

The Effectiveness of Couple Therapy: Pre- and Post-Assessment of Dyadic Adjustment and Family Climate

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ABSTRACT. Most theories and methods about couple therapy are developed and tested in Anglo-Saxon countries. In this clinical study, we tested these theories and methods within a Swedish public health context. We assessed the outcomes of 131 couples (262 individuals) using the Dyadic Adjustment Scale (DAS) and the Family Climate (FC) survey. Initially, the couples displayed severe marital distress and a dysfunctional *family climate*. Both *marital satisfaction* and *family climate* improved considerably, which confirmed the effectiveness of these methods in a Swedish context. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2005 by The Haworth Press, Inc. All rights reserved.]

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INTRODUCTION

In Sweden, most therapists use couple therapy methods that have been designed and tested in the USA and other Anglo-Saxon countries. We assume that most studies in these countries have been performed as research therapy or used in private practice. We were interested in testing how these theories and methods work in Swedish culture performed as a clinical study in a public health context. According to Shadish and Baldwin (2003), "The effects of marriage and family interventions in clinically representative conditions have not been studied much" (p. 561).

In Sweden, couple therapy is used primarily in municipal family counselling and church family counselling (Hansson, 2001). About 40-50,000 cases are treated by public health services every year, but few of these cases have been empirically evaluated. Couple therapy helps couples find solutions to conflicts so they can improve their relationships and avoid a destructive separation (SOU, 1994). While attending family counselling, many couples exhibit negative and hostile patterns (Bodenmann et al., 2001). Many couples wait too long before seeking professional help and usually only resort to marital therapy when their relationship is beyond repair.

Research has established a strong correlation between quality of marital relationships and quality of health (Glenn and Weaver, 1981). Compared to other important aspects of life such as work, health, friends, economy, social life, leisure time, and family life, positive marital life promotes positive global well-being (Glenn, 1990). Women exhibit this correlation more than men do. Several studies have found a strong relationship between measures of marital quality and global subjective well-being; however, the data does not suggest a causal relationship. Numerous studies in the USA have shown that married people more than unmarried people report considerably higher levels of happiness (Glenn and Weaver, 1988).

It appears that both mental and physical health is related to marital status, but the associations are not simple (Levenson et al., 1993). Women derive mental and physical health benefits from good marriages, whereas men benefit from marriage despite the quality. Married men, as compared with single men, have shown the lowest rate of mental-health problems, whereas single women have scored the lowest rates

of mental health problems compared with married women (Levenson et al., 1993).

Research indicates that marital distress is associated with suppressed immune function, cardiovascular arousal, and increases in stress-related hormones. For men, marriage (as an institution) seems to offer health-buffering effects, whereas women are more likely to experience health-related problems if marriage is distressed (Gottman and Notarius, 2002). Women seem to be more negatively affected by emotional disengagement, and men are more negatively affected by conflicts (Johnson and Lebow, 2000).

In a review study, Kiecolt-Glaser and Newton (2001) note that “marital functioning is consequential for health; negative dimensions of marital functioning have indirect influences on health outcomes through depression and health habits, and direct influences on cardiovascular, endocrine, immune, neurosensory and other physiological mechanisms (p. 473).

Divorces and marital problems are connected with or increase the risks of a number of family problems and can adversely affect psychological and physical well-being of all family members. Divorced men have an increased risk of suicide, mental problems, physical diseases, and violence (Bray and Nouriles, 1995). Separated and divorced women have an increased risk of depression as well as physical and psychological impairment. Children in families with conflicts or with divorced parents have an increased risk of behavioural problems such as opposition, aggression, depression, and anxiety symptoms (Bray and Nouriles, 1995). Based on this, reducing marital conflicts and preventing divorce should be given a high priority.

