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Cognitive-Behavioral Psychotherapy for Couples: An Insight into the Treatment of Couple Hardships and Struggles

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Abstract

In this chapter, a comprehensive literature review of the theoretical underpinnings and clinical practices of cognitive-behavioral couple therapy (CBCT) will be presented. First, a description of the theory underlying CBCT and the role of the therapist will be reviewed. Different mandates and motives for couples to consult in CBCT will then be described, with attention given to specificities for diverse populations. The assessment process and main intervention techniques used by CBCT therapists will be presented, including communication training, problem and conflict resolution, cognitive restructuring, identification and expression of emotions, expression of affection and sexual problems as well as acceptance and tolerance of differences. The chapter will conclude with a critical analysis of CBCT and suggestions for future clinical developments.

Keywords: cognitive-behavioral couple therapy, assessment, intervention, couple distress, couple adjustment

1. Introduction

Intimate relationships are of great significance for most adults and highly impact overall well-being and health [1, 2]. Indeed, satisfying intimate relationships can provide happiness, social support as well as buffer the repercussions of numerous stressors [2–4]. However, when these relationships are characterized by significant distress, destructive conflicts or general dissatisfaction with the relationship, they can also lead to deleterious consequences to physical and psychological health [1] as well as great suffering [2].

Cognitive-behavioral couple therapy (CBCT) aims at assisting romantic partners who report distress in their relationship. Over the years, CBCT has been extensively evaluated in treatment outcome studies, which have repeatedly concluded in its effectiveness for decreasing couple distress and dissatisfaction as well as for addressing communication or problem-solving difficulties [5–7]. Studies have also found that such improvements seem to be maintained for up to 2 years by most couples [8].

In this chapter, a comprehensive literature review of the theoretical underpinnings and clinical practices of CBCT will be presented. First, a description of the theory underlying CBCT and the role of CBCT therapists will be offered. Possible mandates and motives for consulting in CBCT will then be described, with particular attention to the specificities in CBCT for diverse populations. The assessment process used in CBCT will also be addressed, allowing readers to understand the particularities of psychotherapeutic work with couples. Subsequently, the main intervention techniques used in CBCT will be defined: communication training, problem and conflict resolution, cognitive restructuring, identification and expression of emotions, expression of affection and sexual problems as well as acceptance and tolerance of differences. The chapter will conclude with a critical analysis of CBCT and suggestions for future clinical developments.

2. A brief history of the theoretical underpinnings and objectives of CBCT

The origins of CBCT stem mainly from Stuart's [9] work on behavioral exchanges between partners. He based his analysis of couple interactions on learning principles [10] and social exchange theory [11], postulating that individuals' evaluation of their relationships would depend on the ratio of benefits to costs, resulting from positive and negative exchanges with others. Stuart [9] thus proposed a behavioral exchanges paradigm where successful relationships could be differentiated from dysfunctional ones by the frequency of positive and negative behavioral exchanges. Positive behaviors include constructive problem solving as well as empathically expressing and listening to each other, whereas negative behaviors refer to the expression of criticism, hostility, contempt or withdrawal from interactions with the partner. Early behavioral couple therapies [12, 13] focused primarily on behavior changes and the acquisition of skills aimed at increasing the frequency of positive behaviors and reducing aversive behavioral interactions through the development of effective communication and problem-solving strategies [14].

During the last decades, behavioral couple therapy expanded by including interventions that also addressed emotions and cognitions contributing to conflicts and dissatisfaction. This was achieved by highlighting the importance of attributions, dysfunctional beliefs and distorted cognitions in romantic partners' evaluation of their relationship [15]. For instance, by selectively attending to specific behaviors or characteristics in the partner or by approaching the partner with expectations or standards about how he or she should be or act, individuals will

see variations in their appreciation of their partner and of their relationship. Cognitions also depict the way partners process information originating from the others' behaviors, which guide their interpretation of events as well as expectations towards the other and the relationship [15].

Work from Jacobson and Christensen [16] increased focus on acceptance strategies as a way to help partners recognize that they are different and eventually learn to respond constructively to difficulties or incompatibilities within the relationship. In 2002, Epstein and Baucom further enhanced CBCT by including work on partners' needs for intimacy and increased attention to emotions, not only as a result of modifications in the dysfunctional behaviors but also as a primary target of therapy. According to these authors, emotions can significantly impact relationships through various means: in their expression, through their impact on the interpretations (cognitions) made as well as by affecting behaviors expressed towards the other. Epstein and Baucom [17] also emphasized the importance of considering partners' vulnerabilities and the impact of the couple's environment as part of the multiple factors that can alter partners' cognitions, emotional responses and behaviors.

A specificity of CBCT lies in its dynamic understanding that cognitions can influence intimate relationships through each partner's interpretations or appraisals of stressors and of their partner's behaviors [3]. Moreover, the interpretations partners make about the behaviors of the other will determine the positive and negative emotions experienced towards the other. As shown in **Figure 1**, these emotions are considered to influence future cognitions and behaviors [14]. As such, in CBCT, behaviors, cognitions and emotions are observed as inter-related and equally important in relationship functioning [18].

In summary, the main objective of CBCT is to help couples understand their difficulties in order to enhance their relational well-being by identifying and challenging the processes at play in partners' interactions while taking into account the external factors that can affect them. To do so, CBCT not only relies on behavioral interventions in the treatment of couple difficulties, but also emphasizes the importance of working on various cognitive, emotional and environmental factors that affect a couple's functioning [18]. CBCT interventions also aim at helping couples identify, regulate and express intense or negative emotions when they arise in and out of sessions. By doing so, CBCT therapists help couples develop their ability to observe and change their automatic thoughts, assumptions and standards as well as identify the impact that their ways of behaving, thinking, interpreting and feeling have on their relationship [3].

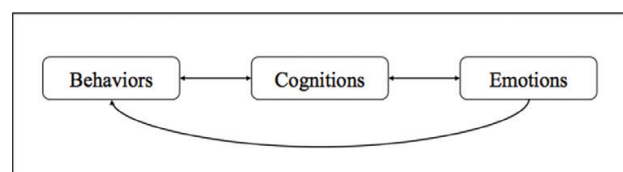


Figure 1. Interrelations of behaviors, cognitions and emotions in cognitive-behavioral couple therapy.

