

Outcomes in couple therapy: Reduced psychiatric symptoms and improved sense of coherence

ANN-MARIE LUNDBLAD, KJELL HANSSON

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In Sweden, only a few empirical studies of couple therapy have been performed. This is the hitherto most comprehensive assessment of clinical treatment. Effectiveness of treatment is reported and compared with non-clinical ratings. Initially the couples displayed marital distress, many psychiatric symptoms, dyadic interactions characterized by high criticism and a low sense of coherence. In Sweden, couple therapy is primarily aimed to reduce marital distress and does not focus on individual disorders. It should be seen as innovative that overall psychic symptoms (Global Symptom Index, GSI) as well as depressive symptoms were reduced (more than one standard deviation) for both women and men to the extent of 50–55%. Normal values were attained by 73–78%. Of those who initially identified a low sense of coherence, 22% of the women and 37% of the men improved (more than one standard deviation). Normal values were attained by 68–70%. The treatment was relatively short, which meant that, with relatively limited treatment, it was also possible to attain relatively significant improvements in all dimensions of psychiatric symptoms.

• *Couple therapy, Depression, Sense of coherence, Symptoms.*

Ann-Marie Lundblad, Orregatan 11, SE-504 54 Boras, Sweden, E-mail: ami.lundblad@bigfoot.com; Accepted 9 January 2004.

In Sweden, an extensive amount of couple therapy is performed as a part of family counselling, but the therapy has only been scantily evaluated in an empirical study (1).

Previous research has identified strong links between marital quality and health (2). Although both mental and physical health is related to marital status, the associations are not simple ones (3). Women derive mental and physical health benefits from good marriages, whereas men benefit from marriage regardless of quality. Married men have shown the lowest rate of mental health problems, and this is equivalent to single women (2). Single men have higher mortality compared to married men.

For men, marriage as a state seems to offer health-buffering effects, whereas women are more likely to experience health-related problems if their marriage is distressed (4). It is also known that divorces and marital problems are connected with or increase the risk of a number of family problems (5).

Expressed emotion (EE) is an interesting concept in family therapy and in family psychology. Many studies have confirmed that EE, especially in the forms of

criticism and hostility, is a significant and robust predictor in the relapse of schizophrenia (6). The concept of EE has also been interesting in contexts of depression, anxiety and within marital relationships (7). In couples, high EE is related to distress. Sense of coherence has lately become interesting as a health-promoting approach to life and has been viewed as a stress-resilience factor (8). This makes the concept important to investigate in family relations and in public health. From these perspectives, the reduction of marital distress and family disruptions would have a high priority.

Meta-analyses assessing couple therapy outcomes (9–11) conclude that this form of treatment increases satisfaction more than no treatment. There is also literature indicating that this form of treatment gains at least as good outcomes as other forms of psychotherapy.

Combined with traditional treatment or as sole treatment, couple therapy has lately been used to address diagnosable disorders and problems (12). Numerous studies have found that depressive symptoms are strongly linked to marital distress. Combining couple

therapy and individual treatment has shown significant improvement both in marital satisfaction and in symptom reduction (13, 14).

Many couples entering couple therapy change but will not be "symptom free" (15). Overall, couple therapy found outcome effect sizes of improvement in the range of 60–75%. Statistical significant change from "distressed" to "non-distressed" levels has reached an average level of 35–40%. Some couples may gain negative effects from treatment, leading to deterioration. The negative effect rates are estimated at 5–10%.

Research on couple therapy outcome has concluded that couples with less distress, younger, emotionally engaged and not polarized with respect to gender roles are more likely to gain successful therapy outcome compared to those more severely distressed, couples with depression or couples who have accomplished repeated problem-solving efforts (16).

Drop-outs from research samples should be more noticed. Across the field of psychotherapy research as a whole, drop-out levels tend to be moderately high, averaging around 50% (17). In a review of 115 longitudinal studies ($n=45,000$ marriages), an average of 31% (range 2–85%) attrition was found (18).

Presentation of the study set-up

This study was conducted within family counselling in Sweden, which falls under the responsibility of municipal social welfare. Visitors attend voluntarily and are rarely referred by others. Counselling is surrounded by a special professional confidentiality called "absolute secrecy". Average charges are SEK 100–200 (US \$15–30). Costs are low to help allow "everyone" to attend. This is the only counselling within public services that addresses couples that do not have a special diagnosis.

