



Integrative Behavioral Couple Therapy vs. Traditional Behavioral Couple Therapy: A theoretical review of the differential effectiveness

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ABSTRACT

The purpose of this review is to compare the differential effectiveness of two couple therapies, the Traditional Behavioral Couple Therapy (TBCT) and the Integrative Behavioral Couple Therapy (IBCT). Although the latter can be seen as an evolution of the first, both are based on different theoretical concepts. Starting from the analysis of 12 studies comparing TBCT and IBCT, conclusions about effectiveness and future perspectives of both approaches are discussed. Our results show that TBCT and IBCT have distinct courses of change and differ fundamentally in what the therapist does in-session, impacting couple behavior both in and out of session. Currently, in line with the most important randomized trials in this field, a slight advantage for IBCT over TBCT in treating distressed couples at two points in time —when treatment is completed and in the first years post-therapy— can be confirmed, although at a five-year follow-up results equalize. Furthermore, some studies cannot confirm significant changes, but clinically relevant ones, which point toward a higher impact of IBCT. Lastly, the article includes limitations of the review as well and offers some orientations, which should be considered for future research.

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Terapia Integral de Pareja vs. Terapia Conductual de Pareja: una revisión teórica de su eficacia diferencial

RESUMEN

El propósito de esta revisión estriba comparar la eficacia diferencial de dos terapias de pareja: la Terapia Conductual Tradicional de Pareja (TBCT) y la Terapia Conductual Integral de Pareja (IBCT). Aunque esta última puede considerarse una evolución de la primera, hoy en día ambas se apoyan en diferentes conceptos teóricos. A partir del análisis de 12 estudios en que se comparan, en el artículo se presentan conclusiones sobre su eficacia y perspectivas de futuro de ambos enfoques. Los resultados muestran que la TBCT y la IBCT ofrecen distintos cursos de acción y se diferencian fundamentalmente en lo que el terapeuta hace dentro de la sesión, y en lo que afecta el comportamiento de pareja dentro y fuera de la sesión. En la actualidad y de acuerdo a los estudios aleatorizados más destacados, se puede confirmar una ligera ventaja de la IBCT sobre la TBCT en el tratamiento de parejas con dificultades al menos en dos momentos temporales: justo al terminar el tratamiento y en los primeros años después de la terapia; no obstante, en un seguimiento a cinco años se iguala la efectividad de los dos tratamientos. Por otro lado, algunos cambios no significativos pero clínicamente relevantes apuntarían hacia la mayor utilidad de la IBCT. Finalmente, el artículo pone de relieve las limitaciones de la revisión y ofrece algunas orientaciones que deben tenerse en cuenta para futuras investigaciones.

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During the last decade, the acceptance and application of couple therapy has vastly increased, and whereas couples therapy was once a treatment of last resort, it is now the preferred treatment of relationship distress and DSM disorders (Johnson & Lebow, 2000). The linkage of relationship distress to the disruption of individual emotional and physical well being emphasized the importance of improving and extending empirically based strategies for treating couple distress (Snyder, Castellani, & Whisman, 2006). Until now, the efficacy of six different couple-based treatments for couple distress is supported: traditional behavior therapy, cognitive-behavioral therapy, integrative behavioral therapy, emotionally focused therapy, integrative systemic therapy, and insight-oriented couples therapy (Snyder et al., 2006). Still, Traditional Behavior Couple Therapy (TBCT; Baucom & Epstein, 1990) with its primary intervention components in (1) behavior exchange and (2) communication and problem solving training (Dimidjian, Martell, & Christensen, 2008) is found firstly to be the most used therapy modality by therapists (Northey, 2002); secondly, the most validated treatment modality, with over two dozen well controlled outcome studies up until today; and thirdly, is proven to be an effective intervention for distressed couples on several occasions (Baucom, Epstein, Taillade, & Kirby, 2008).

Despite the fact that TBCT remains the only couple therapy to date that meets the most stringent criteria for empirical support, TBCT appeared to be limited in its ability to produce clinically meaningful change in severely distressed couples (Snyder, Mangrum & Wills, 1993), older couples (Baucom & Hoffman, 1986 as cited in Cordova, Jacobson, & Christensen, 1998), emotionally disengaged couples (Hahlweg, Schindler, Revenstorf, & Brengelmann, 1984 as cited in Cordova et al. 1998; Johnson & Lebow, 2000), and couples who were polarized with respect to gender role preferences (Jacobson, Follette, & Pagel, 1986). Hence, it became increasingly clear that TBCT's emphasis on promoting change seemed to be a poor fit for some couples and some problems (Dimidjian et al., 2008). Additionally, results showed that 38% of the couples who received TBCT treatment had divorced during a four-year follow-up period (Snyder, Wills, & Grady-Fletcher, 1991) and in a two-year follow-up analysis of Jacobson, Schmalzing and Holtzworth-Munroe (1987) results were not that encouraging: approximately 30% of couples who had recovered during therapy relapsed afterwards.

