JMFT Journal of Marital and Family Therapy
Journal of Marital and Family Therapy 42(1): 32–44
doi: 10.1111/jmft.12120

THE GAP BETWEEN COUPLE THERAPY RESEARCH EFFICACY AND PRACTICE EFFECTIVENESS

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Meta-analyses of randomized controlled trials of couple therapy find large improvements in couple adjustment, but published evaluations of the effectiveness of couple therapy in routine practice find only small-to-moderate effects. The current study analyzes possible explanations for the research-efficacy to practice-effectiveness gap and offers suggestions for enhancing couple therapy effectiveness. Major recommendations are that therapists should clarify whether couples' therapy goal is to clarify commitment to the relationship or to improve the relationship; use standardized assessment of the individual partners and the relationship; and use systematic monitoring of therapy progress and the therapeutic alliance. It is also possible that the greater use of evidence-based therapies when treating couple relationship distress could enhance couple therapy outcome.

There is a fascinating paradox in couple therapy: In most research studies, couple therapy produces large improvements in couple adjustment, yet in effectiveness studies of couple therapy in more typical practice settings, it typically produces much smaller gains. In this article, we analyze potential explanations for the gap between research efficacy and practice effectiveness, use that analysis to offer suggestions on how to improve effectiveness, and also offer suggestions for the conduct of effectiveness research.

EFFICACY AND EFFECTIVENESS

There is a well-recognized distinction in psychotherapy research between research efficacy and clinical effectiveness (Nathan, Stuart, & Dolan, 2000). Efficacy refers to treatment effects observed in randomized controlled trials, whereas effectiveness refers to treatment effects in routine practice. Efficacy and effectiveness trials differ in many ways. Specifically, in efficacy trials, participants usually are screened for meeting predefined inclusion and exclusion criteria, undertake systematic assessment before and after treatment, and provide informed consent to accept a particular treatment condition with specified goals and duration (Nezu & Nezu, 2008). In addition, treatment is usually described in written manuals, and therapists often are trained and supervised to ensure the integrity and quality of the treatment provided. In contrast, in effectiveness studies, there often is less selectivity than in efficacy trials about which clients are accepted into treatment, comprehensive assessment might or might not be undertaken, clients often negotiate the goals and type of treatment, and therapists can often operate more or less autonomously with limited or no supervision of their practice.

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We thank David Hardwick for help with manuscript preparation.

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Efficacy trials prioritize the internal validity of the study in order to be able to demonstrate it is the treatment that has an effect. Effectiveness trials prioritize external validity, the effects of treatment when delivered in a manner typical of routine care. In essence, efficacy shows how well a treatment can work under tightly defined conditions, whereas effectiveness shows how well a treatment typically works in routine service delivery.

EFFICACY AND EFFECTIVENESS OF COUPLE THERAPY

There are now more than 35 randomized controlled trials of couple therapy, of which the vast majority evaluated either behavioral couple therapy (BCT) or emotion-focused couple therapy (Snyder & Halford, 2012). A review of eight meta-analyses of these studies concluded that couple therapy produces a large effect size gain relative to control conditions, $d = .84$ (Shadish & Baldwin, 2003), and a separate meta-analysis of 17 BCT studies reported large effect size pretherapy to posttherapy improvement, $d = .82$, in couple adjustment (Baucom, Hahlweg, & Kuschel, 2003). There are variations in effect size estimates across studies and across meta-analyses, but there is little evidence of systematic differences in efficacy of different approaches particularly once other covariates (e.g., reactivity of measures, severity of initial presentation) are controlled (Lebow, Chambers, Christensen, & Johnson, 2012; Shadish & Baldwin, 2003; Snyder & Halford, 2012).

Four longitudinal effectiveness trials have evaluated change in relationship adjustment across the course of couple therapy in routine community practice (Doss et al., 2012; Hahlweg & Klann, 1997; Klann, Hahlweg, Baucom, & Kroeger, 2011; Lundblad & Hansson, 2006). Four other studies also evaluated the effects of couple therapy in community practice. Two studies were randomized controlled trials of the effects of therapy progress monitoring on couple therapy outcome, but neither study reported the immediate effects of couple therapy on couple adjustment (Anker, Duncan, & Sparks, 2009; Reece, Toland, Sloane, & Norsworthy, 2010). In a third couple therapy effectiveness study, the only outcome measure was the therapists' perceptions of outcome (Ward & McCollum, 2005). Finally, a large-scale survey of consumer evaluations of psychotherapy showed couple therapy was rated as less effective than individual therapy, but did not evaluate effects on couple relationship adjustment (Seligman, 1995). We do not include any of these last four studies as they did not assess change in couple relationship outcomes as reported by the clients, which has been the usual way of evaluating outcome in efficacy trials.