Assessments of various methods of treatment have often been performed, and various models have been compared with each other. In these comparisons, it has not been possible to verify measurable differences (Gurman and Fraenkel, 2002). Meta-analyses that assess couple therapy outcomes (Hahlweg and Markman, 1988; Hazzelrigg et al., 1987; Shadish et al., 1993; Shadish and Baldwin, 2003) note that this form of treatment increases satisfaction more than no treatment. In addition, literature indicates that the outcomes of this form of treatment are at least as good as other forms of psychotherapy. Many couples entering couple therapy change but will not be “symptom free” (Gurman and Fraenkel, 2002). For the most commonly studied methods of treatment, couple therapy helped improve relationships in 60-75% of couples. Statistical significant change from distressed to non-distressed levels has reached an average level of 35-40%. All couple therapies that have been

reasonably well tested have been proven effective. The durability of change is also important, but empirical tests have not been extensive. At this stage, a significant number of couples may relapse. Some couples may experience negative effects because of treatment. Negative effects are estimated at 5-10%. Dropouts within the field of psychotherapy research tend to be moderately high, averaging around 50% (Stanton and Shadish, 1997). More study should be devoted to this phenomenon.

In Sweden, couple therapy research concentrates on consumer satisfaction. There has also been some empirical research. In a normal group, cross sectional studies of long-term marriages have noted a positive association between *marital satisfaction* and sense of coherence but no association in a clinical group (Kaslow et al., 1994; Lundblad and Hansson, 1996). Two post-treatment studies indicate positive outcomes regarding *family climate* (Gustafsson and Nyqvist, 1991, Olsson, 1995), and a two-year follow up study indicates maintained and partly improved outcomes on the same variable (Berggren et al., 1998). No controlled or randomised studies have been performed in Sweden.

Presentation of the Study Set-Up

This study was conducted in family counselling clinics in Sweden, which falls under the responsibility of municipal social welfare. Visitors attended voluntarily and were rarely referred by others. The counsellors followed special confidentiality regulations that require absolute secrecy. Average charges are SEK 100-200 per session (15-30 US dollars). To encourage low-income participation, costs are kept low. This is the only counselling in public health services that addresses couples that do not have special diagnosis. The counselling includes couple therapy, information about legal and social benefits, mediation between separated couples, and guidance and support to couples and individuals. The counselling information and education aims to help patients develop strategies that will prevent negative behaviours (SOU, 1994). Psychosocial treatment is the primary mode of treatment. Psychotherapy is performed when resources are available. Approximately 30% of all visitors met the criteria for participation in this study. It was set up as a multi-site study performed in six family counselling agencies in southwest Sweden (Lundblad and Hansson, 2003). Sixteen therapists were involved. This part of the study was quantitative pre- and post-treatment and has been assessed using the Dyadic Adjustment Scale (DAS) and the Family Climate (FC) rating scale. The couples completed

self-rating forms before and after treatment. After treatment, participants also completed a satisfaction survey.

Aims

This study analyses results of couple therapy in the form of *marital satisfaction* and *family climate* in the study group before and after treatment, and the study compares these results with a non-clinical population. In addition, this study examines how theories and methods constructed in an Anglo-Saxon culture can be adapted to Swedish culture. A survey about consumer satisfaction is also presented.

METHOD

Participants and Procedure

This is a non-randomised single group clinical study, and the committee on ethics approved the study (Dnr L 028-98).

Over a two-year period (1998-2000), couples living together and attending family counselling together were asked to participate in the study. A total of 312 couples (624 individuals) and 5 women accepted. Each participant was given written information about the research project before agreeing to participate. The inclusion criteria were adequate knowledge of the language and an agreement to attend at least three joint counselling sessions for couples (Lundblad and Hansson, 2003). Approximately 30% of all visitors met the criteria for participation in the study. Each participant individually completed the self-rating forms, usually during the first visit. Some variables were registered for all participants during the time of investigation: age, 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%) couples were assessed after treatment. Often couples drop out of family counselling before completing treatment.

Sixty percent of participating couples were younger than 40 years old, 25% were between 40-49 years old, and 15% were older than 49. Eighty-five percent had children younger than 18 years old. Socio-economic classification was made, and the study group formed an approxi-

mate estimation of Swedish statistical norm groups except for senior citizens (> 65 years), a category rarely represented in this study.

