CHAPTER 1

Introduction to Cognitive–Behavioral Couple Therapy Concepts and Methods

Cognitive-behavioral concepts and methods for understanding and treating problems in couple relationships constitute a major theoretical model that has developed since the 1960s and is well supported by research (for reviews, see Baucom, Epstein, Fischer, Kirby, & LaTaillade, 2023; Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Fischer, Baucom, & Cohen, 2016; Lebow & Snyder, 2022). Consequently, cognitive-behavioral couple therapy (CBCT) is routinely included in couple and family therapy textbooks (e.g., Lebow & Snyder, 2023; Nichols & Davis, 2016). CBCT methods are widely used by clinicians, including many who adhere primarily to other theoretical models but integrate cognitive-behavioral interventions in their treatment plans (Northey, 2002). The conceptual model of CBCT and the range of assessment methods and interventions have expanded substantially over the years to complex influences among partners' cognitions, emotional responses, and behavioral interactions. An increased focus on multiple layers of contextual factors that influence a couple and its members (ranging from personal histories, needs and personality characteristics to broader ecological influences such as extended family, jobs, culture, and societal conditions) has resulted in a much more comprehensive systemic model for assessment and treatment. Thus, CBCT can help therapists understand opportunities and challenges that contexts create for couples, making it an excellent model for treating couples whose lives are affected by discrimination, social inequities, climate disasters, disease pandemics, and the like.

The popularity and wide applicability of CBCT as a treatment framework have been due to its comprehensiveness in addressing the major realms of intimate relationships: individuals' internal *cognitions* and *emotions* regarding their experiences with significant others and the overt *behavioral interactions* between partners. In addition, CBCT procedures for assessment and intervention (e.g., identifying thoughts that elicit partners' aggressive actions; teaching communication and problem-solving skills) are straightforward and easy to explain to clients. CBCT developed as an integrative framework representing the merging of several components that capture individual partners' intrapsychic processes, intergenerational influences from partners' families of origin, a couple's current behavioral interactions (e.g., the common circular demand–withdraw pattern), and ecological contextual influences. Furthermore, the attention in CBCT to each couple's contextual stressors broadens assessment and treatment planning to address conditions that influence a relationship as it develops over time. The conceptual richness and clinical sophistication of CBCT allow therapists to apply it to complex relationship issues such as infidelity, partner aggres-

sion, and sexual problems, a member's physical or mental health problem, and couples coping with external stressors such as discrimination and limited material resources.

This chapter presents an overview of (1) the theoretical roots of CBCT, (2) core behavioral, cognitive, and emotional domains that are addressed, (3) the range of interventions used to modify problematic behavioral patterns, cognitions, and emotional responses (described in detail in Chapter 4), and (4) how CBCT is applied to relational problems and problems involving individuals' physical or mental health issues. It also touches on (5) how CBCT practitioners attend to "common factors" (e.g., the therapeutic alliance, therapist cultural sensitivity) that have been found to influence the effectiveness of various therapy models. Finally, we describe examples of how CBCT can be integrated with other theoretical orientations, and we provide a summary of existing research support.

This book emphasizes treatment of couples that are in relationships involving some degree of commitment, not those who are casually dating. However, the interventions are relevant for relationships at all stages of development. Some of the concepts and methods can be applied in premarital counseling in a preventive way, as they often are used in relationship education and enhancement programs (e.g., Carlson, Rhoades, Johnson, Stanley, & Markman, 2023; Halford, 2011; Halford & Moore, 2002; Markman & Rhoades, 2012; Markman, Stanley, & Blumberg, 2010). CBCT can be applied with couples who are diverse in age, race, ethnicity, gender identity, sexual orientation, and socioeconomic status, although therapists must be culturally attuned to understanding the concerns couples bring to therapy based on their backgrounds.

THEORETICAL ROOTS OF CBCT

The core theoretical concepts of CBCT have been derived from a few major sources: (1) learning theory, (2) family systems theory, (3) basic research findings in cognitive psychology regarding human information processing, (4) the theoretical base underlying cognitive therapy, and (5) models of emotional experience and expression. The following are brief summaries of these roots that are integrated into CBCT.

Learning Theory Combined with Social Exchange Concepts

The earliest forms of CBCT focused on behavioral interactions between partners that contribute to individuals' levels of satisfaction with their relationship, as well as principles regarding learning from one's experiences. Behaviorally oriented couple therapists (Jacobson & Margolin, 1979; Stuart, 1980; Weiss, Hops, & Patterson, 1973) applied social exchange theory (Thibaut & Kelley, 1959), which proposes that an individual's level of satisfaction with a relationship depends on the ratio of benefits to costs experienced in the relationship. An individual will be relatively dissatisfied with a relationship that is perceived as providing a poor benefit-to-cost ratio, especially when comparing the existing ratio to a more favorable ratio that one predicts would occur in an alternative relationship. This model of relationship satisfaction is consistent with Western cultures within which CBCT was developed (Epstein, Falconier, & Dattilio, 2020).

A related premise of the behavioral model is that members of a relationship continually provide consequences for each other's actions that influence the likelihood that each person will exhibit those actions. Learning theory concepts focus on processes through which both constructive and problematic behaviors are acquired and controlled through interactions with one's environment, especially with other people. Even though learned patterns may become fairly persistent,

learning theory proposes that they can be modified through similar types of experiences with one's environment.

Concepts that have been applied to understanding and treating couple relationship problems derive from B. F. Skinner's (1953, 1971) model of *operant conditioning*, which involves increasing or decreasing an individual's specific action by controlling consequences of the action. Behaviors that lead to rewards tend to increase (positive reinforcement), as will those behaviors that lead to removal of an aversive condition; for example, an individual nags until the partner complies with the request, leading the partner to become more compliant with the person's requests (negative reinforcement). In contrast to reinforcement processes, a person's behavior can be decreased when it is followed by a consequence assumed to be aversive (punishment), or by discontinuing the reinforcement (extinction) (Weiss, 1978). Thus, when members of a couple provide each other with reinforcing and punishing consequences, they shape each other's behaviors. The partners need not be aware of this process or of intentionally influencing each other's actions.

Another operant conditioning concept is *discriminative stimuli*, conditions that are cues that reinforcement or punishment is likely to occur. Thus, members of a couple learn that particular nonverbal cues signal whether or not the other person is likely to be receptive to affectionate behavior. Sometimes partners intentionally exhibit such cues, and some arguments occur when the intended recipient of a cue fails to notice and respond appropriately to it. Because partners mutually provide each other with discriminative stimulus cues and consequences for each other's actions, these mutual influences are consistent with circular causal processes captured in family systems theory.

Because operant conditioning processes involving shaping responses via consequences is an inefficient way of learning complex human behavior such as social skills, social learning theorists (Bandura, 1977; Bandura & Walters, 1963) focused on how an individual can observe a complex behavior modeled by another person and then imitate it. The observer is more likely to imitate the model if the model has high status or has been seen receiving reinforcement for the behavior.

Based on these learning and social exchange principles, initial behavioral approaches to couple therapy focused on interventions to increase partners' positive actions and decrease negative ones, especially contracts in which each individual agreed to enact particular behaviors that the other person desired (Jacobson & Margolin, 1979). In addition, observational learning principles were used to teach partners skills for communication (expressing and listening) and problem solving (see Chapter 4) to increase mutual understanding and the likelihood that they would meet each other's needs (Jacobson & Margolin, 1979; Stuart, 1980). Furthermore, communication behaviors that are foci in skills training have been guided by research that has identified patterns associated with distress and instability in couples' relationships. Researchers (e.g., Gottman, 1979, 1994; Revenstorf, Hahlweg, Schindler, & Vogel, 1984; Weiss et al., 1973) identified behavioral interaction patterns (e.g., escalating reciprocal exchanges of negative behavior, demand–withdraw patterns) that differentiated distressed from relatively happy couples and that predicted dissolution of relationships. Because the interventions were developed on the basis of research primarily on samples from Western societies, therapists need to be mindful of adapting communication and problem-solving training to cultural differences that may contribute to a couple's patterns.

