting, CBMT is aimed to increase spouses' awareness of the dynamics of their problems, increase their optimism to solve the problems, and do the actions to solve them.

In more recent forms of cognitive-behavioural marital therapy, affective approaches have also been added to the cognitive and behavioral interventions above. Eipstein & Baucom's (2002) enhanced cognitive-behavioural therapy for couples include some affective interventions to access and heighten emotional experiences.

CURRENT POSITION OF CBMT

As a new therapy, CBMT is still struggling to demonstrate its power in the field of marital therapy. The term "cognitive-behavioural" even has not yet been acknowledged as an independent construct different from the previous well-known "behavioral", indicating that they have not developed a clear boundary. A decade ago when Snyder, Wills, and Grady-Fletcher (1991a) published their research finding that "behavioral marital therapy" showed far less satisfactory long term effectiveness compared to insight-oriented marital therapy (IOMT), cognitive-behaviorist protested

the finding, claimed that the behavioral approach applied in the study was out of date (Jacobson, 1991, Baucom & Eipstein, 1991). Jacobson (1991), based on his intensive analysis of Snyder colleague's manuals of the two approaches compared, asserted that the behavioral approach applied has missed a great deal of state-of the art technology of the "new wave BMT", including cognitive techniques and emotional fostering. Snyder, Wills, and Grady-Fletcher (1991b) defended themselves against this protest by disagreeing that their BMT approach has excluded some essential interventions.

Baucom & Eipstein (1991) participated in that debate by discussing about what the cognitive behavioral marital therapies of the 1990s really look like. In their article titled "Will the real cognitive behavioral marital therapy please stand up?" they wrote that BMT has been broadened to include major foci on cognitive and affective aspects of the relationship. New interventions have been developed to address these variables, or at least previously existing interventions have been articulated or made more explicit. In the same issue of the same journal, however, Johnson & Greenberg (1991) cynically critique the broadened focus of BMT as "building a proliferation of ill-defined therapies and de-contextualized interventions".

It is interesting to note that in the debate described above the authors delivered their thoughts without even differentiate the terms of "cognitive-behavioural" and "behavioral". Apparently the two approaches have not developed clear boundaries, and BMT is acknowledged as a previous and overlapped sequence of CBMT. It is not surprising then that literatures evaluate CBMT effectiveness by referring to BMT studies, beside because the real CBMT effectiveness studies have not been sufficiently available. CBMT now have to set up a clear identity and prove its power. One of the most fundamental ways to do is evaluating the accuracy of its theoretical ideology.

EVALUATING CBMT: REFLECTING FROM ITS MEAGER POWER

Evaluating the therapeutic power of CBMT is necessary to appraise its theoretical accuracy. CBMT has not been broadly studied, and among the studies on CBMT, only a few are methodologically sound (Dunn & Schwebel, 1995). Therefore, the following analysis of CBMT effectiveness will be based on researches in BMT too when relevant. The general findings from CBMT outcome researches are that CBMT, as BMT, found to be more effective in reducing marital distress, compared to no-treatment or waiting-list. Baucom and colleagues in their two studies (in Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; and Dunn & Schwebel, 1995) supplemented BMT with cognitive restructuring targeted at couples' attribution for marital events and their standards for what marriage should be. They found that both

BMT alone and CBMT alone were more effective than a waiting-list in altering marital adjustment, improving communication, and altering presenting complaints.

Halford, Sanders, and Behrens (1993) assigned 26 married couples to one or two treatment condition: BMT or enhanced BMT. Enhanced BMT included cognitive restructuring procedures as well as generalization training and affect exploration. The affect exploration component involved the spouses' exploration of their feelings about difficult marital interactions. Generalization training taught couples how to apply their skills to important, high risk situations in their daily lives. Findings indicated that both treatments resulted in increased marital adjustment.

There have also been a number of meta-analytical studies reviewing the outcome of marital therapies including CBMT. Dunn & Schwebel (1995) and Baucom *et al.* (1998) found that CBMT, as other treatments including BMT, IOMT, and emotion focused therapy (EFT) were more effective than no treatment in fostering favorable changes in several areas of couples' relationships.

Studies generally found that BMT and CBMT were not different in their effectiveness, which means that the supplementation of cognitive interventions in CBMT added nothing to the previous BMT effectiveness. Baucom and colleagues' findings (in Baucom *et al.*, 1998) suggest that CBMT intervention resulted in changes that are comparable to those of BMT. Harford's study (1995) also failed to show significant differences between BMT and enhanced BMT treatment effects. Baucom *et al.* (1998) even judged CBMT as less efficacious than BMT because the CBMT has not been proved to be more effective than control condition as many as BMT. Almost no study showed the power of CBMT compared to BMT. Dunn and Schwebel's found that CBMT is more powerful than BMT in producing significant post therapy change in partners' relationship-related cognition; however it did not produce more increase in general quality of relationship. Fincham, Bradbury and Beach (1990) one decade ago stated that empirical findings suggest that interventions that investigators construe as cognitive do not add to the effectiveness of other marital therapy techniques, and even a flood of research on cognition in marriage has not provided much guidance to practicing clinician. Until recent years there is not enough empirical evidence to debate this statement.