Initially, participating couples assessed severe marital distress, disturbed *family climate* with *distance* and *chaos*, a low sense of coherence, many psychiatric symptoms, and interactions characterised by high criticism (Lundblad and Hansson, 2003).

Therapy Methods

No specific methodological couple therapy training is used in Sweden. Therapists commonly use eclectic methods. In this research, treatment was not performed according to a manual. To understand how the participating therapists worked, we asked them to identify and define five of the most frequently used therapy methods. A compressed version of these descriptions was made using content analysis. The therapists were then asked to make a paired comparison about the extent they were using one method compared to the others on a 9-point scale. Each method was compared to the others. After this, we constructed a rank order for each therapist. From this, we concluded that the most frequently used method was systems theory followed by educational, solution-focused, and cognitive methods. Psychodynamic methods were the least used methods. There were no essential methodological differences between the therapists.

Instruments

The Dyadic Adjustment Scale (DAS) is a measure of *dyadic satisfaction* (Spanier, 1976). The scale consists of 32 items with sub-scales about *dyadic consensus*, *dyadic satisfaction*, *dyadic cohesion*, and *affectional expression*. The score varies from 0-151. The total scale and the sub-scales can be considered as measures of different aspects of *marital satisfaction*. The Swedish version has a satisfactory Cronbach's alpha (0.87-0.93) (Hansson et al., 1994).

The Family Climate Scale (FC) is a list of 85 adjectives that are selected to reflect different aspects of the emotional atmosphere in the family (Hansson, 1989). Four independent factors have been identified: *closeness*, *distance*, *expressiveness*, and *chaos*. An index was calculated for each of the factors. Cronbach's alpha for *closeness* was .98, for *distance* it was .91, for *expressiveness* it was .71, and for *chaos* it was .92. In this study, we have chosen to exclude the factor *expressiveness*.

Consumer Satisfaction (CS) was specially designed for this study. It comprised questions about problems raised in consultation, duration of distress before consultation, expectations or aims in treatment, contents of treatment performed, relational and/or personal change as an outcome of treatment, beneficial outcomes, and/or participation of children in the sessions. Couples were also asked if they would consider resuming family counselling.

Comparing Non-Clinical Groups

Because we did not have access to one non-clinical group for both the rating forms, we were forced to use two non-clinical groups.

Dyadic Adjustment (DAS): The study group was a positive selection of a non-clinical population not having assistance from psychiatry and social welfare. The sample was collected as a research project within psychotherapist education. Mean age for women was 40 years (SD 6.1), and for men it was 42 years (SD 6.7) (Vasteras, 2001).

Family Climate (FC): The study sample was mothers and fathers with an adolescent child from the Twin Mom Study (GEMA) in Sweden. The sample was recorded from the twin mother registry. Mean age for mothers was 44 years (SD 4.4) (Reiss et al., 2001a and b).

Statistical Methods

In this study, the statistical methods used were paired t-test for differences between dependent groups (before and after treatment), unpaired t-test for differences between independent groups, χ^2 for frequency differences, and ANOVA for differences between independent variables.

Results were assessed using 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 (SD) of that mean. We chose to assess one SD below or over mean (M) value as a cut off point. For the Dyadic Adjustment Scale, values below one SD of the mean (M) were estimated as dysfunctional, and all values within one SD of the mean (M) or higher were assessed as normal values. For Family Climate, the dimension of *closeness* was assessed the same, but for *distance* and *chaos* values over one SD of the mean (M) were estimated as dysfunctional and values within or below the mean (M) were assessed as normal values.

RESULTS

A total of 305 after treatment assessments were performed; these were the cases where couples or one party filled in the rating forms before and after treatment. Of these, 147 were couples (294 individuals), 8 were women in couples, and 3 were men in couples. The average number of counselling sessions was $M = 8.8$ ($SD 5.1$), and 50% of the couples attended fewer than nine (3-8) sessions. The most frequent number of sessions was five. For the 27 (17.1%) couples who separated during the period of treatment, *marital satisfaction* (DAS) and *family climate* (FC) were excluded in the after treatment assessment because these forms presuppose the parties are living together. This article records the 131 couples that have continued living together. The dropout figure was 159 couples.