Although approaches to couple problems based on learning theory tended to focus on behavior, Bandura's (1977) social learning model also included a cognitive component involving individuals' *expectancies* regarding the probability that a particular action on their part would lead to particular consequences from their partner. For example, an individual may have developed an expectancy that attempts to discuss issues with a partner will result in the partner withdrawing, which may lead the individual to pursue the partner more strenuously or to give up and withdraw

as well. A therapist identifies the negative expectancy and may use coaching in communication skills to reduce the couple's demand–withdraw behavioral pattern *and* the associated expectancy. Thus, understanding and modifying a couple's negative behavioral patterns is improved by taking partners' cognitions into account. However, social learning theory did not provide a fine-grained model of complex forms of cognition that influence relationships, and the development of CBCT depended on integrating behavioral concepts and methods with other models that focus on forms of cognition that influence relationships.

Family Systems Theory

Dattilio (2010) noted that some family systems theorists critiqued behavioral and cognitive therapy models as being dominated by linear causal concepts, but Patterson's (1982) behavioral model of coercive family systems in which children with conduct problems and their parents direct aversive behavior toward each other and the behavioral couple therapy concept of reciprocal behavioral exchanges between partners (Jacobson & Margolin, 1979; Stuart, 1980) clearly focused on mutual influences between significant others. The process identified in CBCT in which partners continuously provide consequences for each other's responses is consistent with the systems concept of feedback. For example, when partners reciprocate each other's verbal aggression, leading to an escalation of the conflict, the concept of positive feedback fits in describing how the members' responses to each other amplify the negative interaction pattern. Even though each member of a couple is considered responsible for their own actions (especially abusive behavior), the CBCT model emphasizes the systemic characteristics of the relationship and interventions that take into account partners' influences on each other.

Epstein and Baucom's enhanced CBCT model (Baucom et al., 2023; Epstein & Baucom, 2002) also applies family systems concepts of boundaries and hierarchy. Boundaries within and around a relationship are defined by who interacts with whom and in what roles. They involve partners' overt behavior and their internal cognitions about what patterns are appropriate. For example, when an individual shares intimate information about the couple's relationship with extended family members, it may violate their partner's standard about an appropriate boundary between the couple and the outside world. Similarly, if a person purchases an expensive item without consulting their partner, this action may reflect skewed power in the couple's relationship, as well as their different standards about decision making.

Finally, Epstein and Baucom's (2002) enhanced CBCT model integrated Bronfenbrenner's (1979) ecological model, which focuses on multiple levels of contextual factors that influence a relationship. The partners must cope with factors such as extended family relationships, friends, schools, and jobs; characteristics of the local community, such as crime; and broad societal-level factors such as immigration stresses, forms of discrimination, and adverse economic conditions. CBCT examines how the demands of these factors influence couple interaction patterns (as when job demands limit a couple's time together) and the types of cognitions, emotional responses, and behavioral responses the partners exhibit in attempting to cope with them.

Social Cognition Theory and Research

Behaviorally oriented couple theorists and therapists have drawn on basic research findings regarding human information processing to identify forms of cognition that can influence part-

ners' behavioral responses to each other. For example, Jacobson and Margolin (1979) labeled the perceptual bias that occurs when partners notice each other's negative behavior and overlook positive behaviors as *negative tracking.* They also noted how members of unhappy couples commonly made seemingly biased negative attributions about the causes of each other's displeasing actions. For example, if a member of a couple intends to behave positively toward a partner, but the partner attributes the other's actions to the partner having negative motives, the partner will be likely to experience negative emotions and behavior in response to the other's actions (Fletcher, Overall, Friesen, & Nicolls, 2018).

Social cognition research has focused on two major categories of thinking: (1) relatively stable *knowledge structures* regarding relationships and (2) *moment-to-moment "online" processing of information* about events currently occurring between partners (Fletcher et al., 2018). A variety of terms have been used to label the relatively stable internalized concepts involved in knowledge structures (e.g., schemas, scripts, working models, mental models). Individuals develop these persistent concepts through their experiences with others beginning very early in life. They provide cognitive templates that provide the individual with explanations for current experiences (e.g., "I get angry easily in close relationships because I grew up in an emotionally volatile family"). In addition, they influence the outcomes that one predicts in interactions with others (e.g., "If I express my opinions, I will be ignored"), and they increase one's ability to exert control over particular aspects of relationships (e.g., "After you compliment a person, they are more likely to comply with a request you make").

These knowledge structures or personal theories vary from global views of relationships with people in general (e.g., how trustworthy one believes that people tend to be) to concepts regarding romantic relationships in particular, to concepts about a specific personal romantic relationship (Fletcher et al., 2018). An individual's knowledge structures or theories about a current relationship become more complex as more experiences with the partner accumulate, and the level of satisfaction with the relationship depends on how closely the actual experiences with the partner match the individual's standards for a close relationship (Baucom, Epstein, Rankin & Burnett, 1996; Campbell & Fletcher, 2015). Research indicates that established knowledge structures tend to be resistant to change and that individuals selectively attend to information that is consistent with their existing beliefs (Meichenbaum, 1985). However, there still is potential for them to be modified through new life experiences that disconfirm them (Fiske & Taylor, 1991; Fletcher et al., 2018; Fletcher, Simpson, Campbell, & Overall, 2013). An example of knowledge structures that exhibit significant stability in adulthood are the "working models" identified in attachment theory (Bowlby, 1969), beliefs that individuals have regarding their own lovability and of the emotional availability of an attachment figure such as a parent or romantic partner. Relatively stable attachment working models have been found to influence more momentary cognitions; for example, individuals with more anxious insecure attachment make more negative attributions about the causes of their partners' negative behavior (Fletcher et al., 2018). Research findings such as these have important implications for clinical assessment and intervention, highlighting the need to identify partners' schemas and how they contribute to negative couple interactions and relationship distress.

Another important aspect of relatively stable knowledge structures that has implications for understanding the role of cognition in close relationships and addressing them in therapy is that individuals commonly access them automatically and unconsciously rather than intentionally (Fletcher et al., 2018). Thus, an individual notices a partner's specific verbal or nonverbal behavior

(e.g., a scowling facial expression), attaches meaning to it by comparing it to memories of similar events associated with such behavior (e.g., associates a scowl with a significant other's past violent behavior), and experiences fear and an urge to escape. All of this cognitive processing may occur almost instantaneously, without any intentional analysis, and both members of the couple might be taken by surprise as the individual cannot explain the sudden discomfort. Although individuals' level of awareness of such influential cognitions may vary widely, there is evidence that people shift into more conscious analysis when confronted with negative, upsetting events and unexpected events (Fletcher et al., 2018). For example, upon discovering a partner's infidelity, individuals commonly engage in extensive cognitive analyses, searching for information to explain what occurred, one's failure to identify clues about it sooner, and how to reshape positive beliefs about the partner that have been invalidated (Baucom, Snyder, & Gordon, 2009; Janoff-Bulman, 1992). As we describe later, cognitive assessment in CBCT is designed to access as much as possible partners' schemas that are less conscious.

Baucom, Epstein, Sayers, and Sher (1989) classified two relationally oriented forms of cognition as schemas: relatively stable *assumptions* that individuals hold about characteristics of individuals and relationships (e.g., an attachment working model that one cannot rely on a partner to reliably meet one's emotional needs) and *standards* about characteristics that individuals and relationships "should" have (e.g., "A caring partner should always place the other person's needs above their own"). In contrast to those two forms of knowledge structures, *selective perceptions* of present events occurring between partners, *attributions* about causes of one's own and others' behaviors, and *expectancies* involving predictions about likely responses one's actions will elicit from one's partner are forms of moment-to-moment processing of information (Baucom & Epstein, 1990; Epstein & Baucom, 2002). Although all of these forms of processing information that individuals are exposed to in daily life are normal, they are susceptible to distortion that can lead to inappropriate responses. Distortions in perception and inferences have been found to contribute to a wide range of psychopathology (e.g., depression, anxiety disorders, eating disorders) as well as relationship problems (Dobson & Kendall, 1993). A variety of cognitive distortions (e.g., all-or-nothing thinking, selective abstraction, and personalization) have been identified in the model underlying Beck's cognitive therapy (Dobson, Poole, & Beck, 2018). Studies have indicated that individuals' cognitions about intimate partners, such as negative attributions about the causes of a partner's negative actions, are associated with unhappiness about the relationship *and* the individual's negative behavior toward the partner (Epstein & Baucom, 2002). Using such findings to guide assessment and treatment within a CBCT (or other) model is consistent with Karam and Sprenkle's (2010) *research-informed clinical model*, in which clinicians keep abreast of findings about factors that contribute to types of client problems, as well as regarding the effects of specific interventions. Knowledge about cognitive factors in relationship problems has been important in expanding behavioral models to take into account partners' subjective experiences that influence how they behave toward each other.

