Marital Distress

There are few problems as frequently encountered or as pervasive in their impact as marital distress. Any person who has experienced significant marital distress, or witnessed the feelings of a friend or relative in the midst of such distress, easily recognizes that marital distress is among the most stressful and upsetting of human problems. Powerful feelings of sadness, anger, rage, disbelief, shock, and depression typically accompany high levels of marital distress. Marital distress is often a major factor in the genesis of diagnosable individual psychopathology such as dysthymic disorder. And for many, marital distress ultimately results in divorce with its myriad of additional difficulties and risk factors.

Statistics regarding distressed marriages in our society point to how omnipresent and insidious a problem this is. Epidemiological studies typically find 20% of the population to be maritally distressed at any moment in time (Gurman & Fraenkel, 2002). The divorce rate has stabilized, with approximately half of all marriages ending in divorce. Ten to fifteen percent of couples separate in the first four years of marriage, and only 70% make it through the first decade of marriage.

Whisman (1999) found a strong association between marital distress and the prevalence of psychiatric disorders in general, and that of each of the 15 major groups of psychiatric disorders. Typically, rates of these disorders were double for those who were maritally distressed compared to those who were not. Among those with significant levels of marital distress, 15% had concurrent mood disorders, 28% anxiety disorders, and 15% alcohol or substance use disorders. Numerous studies have also demonstrated the impact of marital distress on physical health, decreased work productivity, and on the frequency and severity of problems in children (the latter especially in marriages in which there are high levels of conflict) (Snyder & Whisman, 2004). Given its impact, it is no surprise that marital distress is the most frequent problem for which people seek psychotherapy; with a full 40% of clients surveyed reporting this as the reason they sought treatment (Gurman & Fraenkel, 2002). A couple of clarifications are necessary concerning the term “marital distress” as used in this Update. Marital distress refers to one or both partners in a committed relationship experiencing a high level of dissatisfaction about that relationship and distressed feelings accompanying that state. Thus, marital distress only requires that one partner be experiencing the relationship as distressed; if one partner does, the relationship is also distressed. And to experience marital distress, one does not need to be legally married. Those in-living, committed relationships who are not married are equally likely to experience these difficulties. For example, gay and lesbian couples living in states that do not legally recognize their unions are no less vulnerable to these problems than legally married couples.

Thus, the word “marital” is employed to describe the full range of committed couple relationships and therefore the terms “marital therapy” and “couple therapy” are interchangeable in what follows.

Diagnosis and Assessment

In a sense, the assessment of the extent of marital distress is a fairly simple operation. The level of distress of a marriage is substantially determined by the viewpoint of the participants. If a person believes himself or herself to be maritally distressed, then he or she is.

Yet, there are many complications in the assessment of the extent of marital distress that make its assessment far more complex than simply asking the obvious first question “How are things going in your marriage?” One complicating factor is that the feelings expressed about marriage are greatly affected by the events of the moment and can change considerably over short periods of time. Frequently, couples will begin couple therapy appearing to be highly distressed, only to emerge in subsequent sessions as far more positive about their relationship than at first thought possible. Thus, marital distress needs to be tracked over time to label a marriage as distressed.

Additionally, individuals in distressed relationships sometimes do not report themselves to be distressed. Reasons range from the desire to present well, to being fearful of their partner’s response. And standards for what is acceptable in marriage vary enormously with culture and individual personality. Add to this, factors such as infidelity that can instantly move a marriage from satisfying to highly distressed, and the task of assessing the level of marital distress becomes complex.

Observation of couple processes offers a second important source of information about marital distress that provides different and complementary information to self-report. Although there is an association between reporting marital distress and showing the behaviors that are signs of such distress, and which predict the emergence of further relationship difficulties, the correlations between self-report and behavioral observation are much lower than might be thought (Gottman, 1999). Most measures of behavioral observation were developed in laboratories, using videotape and coding behavior. However, most of the key behaviors that have been identified in these analyses can be readily tracked by therapists through observing in-session behavior and learning about behavior between sessions. Thus, assessing the degree of marital distress involves combining client self-report and behavioral indices.