The question why the addition of cognitive approach (i.e. from BMT to CBMT) did not result in increased therapeutic power has stimulated discussions in this area. There are some points of possible explanations that are commonly discussed in literatures. The first is related with the objections that have been faced by the previous BMT regarding its structure. The second critique against CBMT lays on its theoretical

ideology that put too much focus on cognitive explanations of marriage. BMT and CBMT experts as well as other therapy experts (e.g. IOMT, EFT) have been contributing in those two types of discussion. The third discussion involves some authors who believe in the central role of cognitions in marriage but are not satisfied with CBMT accomplishments. Their analyses are typically based on how researches on cognition role in marriage or marital therapy settings are conducted and how the results are implemented. The first and the second discussions contain some more practice-related issues; therefore analysis below will focus on those two discussions.[3]

Regarding the structure, Markman (1991) introspectively criticized the way BMT overemphasizes structure in the manual. Markman wrote that the “default option” for the BMT therapist is to fall back on structure and skill training. The power of BMT to change behavior comes from the order of the sequence in which techniques are applied (Wills BMT manual, in Markman, 1991), thus the manual in several places reminds the therapist to follow the program and to convey the couples the benefits of doing so. Markman admitted that BMT therapist might be dealing with a couple by focusing more on the program than the couple, and creating the impression that the couple is working with a *robotherapist*. The problem with highly structured interventions is that it does not provide much space to address other issues that might come up during sessions such as generalization, as well as to validate affects and stimulate insights. An evidence of the disadvantage of highly structured treatments was provided by Jacobson (in Snyder *et al.*, 1991a) who found that provision of highly structured treatments not tailored to the needs of particular couples predict higher relapse at 1 or 2 year follow-up.

The second explanation of CBMT failure in demonstrating its effectiveness is related with its theoretical foundation, which focuses too much on the cognitive explanations of marriage. The study of Snyder *et al.* (1991a) mentioned previously in this essay has sparked discussions in this field. Markman (1991), commenting on that study, supposed that IOMT was more powerful than BMT because of its effective ingredients in helping couples learn how to *manage and handle negative affect*. It provides couple with the ability to express negative feelings and to listen, non defensively, to their partner’s negative feelings. In contrast, BMT manuals may teach therapists a structure for handling couples but may not teach couples the structure they need for handling negative affect and conflict, which is very important to maintain their marital functioning.When normal marital conflicts are not handled well,

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[3] *Please note again that discussions will also be based on BMT findings when relevant, because pure CBMT sources are limited.*

unresolved negative feelings start to build up, fueling destructive patterns of marital interaction and attacking the positive aspects of the relationship.

In BMT, the emphasis is not providing couples with skills to accept and handle those negative affects, rather, is the skills to alter destructive affect expressions to more constructive ones. This is another weakness of BMT.Snyder *et al.* (1991a) judged BMT as more change-focused rather than acceptance-focused. They showed the empirical findings showed that subjects engaging in proportionately higher rates of problem solving and information exchange at termination showed poorer outcome 4 years later. This finding, according to them, may reflect couples who prematurely propose unacceptable problem solutions without sufficient disclosure and affirmation of each partner's feelings regarding the conflict. Baucom & Eipstein (1991) countered this critique by stating that to encourage an acceptance in a partner means to make a change too; thus the issue is not change versus no change, but rather a balance of changes in cognition, behavior, and affect.

Others criticized BMT/CBMT as lacking attention on affect. Snyder *et al.* (1991b), explaining why in their study couples treated with IOMT fare so well at long term follow-up whereas those treated with BMT do not, proposed that insight oriented techniques challenge latent affective components to relationship distress not adequately addressed by either traditional or newer cognitive-behavioural interventions. They further suspected that spouses' destructive attributions regarding their partner's role in marital conflicts are modified significantly and in a more persistent manner once individuals come to understand and resolve emotional conflicts they bring to the marriage from their family of origin and relationship histories. Jacobson (1991) disagreed with this opinion and stated that in the new BMT (i.e. CBMT) there are affective interventions that a therapist must do such as creating therapeutic environment in sessions, fostering collaboration between spouses at home, providing empathy and emotional nurturance, and fostering hope in distressed couples. It can be noticed from the content of this debate, however, that what they mean by "addressing affect" in those two interventions are different; in IOMT addressing affect is more the content of the therapy, whereas in BMT/CBMT addressing affect seems to be one of the tools or a part of the procedure to reach the goal.

Coyne (1990) even still doubts about the accuracy of the current cognitive theories on marriage. He judged the cognitive explanations on marriage, such as attributions and schemas, as a rough adoption from depression theory that will not be able to explain well the dynamics of change involved in a marital relationship. He suggested that a theory that would be adequate would not look much like current

cognitive theories (i.e. attributions, schemas) and would put a greater emphasis on what transpires between people.