Cognitive Therapy Models

During the same period when behavioral models of couple and family therapy were capturing complex behavioral interaction patterns in intimate relationships, cognitive models of individual psychopathology and therapy (Beck, 1976; Ellis, 1962; Meichenbaum, 1977) also were developing as a major alternative to traditional psychodynamic models. Ellis's model focused on relatively stable irrational beliefs that individuals develop while growing up in a social context (e.g., that

one must be perfect in order to be a worthwhile person); these beliefs produce emotional distress and dysfunctional behavior when real-life experiences fail to match one's unrealistic standards. Beck's model also included unrealistic stable schemas regarding characteristics of the self and world but differentiated them from much more transitory automatic thoughts regarding one's immediate experiences. In the Beck model, a life event (e.g., taking an exam in school) activates an individual's underlying relevant schema (e.g., perfectionism as a personal standard), leading to stream-of-consciousness automatic thoughts (e.g., "I'm not smart enough to do well on this test. I'm a loser!"; Dobson et al., 2018). The model also includes a variety of cognitive distortions or information processing errors (e.g., all-or-nothing thinking) that contribute to distressing automatic thoughts.

Meichenbaum (1985) presented another useful model focused on cognitions that occur during individuals' responses to stressful life experiences. Similar to the Beck model, Meichenbaum notes that individuals' cognitive processing commonly is fairly automatic and beyond awareness, and that individuals can be coached in developing awareness of distressing cognitions that can be tested for appropriateness and modified. In particular, Meichenbaum emphasizes assisting individuals in developing skills for "stress inoculation" that involves conscious, intentional rehearsal and use of positive "self-statements" about stressors. Positive coping self-statements are developed for preparing for an anticipated stressor (e.g., "Just think about what I can do about it"), confronting and handling it (e.g., "One step at a time"), coping with feelings of being overwhelmed (e.g., "Relax and slow things down"), and evaluating one's coping efforts (e.g., "I can be pleased with the progress I'm making"). Given that members of a couple can be stressors for each other, this stress inoculation model has great relevance.

These cognitive models initially were developed primarily to understand problems with individuals' personal functioning such as depression and anxiety. Increasingly, however, they were applied to address couple and family relationship problems that can be among the most stressful experiences in people's lives (Beck, 1988; Dattilio & Padesky, 1990; Ellis, Sichel, Yeager, DiMattia, & DiGiuseppe, 1989; Epstein, 1982; Epstein, Schlesinger, & Dryden, 1988). In a couple's relationship, each member is a source of life events that the other appraises cognitively, influencing the individual's emotional and behavioral responses to their partner. An individual's appraisals are automatic thoughts shaped by underlying schemas such as beliefs or standards regarding the characteristics that a caring family member "should" possess (Baucom & Epstein, 1990; Epstein & Baucom, 2002).

Some of the initial literature on applications of cognitive therapies to relationships primarily described an extension of individually based Ellis and Beck models, identifying each individual's distorted or unrealistic cognitions and intervening with each person to modify them. However, increasingly writers presented a more integrative *cognitive-behavioral* model that simultaneously attends to a couple's dyadic behavioral interactions and each member's cognitions about them, as well as emotional responses. For example, assessment of a couple that presents with escalating verbal arguments would include an inquiry about each person's thoughts about instances of negative behavior from the other (e.g., "He has no respect for me. I'm not going to let him get away with treating me like that!") and associated emotional responses (e.g., anger).

Models of Emotional Experience and Expression

The absence of the term *emotion* in the title "cognitive-behavioral therapy" (CBT) unfortunately has contributed to an impression among the lay public and some mental health professionals that

the concepts of the model and the methods of the treatments pay little attention to people's emotions. In addition, groundbreaking publications by founders Beck, Ellis, Meichenbaum, and others described associations between dysfunctional cognition and disorders such as depression and anxiety. For example, Beck (1976) described associations between particular cognitive themes and emotions, such as depression linked with perceived loss associated with depression, danger with anxiety, and violation of one's rights with anger. This model led some readers to conclude that cognitive approaches only proposed a linear causal link in which disordered thinking produced negative emotions and behavior, but not vice versa. More recent publications have focused more on affective components of CBT models regarding individual and relational functioning, and the pathways through which emotional states can influence cognitions and behavior. Writers have emphasized that emotions are natural responses that have had evolutionary adaptive value and that a wide variety of positive and negative emotions are normal and common aspects of human experience. They have also reported that emotional states influence cognition and behavior; e.g., motivate avoidance behavior, interfere with cognitive and behavioral problem-solving skills, shape selective attention to others' positive or negative actions, and elicit negative interpersonal behavior such as aggression as well as positive acts such as altruism (Leahy, 2015; Linehan, 1993; Nezu, Nezu, & Hays, 2019; Rizvi & King, 2019).

Furthermore, the conceptual model of emotionally focused therapy (EFT; Greenberg & Goldman, 2008; Johnson, 1996; Johnson, Wiebe, & Allan, 2023) proposes that members of a couple continuously regulate each other's emotions. One member's cues of emotion (e.g., tears) signal the other member about the individual's unmet needs and how the individual is likely to respond to the partner's actions (e.g., increased upset if the partner fails to reassure the individual of their love). The EFT model also proposes that individuals commonly hide vulnerable "primary emotions" such as sadness and fear under harder defensive "secondary emotions" such as anger. Consequently, EFT therapists guide partners in identifying and expressing vulnerable feelings, which increases the likelihood that they will elicit caring responses from each other. Thus, increased awareness and communication of emotional responses can alert partners about unmet needs and motivate them to take action to rectify the problem. Goldman and Greenberg (2006) stress that better emotion regulation is needed, either to increase recognition and expression of hidden emotions or to reduce excessive emotional responses. They emphasize how members of a couple "co-regulate" each other's emotions, continuously influencing the degrees of positivity and negativity in the other's emotional experience. The CBCT model that has developed over time overlaps with that of EFT, with both deficits and excesses in emotional awareness and expression considered to be problematic, and with the goals of therapy including increasing partners' awareness of their emotions and developing their skills for communicating their emotional states constructively to each other (Baucom & Epstein, 1990; Baucom et al., 2023; Epstein, Dattilio, & Baucom, 2016; Epstein & Baucom, 2002; Rathus & Sanderson, 1999).

Research on emotions in close relationships has indicated that positive and negative emotions are relatively independent rather than opposite poles of a single dimension (Planalp, Fitness, & Fehr, 2018). Consequently, reducing an individual's experiences of negativity does not automatically result in an increase in positivity. Therefore, CBCT interventions for decreasing negative couple interactions are balanced with interventions to increase positive interactions (Epstein & Baucom, 2002). Gottman (1999) also advocates CBT-like strategies for implementing "repair" attempts for couples to counteract negative with positive interactions (e.g., taking responsibility for a problem, expressing affection).

BEHAVIORAL, COGNITIVE, AND EMOTIONAL DOMAINS ADDRESSED IN CBCT

Based on the integrative CBCT theoretical model that we have described, assessment and interventions target the core domains of behavior, cognition, and emotion. The following are brief summaries of the characteristics addressed in each domain.