Dropout Analysis

Differences between after treatment assessed cases and dropouts were analysed with regard to initial values of rating-forms in total and divided into therapists, agencies, the number of sessions performed, demographic variables (age, gender, children, and duration of relationship), and after treatment assessed frequency. We assessed initial values for the rating forms (DAS and FC) to compare participants and dropouts. There was no overall difference for DAS and FC. The circumstances were the same for therapists and agencies (one factor ANOVA). Participating couples attended significantly more sessions than those who did not complete the after treatment assessment ($t = 5.86$, $p < .001$). Demographic figures about age showed a mean difference between dropouts (women, $M = 35.8$ years; men, $M = 38.1$ years) and participants (women, $M = 38$ years; men, 38.1 years), where the dropout figures were the highest for younger women ($t = 2.47$, $p < .01$) and men ($t = 2.26$, $p < .02$). More couples with older children (> 18 years) ($t = 2.95$, $p < .003$) were assessed after treatment. These assessments can be seen as two sides of the same coin. The after treatment assessed frequency divided amongst agencies ($\chi^2 = 15.65$, $DF = 5$, $p < .01$) and therapists ($\chi^2 = 39.0$, $DF = 15$, $p < .001$) displayed significant differences.

The analysis indicates that there were no differences in initial values of DAS or FC. However, there were clear differences in the follow up (after treatment) frequency between agencies and therapists.

Marital Satisfaction (DAS)

Marital satisfaction was assessed using the Dyadic Adjustment Scale (DAS). A high score indicates a high level of satisfaction about each aspect (Kaslow et al., 1994; Lundblad and Hansson, 1996) (see Table 1).

Both genders in the study group reached significant improvements in overall *marital satisfaction* and in all sub-scales. There remained a difference in *marital satisfaction* (total adjustment) between women and men ($t = 2.05$, $p < .05$). Neither women nor men as a group reached the mean values of the comparing non-clinical group (Vasteras, 2001). For women, low *marital satisfaction* at the start was a predictor for an increased tendency to get divorced ($t = 2.57$, $p < .01$).

In order to assess clinical significance regarding the results of treatment, women and men were divided into dysfunctional and normal values compared with values from a non-clinical group (Vasteras, 2001) before and after treatment (M, SD). Values more than one SD below the mean (M) were regarded as dysfunctional. Values within one SD (or higher) of the mean (M) were regarded as normal.

Initially, 97 (75%) of the women and 82 (66%) of the men assessed dysfunctional (low) values in *marital satisfaction*. Fifty-four percent of participants who started treatment with dysfunctional values improved with treatment. Sixteen percent of the women and 12% of the men who initially assessed high (normal) satisfaction worsened. Forty-three percent of the women and 60% of the men reached normal values after treatment (see Table 2).

TABLE 1. DAS: Assessment of Couple Therapy Before (1) and After (2) Treatment and Comparison with a Non-Clinical Group (M, SD)

	Couple Therapy 1		Couple Therapy 2		Non-Clinical Group	
	Women M (SD) n = 153	Men M (SD) n = 153	Women M (SD) n = 130	Men M (SD) n = 125	Women M (SD) n = 89	Men M (SD) n = 89
1.	89.8(20.4)	94.6(22.4)	103.6(21.8)***	107.8(18.5)***	118.3(10.6)***	117.3(10.7)***
2.	43.1(9.5)	44.7(9.4)	48.4(9.0)***	49.6(8.4)***	53.9(5.4)***	53.1(5.5)***
3.	28.9(6.7)	31.6(6.4)	33.4(7.1)***	36.2(6.6)***	40.3(4.4)***	40.1(3.9)***
4.	10.5(4.4)	12.1(4.3)	13.3(4.4)***	14.3(4.1)***	15.0(3.4)**	15.4(3.8)*
5.	6.1(2.5)	6.4(2.3)	7.6(2.2)***	7.7(2.4)***	9.0(1.5)***	8.8(1.8)***

1 = Total dyadic adjustment; 2 = Consensus; 3 = Satisfaction; 4 = Cohesion; 5 = Affectional expression.
*** = $p < .001$, ** = $p < .01$, * = $p < .05$.