Figure 1 presents the effect size of change in the four effectiveness studies and in the meta-analysis of efficacy trials by Baucom et al. (2003). As shown, in effectiveness trials, effect sizes ranged from small to moderate and overall were notably smaller than the mean effect size in the efficacy trials. It is important to note that the Doss et al. (2012) study included a proportion of couples who, while referred for couple therapy, were not clinically distressed on the self-report measure of adjustment at presentation. If those couples are excluded, then the effect size was $d = .6$ for distressed couples, larger than .45 for all couples, but still smaller than typically reported in efficacy trials. Moreover, the effectiveness trials had substantial attrition; more than 50% of couples failed to complete the study in each trial (Doss et al., 2012; Hahlweg & Klann, 1997; Klann et al., 2011; Lundblad & Hansson, 2006), and Lundblad and Hansson (2006), who reported the largest effect size for couple therapy effectiveness, had posttherapy data for just one-third of couples initially assessed. If a conservative intention to treat analysis is applied, which assumes couples dropping out do not improve, the effect sizes of routine couple therapy are less than half those shown in Figure 1.

Another way to contrast efficacy and effectiveness is evaluating the variability and clinical significance of change, as described by Jacobson and Truax (1991). The two largest trials of couple therapy efficacy are Christensen et al. (2004) and Snyder and Wills (1989). Both studies compared two different approaches to couple therapy in a randomized controlled trial and found little difference in the immediate effects between the conditions. Each trial reported variability and clinical significance of change in large samples of couples, and we use the outcomes collapsed across conditions in each study as a benchmark of change in efficacy studies. Two of the effectiveness studies (Doss et al., 2012; Hahlweg & Klann, 1997) also presented variability and clinical significance of change in comparable ways to the efficacy studies. Figure 2 presents the percentage of couples who were unimproved, improved, and recovered at the end of therapy in efficacy and effectiveness

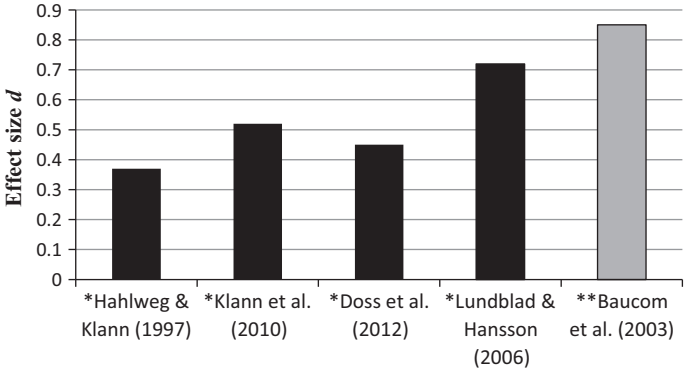

Figure 1. Effect size of pre-therapy to post-therapy changes in efficacy and effectiveness trials of couple therapy. *Effectiveness trials; **Meta-analysis of efficacy trial.

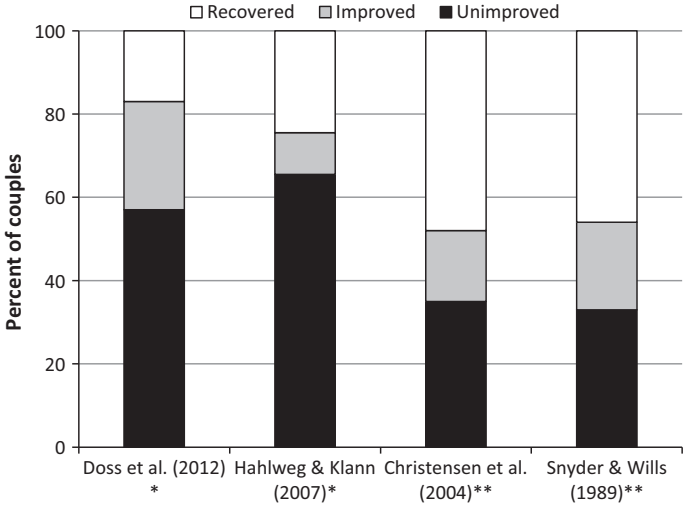

Figure 2. Comparison of variability and clinical significance of change immediately after therapy in efficacy and effectiveness trials. *Effectiveness trials; **Efficacy trials.

studies. Following Jacobson and Truax (1991), improved was defined as a reliable increase from pretreatment to posttreatment mean of the two partner's relationship satisfaction and recovered as a reliable increase in relationship satisfaction in combination with a move from the distressed to the nondistressed range of couple relationship satisfaction.