Subsequently, Christensen and Jacobson suggested that the recipe for positive therapy outcome was not an emphasis on change but rather an increased emphasis on emotional acceptance in the couple (Dimidjian et al., 2008) and consequently they developed the Integrative Behavioral Couple Therapy (IBCT) (Christensen, Jacobson & Babcock, 1995). TBCT and IBCT both prove effectiveness for treating marital distress, but do this by operating from two very different theories of change. Lebow, Chambers, Christensen, and Johnson (2012) point out that IBCT and TBCT are clearly different in terms of what the therapist does in-session and in terms of how the couples respond to it, both in and out of session. IBCT suggests that fostering acceptance is an essential step towards improving couple's distress, whereas TBCT postulates that effective skill building is not only necessary but sufficient for mitigating distress (Cordova et al., 1998). Thus TBCT is designed to quickly and effectively teach distressed couples the skills thought to be necessary for improving the relationship and maintaining improvements over time, whereas IBCT's working concept is based on acceptance and tolerance rather than change (Cordova et al., 1998).

Ultimately, IBCT differs from TBCT in three fundamental points: in the focus of change –in IBCT the emphasis is on the recipient of behavior whereas in TBCT the emphasis lies in the agent of behavior; in the strategy of change –in IBCT the primary mechanism of change is through “contingency-shaped behavior” in contrast to “rule-governed-behavior” in TBCT; and finally in the techniques used in therapy –in IBCT there is an integration of strategies for change with

strategies to foster acceptance and tolerance (Dimidjian et al., 2008). Acceptance strategies include empathic joining (partners express their pain in a way that does not include accusations of the partner) and unified detachment (aimed at helping the partners to distance themselves from their conflicts by encouraging an intellectual analysis of the problem and by emphasizing the use of detached and descriptive discussions rather than emotionally laden ones; Dimidjian et al., 2008). Tolerance strategies focus on pointing out the positive features of negative behavior, practicing negative behavior in therapy session and faking negative behavior between sessions as well as self-care. Finally, change strategies contain behavior exchange and problem-solving training (Dimidjian et al., 2008; Jacobson & Christensen, 1998).

Thus, IBCT is based on an essentially different understanding of relationship distress from the one underlying TBCT (Dimidjian et al., 2008). Ergo, this paper has the objective to revise the differential effectiveness of IBCT and TBCT, with the idea of outlining a picture about the already well-functioning applications of both therapies in order to draw conclusions about future indications for research and administration of the therapies in the field of clinical and health psychology.

Method

Materials

Twelve academic research papers about the two treatments, TBCT and IBCT, published between 1997 and 2011, were used to review the effectiveness of the therapies. In all studies the treatments were implemented through well-established protocols: The manual of Jacobson and Margolin (1979) was used for TBCT and Jacobson and Christensen's for IBCT (1998). The number of sessions, equivalent in both treatments, ranged between 20 and 26 sessions. Both treatments were applied by therapists who were experts in couple therapy with at least 3 years of experience, carrying out both protocols in accordance with the randomized treatment assignment. To ensure proper implementation of each of the treatments, observational measures (by other therapists) were taken, which evaluated the correct application of both protocols and therapists were monitored during the entire process individually and in-group supervision.

Procedure

To obtain current research literature, Scencedirect (Elsevier B.V.), Ovid (WoltersKluwer), Onlinelibrary Wiley, PsycINFO, and PsycARTICLES databases were searched. The most used keywords for the search contained “Family therapy”, “Couple therapy”, “Traditional-behavioral couple therapy” and “Integrative-behavioral couple therapy”. Journals offering a major source of articles were the *Journal of Consulting and Clinical Psychology*, *Journal of Marital and Family Therapy*, *Behavior Therapy* and *Journal of Behavior Research and Therapy*. The search language was English.

Information analysis

The studies obtained were reviewed according to the following parameters: (1) year of publication, (2) number of participants, (3) type of analysis, (4) results, and (5) limitations. All available studies evaluating the effectiveness of IBCT with TBCT were intended to be included.