Behavioral Domain

Based on social learning principles and social exchange theory, CBCT focuses on the *frequencies of positive and negative verbal and nonverbal behaviors* that members of a couple direct toward each other. It also focuses on their association with each partner's subjective level of satisfaction with the relationship. Commonly, particular types of behavioral deficits or excesses that are linked to a couple's presenting concerns (e.g., deficits in types of shared activities that result in a general sense of limited intimacy) become foci. In a *functional analysis*, events from each individual are identified that elicit the other's specific actions, as well as the behavioral *consequences* that partners provide for each other's actions. Problematic dyadic sequences and patterns (e.g., escalating reciprocation of negative actions; a demand–withdraw pattern) are identified.

Also tied to social learning theory are partners' *behavioral skills* for expression and empathic listening, as well as for systematic, constructive problem solving, which are evaluated for potential intervention. Partners are coached in translating global complaints into specific behaviors that can be increased or decreased. Specialized skills for managing particular roles in couple and family life (e.g., joint parenting, money management, sexual interaction, dyadic coping with a child's chronic illness) also are selected for intervention, as needed. Overall, clinicians attempt to differentiate between *micro-level behaviors* that are limited to specific situations (e.g., a couple argues about differences in their ideas of how to get their young child to go to sleep at a reasonable time) versus macro-level behavioral patterns that occur across a broad range of situations (e.g., a couple exhibits mutual verbal aggression in a variety of situations as they engage in a general power struggle).

Cognitive Domain

The five types of cognition identified by Baucom, Epstein, and colleagues (Baucom & Epstein, 1990; Baucom et al., 1989; Epstein & Baucom, 2002) are foci of CBCT. They include two that are forms of schemas: *assumptions* are beliefs about the characteristics of individuals and close relationships (e.g., a man's assumption that women like to control men; attachment "working models"), whereas *standards* are beliefs about characteristics that individuals and close relationships "should" have (e.g., an individual's standard that intimacy requires that partners disclose all of their innermost thoughts and emotions to each other). The other three types of cognition, which tend to involve relatively transitory automatic thoughts, are *selective attention, attributions*, and *expectancies*. Selective attention (also labeled selective abstraction) involves noticing some aspects of the available information in a situation and overlooking other information. *Attributions* are inferences that individuals make about the factors influencing observed events, including a partner's behavior (e.g., a man's partner failed to act excited when he gave her a surprise gift, and he attributed her lack of enthusiasm to her not appreciating him, an inference that turned out to

be inaccurate, as he learned that she had heard earlier that day that her mother was seriously ill). *Expectancies* are predictions about probabilities that particular events will occur in the future (e.g., an individual has an expectancy that telling their partner they are not enjoying the partner's form of sexual touch will hurt the partner's feelings severely, a prediction based on negative experiences from a previous relationship).

In addition to those five types of cognition, CBCT attends to cognitive distortions or errors in information processing that have been described extensively in the cognitive therapy literature (e.g., A. T. Beck, Rush, Shaw, & Emery, 1979; J. S. Beck, 2021; Dobson et al., 2018; Leahy, 1996). Examples are *magnification* (e.g., appraising a negative event as especially severe) and *personalization* (e.g., an individual infers that a partner's bad mood is related to themself rather than to other events in the partner's life). Handout 1.1 (available on the book's web page at *www.guilford.com/epstein-materials*) presents a list and definitions of common cognitive distortions for use by therapists and clients. Cognitive distortions typically are involved in unrealistic or inaccurate assumptions, standards, selective attention, attributions, and expectancies. For example, an attribution that a partner's lateness in arriving home is due to the partner not prioritizing the couple's relationship potentially involves the distortions of *arbitrary inference* and *personalization*.

Other characteristics of partners' relationship cognitions that are foci of CBCT are the extent to which individuals are *conscious* of their cognitive processing, the degree to which they *intentionally engage in cognitive activity* (e.g., self-reflection) rather than it occurring automatically, and how actively they *evaluate the validity or appropriateness* of their cognitions. These characteristics are similar to those commonly included in the concept of *psychological mindedness* (Conte, Ratto, & Karusa, 1996).

Emotion Domain

In the cognitive therapy models that initially were developed to understand and treat individuals' problems with depression, anxiety, anger, and other emotions (Beck, 1976; Ellis, 1962; Meichenbaum, 1977), the emphasis was on how forms of distorted and negative thinking produced dysfunctional emotional responses. That type of causal path became a significant component of CBT approaches to a wide variety of client presenting problems, including couple relationship distress (Baucom & Epstein, 1990; Beck, 1988; Dattilio & Padesky, 1990; Rathus & Sanderson, 1999), and it still is. Consequently, in CBCT, therapists routinely inquire about automatic thoughts that preceded and appear to have elicited individuals' specific emotional responses to their partners. In addition, therapists probe for an individual's underlying schemas that are activated by a partner's behavior, eliciting negative automatic thoughts and emotions. For example, an individual discovers that a partner shared with the partner's family members information about the couple's arguments. This action violated the individual's personal standard that members of a couple should maintain a firm boundary around intimate aspects of their relationship aspects and elicited his automatic thought "My partner is disloyal to me!" and considerable anger.

As we noted previously, however, the basic models underlying cognitive therapy, as well as theory and research on emotional experiences, have not been strictly linear, and emotions also are viewed as influencing cognition and behavior. Moods such as sadness, anxiety, anger, and shame shape individuals' perceptions of events and prime particular behavioral responses. In Beck's model, an individual's depression or anxiety serves as a negative filter that can affect perception and memory ("I've always been a failure." "My partner never shows that she loves me." "I'm too

anxious to speak up in class."). Weiss's (1980) concept of *sentiment override* describes how an individual's existing general feelings about a partner (e.g., overall persistent unhappiness and anger) determine their emotional and behavioral response to the partner more than the other's actions in the moment. Shame responses narrow individuals' self-perception and evaluation, and also tend to elicit withdrawal from significant others (Epstein & Falconier, 2017). As we have noted, Goldman and Greenberg (2006) emphasize how members of a couple regulate each other's emotions, sending and receiving verbal and nonverbal information about emotional states that influence the other's moods and actions.

Consequently, CBCT clinicians assess partners' relatively stable emotions (e.g., chronic depression, persistent negative sentiment toward the other person) and momentary shifts in emotional states that are both elicited by and elicit their own and the other's emotions, cognitions, and behavior. They also inquire about other emotions that may underlie those that an individual expresses overtly (e.g., anxiety underlying expressed anger toward a partner) but that the person may fail to mention: a process similar to the search for unstated "primary emotions" in the EFT model. One advantage of conducting conjoint couple therapy sessions is the opportunity to observe first-hand the interpersonal processes between partners in which those emotions operate.

INTERVENTIONS USED TO MODIFY PROBLEMATIC BEHAVIORAL PATTERNS, COGNITIONS, AND EMOTIONAL RESPONSES

This book provides detailed descriptions of CBCT interventions for couples' problematic behavioral interaction patterns, cognitions, and emotional responses in order to assist clinicians in devising treatment plans to address a variety of presenting problems. The following is a brief overview of the variety of interventions used in CBCT. These interventions are summarized in Handout 1.2 (available at *www.guilford.com/epstein-materials*), which can be shared with a couple as a psychoeducational part of the therapist–client collaboration. This book's chapters that focus on specific presenting problems describe particular ways in which therapists use these interventions to alleviate negative patterns and build couple strengths.

Interventions for Behavior

Based on social exchange and learning theory principles, clinicians typically begin with a *systematic assessment* of the presenting problems, their history, and a functional analysis of the behavioral patterns and members' associated cognitions and emotions (Dattilio & Epstein, 2016; Epstein & Baucom, 2002), which we describe in detail in Chapter 3. The functional analysis focuses on the conditions preceding a particular cognitive, emotional, or behavioral response (e.g., an individual arrives home from work and hugs their partner) and the consequences that follow the response (e.g., the partner withdraws behaviorally from the individual's hug), which influence when and how often the individual exhibits the response (hugs occur infrequently). Information about such patterns is derived from the couple's reports about their interactions in daily life and from the therapist's observation of the couple's behavior during therapy sessions.