As is evident in Figure 2, rates of couple recovery in clinical effectiveness trials are less than half that reported in research efficacy trials. Moreover, about 60% of couples showed no reliable benefit from couple therapy in effectiveness studies, while about 35% of couples show no benefit in efficacy trials. (Note: The statistics presented are just for those couples who were clinically distressed at presentation for the Doss et al. (2012) study, for those who presented without clinical distress 80% showed no reliable improvement.) The Klann et al. (2011) effectiveness trial did not report rates of reliable improvement and so we could not include it in Figure 2, but they did report that 33% of couple recovered. This is better than the recovery rate in the other two effectiveness trials, but still less than the rates of recovery in the efficacy trials. Lundblad and Hansson (2006) did not report on the variability or clinical significance of change. Four meta-analyses of couple therapy efficacy trials further support the research practice gap in clinical outcome, reporting that between 41% and 54% of couples move from the distressed to nondistressed range of relationship

functioning as a result of therapy (Hahlweg & Markman, 1988; Shadish & Baldwin, 2003; Shadish et al., 1993). Again, if we take into account the very high attrition rate from effectiveness trials, the improvement rates present in Figure 2 are the most optimistic view we can take of couple therapy effectiveness.

With only four published effectiveness trials, any conclusions drawn need to be cautious. Moreover, while the majority of efficacy trials have been conducted in the United States, three of the four effectiveness trials were conducted elsewhere (one in Sweden and two across Germany and Austria). There is no evidence of systematic differences in couple therapy efficacy across Western countries; for example, large effect sizes have been reported for cognitive-BCT delivered in Australia (Halford, Sanders, & Behrens, 1993), Germany, and the United States (Jacobson et al., 1984). However, national differences in systems of service delivery might influence effectiveness of couple therapy outcomes. Additional effectiveness research is highly desirable, but there already is consistent evidence that couple therapy effectiveness is more modest than efficacy.

POTENTIAL EXPLANATIONS FOR THE EFFICACY–EFFECTIVENESS GAP

There are many possible explanations for the couple therapy research efficacy to clinical effectiveness gap. One possibility is that the type of therapy provided differs between efficacy and effectiveness trials. A second possibility is that the types of couples included in efficacy and effectiveness trials differ in important ways. A third possibility is that efficacy studies always conduct comprehensive assessments of both the individual and couple, which is much rarer in routine practice, and perhaps comprehensive assessment facilitates a better outcome. A fourth possibility is that there may be more quality control in efficacy studies (e.g., close monitoring and supervision). Finally, organizational factors in community service delivery (e.g., high demand services not being able to offer weekly sessions) might negatively impact on client outcomes. We consider each of these possibilities below.

Type of Therapy

A potential influence on the efficacy–effectiveness gap in couple therapy is the type of therapy offered. As noted previously, cognitive-behavioral and emotion-focused therapies are the only couple therapies replicated to be efficacious; yet, most practicing couple therapists do not espouse these evidence-based approaches as their preferred mode of couple therapy (Anker et al., 2009; Boughner, Hayes, Bubenzer, & West, 1994; Hahlweg & Klann, 1997; Lavee & Avisar, 2006). Rather therapists most commonly describe their approach as eclectic, systemic, or strategic (Anker et al., 2009; Boughner et al., 1994; Klann et al., 2011), and none of these approaches have been replicated as efficacious in randomized controlled trials. However, as Dattilio, Piercy, and Davis (2014) note, the absence of randomized controlled trials of some widely used couple therapy approaches is not evidence that those approaches would not be efficacious if tested in randomized controlled trials.

The existing couple therapy approaches that are efficacious in randomized controlled trials have not been shown to be reliably different to each other in efficacy (Shadish & Baldwin, 2003). Moreover, there is no clear evidence that these "evidence-based" approaches produce better outcome than other widely used couple therapy approaches that have not yet been evaluated in randomized controlled trials. It is possible that effectiveness of couple therapy would be increased if more couple therapists used cognitive-behavioral or emotion-focused couple therapy, but this needs to be tested rather than assumed.

While the randomized controlled trial has long been regarded as the gold standard for establishing the effects of a treatment (Nezu & Nezu, 2008), it is also evident that interventions that are efficacious in randomized trials do not necessarily translate well into effective routine practice (Society for Prevention Research, 2004). Effectiveness research provides an important complementary vehicle to establish the outcomes of couple therapy, including for therapies which have to date not been tested in randomized controlled trials (Dattilio et al., 2014). Results from effectiveness trials can be benchmarked against treatment gains observed in efficacy trials (large effect size outcomes of $d = .82$) and no treatment controls (no change, $d = -.06$; Baucom et al., 2003). In addition, effectiveness studies that compare outcomes for couples receiving treatment-as-usual

versus one of cognitive-BCT or emotion-focused couple therapy could test more directly the effects of therapy approach.