Results

In the trial of Cordova et al. (1998), 12 maritally distressed couples were assigned either to TBCT or to IBCT. The research group found that IBCT leads to an identifiably different type of change over the

course of treatment and they assume that these changes may be related to changes in couples' satisfaction. To begin with, results showed that IBCT couples engage in more significantly non-blaming discussions of mutual problems than TBCT couples. This means that IBCT couples talk more about their irresolvable problems without blaming each other and without pushing for change during middle and late therapy sessions ($d = 1.75$). Moreover, TBCT couples did not show detachment at all during middle session ($d=1.02$) and late session ($d = 1.83$) in comparison to IBCT couples. Additionally, IBCT couples express more soft emotions than TBCT couples during late session ($d = 1.13$), which could facilitate increased intimacy, understanding, and shared empathy. There seems to be support for a relationship between in-session communication and changes in marital satisfaction, and increases in non-blaming discussions of mutual problems were significantly associated with decreases in global distress ($r = -.55, p = .03$).

The second study reviewed was the one by Jacobson, Christensen, Prince, Cordova, and Eldridge (2000), who conducted a small clinical trial in which 21 distressed married couples were randomly assigned to IBCT or TBCT. Results showed that therapists administering both treatments could keep them distinct and that IBCT produced greater improvements in marital satisfaction and stronger effect sizes (DAS $d = 0.56$ for husbands and wives; GDS $d = 0.62$ for husbands and $d = 0.78$ for wives) than TBCT, but not significantly better taking into account the small sample size. "IBCT evidenced greater increases in marital satisfaction than TBCT, and that IBCT resulted in a greater percentage of couples who either improved or recovered on the basis of clinical significance data" (Jacobson et al., 2000, p. 351). "Because of the small sample size and inadequate statistical power of the present study, we made a decision to confine our analyses to descriptive statistics reflecting both effect size and clinical significance of the group differences but not to use statistical analyses for hypotheses-testing purposes" (Jacobson et al., 2000, p. 354). Jacobson et al. (2000) argue that successful acceptance work can be a more effective way of shifting contingencies of reinforcement in a way that supports spontaneous change. In their study, they detected that empathic joining and unified detachment were encouraged in IBCT but not in TBCT. Additionally Jacobson et al. (2000) stated that IBCT seems to successfully apply to couples-group format and treatment of marital discord with coexisting depression in one spouse ($d = 1.12$). Thus, 64% of TBCT couples and 80% of IBCT couples improved or recovered by the end of therapy. Atkins, Eldridge, Baucom, and Christensen (2005) in their study with 19 couples showed that IBCT and TBCT are effective in improving marital distress for discordant couples who are also experiencing infidelity. Evidence suggests that couples who had an affair and who revealed this affair prior to or during therapy showed greater improvement in satisfaction than couples without infidelity. Another study by Atkins, Berns, George, Doss, Gattis, and Christensen (2005) found out that couples who are initially very sexually unhappy in their marriages show more rapid improvement with TBCT early in treatment. However, this process slows down and even reverses later in therapy. On the other hand, IBCT couples with similar levels of sexual dissatisfaction show slower but more steady improvement over the entire period of therapy. Furthermore, strongest improvement in therapy was shown for couples been married for 18-years ($B = 0.019, t(704) = 2.84, p < .01$) with little benefit from therapy for couples been married for less than 10 years.

Additionally, Trapp, Pace, and Stoltenberg (1997, as cited in Christensen & Heavey, 1999) showed that IBCT was as effective in reducing depression as cognitive therapy for depression in 29 depressed women who were also maritally distressed. In addition, Wimberly (1998, as cited in Dimidjian et al., 2008) randomly assigned 8 couples to a group format of IBCT and showed that they were significantly more satisfied than nine wait-listed couples at the end of therapy. In the study by Doss, Thum, Sevier, Atkins and Christensen

(2005), one of the most interesting findings was the differential amount of change both early and late in therapy in frequency and acceptability of target problem behaviors. In the first half of therapy, the frequency of target problem behaviors significantly improved, with significantly more change in the frequency of target problem behaviors in TBCT than in IBCT. However, spouses in both therapies reported significant decreases in the frequency of target problem behaviors in the second half of the therapy. Moreover, although the frequency of positive behaviors improved significantly in the second half, the frequency of negative behaviors increased significantly during the second half of the therapy in both treatments. Acceptance of target problem behaviors, however, showed significantly greater increases in IBCT than in TBCT, both early and late in treatment. In contrast to the frequency measures, there was no evidence of relapse in any of the acceptance measures. Consequently, it seems that increases in acceptance remains important for both therapies, whereas the amount of change in the frequency of partner behaviors becomes less critical, and that IBCT generally created more change than TBCT in emotional acceptance, which in turn was related to marital satisfaction. One study by Sevier, Eldridge, Jones, Doss, and Christensen (2008) analyzed changes in couple communication in 134 distressed couples, assigning them either to TBCT or IBCT. They found that over time in therapy, during discussions of relationship problems, positivity (which is positive and constructive communication) and problem solving increased, while negativity (negative communication) decreased and TBCT couples showed the largest gains in positivity and reductions in negativity compared to IBCT couples. TBCT participants also showed larger declines in negativity, and in both discussion types increased marital satisfaction was associated with increased positivity and problem solving. Likewise, declines in marital satisfaction were associated with increased negativity during relationship problem interactions and increased withdrawal during personal problem interactions. The authors mentioned applying more measurement occasions, and that the coding system was more relevant to TBCT than to IBCT.

