William W. Eaton, Jack Burke; Project Officers were Carl A. Taube and William Huber. We also acknowledge the research assistance and word processing of Miss Jean Lavelle and Miss Denise Spriggs.

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MARITAL THERAPY AND EMPLOYEE ASSISTANCE PROGRAMS

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Organizations serving employees should expect to come under increasing pressure to provide help for marital problems. While many forces have contributed to the view that marital therapy is a luxury service, this view is increasingly at odds with the data. To argue successfully for the provision of marital therapy services or to provide appropriate referral for treatment, however, it is necessary to have information both about the various problems which are related to marital discord and the various time limited and cost effective approaches to marital therapy which are currently available. The current paper provides this information as well as directing interested persons to the primary sources for outcome research on marital therapy and clinical intervention in marital therapy. It is argued that EAP professionals may play an important role in enhancing the maintenance of marital therapy outcome.

Most employed individuals are also married. This simple fact of social organization has several implications for professionals who serve the needs of employees. First, it suggests that many of the problems for which employees seek help will have either marital antecedents or else marital sequelae. In fact it has been known for some time that marital problems are among the most common of complaints in outpatient mental health settings (Sager, Gundlach, Kremer, et. al. 1968). Accordingly, organizations which serve employees can expect to come under increasing pressure over time to provide help for marital problems. Second, it suggests that marital relationships are likely to be an important context for understanding many of the remaining problems presented by employees. Specifically, it is likely that the positive resolution of many of the problems with which employee assistance professionals work will be influenced by events in the marital relationship. For example, a growing literature suggests that treatment outcome is less favorable and relapse following treatment more likely for patients in unsatisfying relationships (e.g. Hooley, 1986). Finally, it suggests that some employers will attempt to follow the lead of third party payers in restricting access to services for marital problems because they are too common and so services may be too commonly requested. Indeed, at present marital and family therapies are excluded from coverage under many insurance policies and are viewed as luxury services by many HMO's and mental health centers. Likewise, psychiatric professionals, who may be more attuned to biological factors, or psychologists, who may be more attuned

Journal of Employee Assistance Research, Vol. 1, No. 1 (Summer 1992).

to intra- individual factors may dismiss marital variables as being of only peripheral importance, complicating the task of the EAP professional in providing optimal referrals and comprehensive care. So, while the ubiquity of marriage is a reason for greater attention to marital effects and marital interventions, it is necessary to face potential objections to greater attention to marital problems both on the grounds of cost and on the grounds that individual or somatic interventions should be considered primary.

How can EAP professionals both respond to the challenge of providing better services in an area which is important to employees and yet deal with the fear of potential cost explosion? We believe the key element in both cases is to have available the empirical evidence which addresses the issue of marital therapy as a critical element in successful treatment of various disorders, and information about cost-effective, time-limited approaches to marital therapy. This type of information allows the EAP professional to recommend those forms of intervention which have been supported in the outcome literature and recommend them for those situations in which marital intervention is most likely to provide substantial benefit.

Is the Marital Relationship Worthy of Attention?

One reason health professionals pay attention to marital problems is the importance individuals place on marriage and family. Integrity of the marriage is valued by many persons seeking help for other problems. Indeed, often it is made clear by the person seeking help that they do not value the resolution of their focal problem as much as they value the restoration or preservation of a more harmonious or stable family life. Disruption of marital functioning constitutes a serious loss in the quality of life, and reduction of a focal problem which does not address the associated disruption of marital functioning is often unsatisfactory to persons seeking help. From the standpoint of consumer demand, then, attention to marital problems will often become a focus of attention.

However, marital problems may also be a fundamental link in the chain of events leading to first episodes or relapse in a variety of disorders, including depression (Brown & Andrews, 1986), anxiety (Barlow, O'Brien, & Last, 1984), substance abuse problems (Billings, Kessler, Gromberg, & Weiner, 1979), and psychotic disorders (Falloon, Boyd, McGil, Razani, Moss, & Gilderman, 1982). Across a range of problem areas, many of which are common and capable of producing considerable disturbance in the work place, then, it will be prudent to have a marital approach as an adjunctive (or primary, Beach, Sandeen, & O'Leary, 1990) intervention. If effective and appropriate procedures can be advanced for carrying out the marital component of the overall treatment, this provides a complete rationale for the recommendation of marital therapy.