Based on the assessment, the CBCT clinician may use a number of types of interventions to attempt to modify behavioral components of negative patterns. Overall, interventions focus on (1) improving communication, problem-solving, and dyadic coping skills; (2) replacing negative

interaction behavioral patterns (e.g., demand–withdraw, reciprocal verbal aggression) with constructive behavior; and (3) increasing positive, pleasing actions because simply decreasing negative actions does not necessarily result in members of a couple being happy.

Therapists conduct interventions during therapy sessions but also emphasize partners' engagement in homework activities during daily life, such as practicing communication skills, as research has indicated that homework promotes the transfer of changes to daily living (Dattilio, Kazantzis, Shinkfield, & Carr, 2011).

- **Improving communication, problem-solving, and dyadic coping skills.** CBCT clinicians use skills training procedures to enhance partners' skills for expressing themselves clearly and constructively and for listening to each other's expressions empathically. They also teach couples skills for collaborating to solve problems in their relationship. The steps in problem solving include defining the characteristics of a problem in behavioral terms, generating alternative potential solutions, collaborating as a couple in evaluating the advantages and disadvantages of each solution, reaching consensus about a solution, devising a plan to implement that solution, and revising the solution if the results indicate that it was ineffective (Epstein & Baucom, 2002). Furthermore, CBCT includes enhancement of a couple's skills for dyadic coping with various life stressors affecting one or both partners. As described in Chapter 4, the collaborative nature of dyadic coping differs from partners' individual coping styles. All three types of skill training include initial psychoeducation about the importance and methods of using constructive and effective skills with one's partner, didactic presentation and modeling of the desired skills by the therapist, and coaching of the couple as they practice the skills.

- **Replacing negative interaction patterns with constructive behavior.** When the assessment identifies a negative behavioral pattern, the clinician reviews the evidence of its problematic consequences with the couple and works to motivate them to experiment with alternative behaviors. The therapist provides brief psychoeducation regarding research evidence for drawbacks of a pattern such as demand–withdraw or reciprocal verbal attacks, notes how each partner can make a contribution to changing their own part in the pattern, encourages each partner to make a commitment to such changes, collaborates with the couple in specifying the constructive behaviors that they are aiming for, blocks any instances of the negative behavior during sessions, and coaches partners in substituting positive behaviors at those times (Epstein & Baucom, 2002; Epstein & Falconier, 2014). Interventions focused on changing negative behavior commonly are combined with others that address cognitions and emotions that can interfere with behavior change—for example, an individual's expectancy that unless they are verbally aggressive with their partner, the partner will not take them seriously.

- **Increasing positive, pleasing actions.** Because decreasing negative behavior does not ensure an increase in positive behavior, clinicians set a goal of identifying actions that produce pleasure for the couple and developing plans for them to engage in those actions. Couples commonly express relief when their negative interactions decrease but still long for a more pleasing, intimate relationship, so efforts to identify and increase pleasing behavior are very important (Baucom & Epstein, 1990; Epstein & Baucom, 2002). Early forms of behavioral couple therapy (e.g., Jacobson & Margolin, 1979) engaged couples in behavioral contracts in which each member identified pleasing actions they desired from their partner. However, more recent "guided behavior change" procedures (Baucom et al., 2023; Epstein & Baucom, 2002) focus on increasing forms of

behavior that address particular needs of a couple. For example, a couple that complains of feeling a lack of intimacy can be coached in interacting in ways that have potential to increase their sense of closeness. Because partners often differ in the actions they find most pleasant, cognitive interventions may be needed to reduce conflict over personal standards about the "best" ways of relating.

Interventions for Cognitions

CBCT addresses partners' automatic thoughts, relatively stable underlying schemas, and the cognitive distortions involved in dysfunctional thinking that cognitive therapists have emphasized (A. T. Beck et al., 1979; J. S. Beck, 2021; Dattilio, 2010; Leahy, 1996). The five types of relational cognitions that Baucom et al. (1989) identified include three that involve automatic thoughts (selective perceptions, attributions, expectancies) and two that are forms of schemas (assumptions and standards). The interventions are similar to those used in individual cognitive therapy, but they are tailored to treating partners jointly. An advantage of joint sessions is that a person's partner is available to introduce information that may modify the person's negative cognitions. However, individuals may be defensive when a therapist coaches them in examining the appropriateness of their thoughts, due to concern of losing face in front of their partner (or giving the partner "ammunition" to use in arguments). Therefore, therapists must be tactful in using "cognitive restructuring" during conjoint sessions.

An additional complication that may arise in couple therapy occurs when the members of a couple share a common problematic cognition, validating each other's perspective (Dattilio, 2010)—for example, when partners both attribute one member's depression symptoms primarily to innate biological causes that are unlikely to change. The major types of therapeutic interventions for cognitions in CBCT are based on traditional cognitive therapy methods, but couple therapists emphasize creating an environment in joint sessions that helps the partners be open to examining their own and shared cognitions, supporting each other's self-examination. They include (1) identifying automatic thoughts and associated emotions and behavior, (2) identifying cognitive distortions, (3) testing and modifying automatic thoughts, (4) testing expectancies with behavioral experiments, (5) using imagery, recollections of past interactions, and role-playing techniques, (6) using the "downward-arrow" technique, and (7) exploring relationship histories to evaluate assumptions and standards.

- **Identifying automatic thoughts and associated emotions and behavior.** In a psychoeducational manner, the therapist introduces the couple to the concept of automatic thoughts and encourages them to monitor their thoughts that are associated with their negative, as well as positive, emotional and behavioral responses to each other. The therapist coaches them in practicing this monitoring during sessions and as homework. A modified version of the Daily Record of Dysfunctional Thoughts (Beck et al., 1979), which was developed initially for use in individual cognitive therapy, is used to collect examples that link partners' automatic thoughts to their emotional and behavioral responses to each other. This is a prerequisite for "cognitive restructuring" methods that guide couples in examining the appropriateness and validity of their thoughts.

- **Identifying cognitive distortions and labeling them.** The therapist also introduces the couple to a typology of common cognitive distortions in a psychoeducational manner by sharing

a list of them (Handout 1.1), with definitions, and providing examples. Whenever possible, the therapist uses material from the couple's expressed cognitions to illustrate particular cognitive distortions. The goal is to help the partners become adept at noticing the cognitive distortions in their own stream-of-consciousness automatic thoughts.

- **Testing and modifying automatic thoughts.** The basic process in modifying problematic automatic thoughts involves each member of the couple being open to considering alternative ways of thinking about situations that upset them (e.g., anger over a partner's failure to phone to warn the individual that they would arrive home late from work). The individual is asked to search for information that would support or contradict the negative thought (e.g., memories of other instances when the partner did or did not exhibit thoughtful behavior), to brainstorm alternative reasons that might explain why the partner failed to call, or to examine how reasonable the individual's personal standards regarding attentive behavior are. Challenging core schemas or beliefs about relationships commonly is a gradual process (Dattilio, 2010; Fletcher et al., 2018).

- **Testing expectancies with behavioral experiments.** In CBCT, therapists guide partners in devising "behavioral experiments," to test their expectancies that particular actions will lead to certain responses from each other (Dattilio, 2010; Epstein & Baucom, 2002). For example, a woman may predict that her partner will ignore her suggestions when they are discussing possible solutions to a problem. Their therapist may guide the couple in setting up an experiment in which both members have an opportunity during the therapy session to propose solutions, and both partners observe how their discussion progressed. Even if the woman initially discounts her partner's acknowledgment of her ideas by attributing the partner's openness to an attempt to impress the therapist, the therapist can point to the results of the experiment as some evidence that the initial negative prediction did not "come true."

- **Using imagery, recollections of past interactions, and role-playing techniques.** When members of a couple have difficulty identifying their cognitions (as well as emotions and behaviors) that occurred during past incidents, experiential methods such as imagery and role playing may help to revive memories. Furthermore, these techniques can lead partners to re-experience their initial reactions, so that a role play may transform into a real couple interaction with associated cognitions and emotions. In addition to re-creating experiences that were distressing (but doing so cautiously to avoid retraumatizing victims of abuse), encouraging partners to access early experiences when they felt intimacy can increase their motivation to put effort into therapy sessions.