3. The role of CBCT therapists

CBCT therapists hold different roles that will vary depending on the stage of therapy and the needs of clients [19]. For instance, during the first sessions of CBCT, the therapist typically uses psychoeducation to inform clients about the approach and related intervention and acts as a facilitator by creating a safe and supporting environment where emotions or concerns may be expressed freely. He/she will also act as a collaborator to develop the treatment goals. However, a more directive approach will also be used by CBCT therapists to address dysfunctional interactions or the escalation of conflicts in order to create and preserve a safe environment for therapy and help partners understand what is going on and learn new ways of dealing with their disagreements [20]. A directive approach might also be needed to deal with crisis interventions (see Section 4.4). Throughout sessions, CBCT therapists can also take a more didactic role, for instance, when they teach communication and problem-solving skills for couples [12]. They will also act as guides when they help partners identify the interrelations between their cognitions, emotions and behaviors [17].

In CBCT, the therapist undertakes the responsibility of establishing and maintaining the therapeutic alliance with both partners [19]. In order to lay the foundations for a healthy therapeutic alliance, the therapist is thus expected to swiftly orchestrate sessions by fairly allocating speaking time for each partner to express themselves [20], while demonstrating neutrality and empathy [21]. If situations occur in which therapists feel unable to remain neutral towards a couple and if it significantly hampers their ability to help partners, they should seek supervision. Special consideration must also be given to the management of secrets between one partner and the therapist, for instance, in cases when an ongoing extradyadic affair is admitted by a partner during the individual session of assessment (see Section 5.2 for the phases of the assessment interviews). In such situations, it is advised that the therapist takes a neutral position by explaining to partners that he/she cannot engage in therapy while withholding information that would affect the process of therapy or bring he/she in collusion with one of the partners against the other [20].

4. Possible mandates and motives for consultation in CBCT

The first step a CBCT therapist undertakes is to question partners' objectives and expectations with regards to therapy. Poitras-Wright and St-Père [22] have proposed three main therapeutic mandates in couple therapy: alleviation of distress, ambivalence resolution and separation intervention. According to Tremblay and colleagues [23], therapeutic mandates can also be reliably classified and revised during the course of treatment to take into account the specific needs of couples which may change over time. The following sections describe how these different mandates are conducted in CBCT, with an additional section allocated to crisis intervention.

4.1. Alleviation of distress and relationship improvement

Over the years, CBCT has accumulated strong empirical support for its efficiency to alleviate relationship distress and enhance couple functioning [18]. These therapeutic gains would also seem to persist years after the end of treatment [24]. Research has shown that the therapeutic goals couples formulate regarding alleviation of distress revolve around communication problems, dissatisfaction with manifestations of emotions and affection, sexual problems, financial problems as well as decision-making or problem-solving issues [25–27]. Since some of these concerns are quite frequent, they are typically addressed with the common CBCT interventions presented in the fifth section of this chapter. However, many couples also consult for difficulties that require a more distinct approach, some of which include the presence of conflicts and violence, extradyadic affairs, infertility as well as various psychological or health-related problems partners might have.

4.1.1. Conflicts and violence

Many couples find it difficult to resolve their conflicts, and this difficulty heavily affects their functioning and satisfaction within the relationship [28]. Yet, it is how a couple handles disagreements that will determine how satisfied partners are with their relationship [29]. Accordingly, unresolved conflicts constitute one of the most frequent consultation motives for couple therapy [25]. As such, CBCT offers techniques aiming at the enhancement of positive interaction patterns in couples as well as the improvement of communication and problem-resolution techniques in order to diminish conflicts within couples [30].

Conflicts between spouses can also spiral into violence [31], for instance, when partners escalate their conflicts to a point where they will resort to psychological or physical violence. Indeed, partner violence is a serious challenge that many couples face but that is frequently under-reported or concealed by partners who may, for example, rather report consulting to address difficulties in dealing with conflicts [32]. During the assessment phase of CBCT, the presence of violence must systematically be assessed in order to decide whether or not CBCT should be conducted [33]. For instance, when partner violence is severe or perpetrated by one partner towards the other, couple therapy is usually contraindicated because it could lead to further violence. The therapists should then deliver a crisis intervention (see Section 4.4 for crisis intervention) [32, 33]. On the contrary, when partner violence is situational and minor to moderate and when both partners agree to cease all acts of violence during therapy, CBCT can be useful in preventing the escalation of conflicts to more severe forms of violence [33, 34]. Indeed, a few therapies using a CBCT framework or techniques have been developed to treat moderate intimate partner violence and show promising results in the reduction of mild-to-moderate violent behaviors [35–38]. Such therapies include interventions that promote positive interactions between partners, assertion and communication skills, increased imputability in conflicts and an understanding of the escalation of conflicts into violence. These interventions also seek to challenge the cognitive distortions that are entangled in conflicts and to help partners to better control their anger and other negative emotions as well as to help them negotiate time-outs during conflict.

4.1.2. *Infidelity/extradyadic affairs*

Infidelity is a relational problem that many who consult in couple therapy might eventually face [39]. Indeed, studies have shown that from 20 to 40% of couples will experience infidelity at least once [40] and 20–57% of men and 14–32% of women will report having had an extradyadic affair at least once in their life [41–43]. According to therapists, infidelity represents one of the most prevalent and difficult problems to treat in couple therapy [44, 45]. This is mainly due to the feelings of betrayal and relationship distress that commonly result from extradyadic affairs [46, 47]. This problem is also particularly difficult to address in treatment because it frequently puts partners in a situation where they question their desire to continue their relationship [48, 49]. This being said, many studies have concluded in the effectiveness of CBCT in the treatment of extradyadic affairs in terms of decreased psychological symptoms of depression and relationship distress [40, 50, 51]. Since CBCT commonly addresses infidelity as a form of interpersonal trauma experienced within the intimate relationship [52], interventions for this problem generally aim at dealing with the crisis following disclosure of the extradyadic affair and at the exploration of factors that might have contributed to the affair. This will be accomplished by giving the extradyadic affair a meaning [17, 52]. Since this type of couple difficulty tends to take place when the needs of a partner are not fulfilled in the current relationship [46–48], forgiveness-based interventions can also be used to help partners better understand the circumstances in which infidelity has taken place and repair the relationship. Partners will then learn how to “reconnect” after having been hurt by the other, to “turn the page” and to move forward [52].