What is Known about Marital Discord?

The empirical base for understanding the development and maintenance of marital discord has expanded rapidly in the last 15 years (Weiss & Heyman, 1990). While we will not attempt to provide a comprehensive review of this work, it may be useful to briefly summarize the most clinically relevant aspects of the basic work.

As couples become discordant, they find the balance of events in their relationship changing in a negative direction (Barnett & Nietzel, 1979; Birchler, Weiss, & Vincent, 1975; Margolin, 1981). They become more reactive to negative behavior from their spouse, exaggerating the stress engendered by negative exchanges (Levenson & Gottman, 1983; Jacobson, Waldron, & Moore, 1980; Jacobson, Follette, & McDonald, 1982). They begin to more readily reciprocate negatives from their spouse (Billings, 1979; Gottman, 1979; Margolin & Wampold, 1981; Revenstorf, Hahlweg, & Schindler, & Vogel, 1984; Smith, Vivian, & O'Leary, 1990). Both spouses may begin to perceive their partner's behavior as more negative (Floyd & Markman, 1983), and more blameworthy or deserving of punishment (Fincham, Beach, & Nelson, 1987). In conjunction with this increase in frequency and perceived negativity of marital exchanges between spouses, discordant spouses are also more confident that their negative judgements of their spouse are true (Noller & Venardos, 1986). These changes result in considerable difficulty in attempting to resolve existing problems or even discussing low level disagreements (Gottman, Markman, Notarius, 1977; Koren, Carlton, & Shaw, 1980), generating considerable frustration for the discordant couple. This increasing frustration is likely to be manifested in higher rates of criticism, demands, or nagging on the part of one spouse and withdrawal, avoidance, and hurt feelings on the part of the other spouse (Christensen, 1987). In short, the spouses often find themselves in a "coercive spiral" (Patterson & Reid, 1970; Weiss, Hops, Patterson, 1973) in which each partner tries to influence the other in an escalating exchange of negative behavior.

Clearly, in the context of ongoing marital discord the ability of each spouse to provide support for the other is severely compromised. Yet, married persons list their spouses both as their number one source of support and their number one source of negative interaction (Beach et al., in press). Accordingly, when stresses are encountered it is the spouse who is most commonly approached for various forms of support and when support is available, at least some of the potentially negative consequences of severe and threatening stressors may be averted (Brown & Harris, 1986). Accordingly, marital discord disrupts one of the primary buffers against severe stressors at the same time that it adds new major threats and stressors in its own right.

Approximately 20% percent of all married couples are experiencing marital discord at any given time (Beach, Arias, O'Leary,1987), but only about 29% are willing to characterize their relationships as less than "very happy" (Glenn, 1991). Nonetheless, about half of all newlyweds in first marriages will divorce (Glick, 1984). Further, the likelihood of attaining "marital success" appears to have declined in recent years (Glenn, 1991). In addition to the associations mentioned earlier with mental health problems, marital discord and marital disruption are also associated with a variety of physical disorders for spouses (Somers, 1979), and with mental health problems for their children (Emery, 1988).

This thumbnail sketch of what is currently known about marital discord highlights the fact that marital discord is, in itself, a very troubling problem. Most persons who experience marital discord hope to do something about it. And, if no effective means of reducing the level of discord is found the individual is likely to suffer one or more of a variety of negative psychological or physical problems. There are good reasons to suspect that within any large work setting there will be a large group of persons who are in need of services directed at improving the quality of their marital relationship. However, this leaves open the question of what sort of treatment should be recommended.

Can Marital Discord be Treated?

Overall marital therapy is successful 70% of the time in increasing marital

satisfaction for an extended period of time (O'Leary & Wilson, 1987). Only in the last 15 years, however, has systematic outcome research been conducted in the field. Currently many types of therapy exist with many divergent labels, but closer scrutiny of their techniques and strategies often suggests substantial overlap. Nonetheless, it is not the case that all approaches are the same or that all are equally well supported in the outcome literature. We now turn to the outcome literature on the effectiveness of marital therapy.