The primary method of working is psychosocial treatment. The counselling involves couple therapy, information about legal and social benefits, mediation between separated couples, guidance and support to couples and individuals. It is also aimed at providing preventive efforts in the form of education and information (19).

This part of the study was a quantitative pre- and post-treatment assessment. We hypothesize that couple therapy is a way to reduce individual psychiatric symptoms and improve sense of coherence for participating women and men. It was set up as a multi-site study performed in six family counselling agencies in southwest Sweden (20). Sixteen therapists were involved. The couples filled in self-rating forms before and after treatment.

Aims

This study aims to report results of couple therapy in the form of overall symptoms, depression, expressed emo-

tions and sense of coherence, in the study group before and after treatment, and to make a comparison with a non-clinical population.

Method

Participants and procedure

This is a single group clinical study and it was not randomized. The study was approved by a committee on ethics.

Over a 2-year period (1998–2000), couples living together and attending family counselling together were asked to participate in the study. A total of 312 couples and five women accepted. The inclusion criteria were adequate knowledge of the language and an agreement to attend at least three joint counselling sessions for couples (20). Approximately 30% of all visitors during the period of investigation met the criteria for participation in this study.

Each person in the couple individually completed the self-rating forms, usually in conjunction with the first visit. Some variables were registered for all visitors during the time of investigation: ages, number and ages of children, relationship variables, initial problems, intentions and goals of treatment, and number of sessions attended. During the period of collection, three therapists (out of sixteen) did not complete the follow-ups of their participating couples because they ended their employment. One hundred and fifty-eight (49.8%) cases were assessed after treatment.

Sixty per cent of participating couples were younger than 40 years, 25% were between 40 and 49 years, and 15% were older. Eighty-five per cent had children <18 years. A socio-economic classification was made and the study group formed an approximate estimation of Swedish statistical norm groups except for senior citizens, who are rarely represented in this study.

Initially participating couples assessed severe marital distress, disturbed family climate with distance and chaos, many psychiatric symptoms, interactions characterized by high criticism and a low sense of coherence (20).

Instruments

The Symptom Check List (SCL-90) (21) is a widely used measure that contains 90 items referring to expressions of psychosomatic and emotional distress. A low score on this questionnaire was considered an indication of "good mental health". This questionnaire has been standardized to Swedish conditions (22). Cronbach's alpha was 0.89 (23).

The Questions about Family Members (QAFM) questionnaire attempts to measure EE (24). It consists of 30 items that describe a dyadic relationship with another family member. The questionnaire has been homogenized by factor analysis, resulting in four factors:

two factors about “given EE” [critical remarks (CR) and emotional over-involvement (EOI)] and two factors about “perceived EE” (perceived criticism and perceived emotional involvement). Expected differences between clinical and non-clinical groups have been found. Cronbach’s alpha for CR was 0.87, for EOI it was 0.81, for perceived criticism it was 0.73 and for perceived emotional involvement it was 0.69. In this study we have chosen to assess the two original dimensions of EE: CR and EOI (6).

The Sense of Coherence (SOC) instrument measures a person’s stress-resilience capacity and as such becomes a health-promoting factor (8). SOC consists of 29 items with seven alternatives for each item. The scores vary between 29 and 203. In earlier studies, this instrument has shown itself to be reliable (Cronbach’s alpha is 0.89) (8, 25).

Therapy methods

No specific couple therapy training is performed in Sweden. Each therapist was requested to define essential characteristics about five different methods: systems theory, psychodynamic, cognitive, solution focused and educational. These were put together and a compressed version was made. This was used as a definition before the ratings. After this, paired comparisons about the extent they were using one method compared to the other on a 9-point scale were done. Each method was assessed against the others. The most frequently used method was systems theory, followed by educational, solution focused and cognitive approaches. The therapists assessed their methods to be similar. Psychodynamic methods were used least of all.

Comparing non-clinical groups

Because we had no access to one non-clinical comparison group for all the rating forms, we were forced to have three different groups:

- Psychiatric Symptoms (SCL-90): the study sample was composed to standardize the questionnaire for Swedish conditions (22).
- Questions about Family Members (QAFM): the study sample was mothers and fathers from the Twin Mom Study (GEMA) in Sweden (26, 27).
- Sense of Coherence (SOC): the study sample was from a longitudinal Swedish population study on mental health (25).