4.1.3. *Infertility*

According to Sullivan et al. [53], the number of couples who encounter fertility problems is growing, with an average of 10–15% of couples experienced fertility issues. Importantly, for many couples, infertility constitutes a major crisis, and even a significant traumatic event that has important repercussions on partners' individual and relational well-being [54]. Indeed, infertility as well as the many consequences related to its treatment, such as its cost, its time requirements and the uncertainty of its results [53, 54], can lead to psychological consequences, especially high levels of stress [55], depression, low self-esteem, marital and life dissatisfaction [56, 57], sadness and denial [54] as well as feelings of guilt [54]. Some interventions using CBCT techniques have been developed to treat this problem [53, 58] and aim at facilitating disclosure and communication between partners, exploring the meaning and nature of grief (e.g., when partners learn they cannot have children), enhancing the couple's ability to understand and support each other and developing useful strategies for stress reduction and problem solving related to infertility.

4.1.4. *Individual problems*

In general, studies have demonstrated that couple-based therapies are effective across a wide range of individual problems and disorders that not only address an individual's psychological functioning but also his or her partner's relationship satisfaction. Consequently, CBCT has also been customized to treat a plethora of individual difficulties [19]. This approach argues

that by including the partner in the treatment of an individual's difficulties, the latter will benefit from support from his or her partner, which in turn will enhance the couple's functioning and alleviate personal difficulties [18, 59]. Alcohol use disorder is an example of an individual problem that is widely recognized as exerting a devastating effect on couple functioning and satisfaction [60, 61]. Indeed, adults with an alcohol use disorder are four times more at risk of separation and divorce than those who do not present such problems [62]. The perceived quality of the romantic relationship is also known to modulate the effect of substance use on couple functioning, so that satisfied couples experience less distress caused by substance abuse than dissatisfied couples [63]. Interestingly, support was found for the use of CBCT to reduce alcohol and drug use disorders as well as increase relationship satisfaction [64, 65]. For instance, CBCT for alcohol use disorder, which draws upon cognitive-behavioral methods for the treatment of alcohol use disorders [66] and behavioral couple therapy [67], simultaneously aims at decreasing alcohol use and increasing relationship stability and satisfaction [62]. The underlying assumption of this therapy is that drinking behaviors might be intertwined with the ability to cope with negative couple interactions. As such, by learning new ways to interact with the partner and by staying abstinent, partners are better able to cope with relationship distress [62].

Mood disorders, particularly depression, are also known to have a bidirectional association with couple functioning [68], with lower relationship quality leading to higher depressive symptoms and higher depressive symptoms generating lower relationship quality [69]. As such, when depressive symptoms act as risk factors or follow relationship difficulties, couple therapy for depression has been shown to be effective in reducing depressive symptoms and relationship problems [70]. This therapy aims at enhancing positive interactions between partners and diminishing negative interactions as well as improving communication and problem-solving abilities [71]. Couple-based interventions have also shown encouraging results for the co-occurring treatment of couple distress and bipolar disorder [72], emotion dysregulation [73], post-traumatic stress disorder [74, 75], obsessive-compulsive disorder [76], anxiety disorders [77] as well as anorexia nervosa [78].

4.2. Ambivalence resolution mandate

Sometimes, couples consult in therapy because one or both partners are unsure whether to end the relationship [79]. Drawing from their empirical results, Boisvert and colleagues [25] highlighted that one out of four couples consulting in therapy tend to report such ambivalence. In these situations, CBCT therapists usually suggest an ambivalence resolution mandate in order to help couples take a decision on the future of their relationship [80]. Yet, this mandate is not much addressed in the CBCT literature. Among the few authors offering clinical guidelines on this topic, Wright and colleagues [14] propose to include the exploration of emotions, beliefs and expectations of each partner regarding the continuation of the relationship, while putting any harsh decisions or behaviors about the relationship on hold until a final decision is reached by both partners. The therapist then helps partners define a new therapeutic mandate based on their decision, whether it is relationship improvement or separation.

4.3. Separation mandate

Whether it results from a decision taken within the course of treatment or whether it is formulated as a primary therapeutic objective, a separation mandate can be put forward to help partners accept and deal with separation [81]. Indeed, albeit difficult, separation can generate alleviation of distress in certain couples [79]. According to Lebow [82], the CBCT techniques used in therapy with a separation mandate usually include psychoeducation on how to deal with the consequences of the separation as well as feelings towards one another after the separation. Problem-solving techniques and communication training are also often conducted in session to alleviate the possible consequences of the separation for couples with a separation mandate in CBCT.

4.4. Crisis intervention

Although crisis intervention is not a therapeutic mandate *per se*, it can be required prior to CBCT, for instance, when a partner expresses severe personal difficulties (e.g. manifests a suicidal or homicidal risk), discovers the other has been unfaithful or when severe violence occurs within a relationship. It is thus necessary for therapists to be able to identify, assess and deal with such situations in order to help the couple regain stability and security before conducting any other intervention. To do so, Wright and colleagues [14] have developed guidelines for couple therapists. The first action to be performed is to ensure the safety of each partner, and by extension of their children, if applicable. When a suicidal and/or homicidal risk is present, the same guidelines used in individual psychotherapy are applicable in CBCT with a particular attention given to the safety of both partners. The therapist must then assess whether couple therapy should be continued or if individual therapy with a different therapist would be better suited to address these difficulties before starting or resuming CBCT [68, 77]. If ongoing severe violence occurs within a relationship and especially when it is perpetrated by one partner towards the other, rather than minor and bidirectional (see the Section 4.1.1 on conflicts and violence), couple therapy is usually contraindicated and specific procedures must be undertaken to control aggressive behaviors and protect the victim. Guidelines for such situations have been suggested by Lussier and colleagues [32, 36] and by Bélanger and colleagues [33]. After safety has been ensured and the crisis has started to resolve, the therapist can help couples make sense of this experience and feel validated in their distress, which can potentially strengthen the therapeutic alliance. Only then does the therapist and partners discuss new therapeutic goals if partners decide to remain in therapy.