Aside from the potential specific effects of particular types of therapy, it is also possible that therapist allegiance to the model of therapy is stronger in randomized controlled trials than that in effectiveness trials, and allegiance is a reliable predictor of the effects of psychotherapy (Munder, Flueckiger, Gerger, Wampold, & Barth, 2012). Efficacy trials are often conducted by the developers of particular therapy approaches, and those developers often have strong commitment to the model they are evaluating (Sanders, 2015). In contrast, as noted previously, effectiveness trials are delivered by clinicians who often espouse an eclectic approach rather than being advocates for a particular approach.

Mean number of therapy sessions is usually higher in efficacy than effectiveness trials. Couple therapy efficacy trials typically provide anything from 15 to 30 sessions of therapy (Snyder & Halford, 2012). In contrast, across four effectiveness trials, the mean number of couple therapy sessions ranged from 9 (Doss et al., 2012; Lundblad & Hansson, 2006) to 14 (Hahlweg & Klann, 1997), with substantial proportions of clients attending a very small number (<4) of sessions. However, it seems unlikely that just providing more therapy would enhance effectiveness as couples who attend more sessions in effectiveness trials do not show larger gains from therapy than those attending fewer sessions (Klann et al., 2011).

Couple Characteristics

Efficacy studies typically include stringent inclusion and exclusion criteria, whereas effectiveness trials do not. It is possible that the types of couples typically included in efficacy and effectiveness studies differ, which might explain the better outcome observed in efficacy relative to effectiveness studies. Wright, Sabourin, Mondor, McDuff, and Mamodhoussen (2007) examined the representativeness of couples in efficacy studies of couples in clinical practice settings and concluded they were quite similar on the severity of couple distress, the heterogeneity of presenting concerns, clients' socio-demographics, and the presence of coexisting partner psychopathology. With respect to that last characteristic, Wright and colleagues describe a large number of efficacy studies that specifically recruited for couples with major psychopathology in at least one partner (most frequently depression or substance abuse).

There are some differences between couples in efficacy trials and those in more routine clinical settings. Sixty-two percent of couple therapy efficacy studies excluded unmarried cohabiting couples (Wright et al., 2007). Cohabiting couples are a large and increasing proportion of all couple households in most Western countries, such as the United States and Australia, and are at higher risk of relationship distress and separation than married couples (Hewitt & Baxter, in press). Large community agencies, like the one in which our third author works, have substantial proportions of cohabiting couples in their client mix. There is little research on the efficacy or effectiveness of couple therapy with cohabiting couples relative to married couples, and this warrants research attention.

One potential moderator of couple therapy effectiveness is the partners' commitment to the couple relationship. In a study of couple therapy in community practice, at least one partner in 36% of couples stated their therapy goal was to clarify whether to remain in the relationship, while the remaining 64% reported both partners wanted to improve the relationship (Owen, Duncan, Anker, & Sparks, 2012). Couples whose stated goal was to clarify the relationship future were more distressed on presentation, showed less improvement in relationship satisfaction across the course of therapy, and were much more likely to separate in the 6 months after therapy, than couples in which both partners' stated goal was to improve the relationship.

The relationship ambivalence of couples in routine practice contrasts with the implicit stated commitment of couples in efficacy studies. Efficacy studies require participants to provide informed consent to participate in couple therapy that has the stated goal of enhancing the relationship and to participate in quite a large number of sessions. For example, Christensen et al. (2004) provided a mean of 26 couple therapy sessions, and Snyder & Wills (1989) 25 sessions, in their efficacy trials. It seems likely that couples who are willing to commit to an intervention of this intensity are committed to improving their relationship. In contrast, couples who access therapy in routine practice do not have to commit to a fixed number of sessions and likely are highly variable

in their commitment to improving their relationship. This variable commitment might explain, at least in part, why substantial proportions of couples accessing therapy in clinical settings attend only a small number of sessions. It seems likely that some of those clients are clarifying early in therapy that they wish to separate from their partner; they then end the couple relationship and cease attending therapy.

A number of couple therapy writers have argued that assisting distressed couples to clarify the decision to separate, and assisting them to negotiate a separation, can be a useful clinical outcome (Halford, 2001). Specifically, Halford (2001) described a case of a highly distressed couple in which the woman was depressed, the man was abusing alcohol, and their young child had significant behavior problems. At the end of therapy, the woman was no longer depressed, the man had reduced his drinking, the child was behaving more appropriately, the couple had separated, and the partners had negotiated a mutually acceptable agreement on how to co-parent their child. Applying the most widely used couple therapy outcome index of relationship adjustment, the therapy was a failure as relationship adjustment did not improve. However, individual adjustment and other family outcomes showed meaningful clinical improvement. In a large survey of couple therapists, they reported that about one-third of their clients presenting for couple therapy separated, and the therapists often viewed the therapy with a separation outcome as successful (Stanley, Lobitz, & Markman, 1989).