Statistical methods

The statistical methods used in this study were the paired *t*-test for differences between dependent groups (before and after treatment), unpaired *t*-test for differences between independent groups, χ^2 for frequency differ-

ences and analysis of variance (ANOVA) for differences between independent variables.

Results were assessed by statistical and clinical significant changes. Clinical significance was assessed by mean values (*M*) from a non-clinical group and an estimated difference of one standard deviation (*s*) of that mean. We chose to assess 1*s* below or over mean (*M*) value as a cut-off point. For psychiatric symptoms and expressed emotion, all values over 1*s* of *M* were estimated as dysfunctional and all values within 1*s* of *M* or lower were assessed as normal values. For the SOC, all values below 1*s* of *M* were estimated as dysfunctional, and all values within 1*s* of *M* or higher were assessed as normal values.

Results

One hundred and fifty-eight after-treatment assessments were performed for the cases where couples or one party filled in the self-rating forms before and after treatment. Of these, 147 were couples, eight were women in couples and three were men in couples. The average number of counselling sessions was $M \pm s = 8.8 \pm 5.1$, and 50% of the couples attended less than nine (range three to eight) sessions. During the period of treatment, 27 (17.1%) couples separated. The drop-out figure was 159 cases.

Drop-out analysis

After-treatment differences between followed-up cases and drop-outs were analysed with regard to study group variables, agencies and therapist variables. There were no differences in the initial values of the rating forms (one-factor ANOVA), but there were significant differences between the agencies and therapists in the follow-up frequency (agencies; $\chi^2 = 15.65$, *DF* = 5, *P* < 0.01, therapists; $\chi^2 = 39.0$, *DF* = 15, *P* < 0.001).

Psychiatric Symptoms (SCL-90)

This questionnaire was used to assess psychological and emotional symptoms. We have chosen to illustrate overall symptoms (Global Symptom Index, GSI) and depressive symptoms (Table 1).

Both genders in the study group attained significant improvements in overall symptom reduction and in depressive symptoms. There was still a statistical difference compared to a non-clinical population.

In order to assess clinical significance concerning overall symptoms and depression, the study group was divided up and compared with a non-clinical group (22) before and after treatment (*M*, *s*). Values more than 1*s* above *M* were regarded as dysfunctional; values within 1*s* (or lower) of *M* were regarded as normal.

Initially, 76 (50%) of the women and 70 (49%) of the men scored dysfunctional values in overall symptoms (GSI) and for depression these figures were 78 (51%) and 80 (56%) respectively (Table 2).

Table 1. Symptom Check List (SCL-90): Assessment of couple therapy before (1) and after (2) treatment, and comparison with a non-clinical group.

	Couple therapy 1		Couple therapy 2		Non-clinical group	
	Women, <i>n</i> = 154	Men, <i>n</i> = 143	Women, <i>n</i> = 148	Men, <i>n</i> = 138	Women, <i>n</i> = 707	Men, <i>n</i> = 309
GSI	86.6 (47.8)	65.6 (44.5)	53.5 (43.9)***	47.4 (46.7)***	44.1 (39.6)**	28.8 (28.8)***
Depression	20.6 (10.5)	14.1 (9.3)	12.4 (10.5)***	9.6 (9.5)***	9.4 (9.6)***	5.2 (6.4)***

GSI, Global Symptom Index.

P* < 0.01, *P* < 0.001.

Values are mean (standard deviation).

Expressed Emotion (QAFM)

We have chosen to assess the original dimensions of EE: CR and EOI (Table 3).

Both genders in the study group attained significant improvements in both dimensions. Neither women nor men attained normal values compared with a non-clinical population.

In order to assess clinical significance the study group was divided up and compared with a non-clinical group (26, 27) before and after treatment (*M*, *s*). Values more than 1*s* above *M* were regarded as dysfunctional; values within 1*s* (or lower) of *M* were regarded as normal.

Initially, 109 (72%) of the women and 87 (60%) of the men scored dysfunctional values in CR and for EOI these figures were 109 (72%) and 99 (68%) respectively (Table 4).

Sense of coherence (SOC)

One important outcome measure of health is Sense of Coherence (28) (Table 5).

Both women and men improved significantly in the Sense of Coherence after treatment. There was still a statistical difference compared to a non-clinical population.

In order to assess clinical significance regarding the results of treatment, women and men were divided up and compared with values from a non-clinical group (21) before and after treatment (*M*, *s*). Values more than 1*s* below *M* were regarded as dysfunctional; values within 1*s* (or higher) of *M* were regarded as normal.