In couple therapy, it is typical for the evaluation of the extent of difficulty to be conducted in tandem with a broader assessment of what has caused and is maintaining the difficulties present as part of the process of arriving at a formulation for how best to intervene (Pinsof, 1995). Assessment typically examines the relationship across a variety of system levels and levels of individual personality. Although there can be a distinct assessment phase, in most couple therapy assessment overlaps with the other early tasks of therapy. The following sections detail the kinds of questions that are most
typically in focus in assessment, divided into a number of broad levels of client experience.

Client Evaluation of the Relationship. The simplest level of assessment lies in determining each partner’s degree of distress, feelings about the relationship, and areas of concern. Simply asking about the extent of marital problems typically suffices for providing a view of the distress experienced by each partner. However, because positive and negative aspects of relationships often function somewhat independently of one another (Fincham & Linfield, 1997), it is equally important to inquire about the extent of marital problems. Exasperating problems do not necessarily mean there is a lack of positive connection.

A related relationship-centered set of questions concerns each partner’s commitment to the relationship. What is their level of commitment to the relationship? Does that coincide with their behavior? Has divorce been threatened or action toward divorce been taken? Relationships with high levels of commitment more readily withstand times of distress than those that lack this quality. It is vital in this context to recognize the signs that distinguish threats stated in exasperation from plans of action.

It also is essential to learn the content areas in which the couple has difficulty and strength. What are the most frequent and troublesome sources of difficulty and the frequency and intensity of these problems? Under what circumstances do these problems arise? What areas do the partners identify as the key areas of conflict or where change is desired, and what areas do they regard as strengths? The most frequent problems encountered in couple therapy concern communication, power struggles, unrealistic expectations, sex, problem solving, money, and children (Snyder & Whisman, 2004).

Couple Behavior. Much assessment in couple therapy centers on interaction. Look at the patterns that emerge in sessions and track the couple’s reports about their patterns. One prime focus should be on communication and problem solving—whether it’s direct or indirect; clear or confusing. Do regular patterns emerge, such as the demand-withdraw cycle? An often-critical offshoot of these aspects of marriage lies in the processes for resolving conflict. How well do arguments help resolve differences and how fair and rule-governed are those arguments? Is there a successful process for engaging in conflict, or too rapid start up and flooding, and/or avoidance? Are repair attempts successful? Are there softenings that emerge in conflict and the capacity for forgiveness? How present are signs of criticism, defensiveness, contempt and stonewalling that John Gottman points to as the most powerful predictors of divorce? The properties of exchanges within a couple also have crucial importance. In satisfying relationships, couples maintain 5:1 ratios of positive to negative exchange (Gottman, 1999).

Marital violence is encountered less frequently, but when it presents, it has enormous meaning. Couple violence often goes unreported in couple therapy and is far more prevalent than thought (O’Leary et al., 1989).

Couple Cognitions: Consider the cognitions partners have about their relationship. What core beliefs do they hold? Do either of the partners have unrealistic expectations? What is the degree of positive or negative sentiment override? Gottman (1999) has shown that sentiment override often matters more than the events that are occurring.

Couple Affect: Assessing affect is equally crucial. What is the affective bond between the couple and level of connection? What is the level of closeness and attachment, and how acceptable is this to each partner? How satisfying is the sexual/emotional connection? How well can the partners engage in soothing each other especially at times of stress and conflict?

Couple Dynamic Process: With time, a sense of deeper dynamic...
Individual Functioning: Partners have individual lives that impact the relationship. How do the internal dynamics of each partner affect the relationship? Are there co-morbid difficulties such as substance abuse or depression, and how much does each individual psychopathology or difficulties in individual personality affect the relationship? Individuals with high levels of neuroticism have more frequent relationship difficulty; such a pattern is even more pronounced with individuals with personality disorders and chemical dependencies.