- **Using the downward-arrow technique.** Cognitive therapists commonly use the downward-arrow technique to uncover "deeper" thoughts underlying an individual's automatic thoughts, which at first seem relatively trivial but are associated with strong emotional and behavioral responses (A. T. Beck et al., 1979; J. S. Beck, 2021). As the therapist asks a series of questions of the form "And if that happened, what would it mean to you?" or "What might that lead to?," the client reveals a chain of thoughts that leads to a clearly nontrivial distressing meaning. Thus, an individual who initially expresses the automatic thought, "My wife's talking to an attractive man makes me very anxious." may ultimately reveal a catastrophic expectancy that "she will find him a lot more interesting than me and leave me." The therapist then can guide the individual and couple in evaluating the validity of the catastrophic automatic thoughts.

- **Exploring relationship histories to evaluate assumptions and standards.** A therapist searches for the origins of partners' assumptions and standards about intimate relationships by

asking them to report memories of their experiences in families of origin and other significant relationships. Constructing a genogram depicting each partner's family relationships over generations (McGoldrick, Gerson, & Petry, 2020) can help structure this history taking that serves not only as an assessment but also as a means of increasing partners' insight about the factors that have shaped their cognitions about their current relationship. Individuals may have a "the buck stops here" experience, becoming motivated not to respond in the dysfunctional ways that prior generations exhibited.

- **Guiding partners in considering the advantages and disadvantages of potentially unrealistic personal standards for their relationship.** Individuals typically enter a relationship with personal standards regarding the characteristics a relationship "should" have. Although many standards may be appropriate and contribute to a mutually satisfying relationship (e.g., partners should treat each other with kindness), others may be extreme or unrealistic (e.g., partners should be able to sense each other's inner feelings and needs without the other person having to tell them explicitly). Individuals commonly do not question the validity of these standards and react negatively when events in their relationship do not meet them, so guiding an individual in modifying an unrealistic one tends to be a gradual process (Dattilio, 2010; Fletcher et al., 2018).

Rather than directly challenging an individual's relationship standard, which may elicit defensiveness, we find it more useful to begin by exploring with the person the advantages they see in conducting their relationship according to the standard and then exploring potential disadvantages. For example, a hypothetical advantage of believing that a caring partner should be able to "mind-read" one's feelings and needs is that one need not experience the discomfort of disclosing unpleasant feelings to one's partner and can cling to an idealized view of being "in-tune soul mates." However, failing to disclose one's experiences is likely to lead to disappointment and frustration when the partner is unable to mind-read. Although relinquishing romantic beliefs about a relationship can be disappointing, individuals gradually may realize that sharing one's feelings and having one's partner demonstrate support outweighs the distress from suffering in silence.

Interventions to Modify Problematic Emotional Responses

As we have described, members of couples may have difficulties either with deficits in awareness and expression of emotions or with excessive experiences and expression of strong emotions such as anger, anxiety, depression, and shame. Consequently, clinicians use a variety of interventions to facilitate clients' awareness and acceptance of a wide range of positive or negative emotions as well as constructive outward expression of one's experiences to other people. Broadly, interventions can be divided into (1) methods for *enhancing* one's awareness, experience, and outward expression of emotions and (2) methods for increasing one's ability to *regulate downward* one's inner experience and outward expression of strong emotions.

- **Enhancing awareness, subjective experience, and outward expression of emotions.** A variety of interventions are used in CBCT to enhance the emotional experiences of inhibited individuals (Epstein & Baucom, 2002). When a member of a couple describes experiencing little emotion, one possible reason is past experiences (in the family of origin, past couple relationships, or the current relationship) in which self-expression led to negative consequences. To create a safe environment for awareness and expression of feelings, the therapist can set explicit guidelines for

the couple's behavior within and outside of sessions, in which partners are not allowed to punish each other for expressing themselves. In addition, when an individual lacks experience in paying attention to inner thoughts and emotions, the therapist can use downward-arrow questioning to inquire about such reactions to particular experiences with a partner. The therapist also can engage the individual in imagery and role plays focused on issues in the couple's relationship that may elicit emotional responses. This process of enhancing self-awareness or "psychological mindedness" can be facilitated by coaching the individual in noticing internal cues to emotional states such as bodily sensations. Because some clients tend to use cognitive and behavioral strategies to avoid experiencing aversive emotions, therapists can refocus their attention on emotionally relevant topics when they attempt to change the topic with their partner, engage in distracting behavior, and the like, while conveying empathy for the person's distress and encouraging gradual exposure to uncomfortable feelings. Because an individual may not disclose their discomfort with their partner's presence in the session, the therapist should monitor nonverbal cues of partners' emotional responses to each other and inquire about them.

- **Increasing regulation of the internal experience and outward expression of strong emotions.** Gottman (1994) identified some couples who have "volatile" but stable relationships, experiencing both positive and negative intense emotional exchanges. However, other couples that include one or both members with degrees of poor emotion regulation are at risk for severe conflict, distress, and partner aggression (Epstein, LaTaillade, & Werlinich, 2023; Fruzzetti & Payne, 2015). Those couples are in need of assistance with managing intense emotional responses. In CBCT, therapists can use a combination of interventions that focus on situational constraints on emotional responses and intrapsychic strategies. Regarding the structuring of situations in which emotions are experienced and expressed, therapists can guide couples in scheduling specific times and places when they will discuss distressing topics, while avoiding such discussions at other times. They also can teach couples how to use a time-out in which either partner is allowed to announce that the tension level between them has risen and to suggest a "cool-down" break. Partners also are taught to use constructive skills for expressing their emotions when they reunite after the time-out. Emotion-regulation strategies that focus on internal experiences can include coaching the couple in self-soothing activities such as progressive muscle relaxation, exercising, taking a warm shower, or talking with a calming person. Acceptance-focused techniques can be used to develop partners' abilities to tolerate distressing feelings. Interventions that target unregulated emotions commonly are integrated with cognitive interventions that improve partners' ability to monitor and modify their thoughts that elicit strong emotions, such as stress inoculation techniques described by Meichenbaum (1977).

APPLICATION OF CBCT TO INDIVIDUAL PHYSICAL AND MENTAL HEALTH ISSUES AND SEVERE RELATIONAL PROBLEMS

CBCT has evolved from its early focus on improving the ratio of pleasing to displeasing behavioral interactions between members of a couple, with enhanced global relationship satisfaction the goal, to a model applied to a variety of complex relational and individual functioning problems. On the one hand, it provides sophisticated concepts and methods for understanding and intervening with each partner's internal cognitive and emotional experiences. On the other hand, its dyadic

approach to the mutual influences between the two partners' cognitions, emotional responses, and behaviors makes it a flexible systemic model for treating complex relational problems.

CBCT increasingly has been applied to presenting problems in individual functioning (e.g., alcohol abuse, depression, anxiety disorders, eating disorders) that previously were treated only with individual therapy. Such systemic approaches are based on evidence from both cross-sectional and longitudinal research studies of a bidirectional association between relationship distress and a variety of psychopathology symptoms (Baucom, Whisman, & Paprocki, 2012). In addition, individual therapies for psychopathology commonly do not improve partners' relationship satisfaction (Whisman, 2001). Furthermore, a partner's attempts to be supportive and caring may inadvertently reinforce an individual's maladaptive behavior, as when a partner makes it easier for an agoraphobic individual to avoid feared situations by taking over the individual's tasks that involve going outside the home.

Typically, couple-based treatments integrate traditional interventions for the individual's symptoms with couple therapy interventions to reduce aversive interactions that exacerbate the symptoms and to improve mutual support between partners. For example, programs for alcohol abuse by Birchler, Fals-Stewart, and O'Farrell (2008) and McCrady, Epstein, and Holzhauer (2023) combine interventions for the individual's substance use (e.g., self-help meetings, medication, dealing with urges, drink refusal training) with behavioral couple therapy procedures (e.g., increasing exchanges of pleasing behavior, improving communication and problem-solving skills) to decrease negative couple interactions and enhance mutual emotional support. Couple-based interventions also have been developed for depression (Baucom, Fischer, Corrie, Worrell, & Boeding, 2020; Beach, Dreifuss, Franklin, Kamen, & Gabriel, 2008; Whisman, Beach, & Davila, 2023), anxiety disorders (Chambless, 2012), posttraumatic stress disorder (Monson & Fredman, 2012, 2023), obsessive–compulsive disorder (Abramowitz et al., 2013), and anorexia nervosa (Bulik, Baucom, & Kirby, 2012). In addition, Baucom, Porter, et al. (2009) developed a CBCT-based program for women suffering from breast cancer and their partners that includes training in communication and problem-solving skills that partners use to address cancer-related topics such as medical decisions, sexuality, and fear of mortality. Conjoint interventions can help couples cope with a variety of physical health problems (Baucom, Porter, Kirby, & Hudepohl, 2012).