4.5. Specificities in CBCT for diverse populations

As of now, there are clinical and research drawbacks regarding how CBCT can be effectively offered to couples who present specificities that can affect how they experience intimate relationships, such as same-sex or intercultural couples [18, 83]. For instance, in the past decade, the number of intercultural couples has increased in North America [84, 85] but these couples remain understudied [85]. In addition, even if couples from different cultural backgrounds usually experience the same kind of issues than other couples [86, 87], they may also face unique challenges that require specific attention in CBCT. Indeed, studies have reported that

intercultural couples will experience greater difficulties with communication, marital satisfaction and divorce [88, 89]. As such, intercultural couples might need more negotiation skills than others to deal with couple issues (e.g., discussing the language(s) spoken at home, religion and rituals that will be practiced by the children, etc.). Furthermore, parenting and disciplinary styles often involve debates in intercultural couples [85]. Exploring and negotiating the couples' cultural differences could thus potentially foster intimacy between partners and promote a sense of mutual understanding [90].

Due to widespread heterosexist standards, many lesbian, gay and bisexual couples experience prejudice, rejection, discrimination and lack of social support, which can significantly impede couple satisfaction and functioning [83, 91]. However, research has shown that, in general, same-sex and bisexual couples show more similarities than dissimilarities when compared to heterosexual couples [92] and tend to seek couple therapy for similar reasons [93, 94]. Indeed, most CBCT interventions, such as cognitive restructuring, role playing, assertiveness training, psychoeducation, decision making and negotiation, are used similarly with same-sex, bisexual or heterosexual couples [23]. Communication and problem-solving training can also be of significant importance for certain same-sex or bisexual couples who struggle with internalized homophobia (i.e., refers to negative stereotypes, hate, stigma and prejudice about homosexuality or bisexuality that a person with same-sex attraction turns inward on him/herself), issues regarding disclosure of sexual orientation, conflicts related to relationships or the division of household work and parenting difficulties (for a review, see [83]). Yet, many therapists report difficulties comprehending the unique situations in which same-sex or bisexual partners live [95] or report a lack of confidence about how to intervene with same-sex and bisexual couples. In addition, many therapists have few opportunities to develop their psychotherapeutic expertise with patients from sexual minorities given that the majority of their clients are heterosexual [96]. Therapists must therefore possess a good understanding of the challenges faced by these couples as well as the ability to have a non-discriminatory attitude in order to help their patients overcome prejudice in and out of their relationship [23]. To do so, couple therapists who decide to work with same-sex and bisexual couples should aim at receiving specific training or supervision to further understand and help these populations.

5. Assessment in CBCT

Before conducting CBCT, the couple therapist must inquire on the partners' expectations about therapy, evaluate the level of functioning or distress of the couple as well as the partners' motivation for staying together and in engaging in a therapeutic process [22]. By doing so, the therapist can determine the form of assistance that can be offered and tailor a treatment that will be most beneficial for both partners [2]. The main objective of assessment is to formulate a case conceptualization of the couple. This is accomplished by defining the concerns for which partners have sought assistance, identifying the individual, dyadic and environmental factors at play in the difficulties reported as well as by discerning the couple's existing strengths that might potentially facilitate the therapeutic process [97]. Therapists also aim at understanding both partners' respective goals in therapy and perspectives with regards to the

concerns they report in order to assess their level of commitment in their relationship and in therapy. By doing so, the therapist will be able to determine the appropriateness of CBCT for the clients or propose an alternate course of action. For instance, the therapist might recommend that one or both partners should first follow an individual therapy [17, 19]. Assessment can also continue throughout sessions: as partners become more comfortable or familiar with the therapist, they may reveal more about themselves as individuals and as partners, which allows the therapist to get a more precise understanding of the couple's relational dynamics and, if applicable, to refine the therapeutic objectives and strategies [97].

5.1. Assessment methods

In the assessment phase of CBCT, the therapist gathers information from different sources in order to understand a couple's functioning. This multi-method approach is highly recommended as it allows the therapist to draw a better portrait of a couple's functioning and concerns.

5.1.1. Clinical interviews

Throughout evaluation sessions with a couple, the therapist collects information on both partners by means of semi-structured clinical interviews. Clinical interviewing includes therapists' inquiry of the couple's history and environment, as well as of the partners' individual functioning and backgrounds [19], which will be further explained in Section 5.2 on the phases of assessment interviews. Clinical interviews also allow CBCT therapists to question partners' reactions, emotions and cognitions as they occur in session or when couples are asked to describe their concerns [98].

5.1.2. Self-report measures

The use of self-report questionnaires is highly valuable in CBCT as an adjunct to clinical interview. It can help therapists have access to information that may otherwise remain unknown. The use of self-report measures constitutes a fast and affordable way to assess numerous constructs [99], and it can also grant access to information that might not be disclosed during sessions [100, 101]. Depending on the problems reported by the consulting couple, self-report questionnaires that may be used in the assessment phase of CBCT can evaluate couple satisfaction and adjustment (e.g., Dyadic Adjustment Scale: [102]), partners' cognitions (e.g., Inventory of Specific Relationship Standards: [103]), communication patterns (e.g., Communication Patterns Questionnaire: [104–106]), sexual satisfaction (e.g., the Global Measure of Sexual Satisfaction Scale: [107]), dyadic coping (e.g., Dyadic Coping Inventory: [108]) and support (e.g., Romantic Support Questionnaire: [109]), as well as psychological symptoms (e.g., Psychiatric Symptom Index: [110]) and levels of violence exhibited by each partner towards the other (e.g., Revised Conflict Tactics Scales: [111]; Coercive Control Scale: [112]). The measurement of attachment (e.g., Experiences in Close Relationships: [113]) can also significantly help therapists understand the internal representations of self and other their patients hold in romantic relationships. Finally, considering the high prevalence of childhood trauma in the clinical population, especially consulting for sexual or relational problems (up to 95% [114]), the lack of spontaneous self-report, and given the direct and

indirect influence of such trauma on couple functioning [114–116], it is also central to systematically assess adverse childhood experiences (e.g., Childhood Cumulative Trauma Questionnaire [117]) as part of the standard assessment of couples.

5.1.3. Direct behavioral observation

In CBCT, special attention is also given to the couple's interactions, as they take place during sessions. As such, therapists observe how partners behave towards one another in a problem-solving task. They can take note of the positive and negative behaviors that partners initiate, for instance, with criticism or support when the other speaks [17]. Baucom and colleagues [19] also emphasize the importance of creating tasks or exercises during the assessment phase that will encourage partners to interact in order to allow therapists to better assess the couples' interactions. Couples can thus be asked to discuss a specific concern or problem they report currently having, to share their thoughts on a specific matter as well as try to engage in a decision-making discussion.