Initially, 59 (39%) of the women and 60 (40%) of the men scored dysfunctional values in sense of coherence (Table 6).

Discussion

As far as we know, this study is the most comprehensive assessment of couple therapy within family counselling in Sweden. Both women and men attained positive significant changes in terms of reduced symptoms, improved dyadic interaction in the form of less open criticism and less emotional over-involvement and enhanced sense of coherence. Marital satisfaction and family climate also improved (1).

This study includes a large drop-out figure (approximately 50%), which is a dilemma within this field of research (17, 18).

This was a clinical single group study, which is a limitation when assessing the results of outcome because we did not use a waiting-list control group or a randomized selection to different treatments. We did not consider waiting-list controls for ethical reasons. It has lately been questioned if waiting-list controls are essential in evaluating outcome research, as distressed couples placed on waiting lists make no improvements during the waiting period (29). Randomization requires different treatment methods to be available, but the participating therapists assessed their methods to be similar. Moreover, therapists who used different approaches (psychodynamic) did not want to participate

Table 2. Symptom Check List (SCL-90): Analyses of change of couple therapy in overall symptoms (GSI) and depression after treatment, compared with a non-clinical group.

	Improved ≥ 1 <i>s</i> *		Deteriorated†		Normal‡	
	Women <i>n</i> (%)	Men <i>n</i> (%)	Women <i>n</i> (%)	Men <i>n</i> (%)	Women <i>n</i> (%)	Men <i>n</i> (%)
GSI	41 (54%)	36 (51%)	1 (1%)	6 (8%)	119 (78%)	103 (73%)
Depression	45 (58%)	36 (45%)	4 (5%)	4 (6%)	116 (76%)	103 (73%)

GSI, Global Symptom Index.

Women; *n* = 152, Men; *n* = 142.

*Improved, from those with initial dysfunctional values.

†Deteriorated, from those with initial normal values.

‡Normal, all those assessed as normal after treatment.

s, standard deviation.

Table 3. Questions about Family Members (QAFM): Assessment of couple therapy before (1) and after (2) treatment and comparison with a non-clinical group (*M*, *s*).

	Couple therapy 1		Couple therapy 2		Non-clinical group	
	Women, <i>n</i> = 151	Men, <i>n</i> = 146	Women, <i>n</i> = 145	Men, <i>n</i> = 138	Women, <i>n</i> = 648	Men, <i>n</i> = 646
CR	2.79 (.76)	2.28 (.67)	2.36 (.73)***	2.04 (.65)***	1.81 (.57)***	1.61 (.47)***
EOI	2.90 (.63)	2.73 (.62)	2.56 (.7)***	2.51 (.66)***	1.95 (.50)***	1.92 (.47)***

CR, critical remarks; EOI, emotional over-involvement.

****P* < 0.001.

Values are mean (standard deviation).

Table 4. Questions about Family Members (QAFM): Analyses of change of couple therapy in critical remarks (CR) and emotional over-involvement (EOI) after treatment, compared with a non-clinical group.

	Improved $\geq 1s^*$		Deteriorated †		Normal ‡	
	Women, <i>n</i> (%)	Men, <i>n</i> (%)	Women, <i>n</i> (%)	Men, <i>n</i> (%)	Women, <i>n</i> (%)	Men, <i>n</i> (%)
CR	57 (52%)	39 (45%)	2 (5%)	9 (16%)	75 (50%)	79 (54%)
EOI	59 (54%)	45 (46%)	7 (17%)	12 (26%)	67 (44%)	65 (45%)

Women; *n* = 151, Men; *n* = 145.

*Improved, from those with initial dysfunctional values.

 † Deteriorated, from those with initial normal values. ‡ Normal, all those assessed as normal after treatment.*s*, standard deviation.

in the study. Single group studies seem to overestimate results compared to randomized studies (30). This must be taken into consideration when interpreting results in this study. Furthermore, outcomes cannot be said to be completely the result of treatment but as all assessments point in the same direction, it may be assumed that treatment has affected participating couples.

Comparisons with non-clinical groups were chosen to be as similar as possible with the study group but cannot be said to be completely comparable (25).