Larger System Levels: Marriage is also affected by the larger systems in which it is embedded, including extended family and the broader culture, and a myriad of other relevant factors. How much are extended family involved in the conflict? What role do children have in the conflict? What are boundaries like in relation to other members of the nuclear and extended family? How are problems related to the particular cultural and economic context in which the couple lives? What are the couples’ ideas about gender and how well does the relationship match these expectations? How do these levels of marital happiness and distress relate to where this couple stands in the family life cycle and developmental transitions? Typically, marital satisfaction is highest in courtship and early marriage and undergoes a decline with the birth of children and a further decline when children are adolescents, then rebounds later in life.

There is no formal diagnosis of distressed marriage in DSM-IV, despite the vast importance of this difficulty (American Psychiatric Association, 2004). The only listing in DSM for marital distress is as a relational v-code: partner relational problem V61.1. Co-occurring individual difficulties such as dysthymic disorder and sexual dysfunction can receive formal diagnoses.

MEASURES FOR ASSESSING MARITAL DISTRESS

A number of useful, reliable and well-validated self-report measures are available to be used as adjuncts to in-session interviewing about marital distress. These instruments offer the prospect of placing the degree of a couple’s distress in the context of norms from other relationships and/or provide further information about specific aspects of the relationship.

**The Locke-Wallace Marital Adjustment Test.** This short, self-report questionnaire (Locke & Wallace, 1959) asks couples about areas of agreement and disagreement, followed by questions about diverse aspects of the relationship, such as whether they would marry again or confide in their partner.

**Dyadic Adjustment Scale.** The Dyadic Adjustment Scale (Spanier, 1976) measures the severity of relationship discord in couples. Items load on four factors: dyadic consensus, dyadic cohesion, dyadic satisfaction, and affectional expression.

**Marital Satisfaction Inventory-Revised (MSI-R).** The MSI-R (Snyder, 1997) includes a global distress measure and subscales assessing affective communication, problem solving, communication, aggression, time together, disagreement about finances, sexual dissatisfaction, role orientation, family history of distress, dissatisfaction with children, and conflict over child rearing.

**The Positive And Negative Quality In Marriage Scale.** This scale (Fincham & Linfield, 1997) measures assessment of positive and negative quality in marriage.

**The Weiss-Cerreto Marital Status Inventory.** This instrument (Weiss & Cerreto, 1980) measures the extent to which a married individual is considering dissolution of the marriage or has taken action toward obtaining a divorce.

**The Areas of Change Questionnaire.** This measures the degree to which change is desired from partners in various aspects of marriage (Weiss, Hops, & Patterson, 1973). Its use is principally to target areas in which couples desire change.

**Marital Attitude Scale.** This scale (Pretzer, Epstein, & Fleming, 1991) assesses dysfunctional thoughts and attributions associated with marital discord, and addresses such dimensions as attribution of causality to behavior and personality of the spouse.

**Conflict Tactics Scale-2 (CTS2).** This measure (Straus, 1995) is the most widely-used instrument for assessing physical aggression in marriage and other acts of aggression. There is a general tendency toward underreporting of these behaviors (O’Leary et al, 1989).

**Systemic Therapy Inventory of Change (STIC).** This omnibus measure (Pinsof, Lebow et al., 2005) assesses therapy progress and includes scales to assess individual, family, and child functioning and the therapeutic alliance, in addition to couple functioning.

**Clinical UPDATE**

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**Treatment Options**

Marriage and family therapists today have available a broad range of effective strategies and techniques for helping couples experiencing high levels of marital distress. Although there are many different approaches to marital therapy emphasizing varying aspects of couple experience, these methods increasingly draw from a core set of strategies and interventions so that the most recent versions of most of these approaches show considerable overlap (Lebow, 1997; Lebow, 2004).