TABLE 2. DAS: Analyses of Change of Couple Therapy in *Marital Satisfaction* after Treatment Compared with a Non-Clinical Group

	Improved > 1SD ¹		Deteriorated ²		Normal ³	
	Women	Men	Women	Men	Women	Men
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
DAS	52 (54%)	44 (54%)	5 (16%)	5 (12%)	56 (43%)	75 (60%)

Total study group: Women: n = 129; Men: n = 124; Improved¹ = from those with initial dysfunctional values; Deteriorated² = from those with initial normal values; Normal³ = all those assessed as normal after treatment.

Family Climate (FC)

The *family climate* (FC) was another measure of couple functions.

After treatment, both women and men in the study group reached significant changes in all dimensions. This meant that the *family climate* largely changed in a positive manner. In comparison with a non-clinical group, there remained a statistical difference for the total group. Concerning the men, the initial value for *distance* affected the relationship's continuation or discontinuation. More *distance* in the men led to a higher level of divorce ($t = -2.65, p < .01$).

Concerning *family climate* (FC), the study group was divided into dysfunctional and normal values and compared with a non-clinical group (M, SD) before and after treatment (Reiss et al., 2001a & b). Values more than one SD above or below the mean (M) was regarded as dysfunctional. Values within one SD of the mean (M) were regarded as normal.

Initially, 95 (80%) of the women and 87 (73%) of the men assessed low *closeness* (CL). Great *distance* (DI) was assessed by 61 (50%) of the women and 50 (42%) of the men. A high degree of *chaos* (CH) was initially assessed by 80 (67%) of the women and 75 (63%) of the men. Of those who initially assessed low *closeness*, 51% of the women and 52% of the men improved with treatment. Of those who initially estimated normal values, approximately 8% of the women and 18% of the men worsened. Fifty-six percent of the women and 58% of the men reached normal values after treatment. Of those who initially assessed great *distance*, 79% of the women and 78% of the men improved with treatment, and 19% of the women and 13% of the men with normal values worsened. Approximately 79% of both genders reached normal values after treatment. Of those who initially assessed a great deal of *chaos*,

68% of the women and 71% of the men improved with treatment, whereas 18% of the women and 24% of the men who initially assessed normal values worsened. Sixty-one percent of the women and 66% of the men reached normal values after treatment (see Tables 3 & 4).

Consumer Satisfaction

The most frequently expressed initial problems were communication problems (60%), considering divorce (49%), problem solving difficulties (30%), disagreements about sex and intimacy (30%), life change adjustments (23%), concerns about the children (15%), and infidelity (14%). (Figures shown are averages that include both genders). In most dimensions, women were more concerned than men were. Men were more concerned about sex problems. Both men and women expressed

TABLE 3. FC: Assessment of Couple Therapy Before (1) and After (2) Treatment and Comparison with Non-Clinical Group (M, SD)

Variable	Couple Therapy 1		Couple Therapy 2		Non-Clinical Group	
	Women	Men	Women	Men	Women	Men
	M (SD) n = 148	M (SD) n = 146	M (SD) n = 125	M (SD) n = 122	M (SD) n = 631	M (SD) n = 645
<i>Closeness</i>	0.7(0.74)	0.9(0.82)	1.5(1.00)***	1.5(0.95)***	2.1(0.72)***	2.1(0.76)***
<i>Distance</i>	0.9(0.76)	0.8(0.80)	0.5(0.70)***	0.4(0.59)***	0.2(0.36)***	0.2(0.41)***
<i>Chaos</i>	1.4(1.27)	1.3(1.24)	0.8(1.24)***	0.6(1.02)***	0.2(0.6)**	0.2(0.62)***