Protocols that involve partners in the treatment of individuals' psychological problems tend to fall into three categories (Baucom et al., 2023; Epstein & Baucom, 2002). In *partner-assisted intervention*, the partner of a symptomatic individual also receives psychoeducation about the disorder during couple sessions and serves in a supportive, collaborative role in the identified patient's treatment. Thus, in panic disorder cases both members of the couple receive psychoeducation about the disorder (its causes, symptoms, effects on couple relationships, and effective treatments); both receive interoceptive exposure to conditions that simulate panic symptoms (e.g., breathing through a narrow straw to create sensations of suffocation); and the partner accompanies the anxious individual during *in vivo* exposure exercises to provide encouragement and occasional coaching. In *disorder-specific intervention*, the therapist assesses couple interaction patterns associated with the individual's symptoms, increases their awareness of patterns that may maintain the individual's problem, and coaches them in altering such behavior. Thus, in a case of agoraphobia in which the partner has taken over the symptomatic individual's tasks involving trips outside the home, the therapist would show them how their coping pattern maintains the individual's avoidance and would encourage changes that would increase the individual's autonomous functioning. Finally, in *couple therapy* used to address problems in individual functioning, general conflict and

stress in a couple's relationship that elicit or exacerbate the individual's symptoms are targeted. These three couple-based approaches to treating problems in individual psychological functioning are described in Chapter 10.

Regarding CBCT that is tailored to treating specific types of *severe relational problems*, generic assessment and intervention methods (e.g., behavioral observation of dysfunctional communication behavior and coaching of couples in constructive communication) are integrated with interventions for particular types of cognitions, emotional responses and behaviors that are associated with a particular relational problem. For example, Snyder, Baucom, and Gordon (2007) developed a CBT-based program to help couples dealing with infidelity. Research has indicated that revelation of an affair commonly elicits trauma symptoms in the betrayed individual (including cognitive disorientation as their core assumptions about security in the relationship were shattered), severely disrupted equilibrium in the emotional and behavioral functioning of the two members and their relational routines, and potential escalation of aversive behavior between partners. Betrayal-specific responses that must be addressed include hurt, anger, the desire to reestablish some sense of control over one's life, and the need to reconceptualize the characteristics of one's unfaithful partner. Couple therapy is used to stabilize the functioning of the partners and their interactions, to gain insight into factors that led to the affair, and to make constructive decisions about the future of the relationship. This approach is covered in Chapter 6.

CBCT also has been used to treat couples experiencing psychological and mild to moderate physical partner aggression (but not cases of physical battering), common in the general population but especially among couples seeking therapy (Epstein, LaTaillade, & Werlinich, 2023). It targets partners' anger management skills and cognitions that influence aggressive behavior (e.g., a belief in retribution toward a partner who was hurtful), as well as dyadic interactions that exacerbate couple conflict, such as negative reciprocity. CBCT and solution-focused couple interventions have been found to be safe and effective (LaTaillade, Epstein, & Werlinich, 2006; O'Leary, 2015; Stith, McCollum, & Rosen, 2011). Chapter 5 describes CBCT for partner aggression.

Cognitive-behavioral concepts and clinical methods have long been core components of sex therapy programs, and CBCT provides a systemic approach to working with couples with a variety of sexual problems (Metz, Epstein, & McCarthy, 2018). It addresses both the intrapsychic components of sexual disorders involving desire, arousal, and orgasm and dyadic couple processes that contribute to conflict and sex dysfunction. CBCT for couple sexual problems is described in Chapter 7 of this book.

Interventions to improve individuals' parenting skills commonly incorporate cognitive-behavioral principles and methods (e.g., Barkley & Benton, 2013; Eyberg et al., 1999; Forgatch, 1994; Kazdin, 2009). However, the parenting role frequently is shared by two or more adults who have responsibility for a child's care and upbringing (McHale & Lindhal, 2011), and the success of co-parenting depends on the quality of the alliance between the caregivers. Chapter 9 describes a CBCT approach to enhancing a couple's co-parenting relationship.

Because financial issues are among the most prevalent challenges that couples face together, couple therapists are highly likely to encounter couples who are experiencing financial stress and conflict. Although financial counseling and money management are specialized areas of expertise that lie outside the domain of couple therapy, partners who are experiencing financial stress and conflict commonly can benefit from intervention with their relational dynamics associated with money. Chapter 8 focuses on CBCT for relational aspects of couples' financial issues.

Finally, the increasing diversity of couple characteristics in clinicians' caseloads includes intercultural couples, who commonly present with some relational dynamics associated with partners' cultural differences. Clinicians need to be prepared to address issues associated with each individual's cultural background (e.g., beliefs and traditions regarding partners' appropriate roles in a relationship, discrimination experiences of minoritized group members), as well as challenges the couple experiences dyadically as they navigate their cultural differences. Chapter 11 describes characteristics of intercultural couples and associated CBCT assessment and treatment planning.

STRUCTURAL CHARACTERISTICS OF CBCT

Cognitive-behavioral therapies in general have been described in the extensive clinical literature as highly structured approaches with clearly defined roles for the therapist and clients. This level of structure was derived in part from the empirical perspective that is prominent in the model, in which the clinician conducts a systematic functional analysis of factors that influence the occurrence of problematic symptoms, designs interventions to modify the controlling conditions, and uses the most objective data available to evaluate the outcomes of treatments. The emphasis on empiricism includes a strong tradition of controlled studies investigating the effects of cognitive-behavioral treatments. High-quality efficacy trials require standardized treatment protocols with manuals of procedures that trained therapists follow in sessions, as well as random assignment of clients to treatment and control groups. Although those types of control strengthen the internal validity of the studies, they minimize clinical flexibility as therapists work with clients presenting diverse problems and personal characteristics.

Consequently, books and journal articles describing empirically supported cognitive-behavioral treatments tend to portray highly structured treatments with little apparent room for the operation of *common factors* involving the characteristics of therapists (e.g., warmth, empathy), clients (e.g., motivation to change), and the therapeutic alliance that have been found to account for a large percentage of variance in client improvement in individual and couple therapies (Sprenkle, Davis, & Lebow, 2009). However, in actual clinical practice, therapists have much more leeway to tailor validated interventions to the needs and characteristics of each individual or couple. Certain structural aspects of sessions are standard procedures in CBCT, beginning with the therapist initiating each session by briefly setting an agenda collaboratively with the couple regarding topics to be covered, and ending with the therapist recapping what was covered during the session, inquiring into what the clients found helpful or unhelpful, and collaborating with the partners to devise one or more homework tasks that they will carry out before the next session. Nevertheless, therapists use their personal styles in relating to their clients and introducing CBCT concepts and methods. We strongly believe in using empirically supported treatments, but we consider common factors to be essential for effective therapy. We always have CBCT concepts in our heads, but we express them in sessions in diverse ways that are designed to meet each person's needs. In Chapter 2, which focuses on how one conducts couple therapy, and throughout this book, we describe concepts and methods that can guide treatment planning. We emphasize the roles of clinical assessment and judgment in establishing strong alliances with couples and in designing individualized treatment plans that will assist them in achieving their personal goals.