**Beginning Therapy: Alliance and Assessment.** Couple therapy begins with the vital tasks of building a therapeutic alliance, assessing the problem and what is maintaining it (Pinsof, 1995). This step is vital. Typically, marital therapy begins against the background of high levels of distress and conflict, or may even be the occasion for the sharing of painful feelings that have not been communicated during a period of disengagement. Frequently, one partner has pushed for entry into therapy while the other remains unconvinced that therapy would be helpful. At times, marital therapy is sought simply because it is the only alternative to divorce. If a strong enough alliance is not created that can buffer these tensions, such circumstances set the stage for early dissatisfaction with and termination from couple therapy, before the couple can receive a sufficient amount of the therapy to impact on the relationship distress.

Pinsof (1995) has highlighted the complexity of the alliances that form in couple therapy. Each partner has an alliance with the therapist, but the couple also has an alliance with one another, and the couple has a shared alliance as a couple with the therapist that differs from their individual connections. Couple therapists...
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need to work to build and monitor all these forms of alliance, so that, for example, the possibilities for a split alliance (in which one partner has a positive alliance with the therapist and the other does not) are minimized. Presenting in a warm way that communicates fairness and balance—with control over the process leading to a holding environment that communicates a sense of safety despite the conflict—sets the best possible frame for building alliances and success in therapy.

Assessment is ongoing in the early part of therapy and augmented with information about the response of couples to the beginning of therapy and whatever homework assignments may be generated in that phase. Assessment typically centers more on understanding relationship processes and the factors that are maintaining problems in order to help create a plan for intervention, rather than simply identifying problems and the degree of marital difficulty (Pinsof, 1995).

Goals of Therapy. Different marital therapies basically share the same ultimate goals of reducing marital distress and promoting marital satisfaction and individual well being (Gurman, 1978). Various approaches also share a number of mediating goals; for example, working to set a climate for change, which can lead to strengthening of marriage. And most approaches share the goals of enhancing soothing and attachment, positive sentiment override and what Gottman (1999) calls the “friendship” in the marriage. Whatever the approach, there also frequently is an initial need to contain a crisis and find a way to de-escalate the negative reciprocity that is occurring at the beginning of therapy. However, varying approaches place relatively different degrees of emphasis on other mediating goals such as insight, emotional engagement, problem solving, and skill acquisition (Gurman, 1978).

Levels of Intervention: Strategies of intervention in marital therapy cross a multitude of levels (Lebow, 1997). Specific approaches employ these various strategies to the extent that deficits, and/or in situations in which strong emotion is able to sidetrack the manifestation of these skills. Teaching communication skills typically involves some variation on the speaker-listener technique in which clients learn to speak and empathically listen. One extension of communication training lies in helping partners learn how to problem solve, as couples are taught how to work toward win-win solutions through generating possible solutions, explaining their ideas, and learning to compromise.

Another offshoot of such communication skill building is teaching fair fighting. The ability to argue successfully, process differences, and repair are essential marital skills. Fair fight training involves teaching couples to avoid such “below the belt” tactics as topic shifting, bringing up other issues from the past, name-calling, and stonewalling.

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Emotion Focused Strategies. Other strategies focus more directly on emotion and build on the feelings that come with heightened emotion. In Emotion Focused Therapy (Johnson, 2004), emotion-filled moments become the springboard for helping partners to engage in softening, where the softer, more connected feelings hidden behind more angry and distancing behavior are allowed to emerge and enhance the possibility for connection. In a similar vein, Gottman (1999) highlights the importance of increasing emotional soothing. In couple therapy, emotional heightening and emotional steadying both have roles; different strategies work toward different ends from these two states. As Snyder (2002) points out, couple therapy is both about broadening restricted emotion and containing raw emotion.