Unfortunately, until now most studies have studied just the short-term effects of treatment, the picture of long-term effects being still poor (Christensen, Atkins, Baucom, & Yi, 2010; Lundblad & Hansson, 2006). Just one study by Christensen, Atkins, Berns, Wheeler, Baucom and Simpson (2004) includes a follow-up of two (Christensen, Atkins, Yi, Baucom, & George, 2006) and five years after treatment (Christensen et al., 2010), and has encouraged a large clinical trial comparing TBCT and IBCT in 134 couples. It was designed to be a challenging test of couple therapy, thereby showing the trajectory of change in marital status and satisfaction and not just the final outcome of these measures, thus repeated measures of marital status and satisfaction were taken throughout the study. Initially Christensen et al. (2004) compared the expanded IBCT with traditional TBCT by assigning couples to the two conditions, stratified into moderately and severely distressed groups. During the clinical trial, couples in both TBCT and IBCT improved in marital satisfaction as expected (71% of IBCT couples and 59% of TBCT couples reliably improved or recovered based on self-reports of overall relationship satisfaction) with similar effect sizes from pre- to post treatment for both therapies in the two scales of marital satisfaction –Dyadic Adjustment Scale (DAS) (Spanier, 1976) ($d = 0.86$); the Global Distress Scale (GDS) of the MSI-R (Snyder, 1997) ($d=0.85$). However, the trajectories of the two therapies were significantly different.

Data from two-year follow-ups revealed statistically significant superiority of IBCT over TBCT in relationship satisfaction (Christensen et al., 2010) and at a five-year follow-up 50% of IBCT couples and 46% of TBCT couples still showed clinically significant improvement, and 25.7% of IBCT couples and 27.9% of TBCT couples were divorced or legally separated (Christensen et al., 2010). Data also suggested other important differences between treatments. Although both treatments showed, not surprisingly, a difference in satisfaction scores between

those couples who stayed together and those who separated, this difference was greater in IBCT than in TBCT. In general, couples who stayed together fared better in IBCT than in TBCT and couples who had deteriorated at termination were most likely to remain deteriorated at the five-year follow-up (Christensen et al., 2010). Finally, there was less volatility throughout follow-up in IBCT than in TBCT (Christensen et al., 2006). Thus, both therapies showed substantial effectiveness in relationship satisfaction at termination of therapy, at the two-year follow-up and five years after termination of treatment. Couples who stayed together demonstrated substantial improvement from their pre-treatment satisfaction scores in both therapies, with a slight advantage for IBCT. Still, approximately one fourth of the couples were separated or divorced at the five-year follow-up, and differences between TBCT and IBCT were not statistically significant anymore (Christensen et al., 2010).

The last reviewed study by Baucom, Sevier, Eldridge, Doss, and Sevier (2011) studied, in the same sample of 134 distressed couples, the course of change in couples' communication in a two year follow-up and tested if there was a contrast in these changes between the two behavioral couple therapies. Additionally, the relationship outcome two and five years after the treatment was assessed. As the research group expected, partners' negativity ($ps < .001$) and withdrawal ($ps < .001$) continued to decrease from post-therapy to the two-year follow-up. Unexpectedly, partners' positivity also decreased in the same time range ($ps < .01$) and problem solving did not significantly change over this time span. Treatment differences were also found in the wives' negativity from post-therapy to a two-year follow-up ($d = -0.48, p < .05$) in the sense that negativity among IBCT wives continued to decrease after therapy, whereas that of TBCT wives did not significantly decrease. Also, a significant treatment effect was detected in the husbands' positivity ($d = 0.57, p < .05$) in the sense that in IBCT husbands' positivity did not significantly decrease from post-therapy to the two-year follow-up, but it did in TBCT. No significant effects were found in withdrawal and problem-solving communication. In a post hoc test controlling for withdrawal in all models in which positivity was the outcome, the authors found that the effect of therapy on change was more salient in both husbands ($d = 0.69, p < .01$) and wives ($d = 0.68, p < .01$). It was also shown that while positivity of IBCT wives significantly decreased from post-therapy to two-year follow-up, positivity of TBCT wives decreased significantly more. Additionally, positivity of IBCT husbands did not significantly change from post-therapy to the two-year follow-up, while positivity of TBCT husbands lowered significantly.

Thus, IBCT has shown to be effective in successfully treating marital distress both short and long-term to the same extent, or even more effectively, than TBCT.