This issue of cognitive theory weakness seems to be the most critical issue in enhancing the effectiveness of BMT/CBMT, because in fact cognitive factors are not found as important predictor of CBMT success. Affect, instead of cognitions, is appeared to be the important predictor of BMT success. Hahlweg *et al.* (in Baucom & Eipstein, 1991) found that response to BMT was more closely related to (a) the quality of affection in the marriage prior to treatment, than to (b) the couple's ability to resolve conflict. They also presented data indicating that traditional behavioral approaches may be less well suited to dealing with internal events affecting the qualities of a relationship. With regard to this fact, Johnson & Greenberg (in Snyder *et al.*, 1991) hypothesized that spouses' self disclosure in more emotionally focused therapies facilitates marital intimacy, which in turn may promote cognitive or attributive modifications accompanied by positive interpersonal exchange. In other word, it is predicted that cognitive change may well stimulated by affective change.

A recent investigation by Riehl-Emde, Thomas, and Willi (2003) supports the supremacy of affection in marriage. In their study, they investigate themes that are considered decisive for marital relationship quality and stability. They asked 204 married couples (reference samples) and 31 married couples undergoing therapy (clinical sample) to evaluate a total of 19 themes with respect to their importance for the couple's connectedness. The first rank theme found in this study was "Love", which was described as a deep emotional bond, mutual caring and attraction, trust and closeness. *Love* was the single most important variable found to be related to overall well-being. Moreover, members of both reference and clinical sample named *love* as their pre-eminent reason for staying together. Statistical analysis also revealed that couples note decreases on both the degree of love they feel towards their partner and the degree of love they think their partner feel towards them. The deterioration of love was greater in therapy couples than in reference couples. It is obvious that emotional domain takes an important position in determining marital functioning, and therefore it needs to be given more attention in marital therapies.

To summarize, learning from researches on cognitive behavioral marital therapy as well as behavioral marital therapy, we can notice some weaknesses of CBMT that may have been preventing it from reaching its optimum performance. Too structured, imbalance emphases on change and acceptance, and heavy focus on cognitive and somewhat ignorance on affective domains are the main weaknesses.

FUTURE DIRECTION

Marital therapy is a new field where practice has proliferated and research has lagged behind (Dunn & Schwebel, 1995), and cognitive-behavioural therapy in this field is a new approach as well. Therefore, it is not surprising to find out that the performance of CBMT has not been satisfactory. Learning from current CBMT and BMT accomplishments, there are some suggestions that may be useful for the development of CBMT. The suggestions are listed below.

1. Offering more flexibility on the structure

Clear, structured intervention is the strength of CBMT. However, highly structured treatment not tailored to the needs of the couples has been found as a predictor for higher relapse. Hence, CBMT seems to be best applied in a more flexible structure that can be stretched in accordance to the couple's need.

2. Identifying the appropriate clients

Researches on BMT suggest that some characteristics of clients and problems predict the therapeutic outcomes. Response to BMT are better in couples who present more focused complaints around specific domains of spousal interactions (e.g. sexual behavior, finances, household-domestic concern), but poorer outcome for those complaints emphasizing more general issues (e.g. jealousy, dependency, nonsexual affection). Some demographic indicators have been found related to treatment outcomes too. Younger couples have shown more favorable BMT treatment outcome (Snyder, Mangrum, & Wills, 1993). Crowe (Snyder *et al.*, 1993) found that less educated couples responded more favorably to BMT; however other researches found no relationship between education level and therapy outcomes. To be more effective, CBMT needs to be matched with appropriate clients who will response better to it. Researches are needed for this purpose.

3. Enhancing the cognitive theory and giving more attention to affective domain

Coyne (1990) suggested that current cognitive theories on marriage need progresses. Focus of researches on marital cognitions need to be broadened, and cognitive explanations need to deal more with the dynamics of change in marriage instead of individuals' cognitions about the relationship.

Concurrently, CBMT needs to take more attention on affective processes. A good model of addressing-affect CBMT has been provided by Eipstein and Baucom (2002). They mention some interventions to access and heighten emotional experiences to be done in the therapy, including creating a safe environment for experiencing and expressing emotions, increasing a range of emotional experience by accessing primary emotions, and heightening emotional experiences.

4. Preventive interventions

Jacobson, Dobson, Fruzzetti, Schmaling, and Salusky (1991) found that CBMT was leading to more improvements on marital satisfaction in non distressed couples rather than in distressed couples. Markman (1991) conducted a preventive intervention program for premarital couples called PREP and found that the outcome was very encouraging; 7 years after program, PREP couples, as compared to control couples, have a 50% divorce rate, higher level of marital satisfaction, and lower rate of marital violence. Such findings indicate that CBMT may be perform better as a preventive intervention to keep happy couples happy rather than as a curative intervention to help distress couples become less distressed.

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