5.2. Phases of the assessment interviews

The assessment phase of CBCT is typically formed of three parts: one or two couple sessions in which both partners are present and one individual session with each partner followed by a feedback session for the couple. During the first couple session, the therapist presents his or her qualifications, theoretical orientation as well as the objectives and structure of CBCT [17]. During this session, the therapist also informs partners that all information gathered during individual sessions aims to help design a well-tailored couple intervention so may be discussed during the following couple sessions. The therapist informs the patients that this is a couple therapy process where he/she would not be forced to keep a secret from one partner during treatment [118]. The therapist then collects information on the couple's concerns for which they seek therapy. Assessing each partner's goals is primordial in clinical interviewing since they can be quite dissimilar, for instance, when one partner wants to improve the relationship and the other rather wishes a separation [19]. The therapist then inquires on the couple's relationship history in order to better understand how the relationship has evolved over time. He/she will ask questions on the beginning of the relationship, for instance, by inquiring on the duration of the relationship, on how partners met and what attracted them to one another [118]. The therapist also typically asks partners to describe past hardships or significant events that they have experienced and that might have affected them as a couple and to relate the ways they adapted or the resources they used to overcome them [98]. Finally, assessment of the couple's physical and social environments that are likely to contribute to the couple's problems [19] and evaluation of the couple's sexual functioning [119] are also conducted during the first evaluation session.

The therapist will then meet with each partner separately in order to gather information on their personal history as well as their current psychological and social functioning. The therapist will therefore inquire on each partners' developmental or family history, anterior romantic relationships, medical or psychological health, substance use, possible stressful or traumatic events, academic or professional functioning and how all these factors affect, or not,

their current relationship and perception of their partner [20]. During these individual sessions, specific attention will be given to potential subjects that might not have been explored during couple sessions, such as sexual difficulties, extradyadic affairs or the presence of partner violence [17, 19]. Indeed, potential partner violence, its severity and frequency must be explicitly inquired with both partners, as well as the level of safety victimized partners feel while living with the other [36].

After both partners' individual sessions, the couple and the therapist meet for another session during which the therapist will offer feedback using a cognitive-behavioral formulation of the couple's functioning and the factors that affect it, namely how each partner's cognitions, emotions and behaviors influence one another and affect couple interactions [118, 120]. The therapist also uses the feedback session to present his or her interpretation of the causes of the couple's concerns and to highlight the positive aspects that partners have expressed about their relationship [20]. The therapist then sets the treatment mandates and goals in collaboration with the couple and proposes a treatment plan [19].

6. Intervention techniques commonly used in CBCT

The following section describes the most common intervention techniques used in CBCT. These strategies include the development of communication, problem-solving and conflict resolution skills, cognitive restructuring, the improvement of the identification and expression of emotions, the improvement of the expression of affection and sensuality between partners as well as enhancement of sexual functioning and the development of acceptance and tolerance of differences and incompatibilities.

6.1. Communication training

Communication training is a central feature of CBCT and aims to enhance the way in which partners learn to express and listen, without criticism or attack. Interestingly, this type of intervention has demonstrated observable short-term changes, even in highly distressed couples [14, 17]. In order to lead communication training in CBCT, therapists must learn to recognize and identify dysfunctional behaviors expressed by either partner during sessions, as well as identify the emotions and beliefs that underlie such interactions in order to help couples develop more appropriate and functional dialogs [120]. In order to do so, the therapist first helps the couple identify a topic of conversation that is problematic, but does not involve overwhelming emotions [14]. Then, partners are successively assigned the roles of speaker and listener. The speaker is guided in expressing his or her subjective experiences and feelings within the relationship. The listener is directed in demonstrating openness, non-judgment and to respond with empathy and respect through the use of non-verbal demonstrations, reflections and summaries in order to help the speaker further describe his or her feelings and thoughts and feel listened to while doing so [121]. During this exercise, the therapist's role consists of reinforcing partners efforts, providing partners with constructive comments or suggestions and modeling certain speaker or listener behaviors in order to help partners' perfect communication and

listening techniques [98, 121]. However, in cases where partners bicker during the session, the therapist must quickly take control of the situation and ask them about what did they feel and perceive that triggered the dysfunctional interaction [14]. Following is an example of how a communication training exercise can take place in CBCT.

Melanie and Ethan are new parents and have decided to consult in CBCT in order to deal with feelings of dissatisfaction resulting from difficulties they experience in adapting to their new life as parents. During a session, Melanie and Ethan mention a situation they have experienced which disappointed them both.

Therapist: *I think this situation is a good example we could use to practice the communication skills you have learned last session, don't you think? Remember, when you are the speaker, you must express your subjective experience, by using "I", and focus on your feelings and perceptions. When you are the listener, you must demonstrate openness and respond with reflections and summaries about your partner's experience. (Both partner express they do remember). Who would like to begin?*

Melanie: *I'll start.*

Therapist: *Ok, I would like you to take the role of the speaker for now and Ethan, that you take the role of the listener. We will then exchange roles ok?*

Melanie: *Ethan, I was hurt last Sunday when you came home late from your hockey game without telling me beforehand because I felt you did not care about us.*

Ethan: *You are saying that you were hurt because I came home late without telling you and you felt as if I did not care about you and Lily.*

Melanie: *Yes, exactly. I wish you would also tell me when you plan on being late, so that I would not feel hurt like last Sunday.*

Therapist: *Melanie, could you rephrase it so it will not be a request; at this point try to focus on what you felt or thought during this event.*

Melanie: *Ok. When you do not tell me when you are going to be late, I feel that Lily and I are not your priorities, and that I am not important to you. This is how I felt last Sunday.*

Ethan: *So you are saying you don't want me to play hockey on Sundays because you feel hurt, correct?*

Therapist: *Ethan, try to stay focused on what Melanie said; Melanie, is it what you said?*

Melanie: *No, not exactly. I am not saying I don't want Ethan to play hockey.*

Therapist: *Tell Ethan....*

Melanie: *(Looking at Ethan) In fact Ethan I know that it is important for you. But if you would tell me when you plan on coming home late after the game, I would not feel hurt or not important like I did Sunday.*

Ethan: *So if I hear you well, you would like me to call you when I plan on staying longer for a lunch after the game, so that you won't feel as if I do not care about you and Lily.*

Melanie: *Yes, that's it.*

Therapist: *Perfect, now Ethan, would you like to continue as the speaker and Melanie, as the listener?*

6.2. Problem and conflict resolution

In CBCT, five strategies are commonly used to help couples develop problem-solving skills [17, 98, 121]. First, partners must define and identify one problem on which they want to work. Second, the therapist helps partners understand the meaning this problem holds for them by defining each partners' underlying needs. Third, partners are asked to suggest as many solutions they can think of, using brainstorming, which is known to increase feelings of interest, appreciation and consideration in the relationship as well as being particularly useful in case of serious conflict or strict patterns of interactions. Fourth, partners are asked to select a solution together that will allow to fulfill both partners' wishes, although it is possible they will not be equally satisfied. The fifth and last step involves a trial period that will take place between sessions. A feedback discussion is then held during the following session and, if partners feel unhappy during with the chosen solution, a new solution may be chosen with the therapist.