Cognitive Strategies. Cognitive strategies focus principally on working to change the irrational and unrealistic ideas partners carry about their relationships (Epstein & Baucom, 2002). Through in-session and homework examples, partners learn to approach their ideas in ways that talk back to their irrational, unrealistic expectations (for example, “that my partner should always agree with me”). Reframing also targets cognitions to help partners see each other in a more positive light.
Promoting Acceptance. A number of approaches have begun to accent mutual acceptance rather than behavior change. Gottman, among others, has highlighted that the list of issues that trouble particular couples do not change much over a lifetime. Jacobson and Christenson (1998) have created an integrative approach based in acceptance, and in many approaches there is an increasing focus on the related concept of forgiveness (Fincham, Beach, & Davila, in press).

Exploring and Negotiating Unconscious Processes. Partners enter relationships with a myriad of expectations, some direct and verbalized, some not verbalized but conscious, and some out of awareness (Sager, 1975). Almost all couple therapists work to help negotiate conscious expectations, and most work as well with the unconscious meaning of exchanges. Sager (1975) developed an approach that targeted articulating and negotiating the unconscious parts of the marital contract (for example, one partner will be dependent and the other will take care of that person). In a similar vein, Gurman utilizes interpretation to help partners understand the function the relationship serves for each; and more traditional psychanalytic approaches (Scharff & Bagini, 2002) focus on resolving the transferences from family of origin that partners bring to one another.

Larger System Issues. At times, intervention must extend beyond the couple. Children can readily become the center of marital conflicts (a problem that is particularly prevalent in remarriage families) or there may be issues with family of origin. When dealing with such problems with others, therapeutic options include incorporating these individuals in treatment (and thus engaging in family therapy) or simply having the relationship with these individuals become a focus of treatment without their presence. Working with the interface with the broader culture also needs to become a focus, particularly when expectations in the broader culture are discordant with the needs of the relationship. Examples can be found in the difficulties experienced by gay couples in gaining acceptance for their relationships (Green, 2002) or dealing with the roles of African American couples in a white-dominated society (Hardy 2002) or, more generally, in dealing with the pressures imposed by the workplace on families. Similarly, societal and individual expectations about gender also frequently have a crucial role in marital difficulties. When this is the case, helping the couple find a position that is balanced and mutually supportive around issues of gender becomes an essential task (Rampage, 2002).

Course of Treatment. Marital therapy can be structured to be brief or longer term. Typically, if the treatment is effective, the presenting problems will be resolved within 20 sessions, although many continue marital therapy over longer periods. Most marital therapy first employs direct interventions to resolve difficulties before more complex individual or system options are explored (Pinsof, 1993). Termination typically comes at the couples’ initiation at the point where they feel sufficiently satisfied with the relationship (Lebow, 1994). Most models work to a fading of the therapist at the end of therapy, with the partners continuing the work of the therapy without the therapist.

Managing Resistance/Noncompliance. Regardless of the particular intervention strategy, couple therapy requires a way of dealing with client lack of cooperation and difficulties in follow through. There are numerous approaches to responding to non-compliance, ranging from simply restating the expectation, to labeling and working with the clients’ stage of change, to confrontation, to reframing, and to interpreting the resistance.

Terminology

**Demand-Withdraw Pattern**: A style of interaction in which one partner engages in frequent complaining while the other partner tries his or her best to ignore and/or avoid the first partner. Also called the pursuer-distancer interaction.

**Marital contract**: The agreements both in and out of awareness that partners have with each other about their relationship.

**Positive sentiment override**: The state in which positive thoughts of a couple about each other and their marriage are so pervasive that they tend to supersede their negative feelings so that it takes a much more significant conflict for them to lose their equilibrium as a couple than it would otherwise.

**Softening**: The transformation of a partner from a blaming position to one of asking for attachment needs to be met; a key element in EFT.

**Stonewalling**: A pattern in interactions characterized by the listener withdrawing from the interaction by providing no cues that he or she is tracking the conversation, looking away, maintaining a stiff neck, and saying almost nothing. This is one of John Gottman’s four horsemen that are highly predictive of divorce.