In Table 1 the studies reviewed are summarized, with main characteristics and limitations of each work highlighted.

Discussion

From a today's point of view and based on the information gathered in this review, a slight advantage for IBCT over TBCT in treating distressed couples at two points in time (when treatment is completed and in the first years post-therapy) can be confirmed when looking at the biggest study now available in this field (Christensen et al., 2004; 2006; 2010). It was shown that TBCT and IBCT are both effective in treating marital distress, but have distinct courses of change: TBCT couples improved quickly early in treatment but then tapered off whereas IBCT couples improved gradually but consistently throughout the course of treatment. The authors' interpretation (Christensen et al., 2010) of these findings is that TBCT strategies of behavioral exchange, which delay attention to long-standing issues but focus instead on increasing the frequency of positive activity, may create an initial boost in satisfaction but when

the focus shifts to those long-standing problems, satisfaction may taper off. In IBCT, however, there is no delay in focusing on long-standing issues, which may account for the slower but continual increase in satisfaction. The authors also found a gender difference in the trajectories of husbands and wives, with husbands improving significantly more rapidly than wives in satisfaction. The authors speculated that husbands may fear that therapists will side with their wives in bringing to light their limitations. When husbands experience therapy as something that may benefit them as well, their satisfaction may show faster improvement than their wives'. Following treatment termination, couples showed an immediate drop in satisfaction but then a gradual rise ("hockey-stick" pattern of change) and in couples who stayed together there was a considerable maintenance of that higher level of satisfaction. Christensen and colleagues (2004, 2006, 2010) speculated that the immediate drop in satisfaction after treatment termination might be a natural result of ending the regular focus on the relationship that therapy provides. However, they also offered the alternative possible explanation that the final assessment of satisfaction right after therapy termination may reflect an overestimation of relationship improvement. However, couples in IBCT tended to reverse courses and improve in satisfaction sooner than TBCT couples.

So, although TBCT was found effective in a number of studies, it seems to not be effective for everyone (Cordova et al., 1998) and to not include a "macro level point of view", which IBCT does. Also Hodgson, Johnson, Ketring, Wampler, and Lamson (2005) note that, although research shows the effectiveness of marital therapy more evidence is needed to further understand how change occurs in relationships and they point out the importance of integration of theory, practice and research in the field. Our results also support that couples' in-session communication (fewer non-blaming discussions and more open expression of soft emotions), which is more frequent in IBCT treatments, seems to decrease marital distress (Cordova et al., 1998). It could be argued that the highly structured nature of TBCT sessions suppresses the emotional expression of couples seeking therapy (Cordova et al., 1998). As we see in the study by Atkins, Berns et al. (2005) IBCT is based in spontaneous change, which results from greater intimacy between partners and which may also lead to an improved sexual relationship in distressed couples with sexual dissatisfaction. In general, couples fared to the same extent at termination of therapy and better at a two-year follow-up in IBCT than in TBCT and couples who stayed together fared better in IBCT than in TBCT. Finally, there was less volatility throughout follow-up in IBCT than in TBCT (Christensen et al., 2006) although in a five-year follow-up differences between TBCT and IBCT were not statistically significant anymore, but with an edge given to IBCT (Christensen et al., 2010). This is surprising, as IBCT was developed, in part, to address concerns about long-term maintenance through a focus on emotional acceptance and an emphasis on natural contingencies which stresses the demand for more research on mechanisms of change (Christensen et al., 2010) and requires both therapies to attend to the circumstances which lead to poor long-term (five-year follow-up) efficacy. As IBCT is shown to be effective for treatment outcome and a two-year follow-up in marital satisfaction, Christensen et al. (2010) propose the possible value of booster session interventions to alter the downward slide evidenced by a number of couples for better long-term effects of IBCT.

The latest research also promotes the use of systematic monitoring and feedback during therapy as a potential factor that could enhance treatment outcome (Halford, Hayes, Christensen, Lambert, Baucom, & Atkins, 2012). The findings of their study showed that lack of progress in couple therapy in the first half of therapy (in TBCT and IBCT) predicts poor eventual outcome, which is consistent with the idea that providing couple therapists with feedback on the lack of therapy progress might enhance couples therapy outcome (Halford