Overview of Marital Therapy Outcome Literature

Therapists may reasonably ask why it is necessary to review the literature on effectiveness in the context of discussing what types of interventions might be applied most appropriately within the context of a brief intervention format such as is most typically provided by an EAP setting. Indeed, we believe therapists do often ask such questions. However, the type of outcome research which is available is most appropriate for utilization by settings in which open-ended therapy is unlikely or unavailable. In these settings, information regarding level of effectiveness within a specified time frame of the sort obtainable from outcome studies is potentially a useful element in planning the optimal use of limited staff resources. In addition, careful consideration of the outcome literature can be a good antidote to the sometimes hyper-inflated claims of competing "brands" of marital therapy.

First let us examine what issues should be considered when examining outcome literature. Of primary importance to documenting effectiveness is the existence of a control group and the procedure of random assignment to conditions. Only these attributes allow us to safely argue that something about the treatment itself accounted for differences between groups and that this difference represents a gain over no treatment at all. Without a control group we have no way of knowing how many of the couples would have improved with little or no therapeutic intervention. However, if random assignment is absent we cannot exclude the possibility that the observed differences were due to sampling differences between the two groups. Without either a control group or random assignment, we cannot appropriately infer that the intervention itself is responsible for the differences between groups.

In light of these considerations, we will examine research on the effectiveness of approaches to marital therapy by reviewing only those having a control group and random assignment to groups. We will not examine the large body of literature documenting success rates in the absence of a control group, or review the single-subject design studies in the marital literature. While this literature has played a central role in the development of marital techniques (e.g., Stuart, 1969), there are grave problems with generalizing from treated individuals to the larger population of maritally distressed couples (Beach & O'Leary, 1985).

We are interested in documenting the effectiveness of therapy, so we will not be including studies which have only 4 or fewer sessions followed by assessment. Our aim in restricting the studies to be reviewed is to assure ourselves that the studies which remain meet the minimal criteria for internal validity (Campbell & Stanley, 1966) in experimental design.

We will also restrict our review to those studies which have gone through standard peer review procedures provided for by English-language journals publishing marital outcome work (Beach & O'Leary, 1985). Although this limits the scope of the review, as suggested by Beach and O'Leary 1985, it ensures that certain minimal standards of quality are met by the studies included in the review—i.e., those standards provided by the existing scientific journals. Different journals apply different criteria, but those journals which provide for external peer review give a "stamp of professional approval for the studies they publish" (Beach & O'Leary, 1985, p. 1038).

Insight-oriented marital therapy. Insight-oriented marital therapy aims to help couples interact in a more mature manner by resolving unconscious sources of conflict (e.g., Gurman, 1981; Sager, 1976). Insight-oriented therapy usually emphasizes the unconscious factors which help determine the choice of one's mate and the types of conflicts that later arise. Manuals for therapies which fall in this family of treatments include *Emotionally focused therapy for couples* by Greenberg and Johnson (1988), and an as yet unpublished manual by R.M. Wills cited in Snyder and Wills (1989).

Five studies met our criteria for review. In the earlier studies, by Crowe (1978) and Epstein and Jackson (1978), insight was used without any directive techniques, a form of insight therapy that differs substantially from that described by prominent writers in the area. That is, no homework assignments were used and no attempt was made to encourage the spouses to try new patterns of relating. Accordingly, it was suggested that these studies tell us only that insight in the absence of a clearly specified direction of change is not a valuable approach to marital therapy.

The earliest controlled study testing the efficacy of nonbehaviorally oriented insight therapy was conducted by Crowe (1978). Crowe randomly assigned 42 couples with marital problems to one of three therapy conditions: (1) a directive therapy based on the work of Stuart (1969) and Liberman (1970) (primarily contracting), (2) an interpretative approach based on the work of Skynner (1969, 1976) (insight-oriented marital therapy), and (3) a control condition in which couples met with a therapist who avoided giving either advice or interpretation as much as possible.

On a global measure of marital adjustment used (a 16-question self-report measure), the insight group was significantly superior to the control group at nine month follow-up but not at posttherapy, 3-month follow-up, or 18-month follow-up. No differences between the insight group and the control group were found on improvement in sexual adjustment, general individual adjustment, or specific target problems. Thus, the Crowe study found the insight group to be weaker than predicted by the authors. Indeed, the one difference found (at the .05 probability level) out of the 20 posttherapy comparisons is not different than a result which would be expected by chance alone and cannot be taken as evidence that the insight group fared any better than the control group.