We recommend that therapists assess at presentation whether each partner's goal for therapy is to clarify whether to continue the relationship or to improve the relationship. This initially should be done by talking to partners individually, and then discussing the issue (with permission) with the couple. This would allow therapists to tailor therapy according to the couple's goals and might well enhance the effectiveness of therapy, as mismatch of goals between therapist and client predicts poor therapy outcome (Norcross & Wampold, 2011). In future effectiveness studies, it would be appropriate to report couple relationship outcomes for couples in which relationship improvement is the stated goal of both partners separately from the outcomes of couples whose goal is to clarify whether or not to continue the relationship.

Assessment

Efficacy studies almost always include a comprehensive assessment using some combination of self-report measures, self-monitoring, observational assessments, and individual and conjoint couple interviews. For example, Christensen et al. (2004) administered self-report measures that assessed relationship satisfaction, interpartner violence (IPV), couple communication, relationship stability, individual functioning, and desired areas of behavioral change; they conducted individual clinical diagnostic interviews of each partner, separate individual intake interviews with both partners, and a conjoint clinical intake interview; and the couple completed two different communication tasks that were videotaped. This information was integrated into a feedback session with the couple, and the therapist then negotiated the goals and procedures of therapy with the couple based on the assessment.

In contrast to the use of comprehensive standardized assessments in efficacy studies, most couple therapists in routine practice report they do not perceive standardized assessment as all that important, and they rely predominantly on unstructured conjoint couple interviews to assess the couple relationship (Boughner et al., 1994; Lavee & Avisar, 2006). Unfortunately, information that is collected in conjoint interviews is unreliable, much less reliable than data that are collected by individual interview or self-report inventories (Haynes, Jensen, Wise, & Sherman, 1981). Effectiveness trials require some structured assessment to measure outcome, but typically do not conduct the same comprehensive assessment typical of efficacy studies. For example, Doss et al. (2012) assessed self-reported relationship adjustment, and Hahlweg and Klann (1997) and Klann et al. (2011) assessed self-reported couple relationship adjustment and individual psychological symptoms. However, none of the four effectiveness studies conducted the comprehensive assessments typical of efficacy studies, and none systematically included discussing the results of the assessment with the couple. Hahlweg and Klann (1997) and Klann et al. (2011) did provide therapists with reports of the assessments conducted, but the extent to which therapists actually discussed these reports with couples was not assessed. In our experience, therapists often need training to be comfortable reviewing assessment results with clients as they usually do not use

systematic assessment routinely, and hence, it seems likely assessment discussion occurred infrequently.

The process of standardized and more comprehensive assessment might enhance couple therapy effectiveness in at least four ways. First, comprehensive assessments educate the therapist and the couple about the key presenting concerns and a range of influences on the couple's relationship. On presentation for couple therapy, the two partners often disagree on the nature of the key relationship concerns, and such disagreement predicts poor outcome from therapy (Biesen & Doss, 2013). Assessment might well serve to help develop a shared view by the couple of key issues that therapy should address.

A common challenge in couple therapy is that distressed couples tend to attribute relationship problems to stable, negative characteristics of their partner (Bradbury & Fincham, 1990). Furthermore, holding these partner blaming attributions is associated with couples being unable to identify specific things they can do to enhance their relationship (Halford, Lizzio, Wilson, & Occhipinti, 2007). Benson, McGinn, and Christensen (2012) argue that a common element to evidence-based couple therapy is altering the couple's view of the presenting problem to be less partner blaming and to become more objective, contextualized, and dyadic. It is argued that such a change in attributions assists partners to commit to making individual efforts to enhance the relationship (Halford, 2001). Assessment might well serve an educative function that promotes less partner blaming, and change in attributions for relationship problems. For example, Halford (2001) describes how couples completing assessments of recent stressful life events can prompt the couple's attention to the influence of events on their relationship. In summary, assessment can serve an important role in building a dyadically focused, shared conceptualization of the couple relationship that facilitates couple therapy.

Second, the process of assessment might enhance the therapeutic alliance by helping the therapist not just to establish key concerns, but also to express empathy with those concerns that have been identified. There is a consistent finding that a strong therapeutic alliance with both partners in couple therapy predicts greater improvement in couple relationship adjustment (Anker, Owen, Duncan, & Sparks, 2010; Davis, Lebow, & Sprenkle, 2012). However, there are some distinctive challenges in developing a good therapeutic alliance in couple therapy, such as being empathic with two people who might have very different perspective on the reasons for their relationship problems (Davis et al., 2012). Several texts on evidence-based couple therapy propose that structured assessment helps develop in couples a shared and constructive conceptualization of their problems and that therapist expressed empathy with that conceptualization can promote a positive therapeutic alliance with both partners (Epstein & Baucom, 2002; Halford, 2001).