INTEGRATING CBCT WITH OTHER COUPLE AND FAMILY THERAPY THEORETICAL ORIENTATIONS

As we noted previously, for decades a large percentage of practicing couple and family therapists have been using CBCT methods (Northey, 2002). The systems theory aspects of CBCT and simultaneous attention to partners' cognitions, emotions, and behavioral interactions make it a highly integrative model that is compatible with a variety of other systems-focused couple and family therapy models that include core concepts involving partners' thoughts, emotional responses, and behavioral patterns (Dattilio, 2010). The attention that CBCT pays to partners' intrapsychic experiences involving cognition and emotion (and roots of current responses in individuals' past experiences in family of origin and other significant relationships), as well as current circular processes in couple behavioral interactions, makes it compatible with a variety of other models. Benson, McGinn, and Christensen (2012) identified core principles or processes that are common to evidence-based couple therapies, and they are closely related to the CBCT domains of cognition, affect, and behavioral interaction. Those processes include altering partners' views of their presenting problems to be more objective and dyadic (in contrast to distressed partners' common global blaming of each other), decreasing emotion-driven dysfunctional behaviors (such as partner aggression), uncovering emotion-based avoided behavior (such as partners' avoidance of intimate interactions based on anxiety), increasing constructive communication, and emphasizing relationship strengths. Given these common elements across models, interventions from a variety of models can be used to produce change in a common aspect of couples' relationships. In the couple therapy field, alternative models may target a similar aspect of a relationship that has been identified as contributing to a presenting problem but may prescribe somewhat different interventions to achieve that goal. For example, a pattern in which one member of a couple aggressively pursues the other while the partner actively withdraws can be addressed with diverse interventions from structural, emotion-focused, solution-focused, cognitive-behavioral, and other couple therapy models. Therapists may use different interventions even though they share a view that members of the couple failed to find a mutually comfortable way of meeting their respective intimacy needs.

Furthermore, a therapist may conceptualize couple problems with constructs from another model but use CBCT interventions to enact change. For example, a structural family therapist likely thinks in terms of boundary issues when hearing that a couple argues about the degree to which one of the members shares information about the couple's relationship with friends. A boundary is a concept that people tend to define in terms of partners' interactions with each other and other people, as well as each individual's standards about the appropriateness of those behaviors. In this case, the couple's conflict was based on the gap between the partners' beliefs about how much information about their relationship should be shared with other people, especially when one person's actions violate the other's standard. Structural interventions could be integrated with CBCT approaches to having partners use constructive communication and problem-solving skills to discuss their conflict. Thus, this book emphasizes a CBCT approach to treatment planning, but we believe that the methods described in each chapter can be useful to therapists from other theoretical orientations in conceptualizing a variety of interventions to achieve therapy goals for their clients. In each chapter on a particular presenting problem, we focus on CBCT assessment and interventions, but we often point out how concepts and methods from other therapy models can be applied.

RESEARCH SUPPORT FOR CBCT

CBCT is a couple therapy model that has been identified as empirically supported from treatment outcome studies (e.g., Baucom et al., 1998; Fischer, Baucom, & Cohen, 2016; Lebow & Snyder, 2022). Most studies have focused primarily on the standard CBCT behavioral interventions of communication skill training, problem-solving training, and some form of planned positive behavior exchanges (e.g., contracts), with much less attention to interventions targeting cognitions and emotional responses. Most outcome studies have examined the *efficacy* of treatment in controlled settings with randomized assignment of couples to treatments, a set number of sessions across treatment and control groups, and training of therapists in the treatment protocols, rather than their *effectiveness* in naturalistic clinical settings. Meta-analyses (e.g., Shadish & Baldwin, 2003, 2005) indicated that, overall, treatments that included interventions for cognitions and those restricted to behavioral interventions have produced large effect sizes for improvement in relationship satisfaction. Shadish and Baldwin's (2005) meta-analysis of 30 studies comparing behavioral couple therapy to no-treatment control groups found an effect size of 0.59 in favor of the therapy. Fischer et al.'s (2016) review indicated that behaviorally based couple therapies, some of which included cognitive interventions, had an average effect size of 0.84, similar to the effects found for other therapy models. Christensen and colleagues' randomized clinical trial (Christensen et al., 2004) compared integrative behavioral couple therapy (IBCT), which combines interventions to increase partners' acceptance of each other with communication and problem-solving training to facilitate change (Christensen, Dimidjian, Martell, & Doss, 2023; Jacobson & Christensen, 1996), and what the investigators label "traditional behavioral couple therapy" (TBCT), which is the model developed by Jacobson and Margolin (1979) and others. The two treatments showed somewhat different rates of improvement in relationship satisfaction, but the outcomes were for the most part similar, with large effect sizes of 0.90 for IBCT and 0.71 for TBCT at the end of treatment, which were not significantly different (Christensen et al., 2004). In a 5-year follow-up, Christensen, Atkins, Baucom, and Yi (2010) found even larger effect sizes for improvement in relationship satisfaction of 1.03 for IBCT and 0.92 for TBCT, with 50.0% of IBCT couples and 45.9% of TBCT couples reaching clinically significant improvement according to the index proposed by Jacobson and Truax (1991).

Two studies conducted by Baucom and colleagues (Baucom & Lester, 1986; Baucom, Sayers, & Sher, 1990) investigated whether adding cognitive restructuring modules to TBCT would enhance the outcomes. However, in order to keep the total number of sessions constant, adding sessions of cognitive restructuring necessitated reducing the number of sessions of behavioral interventions. All treatments increased relationship satisfaction more than a waitlist condition, and the cognitive and behavioral interventions were equally effective. There also was some evidence that cognitively focused interventions tended to produce more cognitive change.

Although no further studies on the overall effects of CBCT for improving relationship satisfaction have been conducted, studies we described earlier that tested CBCT protocols that include cognitive and affective as well as behavioral interventions with specific types of severe relationship problems and individual psychopathology have been promising. For example, cognitive-behavioral programs for treating couples experiencing psychological partner aggression and mild to moderate physical aggression (see Chapter 5) have received support through initial efficacy studies (Epstein et al., 2023; Heyman & Neidig, 1997; LaTaillade et al., 2006). The protocol tested by Epstein and colleagues, which included interventions for cognitions, regulation of anger, and behavior,

increased relationship satisfaction, decreased psychological partner aggression, decreased males' use of physical aggression and showed a trend toward a decrease in females' physical aggression, reduced negative attributions about one's partner, increased overall trust in the partner, decreased anxiety and increased positive moods prior to engaging in a conflict resolution discussion with one's partner, and decreased negative communication by both males and females during the couple discussion (Hrapczynski, Epstein, Werlinich, & LaTaillade, 2011; Kahn, Epstein, & Kivlighan, 2015; LaTaillade et al., 2006). Furthermore, Chapter 10 reviews the promising effects of CBCT for forms of individual psychopathology.

Unfortunately, no further outcome studies have been done in isolating the independent effects of interventions focused on modifying partners' negative cognitions and emotional responses, so the existing encouraging results must be considered preliminary. The absence of dismantling studies examining the relative effects of interventions for cognitions, emotional responses, and behaviors likely is due to the complexity and expense of such designs, especially when funding for couple therapy studies is scarce. Furthermore, the vast majority of research has been conducted on Western, middle-class, cisgender, heterosexual couples. Studies with more diverse samples will be essential to fully gauge the breadth of CBCT effectiveness.

KEY POINTS

- CBCT provides therapists a comprehensive and flexible framework for understanding and treating a variety of behavioral, cognitive, and emotional characteristics contributing to problems in intimate relationships.
- CBCT strikes a balance between structure in the assessment and treatment planning process and opportunities for clinicians to use their joining skills creatively to develop a strong collaborative therapeutic alliance with members of the couple to alleviate distressing presenting problems.
- Clinicians who primarily adhere to other theoretical orientations can integrate CBCT concepts and methods into their work with clients.
- Therapists must be attuned to clients' cultural identities, including experiences of discrimination and marginalization that had major impacts on many clients' lives.
- The interplay between two individuals' personal histories and current intrapsychic experiences and the couple's circular behavioral interactions provide opportunities and pathways for intervention. Therapists need expertise both in systemic concepts and methods and in intervention with individual psychological processes.

Guilford Publications
370 Seventh Avenue
New York, NY 10001
212-431-9800
800-365-7006
www.guilford.com