It should be pointed out that the therapists in the interpretative condition were limited to interpretation and not allowed to be directive. Skynner (1981) regards this as a critical deviation from his own preferred mode of therapy, and it may in fact account for the observed weakness of the therapeutic effects. Indeed later studies do suggest that more directive forms of insight-oriented marital therapy can be more effective in resolving marital problems than no therapy.

Epstein and Jackson (1978) conducted a controlled-outcome study which included an interaction insight group which might be described as behaviorally oriented insight group. Epstein and Jackson (1978) randomly assigned 16 couples (mean age not reported) to one of three conditions: (1) a communication group based on the work of Alberti and Emmons (1974), (2) an interaction insight group, or (3) a no-treatment waiting-list group. Subjects in the treatment group met for five sessions of one and one-half hour each over a three-week period. The

communication treatment emphasized assertion training and clear communication. The insight treatment involved instruction in the observation of verbal and nonverbal messages that exacerbate conflict. The major goal was to increase each subject's awareness of the impact of his/her behavior on the spouse's feelings and behavior. In the insight condition, directive interventions for alternate behaviors were kept to a minimum.

An analysis of variance on the pretest scores showed no difference between groups. Dependent measures used were ratings of communication by trained raters on 11 categories of verbal behavior (no reference given) and three scales from the Barrett-Lennard relationship inventory (Barrett-Lennard, 1962) yielding scales scores for degree of empathy, congruence, and unconditional positive regard generally received from the spouse.

Of the 11 coding categories, only one (disagreement) showed a significant change for the insight group relative to the control group. None of the three scales derived from the Barrett-Lennard showed a significant change for the insight group relative to the control group. Since 1 of 14 variables showing a significant change is not different from a result which could be expected on the basis of chance variability, behaviorally oriented insight therapy was not demonstrated to be an effective treatment of marital distress.

In contrast to the non-directive techniques used in both of these early studies, Boelens, Emmelkamp, MacGillavry, & Markvoort (1980) studied an insight-oriented approach that included a clear specification of direction of desirable change. Boelens et al. (1980) randomly assigned 21 couples to one of three therapy condition: (1) a behavioral contracting approach based on the work of Azrin, Naster, and Jones (1973), (2) an insight-oriented approach based on the work of Watzlawick, Weakland, and Fisch (1974) among others, and (3) a wait-list control condition. Outcome was assessed using (1) the Maudsley marital questionnaire (MMQ), which was based upon the marital adjustment scale used by Crowe (1978); (2) the marital deprivation scale (MDS) (Frenken, 1976), which was adapted from the marital attitude evaluation scale of Schutz (1967); (3) partner ratings of severity of their three main marital problems; (4) therapist ratings of the couples relationship; and (5) an observational rating scale measure of rates of positive and negative verbal behavior (MICS) (Hops, Wills, Patterson, & Weiss, 1972).

Pre-post analyses indicated that the two treatments considered together were significantly better than a wait-list control in improving scores on the MMQ, the MDS, the partner ratings of problem severity, the therapists ratings, and the observed level of positive social reinforcement. Only the level of negative social reinforcement failed to change more for the treated groups than for the wait-list. While analyses were not presented which contrasted each treatment separately with control group, it was possible to compute Fisher exact probabilities based on the number of couples showing improvement or showing no improvement in treated versus control conditions. (For the purposes of these computations, couples who had separated or divorced were considered unimproved.) Immediately posttherpay, the group receiving insight-oriented treatment was significantly improved over the untreated group ($p = .0435$). However, at one-month follow-up and six-month follow-up, there was no significant difference between the group receiving insight-oriented treatment and the untreated group. Out of eight couples treated with insight-oriented therapy, at one-month follow-up, two were separated, three remained together but showed no improvement, and three showed improvement. This represented a deterioration from results obtained immediately posttherapy.