Table 1
Results of studies (N=12) of effectiveness of IBCT and TBCT

Authors/Year	N	Type of analysis & measures:	Results	Limitations
Trapp, Pace, and Stoltenberg (1997, as cited in Christensen & Heavey, 1999)	29 depressed women who were maritally distressed		IBCT was as effective in reducing depression as cognitive therapy for depression.	
Wimberly (1998 as cited in Dimidjian et al., 2008)	8 couples	Randomized trial: IBCT vs. Waiting list	Couples in a group format of IBCT were significantly more satisfied than 9 wait-listed couples	Small sample size.
Cordova et al. (1998)	12 maritally distressed couples	Randomized trial: IBCT vs. TBCT GDS of the MSI, (Snyder, 1979)	<ul style="list-style-type: none"> • IBCT leads to an identifiably different type of change over the course of treatment • IBCT couples engage in significantly more non-blaming discussions of mutual problems than TBCT couples ($d=1.75$) • TBCT couples did not show detachment at all during the whole therapy process in comparison to IBCT couples ($d=1.02$ in middle session; $d=1.83$ in late session) • IBCT couples express more soft emotions than TBCT couples during late session ($d=1.13$) • Support for a relationship between in-session communication and changes in marital satisfaction, especially increases in non-blaming discussions of mutual problems, were significantly associated with decreases in global distress ($r=-.55, p=.03$) 	Small sample size and low power to detect differences. No control group.
Jacobson et al. (2000)	21 married couples clinically distressed	Randomized clinical trial: IBCT vs. TBCT DAS (Spanier, 1976) GDS of the MSI	<ul style="list-style-type: none"> • Both husbands and wives receiving IBCT evidenced greater increases in marital satisfaction than couples receiving TBCT • IBCT resulted in a greater percentage of couples who either improved or recovered on the basis of clinical significance data (DAS $d=0.56$ for husbands and wives; GDS $d=0.62$ for husbands and $d=0.78$ for wives) • Types of interactional change targeted by the two treatments are actually reflected in couples' in-session behavior, especially in middle and later sessions. • IBCT and TBCT were found to be distinct treatment as using distinct interventions 	Inadequate statistical power, thus solely descriptive statistics for both effect size and clinical significance. No control group.
Christensen et al. (2004)	134 seriously and chronically distressed married Couples	Randomized clinical trial DAS GDS of the MSI MSI (Weiss & Cerreto, 1980) MSI-R (Snyder, 1997) MHI (Sperry et al., 1996)	<ul style="list-style-type: none"> • IBCT and TBCT showed similar level of clinically significant improvements in marital satisfaction: DAS: $d=0.86$ GDS: $d=0.85$ • IBCT and TBCT show different courses of improvement in satisfaction throughout treatment: changes in IBCT were more slow, but stable whereas in TBCT changes were faster, but then plateaued DAS: $d=0.58$ (therapy on slope) 	Exclusion of not sufficiently dissatisfied couples. More than half of the couples had received couple therapy before treatment. No control group. Therapist with special training and experience.
Atkins, Berns et al. (2005)	134 distressed married couples	Randomized clinical trial DAS NEO-FFI (Costa & McCrae, 1989) COMPASS (Sperry, Brill, Howard, & Grissom, 1996) SCID (First, Spitzer, Gibbon, & Williams, 1994; Spitzer, Williams, Gibbon, & First, 1994) CPQ (Christensen & Sullaway, 1984) CII (Heavey & Christensen, 1991) AFC from the MSI-R FAM & SEX from the MSI-R MSI	<ul style="list-style-type: none"> • Couples who are initially very sexually unhappy in their marriages show more rapid improvement with TBCT early in treatment; however, this process slows down and even reverses later in therapy. • IBCT couples with similar levels of sexual dissatisfaction show slower but steady improvement over the entire period of therapy. • Strongest improvement in therapy was for couples married 18-years ($B = 0.019, t(704) = 2.84, p < .01.$) with little benefit from therapy for those married less than 10 years. 	Couples were disproportionately White and college educated, heterosexual, married, and living together and excluded couples who were batterers or whose partners had one of several DSM-IV criteria (e.g., substance abuse or dependence, antisocial personality). Self-report measures. Solely focus on acute response to treatment.
Atkins, Eldridge et al. (2005)	19 couples with infidelity issues	Randomized trial: TBCT vs. IBCT DAS Infidelity questionnaire	<ul style="list-style-type: none"> • IBCT and TBCT are effective in improving marital distress for discordant couples, who also are experiencing infidelity ($d = 1.12$) • Evidence suggests that couples who had an affair and who revealed this affair prior to or during therapy showed greater improvement in satisfaction than couples without infidelity. 	Because of the small sample size, couples receiving either IBCT or TBCT were combined to evaluate the effects of treatment. Inferential statistics to assess changes in functioning from pretest to posttest were inappropriate, because of small sample size.