Third, assessment can identify psychological disorders in individual partners. Representative surveys of the U.S. population show a moderate-to-strong association between relationship distress and common psychological disorders in the partners—notably depression, anxiety disorders, and drug and alcohol abuse (Whisman, 2007). Therefore, it is not surprising that there is a high rate of individual disorders in the people presenting for couple therapy. For example, in about 40% of couples presenting with relationship problems, at least one partner is drinking at hazardous levels (Halford & Osgarby, 1993), and there is substantial elevation in depressive symptoms in people seeking couple therapy (Klann et al., 2011). Baucom, Whisman, and Paprocki (2012) review evidence showing that adapting couple therapy to address psychopathology in one partner can enhance outcomes in terms of both relationship distress and individual disorders. For example, in distressed couples with a depressed partner, behavioral activation can be included in couple therapy that both enhances the relationship and reduces depression.

Interpartner violence is another area requiring thorough and specific assessment due to the high risk of injury that undetected IPV has on individual partners. Studies of IPV in couples seeking couple therapy find that 36–58% of couples report male-to-female IPV in the past 12 months, and 37–57% report female-to-male IPV in the past 12 months (Jose & O'Leary, 2009). Screening and assessment guidelines for IPV recommend both self-report (e.g., written questionnaires and verbal reports) and partner report be conducted individually to allow partners to self-disclose in safety (Stith, Penn, Ward, & Tritt, 2003). However, available evidence suggests practitioners in routine practice do not adequately screen and assess IPV. For example, in one study, only half of 620 couple and family therapy practitioners routinely screened for IPV, and <10% conducted an

appropriate assessment (Schacht, Dimidjian, George, & Berns, 2009). While historically, couples reporting IPV were not offered couples therapy, the identification of typologies of violence has led some researchers to distinguish between different types of IPV, some of which might be suitable for couple therapy. For couples reporting low-severity IPV (e.g., pushing, shoving, slapping), especially if the IPV is reciprocal, carefully managed couple therapy may be appropriate (Stith & McCollum, 2012). For moderate- to high-severity aggression, and couples reporting fear of their partner, individual treatment for the aggressive partner is recommended. Failure to assess IPV adequately in couple therapy presentations may result in couples receiving couple therapy inappropriately, or receiving couple therapy which fails to suitably address the reduction in violence in the relationship, leading to less positive outcomes.

Fourthly, structured assessment might enhance outcome by being, in itself, therapeutic. Structured assessment, discussion of assessment results, and relationship goal setting have been found to increase relationship satisfaction in distressed couples in two quasi-experimental studies (Cordova, Warren, & Gee, 2001; Halford, Osgarby, & Kelly, 1996) and two randomized controlled trials (Cordova et al., 2014, 2005). In each study, the assessment consisted of two sessions including completion of self-report measures, assessment of communication through direct observation, and self-monitoring of the couple's daily interactions. In a third session, the assessment results were discussed with the couple and potential relationship goals negotiated. Interestingly, the effect sizes of improvement from three sessions were moderate (Cordova et al., 2005) to large (Halford et al., 1996), and equal to or larger than the effect sizes reported for a full course of couple therapy in effectiveness trials (Doss et al., 2012).

Some clinicians express concern that couples might find completing comprehensive assessments takes too long, and "delays the start of treatment." However, in our experience, couples completing assessment that enable them to clarify their concerns, particularly when the therapists is discussing these assessment results empathically with them, rarely experience this process as delaying treatment. In fact, they experience this process as being therapeutic and, as the previously cited evidence shows, couples' perception that well-targeted assessment is helpful is consistent with the research evidence that it is indeed helpful to couples.

The potential value of implementing a more comprehensive multimodel assessment of couples in routine practice does present some challenges to practitioners. Consideration may need to be placed on the costs of purchasing copyrighted measures; and ensuring therapists are appropriately trained in administration and interpretation of measures. Further, it may be unrealistic to expect routine practice to employ fully the multimodel comprehensive assessment used by Christensen et al. (2004). However, it is our recommendation that routine practice (and by extension effectiveness trials) includes a self-report assessment of couple relationship functioning (satisfaction is the most commonly measured construct), IPV, and individual psychological functioning. Additional brief (e.g., 1–3 item) screening measures may be employed to identify other areas that require further assessment if the couple respond positively to a screening item (e.g., alcohol and drug abuse; financial strain; inadequate support).