In a fourth more recent addition to the field of insight-oriented techniques, Johnson and Greenberg (1985a) evaluated the effectiveness of "emotionally focused" marital therapy (Greenberg & Johnson, 1988). This approach borrows techniques from gestalt and systems approaches and utilizes techniques common to cognitive and behavioral approaches. Its unique contribution lies in its focus on unexpressed and/or unacknowledged feelings and on helping couples come to a new understanding of their relationship based on the exploration of these feelings. In their study, 45 couples were assigned randomly to emotion-focussed, problem-solving, or wait-list control. Moderately to severely discordant couples were excluded from the sample (Dyadic Adjustment Scale, DAS, scores below 65). Johnson served as one of the therapists in the emotion focussed condition, with therapists nested under treatment in the study design. Baucom and Hoffman (1986) and Weiss and Heyman (1990) rightly point out that this design feature poses serious problems in the interpretation of the comparison between the two active treatments, yet it does not compromise the comparison of emotion focused therapy with the control group. Emotion focused therapy produced an overall change in marital satisfaction while the control group showed no change.

Although subsequent studies using less experienced therapists and more discordant couples have not replicated the dramatic effects found in the initial study (Johnson & Greenberg, 1985b; Goldman, 1987), the Johnson and Greenberg (1985a) study highlights another source of potentially useful techniques in the treatment of mild to moderate marital discord. In light of the failure to replicate the initial strong effects in more discordant samples, however, one must conclude that a strong case has not yet been made that marital outcome can be substantially enhanced simply through the use of emotion focused techniques in addition to, or instead of, standard behavioral marital therapy. Indeed, other outcome work in progress suggests that there is no additive effect when standard Behavioral marital therapy (BMT) and Emotion-focused therapy are combined (Baucom & Sayers, 1988). However, to the extent that some couples respond particularly well to emotion- focused therapy or to emotion-focused techniques used at certain points in therapy the potential for the enhancement of marital therapy outcome is clear (Baucom & Sayers, 1988; Margolin, 1987; Weiss & Heyman, 1990).

A fifth contribution to the insight-oriented outcome literature is reported by Snyder and Wills (1989). In this study 79 couples seeking treatment for relationship distress were assigned to either a BMT condition, an insight-oriented marital therapy condition, or a treatment on demand wait-list condition. Both treatment conditions resulted in significant improvement, but did not differ significantly from each other. Snyder and Wills (1989) note the similarity between their insight-oriented approach and the therapeutic approach used by Johnson and Greenberg (1985a). These two effective insight-oriented approaches have strong directive components and provide clear messages about the direction of change that would be desirable, which is more similar to how prominent writers have outlined insight-oriented therapy. The Snyder and Wills (1989) study shows also that treatment gains were maintained at six month follow-up.

From the evidence of Johnson & Greenberg (1985a) and Snyder and Wills (1989) insight-oriented therapies with strong directive components can now be said to be roughly equal to other therapeutic approaches with regard to apparent effec-

tiveness, although maintenance beyond six months remains unknown. Again, however, effectiveness is well below the level most marital therapists would hope for, despite the increased length of marital therapy in the Snyder and Wills (1989) study (19 sessions). Thus, once again, while there is evidence pointing to potentially useful new technologies, there is little reason to expect substantially enhanced average outcomes to result from their addition as a standard treatment component.

Behavioral contracting approaches. Behavioral contracting approaches use contracting for increasing the incidence of positive behavior within the marriage. The origins of this approach come from the work of Stuart (1969), Liberman (1970), Azrin, Naster, and Jones (1973). In this approach couples are seen as suffering from a low rate of exchange of reinforcers. The goal of therapy is to increase the frequency of behaviors the spouses desire in one another. Usually, therapists help spouses construct written behavior change agreements. Manuals for therapies which fall in this family of treatments include *Marital Therapy: Strategies based on social learning and behavior exchange principles* by Jacobson and Margolin (1979), and Stuart's (1980) book *Helping couples change: A social learning approach to marital therapy.* In both these cases the therapy described is far more complex than behavioral contracting alone, particularly as it was originally described and tested. However, the two manuals may be taken as mature versions of this form of treatment.