*** = $p < .001$; ** = $p < .01$.

TABLE 4. FC: Analyses of Change of Couple Therapy in *Closeness* (CL), *Distance* (DI), and *Chaos* (CH) After Treatment Compared with a Non-Clinical Group

	Improved > 1SD ¹		Deteriorated ²		Normal ³	
	Women	Men	Women	Men	Women	Men
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
CL	48 (51%)	45 (52%)	2 (8%)	6 (18%)	67 (56%)	70 (58%)
DI	48 (79%)	39 (78%)	11 (19%)	9 (13%)	91 (76%)	91 (76%)
CH	54 (68%)	53 (71%)	7 (18%)	11 (24%)	73 (61%)	79 (66%)

Total study group: Women: n = 120; Men: n = 120; Improved¹ = from those with initial dysfunctional values; Deteriorated² = from those with initial normal values; Normal³ = all those assessed as normal after treatment.

similar concerns about problem solving difficulties. About 60% of the couples had experienced difficulties 2 years or more before consultation, and 30% of the women and 20% of the men stated problems had persisted for 4 years.

Both women and men expected advice and support ($W = 77\%$, $M = 61\%$) from couple therapy. About 50% of the women and 34% of the men wanted to gain a better understanding of their problems. The contents of treatment included (expressed by both genders) clarification matters, improved listening to one another, communication skills, insights about personal and interpersonal matters, problem solving skills, and useful information and knowledge. In couple therapy, 57% of the women and 55% of the men believed their goals were 100% fulfilled, and about 43% of both genders believed their goals were fulfilled to some extent. Only 1% of the participants was dissatisfied.

The outcomes were improved insight about personal matters, increased interaction competence, improved understanding of diversities, improved communication, improved problem solving skills, insights about the interrelation between the spouses, and understanding of interplay. Both women and men thought that their therapy was beneficial for their children, but most of them were negative to children's participation in the sessions, and 97% of the women and 93% of the men noted that they would attend couple therapy again if needed.

DISCUSSION

Most theories and methods of couple therapy are developed and tested in the USA and other Anglo-Saxon countries. In this clinical study performed within public health services, we tested these theories and methods within a Swedish context. As far as we know, this study is the most comprehensive assessment of couple therapy within family counselling in Sweden. Those couples who took part in the study were married or cohabiting and were largely intent on repairing their relationship.

Both women and men attained positive significant changes in terms of enhanced *marital satisfaction* and a *family climate* expressed by greater *closeness* between the genders and less *chaos*. Psychiatric symptoms, dyadic interaction, and sense of coherence were also improved (Lundblad and Hansson, 2003). Dropout figures from follow-up (after treatment) were quite high, which seems to be quite common in psychotherapy research (Stanton and Shadish, 1997). In couple therapy,

one complication might be that both parties need to agree to complete the treatment. Because of the high drop out rate, it is difficult to generalise the results and the effectiveness of treatment.

Because this was a clinical single group study, there is a limitation when assessing the results of outcome. In part, this is because we did not use a wait-list control group or a randomised selection to determine treatment. We did not consider wait-list controls for ethical reasons. It has lately been questioned if wait-list controls are essential in evaluating outcome research because distressed couples placed on waiting lists make no improvements during the waiting period (Baucom et al., 2003). Randomisation 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 in the study. Treatment methods were not manualised. This could have been advantageous because therapists could be free to meet couples differently according to their specific problems. In Sweden, family counsellors are generally well educated, which could have contributed to the results and made it easy to implement the Anglo-Saxon methods in a Swedish context.

Single group studies seem to overestimate results compared to randomised studies (Shadish and Baldwin, 2003). Although the results should be interpreted with caution, it is notable that all results were obtained with relatively short treatment. Furthermore, outcomes cannot be said to be completely the result of treatment; however, because all assessments points were in the same direction, it can be assumed that treatment have affected the couples.