**Tracking Outcomes**: The tracking of outcomes and sharing feedback about progress with clients has been demonstrated to be a helpful ingredient in therapy (Hubble, Duncan, & Miller, 1999).

**Special Problems**: There are situations in which couples present that require special methods of intervention. Issues of sexuality in distressed couples are best dealt with in a digression into sex therapy aimed to directly address this problem (Leiblum & Rosen, 2000) after an initial phase of therapy has reduced the level of marital distress. Infidelity typically introduces levels of trauma and mistrust that require special procedures, particularly concerning issues surrounding trust and forgiveness (Abrahams Spring 1996; Baucom, Gordon & Snyder, 2005; Brown, 1991; Lusterman, 1998). Significant marital violence requires careful planning around safety, as well as an ongoing decision process as to whether marital therapy might place women at greater risk. The presence of what Gottman (1994) describes as the four horsemen—criticism, defensiveness, contempt, and stonewalling—points to the urgent action to reduce these forms of negativity before other strategies can work. And individual psychopathology or personality disorder typically requires specific help to address these problems.

**Ethical Issues**: Ethical considerations are essential aspects of couple therapy (Margolin, 1972). Understandings about confidentiality and record keeping need to be clear and understood at the onset of treatment. The sharing of secrets between a partner and the therapist presents a special problem in couple therapy. Most guidelines suggest couple therapists should not harbor major individual secrets that affect marriages. The couple therapist must endlessly deal with interface issues in marital therapy and vexing issues of personal values.
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SHANNON FAGAN/GETTY IMAGES

Well-established treatments have met the criteria for empirically supported therapies that match individual therapies. Nonetheless, meta-analyses on individual difficulties research on marital therapy has lagged behind the research on individual difficulties. This research has lagged behind the research on marital therapy. Consequently, almost all couple therapists that it is essential for therapists to remain non-judgmental. There also is a consensus among most marital therapists who believe that therapy is to try to preserve and build better relationships, marital therapy does not aim to save marriages at all costs and there is a constructive role for divorce when couples reach irreversible impasses (Pinsof, 2002). However, there are minority positions among couple therapists on both sides of this latter issue: therapists who see themselves as “marriage savers,” and those who place a greater emphasis on personal rather than relational happiness.

Research on Effectiveness/ Empirically Supported Treatments. Research on marital therapy has had a considerable obstacle to overcome in that research about the treatment of relational diagnoses, such as distressed marriages, are almost never supported by government funding. Thus, this research has lagged behind research on individual difficulties. Nonetheless, meta-analyses point to levels of effectiveness that match individual therapies (Lebow & Gurman, 1995; Sprenkle, 2002). And two treatments have met the criteria for well-established treatments within listings of Empirically Supported Therapies (ESTs), Behavioral Marital Therapy (BMT) (Jacobson & Margolin, 1979) and Emotion Focused Couple Therapy (EFCT) (Johnson, 2004). BMT consists of Behavioral and cognitive interventions that include communication training, problem solving training, promoting positive exchanges, and graduated processes to reengage in pleasant experiences together. EFCT focuses on promoting adult attachment through in-session experiences in which vulnerabilities are allowed to emerge and be responded to in a soothing rather than attacking manner.

There also are several couple therapies that qualify as promising, according to EST criteria. These include: Insight Oriented Couples Therapy (Snyder & Wills, 1989), a melding of social exchange and psychodynamic methods that promotes insight; and Integrative Behavioral Couples Therapy (Jacobson & Christensen, 1998), a treatment that integrates behavioral methods with an emphasis on acceptance. Specific treatments for treating distressed couples that have produced promising results in single studies include: a depressed individual utilizing an adapted version of BMT (Beach & O’Leary, 1992); and for couples who have experienced infidelity, utilization of an integrative therapy that includes psychoeduca-

tion, promoting insight and forgiveness, and techniques from behavior marital therapy (Baucom et al, 2005).