Often the contracting approach is combined with other approaches. However, it has been tested three times alone in the context of a controlled-outcome study. The first study of this type was the Crowe (1978) study discussed earlier. Crowe (1978) found that contracting was effective on a number of outcome measures relative to a control group. On the 16-item self-report measure of marital adjustment used, couples in the contracting approach were significantly less maritally distressed than couples in the control group at 9 months and 18 months following therapy. On sexual adjustment, the contracting group was significantly superior to the control group at posttreatment assessment and nine-month follow-up. Similarly, the interpersonal and the intrapersonal target problems selected for therapy each showed significantly greater improvement for the contracting than for the control group at posttreatment and at nine-month follow-up. Thus, out of 20 opportunities to differ from the control condition following therapy, the contracting group differed 11 times in the direction of being superior and no times in the direction of being inferior. In the absence of an omnibus, multivariate F, submitting these differences to a sign test indicates the superiority of the contracting condition.

Boelens et al. (1980) included a contracting-only condition in their study which was discussed earlier. Improvement was found for the treated groups relative to the control group on all self-report measures of the marital relationship and on positive verbal behavior as judged by an observer using the MICS. No significant difference between treated and untreated couples was found for level of marital functioning as rated by an independent assessor, nor was any effect found on rate of negative verbal behavior using the MICS. Change was also rated in terms of overall improvement for each couples. Improvement was defined in terms of the amount of change on target problem scores. Changes of 25 percent or more were counted as improved, while changes less than 25 percent were counted as unimproved. Using this scheme, it is possible to separately contrast the group receiving training in contracting with the control group at posttherapy, one-month follow-up, and six-month follow-up. Although not conducted by the authors, using the Fisher exact-probability test, it is possible to determine the superiority of contracting to no treatment at each point in time with $p = .0435$, $p = .0046$, $p = .0046$ at post, one month, and six month respectively. Thus contracting proved superior to no treatment and maintained this superiority over time.

Baucom (1982) conducted another study on marital therapy in the context of controlled-outcome. Baucom randomly assigned 72 maritally distressed couples (mean age 32) to one of four treatment conditions: (1) quid pro quo contracting only, (2) communication training plus contracting, (3) communication training only, or (4) wait-list control. Outcome was assessed using trained observer rating of positive and negative behavior (MICS) (Marital Studies Center, 1975) and two self-report inventories of global marital satisfaction: (1) areas of change (Weiss et al., 1973) and (2) Locke-Wallace marital adjustment scale (Locke-Wallace, 1959). Comparisons of the contracting-only condition to the wait-list control group showed that contracting was superior at posttreatment on both self-report measure and on negative behavior as coded by the trained raters. Thus, contracting alone was superior to no treatment on three or four measures used. No significant changes in any of the measures were found from posttherapy to 3-month follow-up, indicating maintenance of treatment effects. These results indicate that the contracting was effective in helping alleviate marital distress.

All three studies of contracting alone (Crowe, 1978; Boelens et al. 1980; Baucom, 1982) showed that the use of behavioral contracts between spouses was superior to no treatment control conditions. In addition, the three studies complemented each other nicely in that one assessed the impact of treatment on the individual as well as the couple, and two used both trained raters of marital interaction as well as self report measures to assess the impact of treatment on marital behavior and satisfaction. Thus, it was concluded that contracting approaches or, more specifically, the directive approach to specifying and increasing positive exchange in the dyad while decreasing coercive interaction, were effective in alleviating marital discord even when used alone.

Another contribution to the empirical literature on behavioral contracting is reported by Jacobson (Jacobson, 1984; Jacobson et al., 1985; Jacobson, Schmaling, Holtzworth- Monroe, 1987). This study compared the effectiveness of behavior exchange, communication problem-solving training, and the combination of these two approaches. As expected, all treated couples improved significantly more than wait-list couples. Consistent with prior research, the combined treatment was not significantly better than the component treatments. However, differences did emerge with regard to maintenance of treatment effects. Good maintenance of gains at six months was found for both groups receiving intervention targeted at increasing communication and problem-solving skills. However, the group receiving only behavior exchange (i.e., contracting) intervention showed a significant decline in marital satisfaction by six month follow-up. At longer follow-ups, the combined treatment was nonsignificantly superior to the behavior exchange treatment. Jacobson et al. (1985) concluded that the superiority of the combined treatment, relative to the behavior exchange treatment alone, is only temporary.

Behavioral contracting and communication training. Several earlier studies had examined the more usual pattern of behavioral marital therapy (BMT), which involves communication training as a concomitant or precursor to contracting (Jacobson, 1977; Jacobson, 1978; Turke-