Comparisons with non-clinical groups were chosen to be as similar as possible with the study group. Both women and men attained positive significant changes in terms of *marital satisfaction*, but everyone did not attain normal values. It is noteworthy that the comparing group was a positive selection of “normal” couples and does not reflect a randomised sample of the Swedish population. We have a high rate of family disruptions (50%), but those who remain married may have high *marital satisfaction* (Kaslow et al., 1994). Initial values and results of this study may be seen as an observation of couples coming late for counseling (Bodenmann et al., 2001).

Initially, a large number of couples estimated low *marital satisfaction*. Improved results were reached by slightly more than half of both genders. Some of those with initial normal values deteriorated. Perhaps this can be interpreted as increased awareness of the difficulty of the problems. Women are more affected by marital problems and are more

intent on dealing with them (Levenson et al., 1993; Whisman and Jacobson, 1992). This study confirmed gender-based distribution of the severity of the problems, but in contrast with other research there was no confirmation that women changed more than men in couple therapy (Whisman and Jacobson, 1992). After treatment, the men overall estimated *marital satisfaction* greater than the women. This can be interpreted because of method-related issues, whereby too much attention has possibly been paid to relationship-related problems at the cost of individual and gender-specific difficulties. Another consideration is whether contextual variables such as equality, power, and workload have been dealt with far too little in couple therapy. Because Swedes generally believe there is a high degree of equality between the genders, these issues may have been overlooked. Because women have proven to be more exposed in these contexts and have demonstrated more serious problems, it is important to pay special attention to the specific needs of women in couple therapy.

A large number of the women and men who initially rated non-clinical values expressed communication problems, arguments and aggression, infidelity, and discussions about separation as reasons for their having sought family counselling (background data). Although these couples had a good relationship, they have ended up in a specific crisis or phase of life adjustment. It may also be the case that those who sought help were particularly affected by the situation, and this seems to be more crucial to the decision to seek help than the severity of the problem (Kazdin, 1999).

Initially, the participants' *family climate* was dysfunctional in all respects. When the study group was divided and compared with non-clinical values, most couples experienced low *closeness* followed by *chaos* and *distance*. The treatment resulted in greater *closeness* and less *chaos*. The factor of *distance* was mostly affected positively. Approximately 70% of those who initially experienced much *chaos* improved. The least positive change was for the factor of *closeness*. After treatment, the *family climate* for many couples was still characterised by low *closeness* and *chaos*. From these results, it is clear that affective methods and individual problems need more attention and treatment needs to be more extensive.

In the satisfaction survey, the couples expressed that they experienced problems long before they sought help. The majority of men and women expected advice and support as well as a changed understanding of the problems presented. The treatment included clarifications, communication training, problem-solving, understanding of interaction,

and conveying information and knowledge. Over half of the couples were completely satisfied, and the rest had, to a certain extent, received the help they expected. The treatment had been significant on a personal level—for the relationship and for the children. Nearly everyone was willing to seek more treatment if necessary.

Initially, a large proportion of the family-counselling couples had serious marital problems and a seriously disturbed family function. In many cases, a relatively short treatment was used; the most common treatment was done in five sessions. The results demonstrated significant improvements, but in comparison with non-clinical groups not all of them attained the latter's values. Based on the severity of the presented problems, the amount of treatment was probably not sufficient.

In addition to recording results of couple therapy within public health services in Sweden, we also wanted to test Anglo-Saxon methods in Swedish context and compare outcomes to other international studies. This study points out that these methods work well in this context and that the outcome seems to be comparable to other studies (Snyder et al., 1991; Jacobson and Addis, 1993; Gurman and Fraenkel, 2002). Because empirical studies have uncovered connections between marital quality and health (Kiecolt-Glaser and Newton, 2001), couple therapy as a means of improving marital quality can be seen as preventive healthcare work. Reducing marital problems and working through divorce situations can also be seen as direct curative healthcare work (Burman and Margolin, 1992). The follow-up was performed immediately after the completion of treatment; it may also be interesting to find out how the results hold over time.

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