Quality Control

Monitoring and supervision. Another possible influence on the efficacy–effectiveness gap is quality control over therapy delivery. Usually, in efficacy studies, therapists are highly trained in the treatments being evaluated, and therapy is delivered following written manuals, with predefined content being covered in sessions (Christensen et al., 2004; Snyder & Wills, 1989; Wright et al., 2007). In addition, therapy delivery is usually individually supervised and carefully monitored. For example, in many efficacy studies, couple therapy sessions are videotaped and subsequently coded for their adherence to treatment protocols. In contrast, in routine practice, the approach taken by therapists is not tightly structured, and supervision is almost never as rigorous as in research trials (see Anker et al., 2009; Doss et al., 2012; Klann et al., 2011, for examples).

One meta-analysis of efficacy trials found that the degree of therapy structure (in terms of what is covered and the number of sessions provided) was unrelated to the treatment effect size obtained in relationship adjustment (Shadish & Baldwin, 2003). However, a more recent study concluded flexibility in couple therapy delivery in randomized trials is associated with larger treatment effect sizes (Wright et al., 2007). The inconsistency in findings likely reflects that there is

limited variability in therapy structure across efficacy trials. One exception was an efficacy study by Jacobson et al. (1989) over 25 years ago that specifically tested the effects of flexibility of delivery of behavioral couples therapy and found more flexibly delivered therapy produced better sustained treatment effects than did the same treatment delivered in a more standardized manner, when delivered by experienced couple therapists. The relative inflexibility of therapy delivery in many randomized trials might actually *underestimate* the potential effectiveness of flexibly delivered variations of these evidence-based couple therapies.

While some degree of flexibility in couple therapy delivery might enhance outcome, it is likely that, in order for couple therapy to be effective, the therapy must retain adequate integrity to the approach being used. For example, emotionally focused couple therapy requires a focus on therapy sessions on the emotional experiences of the partners during the couple's interaction. In efficacy trials, supervision is often used to ensure integrity of protocol delivery. The optimal balance of clinical flexibility with integrity of couple therapy approach delivery is an important area for future research.

Systematic progress monitoring. In individual psychotherapy, systematic assessment of therapy progress is important as therapists' clinical judgments about therapy progress do not accurately detect who is deteriorating across the course of therapy (Lambert et al., 2002). In several randomized controlled trials of individual therapy, therapy progress feedback to the therapists reduces premature dropout from therapy and enhances individual outcome compared to treatment-as-usual (Lambert, 2010; Shimokawa, Lambert, & Smart, 2010). A meta-analysis of studies found systematic progress monitoring, coupled with feedback to the therapist, reduced deterioration from 20% of clients (in treatment-as-usual) to 5.5% of clients (Shimokawa et al., 2010).

Systematic progress monitoring has not been routinely incorporated in couple therapy efficacy trials. However, consistent supervision and accountability for therapy is typical of efficacy studies. Systematic progress monitoring in couple therapy might be a cost-effective way to provide such quality control in routine care. There are a number of reasons to suspect progress monitoring in couple therapy could be effective. First, when improvement occurs in couple therapy, that improvement tends to occur most strongly in the early sessions (Behrens, Sanders, & Halford, 1990; Doss, Thum, Sevier, Atkins, & Christensen, 2005). This suggests therapy progress feedback might be useful in early detection of lack of progress, which could inform a change in approach to the couple therapy (Halford, et al., 2012; Pinsof & Wynne, 2000). Recent evidence indicates that about 70% of couples who ultimately do not benefit from couple therapy can be detected by lack of change within the first four sessions (Pepping, Halford, & Doss, 2015). With regard to whether progress monitoring enhances couple therapy outcome, Anker et al. (2009) and Reece et al. (2010) each found that weekly therapy progress feedback based on each partner's individual adjustment, combined with weekly monitoring and feedback on the therapeutic alliance, enhanced therapy gains in individual adjustment relative to treatment-as-usual. However, couple relationship adjustment at the end of therapy was not assessed in either study. As the progress feedback was based on individual adjustment, as opposed to couple adjustment, further research is required to examine whether progress monitoring in couple therapy enhances couple relationship outcomes.

The implicit assumption in the use of systematic progress monitoring is that clients are identified as offtrack sufficiently early in the course of therapy to allow corrective action to be taken to improve outcome. There has not yet been research directly testing whether systematic monitoring of the couple relationship with feedback to therapists enhances outcome in couple therapy—either in couple therapy efficacy trials or in couple therapy effectiveness trials. It is probable, given the evidence from the individual therapy literature, that the systematic monitoring of couple therapy progress with feedback to therapists would enhance couple outcomes in routine practice. Moreover, the experience in several trials of progress monitoring in couple therapy in routine practice settings (Resse et al., 2010; Sparks, 2014) suggests that brief measures that assess therapy progress are acceptable to therapists and couples.