Similar steps as those used in problem-solving can also be used in CBCT to help couples learn how to resolve conflicts [28]. Yet, as conflicts can sometimes involve strong negative emotions, particular attention must be given to the expression of emotions and needs and the exploration of the meaning of the conflict by partners during these exercises [14]. In addition to guiding couples in acquiring these techniques, the therapist also holds the responsibility of observing conflictual interactions that arise in session, for instance, if partners attack or withdraw from an interaction, in order to provide feedback as to the impacts each partners' behavior exert on the other. This will allow the therapist to highlight and challenge the cognitions and emotions that underlie or contribute to these dysfunctional interactions with the intention of decreasing their recurrence [17]. The following case describes how these strategies can be used.

Thomas and Sandra have sought couple therapy due to constant bickering and frustration resulting from problems they have difficulty resolving together. Sandra blames Thomas for the amount of time he spends at work, especially since he has been working on weekends. Thomas gets home late, is often too tired to engage with his partner and goes to bed shortly thereafter. Thomas admits to being exhausted and criticizes Sandra for constant complaints about financial matters.

Therapist: Sandra, why do you want Thomas to spend less time at work?

Sandra: Because we would be able to spend more time together, which would help me feel important and like more connected to him.

Therapist: And you, Thomas, what are you looking for in spending extra time at work?

Thomas: When I'm at work, I don't hear complaints about our financial situation. It would be so great to hear some appreciation of all my efforts to improve our finances and how wearing is my schedule.

Therapist: Thomas, I understand that you would like more appreciation for your hard work. Sandra, you've expressed that spending more time with Thomas would help you feel more valued and connected. Now that you've both addressed your needs, I invite you to name of as many possible solutions you can think of that could help resolve the problem expressed by Sandra.

Sandra: Thomas, maybe you could start by taking the weekends off?

Thomas: I understand where you are coming from Sandra, but my job makes it difficult for me not to work for the whole weekend. What if I try to come home earlier on weeknights?

Sandra: Hum... Why don't you take Sunday mornings off so that we can brunch together just like we used to?

This brainstorming continues until the most suitable solution is provided and agreed upon by both partners. The therapist encourages partners to be open for a trial period until the next session where the solution will be reevaluated based on their feedbacks of the trial period. Since in the first exercise, the couple has addressed a problem that was initially reported by Sandra, the next problem-solving exercise will focus on a problem reported by Thomas, such as his complaints regarding Sandra's lack of acknowledgment of Thomas' efforts concerning financial matters.

6.3. Cognitive restructuring

CBCT therapists are interested in identifying and confronting the distorted ways in which partners process information and how these cognitive distortions, namely selective attention, unrealistic or inappropriate attributions, expectations, assumptions and standards, are related to negative emotions and behaviors experienced within the relationship [31, 122]. Cognitive interventions used in CBCT thus aim at helping couples learn to detect and evaluate the appropriateness of their cognitions. They also aim at helping partners to challenge the cognitions they hold that negatively influence their emotional and behavioral responses towards their partner. These interventions thus allow couples to broaden their perspective on the relationship by gaining a mutual understanding of how the other thinks and interprets events. Partners will also begin to anticipate the impact of those interpretations on their interactions [17]. To do so, CBCT therapists often give information to couples on their cognitive distortions and the impact it can have on their interactions. They then solicit feedback from partners to promote integration of these concepts and encourage partner's ability to detect and question further cognitive distortions [123].

Since CBCT allows couples' interactions to take place within sessions, therapists have the opportunity to address cognitive distortions as they spontaneously arise between partners, to help them question their way of thinking and to consider different alternative explanations or perspectives on the partner and on the relationship [19]. CBCT therapists also guide partners interacting in ways that will allow them to challenge their distortions by sharing their respective experiences on a particular issue [123]. Typically, cognitive interventions are also used to help partners reevaluate the logic or incoherence of their thinking and understand the underlying issues and concerns. For instance, Socratic questioning entails asking questions to partners that help them understand the logic in their inferences or beliefs as well as evidence for their validity. Other cognitive techniques also used in CBCT involve inquiring about the evidence that supports a cognition, weighing its advantages and disadvantages, as well as considering the worst possible outcomes of negative predictions that partners make about their relationship [98, 124]. Cognitive interventions also include helping partners gain a mutual understanding of their difficulties by considering each partner's perspective on the concerns they report [99].

Nancy and Jacob began their relationship before Jacob left a former partner (Sarah). Jacob's history of infidelity is the subject of several arguments with Nancy. Jacob repeatedly told Nancy of his regrets at having been unfaithful with Sarah, and of his feeling that his relationship with Nancy is completely different. However, in the past few months, Nancy has been getting angry and has expressed jealousy when Jacob goes out with friends, convinced that infidelity might be an issue.

Therapist: *I understand you are angry when Jacob goes out with friends. What do you think will happen?*

Nancy: *That Jacob will meet someone and cheat on me.*

Therapist: *What makes you think Jacob might cheat on you?*

Nancy: *Nothing that I can think of ... except what happened with Sarah.*

Therapist: *Do you think that Jacob could be unfaithful to you, even though that has not happened?*

Nancy: *I don't know... Jacob told me that the relationship with Sarah was not a happy one.*

Therapist: *Do you think Jacob is happy with you?*

Nancy: *.... seems happy....*

Therapist: *You are saying that the cheating with Sarah was because Jacob was unhappy in that relationship. You also believe Jacob is happy in the relationship with you. Explain to Jacob why do you think he might be unfaithful to you?*

Nancy: *Actually, there are no concrete signs that indicate that you would cheat on me... I think I'm just afraid of losing you.*

Therapist: *I understand you care a lot about Jacob and do not want to lose the relationship. Jacob, how does it make you feel to hear that?*

6.4. Identification and expression of emotions

In CBCT, emotions that are minimized, avoided, repressed or excessively expressed by partners are known to negatively impact a couple's relational functioning and satisfaction [120]. Indeed, individuals who do not express their emotions are generally more distant and less involved in their relationship, which ultimately leads to less intimacy and satisfaction between partners [30]. As such, CBCT intervention techniques have been developed to identify, modify and enhance tolerance of negative emotions [19]. By enhancing partners' identification, expression and tolerance of negative emotions, CBCT therapists can also help couples identify the sources of their relational dissatisfaction and, eventually, foster higher levels of intimacy between partners.