Table 1 (Continuation)
Results of studies (N=12) of effectiveness of IBCT and TBCT

Authors/Year	N	Type of analysis & measures	Results	Limitations
Doss et al. (2005)	134 married couples	Randomized trial: TBCT vs. IBCT DAS FAPBI (A. Christensen & Jacobson, 1997) CPQ	<ul style="list-style-type: none"> • TBCT led to greater changes in frequency of targeted behavior early in therapy ($p < .01$), whereas IBCT led to greater changes in acceptance of targeted behavior both early and late in therapy ($p < .01$). • Change in behavioral frequency was strongly related to improvements in satisfaction early in therapy; $t(128)=4.28$, $p < .001$, $d = 0.80$, and wives, $t(128)= 3.25$, $p < .01$, $d = 0.58$.) however, in the 2nd half of therapy, emotional acceptance was more strongly related to changes in satisfaction (husbands $t(128) = 2.26$, $p < .05$, $d = 0.41$, and wife's $t(128) = 2.40$, $p < .05$, $d = 0.43$) 	<p>Relatively small number of assessments during the course of therapy, thus, the current study may underestimate the relationship between mechanisms and satisfaction across time and treatment differences.</p> <p>Self-reporting methods.</p>
Christensen et al. (2006)	130 chronically and severely distressed couples	Randomized clinical trial: Follow-up data across 2 years were obtained on 130 of 134 couples DAS MSI-R MAQ (Christensen, 1999)	<ul style="list-style-type: none"> • Both treatments produced similar levels of clinically significant improvement at two years post-treatment (69% of IBCT couples and 60% of TBCT couples). • "Hockey-stick" pattern of change • Couples who stayed together generally fared better in IBCT than in TBCT • Less volatility throughout follow-up in IBCT than in TBCT. • Results showed that client satisfaction with services is strongly related to each component of the trajectory: participants who were the most satisfied with services reported greater marital satisfaction at the end of therapy, a steeper drop in satisfaction following therapy, and a more rapid improvement later in the follow-up period. 	<p>During the two-year follow-up, some of the most distressed couples separated or divorced and thus did not provide measures of marital satisfaction.</p> <p>The removal of the worst cases through divorce may have affected the shape of change.</p> <p>Complete reliance on self-reporting measures.</p>
Sevier et al. (2008)	134 distressed couples	Randomized trial: TBCT or IBCT DAS GDS CIRS (Heavey, Gill, & Christensen, 1998) SSIRS (Jones & Christensen, 1998)	<ul style="list-style-type: none"> • Over time in therapy, during relationship problem discussions, positivity and problem solving increased while negativity decreased • Compared to IBCT, TBCT couples had the largest gains in positivity and reductions in negativity. • TBCT couples had larger declines in negativity • In both discussion types, increases in marital satisfaction were associated with increases in positivity and problem solving. • Declines in marital satisfaction were associated with increased negativity during relationship problem interactions and increased withdrawal during personal problem interactions. 	<p>More measurement points are needed</p> <p>Variability in the number of sessions couples had received</p> <p>Coding systems were more relevant to TBCT than to IBCT.</p>
Christensen et al. (2010)	Follow-up of 134 chronically and seriously distressed married couples for 5 years	Randomized clinical trial DAS MAQ	<ul style="list-style-type: none"> • At five-year follow-up for marital satisfaction relative to pretreatment, effect sizes were $d = 1.03$ for IBCT and $d = 0.92$ for TBCT • 50.0% of IBCT couples and 45.9% of TBCT couples showed clinically significant improvement • Relationship status, obtained on all 134 couples, revealed that 25.7% of IBCT couples and 27.9% of TBCT couples were separated or divorced • IBCT produced significantly but not dramatically superior outcomes through the first two years after treatment termination but without further intervention • Outcomes for the two treatments converged over longer follow-up periods. 	<p>Reliance on self-report measures.</p> <p>Timing of follow-up measures.</p>
Baucom et al. (2011)	134 chronically and seriously distressed married couples	Randomized trial TBCT or IBCT DAS CIRS (Heavey, Gill, & Christensen, 1998) SSIRS	<ul style="list-style-type: none"> • Couples on average continue to improve in targeted communication even after therapy completion • Partners' negativity ($ps < .001$) and withdrawal ($ps < .001$) continued to decrease from post-therapy to two-year follow-up. • Partners' positivity also decreased in the same time range ($ps < .01$) • IBCT wives' negativity decreased from post-therapy to 2-years follow-up ($d = -0.48$, $p < .05$), whereas TBCT wives' did not significantly decrease. • Treatment effect of husbands' positivity ($d = 0.57$, $p < .05$): IBCT husbands' positivity did not significantly decrease from post-therapy to the two-year follow-up, but in TBCT they did. • Post hoc test: Effect of therapy on change was more salient in both groups, for husbands ($d = 0.69$, $p < .01$) and wives ($d = 0.68$, $p < .01$). While IBCT wives' positivity significantly decreased from post-therapy to 2-years follow-up, TBCT wives' positivity decreased significantly more. 	<p>Bias: Separated/divorced couples did not participate in follow-up.</p> <p>Observational data missing on some couples.</p> <p>Observational research: specificity of the observed behavior & neglect of context when coding.</p>

et al., 2012). Also, Johnson and Lebow (2000) state that more attention should be paid to the actual process of change, in order to identify key moments of change and how therapists bring them about.