Therapeutic Alliance

As noted previously, a strong therapeutic alliance predicts greater improvement in couple therapy (Anker et al., 2010; Davis et al., 2012). Some of the previously mentioned characteristics

of couple therapy in efficacy trials might enhance the therapeutic alliance in efficacy trials relative to effectiveness trials. For example, the close supervision typical in efficacy trials might prompt therapists to attend to the alliance and thereby enhance alliance formation. In effectiveness trials, doing systematic assessments and feedback might similarly enhance the formation of therapeutic alliance, by both enhancing therapist empathy and facilitating greater agreement on goals of therapy between the couple and therapist. As noted earlier, goal consensus is an important component of a positive therapeutic alliance. Alternatively, as effectiveness trials often use unproven—and possibly ineffective—approaches to couple therapy, this might result in less change in the early stages of couple therapy than is the case in efficacy trials, and lack of change in couple therapy is associated with a weaker therapeutic alliance (Gebova et al., 2011). In conclusion, it is possible that, on average, therapeutic alliance develops more positively in efficacy trials than that in effectiveness studies, although this possibility has not been directly tested.

Organizational Factors

Wright et al. (2007) concluded that the organizational context of efficacy trials often was not representative of routine practice settings, with many efficacy trials being conducted in university research settings. However, a nontrivial minority (43%) of efficacy trials reviewed by Wright and colleagues were conducted in naturalistic clinic settings (e.g., public institutions, outpatient clinics, community clinics, private practice). Effectiveness trials also have been conducted across diverse settings such as community clinics (Klann et al., 2011), hospital outpatient clinics (Doss et al., 2012), and hospital inpatient services (Tilden, Gude, & Hoffart, 2010).

The various organizational contexts within which couple therapy is provided might influence couple therapy service delivery and outcome. For example, in not-for-profit community organizations, therapists often have high administrative workloads (Petch, Lee, Huntingdon, & Murray, 2014; Riemer & Bickman, 2011) which include Government, insurance company, or organizationally mandated record keeping. Perhaps partly due to these competing demands on therapists' time, and partly due to high demand for services, long waiting lists are common in community clinics, as are heavy caseloads (Petch et al., 2014). This can mean clients are required to wait for several weeks for a first appointment and/or are unable to access weekly therapy sessions. In contrast, the frequency of treatment typical in efficacy studies is more regular, therapists often receive much supervision in therapy delivery, and resources are sometimes more readily available to cover administrative requirements. In some clinical settings (e.g., private practice), at least some administrative work might be delegated to administrative staff, and wait times might not be so long. Future research needs to give information on these sorts of aspects of service delivery to establish what impact this might have on effectiveness of couple therapy delivery.

Organizational context also likely influences the extent of uptake of suggestions we have made in the current study, such as using structured assessments and routinely including therapy progress monitoring. Active support from organizational leaders is crucial to successfully introducing and supporting innovations into couple therapy delivery, as well as effective engagement with the professional workforce (Sparks, 2014).

CONCLUSIONS

There is a gap between the large effect sizes typically reported in research-efficacy trials and the moderate-to-small effect sizes reported in practice-effectiveness studies of couple therapy. One likely explanation for the gap is that efficacy trials include couples who wish to enhance their relationship, while in effectiveness trials in routine practice, there is a mix of couples seeking to enhance their relationship and other couples who seek to clarify whether they wish to continue the relationship. Couple therapists should routinely assess at presentation whether each partner wishes to clarify whether or not to continue the relationship, or seeks to improve the relationship. This screening helps focus couple therapy appropriately. In addition, couple therapists should routinely use systematic multimodal assessment of the individual partners and the relationship, discuss these assessments with the couple, and negotiate the goals of therapy. In addition, therapists should monitor the progress of therapy and the therapeutic alliance and use feedback to identify whether therapy is on track for the couple to benefit.

Currently, the evidence does not show that any of the demonstrably efficacious approaches to couple therapy are more effective than other approaches, largely because there is a dearth of evidence on the efficacy of many widely used couple therapy approaches. It is possible, but undemonstrated, that increasing the use of couple therapies shown to be effective in efficacy trials would enhance couple therapy effectiveness in routine practice. Research comparing evidence-based therapies with therapy as usual in clinical settings is an important direction for future research.

There is a strong need for additional research on effectiveness of couple therapy. It is striking that only four longitudinal effectiveness studies have been published. It would be especially useful in effectiveness research to assess the impact on outcomes of systematic assessment of couples at presentation, formal structuring of therapy goal setting, adopting evidence-based approaches to therapy, the role of quality control in therapy delivery including progress monitoring, and the effects of organizational context of therapy delivery. Having efficacious treatments is not particularly valuable unless this translates into similarly positive treatment gains in routine practice of couple therapy. Only when that is accomplished are we likely to enhance the provision of effective assistance to more distressed couples more of the time.

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