For Wright and colleagues [14], since certain negative or strong emotions that affect couple interactions, such as anger or fear, are often avoided by partners, the therapist must help partners clarify and regulate avoided emotions. To address this, strategies used in CBCT hold the purpose of accessing and heightening partners' emotional experiences as well as helping them receive the emotions expressed by the partner. To do so, therapists generally address spontaneous emotions, as they arise in session or as they are expressed non-verbally by partners. They

will also encourage partners to express feelings and detect how they affect their way of thinking and behaving. When emotions have been identified and understood, partners are encouraged to express them by using the communication skills previously learned. Therapists can also access repressed or minimized emotions by asking partners to describe in detail specific experiences, by using reflections or questions or by encouraging partners to use metaphors and images to describe what they experience [19]. Techniques also include normalizing the expression of both positive and negative emotions, encouraging partners to care and support the other when he/she expresses emotions and guiding partners to stay focused on their emotional experiences rather than concentrating solely on more cognitive or behavioral aspects of an experience, for instance, during a conflict with the partner [19].

Sometimes, therapists also meet couples that struggle with difficulties in regulating negative emotions. These partners will express them in a more dysfunctional manner, potentially leading to serious arguments and even partner violence. With these couples, scheduling times to discuss subjects that trigger such interactions can be useful in order to contain the expression of negative emotions to a specific time and place [125]. Skills specifically addressing emotion regulation as proposed in dialectical behavior therapy [126] have also been included in CBCT. Such interventions include the development of skills that enhance both partners' tolerance to strong or negative emotions and decrease their emotional reactivity in order to provide couples with the ability to deal with emotional interactions they may face together [73].

6.5. Expression of affection and sexual problems

Lack of emotional affection or sensuality and dissatisfaction in the quality or frequency of sexual relations are frequently invoked when consulting in couple therapy. Many sexual problems can also be put forward by couples consulting in CBCT, some of which include various sexual dysfunctions, such as erectile disorders, orgasmic disorders, genito-pelvic pain/penetration disorder and sexual desire/arousal disorder [119]. Indeed, sexuality holds a decisive place in a couple's functioning and satisfaction [127], and thus, it is generally important to address the sexual domain in CBCT. However, since the various biological, social and psychological factors that contribute to the development and the persistence of sexual dysfunctions make their treatment complex [128], it is recommended that couples who experience sexual difficulties benefit from the expertise of a therapist specialized in both sexual and couple therapy [119].

CBCT techniques aimed at the improvement of sexual well-being in couples include a variety of strategies and exercises that allow a broadening and diversification of sexual behaviors for partners and that have been proven effective for addressing sexual dissatisfaction and various sexual dysfunctions [128, 129]. For instance, psychoeducation can help clients learn about sexuality as well as correcting myths, misconceptions or unrealistic notions that partners might have about sexuality through information from the therapist as well as by reading or watching recommended psychoeducational material [130]. Cognitive interventions can also be used to address sexual difficulties by challenging and nuancing cognitive distortions that could be both automatic and irrational, in order to replace them by more positive

and functional cognitions and beliefs towards sexuality [17]. Such cognitive distortions can include beliefs or standards about how sexual relations “must be” that are unrealistic (e.g., “In our sexual relations my partner always has to reach an orgasm”) or negative (e.g., “I have never had a good sex life with my partner”). Indeed, cognitive interventions can be used to address these negative or anxiety-provoking thoughts that interfere with the ability to have satisfying sexual relations with a partner [128].

According to Kelly et al. [131], difficulty in expressing sexual needs and desires is common in couples. Consequently, it is crucial that partners improve their communication skills with regards to sexuality [132]. The several communication training techniques mentioned above can be applied to sexuality, with the objective of promoting optimism and sexual pleasure in the relationship. Indeed, communication training can be used to enhance feelings of love and affection between partners. This is accomplished by helping partners share their sexual needs and find new ways to express affection and caring [128].

Sessions on sexuality can also be dedicated to the exploration of negative emotions that are experienced during sexual relations. Partners are shown how to detect negative emotions, such as anxiety, anger, discomfort, as well as fear of rejection or abandonment, any of which can disrupt intimacy and sexual desire [128]. Identifying and accepting these emotions, the specific context in which they arise, their underlying beliefs as well as their impact on pleasure and intimacy, will increase sexual and sensual exploration and innovation [14]. In addition, strategies aimed at revealing these emotions in session can be of significant use as they allow to explore the underlying beliefs and attachment needs of partners in the sexual problems or dissatisfactions they experience [133].

Behavioral exercises that broaden a couple’s sexual repertoire, diminish avoidant behaviors towards sexuality as well as confront certain cognitive distortions and help partners refocus on sensations and sensuality [119] are also used to treat sexual dissatisfaction or dysfunctions and are recognized as leading to positive outcomes and long-term changes [134]. These exercises are usually explained during session, practiced at home between sessions and later discussed with the therapist [119]. Such behavioral interventions can include self-exploration (i.e., exploration of one’s body and/or genitalia) followed by directed masturbation (i.e., trying different ways of masturbating, in different positions or places) that can be practiced alone at first but then with the partner [119]. Finally, sensate focus is a behavioral exercise for couples that has been developed by Masters and Johnson [135] and that is commonly used to emphasize pleasurable sensations and sensuality and de-emphasize sexual performance, which is considered as being at the root of many sexual difficulties in couples.

6.6. Acceptance and tolerance of differences

Jacobson and Christensen [16] have underlined the importance of acceptance and tolerance in order to enable the integration of new behaviors developed in CBCT. Indeed, the non-acceptation of basic personal differences between partners might sometimes lead to arguments or resentment. Interventions developed by Jacobson and Christensen thus aim at accepting the potential fundamental differences or incompatibilities between partners.