Women and men attend family counselling for marital distress, but it is also known that relational problems are associated with health problems (3). A great number of

empirical work have estimated strong associations between marital distress and affective disorders, especially within the area of depressed women (13). In this setting, depressive symptoms were reduced for both women and men. Treatment has not been focused on individually affective disorders, but as depressive symptoms co-occur with increased marital conflicts and poor communication, traditional couple therapy interventions such as communication skills training and problem solving could be seen as means of reducing psychiatric symptoms.

The dyadic interaction in the study group was characterized by expressions of negativity, and both parties were strongly influenced by their partner. Barely half of both women and men improved. Because these dimensions were found to be both predictive of the onset on and relapse of affective disorders, these dimensions should have high priority in treatment of couple therapy (6, 7). These results indicate that it is of utmost importance that family counsellors address critical comments between partners.

Besides focusing on negative factors, it should be important to implement resilience and coping abilities as meta-theories into the work of couple therapy (31, 32). Twenty-two per cent of the women and 37% of the men improved in sense of coherence. This concept has been characterized as a positive determining factor in stressful situations. The dimensions of manageability and com-

Table 5. Sense of Coherence (SOC): Assessment of couple therapy before (1) and after (2) treatment and comparison with a non-clinical group (*M*, *s*).

Variable	Couple therapy 1	Couple therapy 2	Non-clinical group
	Women, <i>n</i> = 153	Women, <i>n</i> = 149	Women, <i>n</i> = 83
	Men, <i>n</i> = 150	Men, <i>n</i> = 146	Men, <i>n</i> = 65
	<i>M</i> (<i>s</i>)	<i>M</i> (<i>s</i>)	<i>M</i> (<i>s</i>)
Women	131.9 (24.3)	139.0 (22.6)***	150.8 (24.5)***
Men	139.4 (22.3)	145.7 (22.0)***	154.9 (18.4)***

****P* < 0.001.*M*, mean; *s*, standard deviation.

Table 6. Sense of Coherence (SOC): Analyses of change of couple therapy in sense of coherence after treatment, compared with a non-clinical group.

	Improved $\geq 1s^*$		Deteriorated \dagger		Normal \ddagger	
	Women <i>n</i> (%)	Men <i>n</i> (%)	Women <i>n</i> (%)	Men <i>n</i> (%)	Women <i>n</i> (%)	Men <i>n</i> (%)
SOC	13 (22%)	22 (37%)	2 (2%)	2 (2%)	103 (68%)	104 (70%)

Women; *n* = 152, Men; *n* = 149.

*Improved, from those with initial dysfunctional values.

\dagger Deteriorated, from those with initial normal values.

\ddagger Normal, all those assessed as normal after treatment.

s, standard deviation.

prehensibility should be seen as important coping strategies (28) and therefore crucial determinants of health promotion for women and men in couple therapy. Originally, this concept was viewed as a relatively stable characteristic of an individual, but lately it has been emphasized by outcome research that it can be altered. We have not found any comparable results from couple therapy outcomes. Viewing sense of coherence as an ability to handle problems and enhance health, it should be of great interest to assess this dimension in couple therapy. Methods for strengthening sense of coherence should be included in such therapies. Such strategies can be inspired from different theories and methods within family therapy (33).

Taken together, results from this study indicate that about half of the women and men who initially assessed dysfunctional values in symptoms and expressed emotion (CR and EOI) improved to the extent of what we have called clinical significance. The sense of coherence was less altered.

In many cases, a relatively brief treatment was performed, the most common comprising five sessions, and 50% had no more than eight sessions. Generally, from theories of couple therapy, the average number of sessions performed in this study seems to be less than recommended (34). Based on the severity of the problems presented, one can discuss whether this was satisfactory. In spite of this, the results demonstrated significant improvements. The results of this study indicate that the amount of treatment was probably insufficient. Despite this, good results of treatment were attained.

Marriage as an institution has been evaluated as an important element in the prevention and treatment of health problems (3). Couple therapy as a means to improve marital quality and reduce symptoms can thus be seen as preventive healthcare work. Reducing marital problems and working through divorce situations can also be seen as direct curative healthcare work (3). This research emphasises that couples entering family counselling suffer from many and severe personal problems. This indicates that the health of the individuals should be emphasized in this type of therapy.

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- Ann-Marie Lundblad, Licensed Psychotherapist, doctoral student, Nordic School of Public Health, Box 12 133, SE-402 42 Gothenburg, Sweden.
- Kjell Hansson, Professor, Department of Social Work, University of Lund, Box 23, SE-221 00 Lund, Sweden.