Other authors propose focusing on prevention and offer the technique of mindfulness in happy, non-stressed couples (Carson, Carson, Gil, & Baucom, 2004). They showed empirical support of mindfulness to enhance stress coping skills, partner acceptance, individual relaxation, confidence in ability to cope, and overall functioning across a range of domains (Carson et al., 2004). As a limitation of the study, the research group states: like most research

with couples, the sample of this study was almost entirely white, well-educated, middle-class, and entirely heterosexual (Carson et al., 2004), which stresses the demand for more investigations in the field of same-sex couples/marriages, different ethnicities and different social backgrounds.

The lack of differential effectiveness across couple treatment approaches combined with suboptimal improvement and deterioration after two years, have fostered two alternative lines for treating couple distress (Snyder & Balderrama-Durbin, 2012): (a) emphasizing common factors or universal processes hypothesized to contribute to beneficial effects across "singular" treatment

approaches and (b) integrative models incorporating multiple components of diverse treatment approaches (assimilative, transtheoretical, and pluralistic).

Furthermore, Christensen et al. (2010) and Lebow et al. (2012) stress the need to investigate more about emotional arousal, as it is seen quite often in seriously distressed couples, and Lebow et al. (2012) say an important variable that may predict response to treatment is language used during difficult problem-solving discussions. Besides those factors, Atkins, Eldridge et al. (2005) note that most current measures focused on assessing negative qualities of couples, such as conflict, distress, or dissatisfaction. Improvement in prediction may come from using more variables that are reflective of positive qualities of the couple. Also Christensen and Heavy (1999) mention to be uncomfortable with the unequivocal labeling of relationship dissolution as an intervention failure, as sometimes a divorce, or decision to not marry, may in fact be the best outcome for all parties involved. Christensen and Heavy (1999) recommend as well that future intervention research should measure individual outcomes, such as individual wellbeing, social functioning, and psychological symptoms, together with relationship outcomes.

In conclusion, IBCT is proven to be a distinct treatment from TBCT, leading to a different type of change, to more non-blaming discussions, more detachment, more soft expressions, and decreased negativity from post-therapy to two-year follow-up. Thus, the effectiveness of IBCT can be seen as well-established for lower moderate and severe and long-term couples distress, significantly on short- and mid-term, and also well-suited as an effective treatment for individual disorders. Results showed us similar or in some cases better effectiveness of IBCT than TBCT for short- and mid-term, while long-term results are evaporating but still showing a slight advantage for IBCT. Thus, it seems that increases in acceptance remain important for both therapies and that IBCT generally created more change than TBCT in emotional acceptance, which was related to marital satisfaction (Doss et al., 2005). Hayes (2004) also points out that acceptance is a concept which is becoming increasingly more important in behavioral therapy, especially in its evolution as a behavioral therapy of the third generation.

Doss et al. (2005) argue that the results of their current study provide a cautionary warning to those treatments that focus on specific and immediate change, such as TBCT, rather than focusing on emotional acceptance. As TBCT induces greater behavioral changes, while IBCT induces greater changes in acceptance, it is tempting to envision a treatment that starts with TBCT and ends with IBCT (Doss et al., 2005).

Still, it is strongly recommended to do further research which evaluates areas of therapeutic process, mechanism of change, and especially predictors of long-term outcome in different populations, in hetero- and homosexual couples, in varied social classes, age-groups, and disorder specific targeting. Furthermore, it seems essential to implement studies with randomized trials in bigger samples to implement more comparative studies with control groups and other treatment approaches and especially to evaluate couples with different levels of marital distress. Likewise, it seems highly recommendable to expand into prevention programs including mindfulness techniques (which favor increase in acceptance), to offer feedback during the therapy process, and lastly to incorporate in therapist training programs specific "common factors", which seem important for couple therapy outcome.

However, it is important to point out that because of the limited amount of published work, the heterogeneity of the studies and kind of data, which were included in some investigations, the results cannot be seen as perfectly conclusive. Besides, it should be taken into account that in the current study only investigations comparing the effectiveness of TBCT with IBCT were included and that TBCT, independently of this review, shows a long standing history in multiple studies in which its effectiveness against other treatment

approaches was shown. Nonetheless, the biggest limitation of this paper is the missing meta-analytic approach, which is due, on the one hand, to insufficient information in the studies themselves and on the other hand, because of distinct methodologies of the studies, particularly the questionnaires used and the calculations of results. Thus, a meta-analytic approach should be the next step to be taken in research.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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