This is accomplished by developing an empathic understanding of the other's experience and working together to face common hardships [136]. To achieve this goal, strategies target three objectives: acceptance, tolerance and change [137]. Strategies to enhance acceptance aim at offering partners new ways of looking at their problems through empathic joining and unified detachment. Empathic joining brings to light each partner's sense of vulnerability by allowing them to express their perspective on a problem, while being listened by the other partner and the therapist, whose task is to encourage the expression of emotions, rather than accusations or comments on behaviors. Unified detachment encourages partners to discontinue accusations or blame by helping them develop a more objective and less emotional consideration of their problems or differences and by considering them as an "it" (e.g., an object, an animal, a nickname) rather than as a deficiency or a problem in the other. The following example illustrates how this technique can be used.

Robert and John have sought CBCT as a result of frequent arguments they have experienced in the past months. Their arguments usually revolve around their finances and lifestyle. Robert typically prefers staying home and has a frugal lifestyle. John rather enjoys luxuries and spending his evening in trendy restaurants. During a session, Robert expresses his anxiety over their financial situation as John has spent a few hundred dollars in the past week during an evening with friends. John then expresses he feels Robert is treating him like a child by scolding him every time he comes back home.

Therapist: Robert, I understand you must feel anxious about your financial situation and John, I understand you feel as if you are treated as a child. Perhaps we could use this situation to try an exercise called "unified detachment" to help both of you. First, I would like you to identify what part of yourself, or of your personality, is talking during these arguments. Then, try to imagine what form would take this part of yourself during conflicts if it were to be described as a "thing". It can be an object, an animal, a country, whatever you want.

John: I would be a glass of champagne! It is luxurious and bubbly, like me!

Robert: You are right John! If I follow your lead on drinks, I would be a cup of freshly brewed coffee. It's inexpensive but comforting.

Therapist: Perfect! Now, if the glass of champagne and the cup of coffee were to discuss on a date they are planning for Friday night. What would they say to each other?

John: Well the glass of champagne would like to go to the new restaurant on 6th Street.

Robert: The cup of coffee would prefer to stay home, order take out and watch a good movie.

Therapist: And considering these different wishes, what solution can the glass of champagne and the cup of coffee try to find together to spend their Friday night together?

John: Robert, I have an idea! You know we often drink champagne as an aperitif in restaurants and coffee with desert. What would you say if we were to do the same?

Robert: The glass of champagne and the cup of coffee could grab drinks at the restaurant and then finish the evening with take out and a movie?

John: Yes! What do you think of that?

Robert: It is a very good idea! Let's try it!

Tolerance strategies have also been developed in order to stop partners from trying to change the other, for instance, by pointing out the benefits that can result from certain behaviors that are considered negative by partners (e.g., a partner's constant worries and attempts to predict everything that can go wrong in a situation, typical in anxious people, can negatively impact a couple's interactions but can also be very useful when planning a vacation or when taking financial decisions). Change strategies aim at reinforcing and prompting positive behaviors that partners already portray towards each other and include the improvement of communication and problem-solving skills by recreating a conflict they have already experienced and integrating the acceptance and tolerance strategies they have learned [137]. Finally, mindfulness-based interventions can also be used to enhance acceptance of differences. These strategies have been proven to increase relationship satisfaction, sense of relatedness and closeness, acceptance of the partner and to alleviate relationship distress [138]. They include meditation and touch exercises, aim at enhancing partners' acceptance of their experiences without judgment as well as their moment-to-moment awareness of how they feel and behave while interacting with one another, which could eventually help them develop new ways to connect with one another.

7. Conclusion

The current chapter has provided a comprehensive literature review and description of the theoretical underpinnings, possible therapeutic mandates and main assessment and intervention methods used in CBCT. This chapter has also highlighted the empirically demonstrated effectiveness of CBCT for the treatment of a significant number of couple struggles ranging from communication difficulties and dissatisfaction with expressed affection to the management of explosive conflicts. This chapter also demonstrated that CBCT can be very effective in treating individual problems by using the intimate relationship as a therapeutic tool.

The scientific literature suggests that CBCT is a highly effective treatment approach to improve relational well-being as well as a way to address many difficulties and concerns couples may face. This is especially true for difficulties in communication, problem-solving and conflict resolution as they arise spontaneously between partners or as a result of comorbid psychological difficulties in one or both partners, for which specific techniques have been developed and are regularly used by couple therapists. Interestingly, CBCT also offers a good foundation on which therapy can be customized to various needs partners may hold. For instance, recent developments in CBCT have started to incorporate more complex and specific variables in the understanding and treatment of couple functioning by considering the roles of attachment [139], relational schemas [140] and mindfulness [141] as possibly underlying certain couple dynamics.

Results from psychotherapeutic outcome studies presented in this chapter must be examined by considering certain drawbacks. Indeed, evidence-based studies have become the gold standard to evaluate the effectiveness of psychotherapeutic interventions yet, not all studies

on the effectiveness of CBCT include large sample sizes, randomized controlled trials (RCT) or follow-up data extending beyond 6 or 12 months. As such, the effectiveness of CBCT for different couple difficulties must be considered within this reality. In addition, going from theory to practice can be quite a challenge, especially because in CBCT, clients are two different people who consult together. Indeed, CBCT therapists must learn to work not only with both parties' personalities, feelings, cognitions and behaviors but also with the couple's dynamics as they take place during and between sessions. The complexity of this type of therapeutic work also lies in the therapist's role, as he/she is called to inquire about, and directly witness, couples' most intimate moments and feelings while maintaining a respectful and professional distance.

Finally, it is also important to note that regardless of the concerns for which a couple seeks therapy, the CBCT process in itself holds certain limitations. Indeed, both partners must be strongly committed to making their relationship work by demonstrating honesty, openness, caring and interest in the other's experience. They must also demonstrate commitment towards the therapeutic process. For instance, in cases when partners do not really want to see their problem solved (e.g., when changes in the couple are considered as too anxiety-provoking) or when partners come to therapy to have the therapist determine who is "right" or "wrong," it is often difficult to induce change in the relationship and enhance relational functioning. Fortunately, empirical and clinical work from the past decades has offered precious insights in the understanding of such dynamics and in the training of CBCT therapists that are not only aware of these therapeutic intricacies but also use them to further their work with couples.

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