Longer-term follow-up unfortunately indicates that the vicissitudes of life and the many new transitions couples face often make it easy for problems to return. Recidivism rates for couple therapy are typically nearly 50%, though the Insight Oriented approach showed a very low rate of recidivism at five-year follow-up. Clearly, couple therapies need to highlight strategies to maintain change. Because of this problem, open-ended strategies that include the notion of clients returning if problems return are also frequently encountered in clinical practice (Lebow, 1994). And, some problems remain for most couples even in successful therapies; for example, Jacobson and Addis (1993) found in their quite successful BMT that only 35% were without any distress at the end of treatment.

Other Frequently Encountered Models: Beyond the ESTs mentioned above, widely-disseminated approaches include: Object Relations Couple Therapy (Scharff & Bagini, 2002); Bowen Therapy (Bowen, 1978); Enhanced Cognitive Therapy (Epstein & Baucom, 2002); Collaborative Couple Therapy (Wile, 2002); Narrative Couple Therapy (Friedman & Combs, 2002); and a number of integrative therapies including Affective Reconstruction (Snyder, 2002); Brief Integrative Marital Therapy (Gurman, 2002); Contextual (Fishbane, 1998); Feminist (Rampage, 2002); and Integrative Problem Centered (Pinsof, 1995) approaches. All have many proponents among clients and therapists who strongly believe in the value of these treatments, but as yet have not been subject to research to determine whether these approaches are effective.

Relevance to Other Marriages. Although this Update has addressed marital distress, a very similar array of strategies is employed to augment non-distressed marriages. Marital therapy is at least as effective in helping non-distressed couples as it is in helping distressed couples (Lebow & Gurman, 1995). Couple therapy ultimately looks to extend intimacy, not just to resolve difficulties.

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Resources for Practitioners


JACOBSON, N. S., Christensen, A. (1998). Acceptance and change in...


REFERENCES


Marital Distress

S A M P L E C O N S U M E R U P D A T E

Here is a sample of the Consumer Update brochure on Marital Distress. This brochure is designed to educate consumers and to market your services, with space on the back to imprint your name and contact information.

MARKETING TIPS
To market your services to individuals and families who may be faced with this issue, distribute copies of the Consumer Update brochure to:

- Physicians and nurse practitioners in family practice
- Local hospitals and urgent care facilities
- Churches and synagogues
- Community resource centers
- School and university counseling programs
- Mental health agencies and health fairs

HOW TO ORDER
These brochures are available for purchase in packs of 25. The cost per pack is $8.75 for members and $11.25 for non-members. Contact AAMFT Member Services by e-mail at central@aamft.org or by phone at 703-838-9808.

Consumer Update brochures are also available on the following topics:

- Adolescent Behavior Problems
- Adolescent Self-Harm
- Adolescent Substance Abuse
- Adoption Today
- Alcohol Problems
- Alzheimer’s Disease and the Family
- Anger
- Anxiety
- Attention-Deficit / Hyperactivity Disorder
- Bereavement
- Bipolar Disorder
- Body-focused Repetitive Disorders
- borderline Personality Disorder
- Caregiving for the Elderly
- Childhood Sexual Abuse
- Children and Divorce
- Children’s Attachment Relationships
- Chronic Illness
- Depression
- Domestic Violence
- Eating Disorders
- Effect of Anger on Families
- Female Sexual Problems
- Gay and Lesbian Youth
- Infertility
- Infidelity
- Juvenile Sex Offenders
- Male Sexual Problems
- Marriage Preparation
- Mental Illness in Children
- Multicultural Families
- Obsessive Compulsive Disorder
- Panic Disorder
- Postpartum Depression
- Post-Traumatic Stress Disorder
- Schizophrenia
- Substance Abuse and Intimate Relationships
- Suicidal Ideation and Behavior

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