Texila International Journal of Psychology
Volume 4, Issue 1, May 2019

The Effect of Cognitive-Behavioral Marital Therapy (CBMT) on Marital Distresses among Married Couples in Ghana

Article by Daniel Dei
Valley View University
E-mail: dei.daniel@vvu.edu.gh

Abstract

Despite established limitations in Cognitive-Behavioral Marital Therapy (CBMT)in counseling clients with emotional instabilities, CBMT remains the most popular model of marital theyapy in Ghana. This quantitative study intended to ascertain the impact of Cognitive-Behavioral Marital Therapy (CBMT) on marital distresses among married couples in Ghana. The study followed a descriptive-correlational-experimental design. 50 participants selected by means of a proportionate stratified random sampling technique completed adapted versions of the Session Process and Outcome Measures-Client version (SPOM-C) and the Revised Dyadic Adjustment Scale (RDAS) questionnaires both before and after therapy. With the aid of the Predictive Analytics Software (PASW) 18 guide to Data Analysis, disparity mean values among the sample were analyzed. Data on the levels of marital distress were analyzed by descriptive frequencies. The paired t-test technique was used to analyze disparity mean values within the sample. Pearson correlation coefficient analyzed correlation between CBMT therapy outcome and the level of marital distress reported by participants. The study found that CBMT had a significant effect on participants who reported severe marital distress. This implies that CBMT is effective in treating clients who report severe marital distresses than those who report moderate or mild marital distresses in Ghana.

Keywords: *Cognitive-Behavioral Marital Therapy (CBMT), Marital Distress, Married Couples, Marriage and Family Counseling, Marital Therapy.*

Introduction

Otherwise known as cognitive-behavioral couples therapy, cognitive-behavioral marital therapy (CBMT) is a marital and family counseling approach that focuses on ways by which behavioral patterns affect and is affected by spouses or significant others in marital or family relationships (Sher, 2011: 618). It seeks to identify and modify maladaptive behavioral patterns that impinge on marital and family satisfaction. The premise for diagnoses and prognosis of marital and family related problems lies in the fact that the interplay of thoughts and actions of individuals in the marriage or family affect the thoughts and actions of other parties in the relationship (Epstein & Baucom, 1989: 491). As such CBMT is a counseling strategy that helps individuals in marriage or family relationships gain insight and subsequently modify negative behavioral exchanges within their relationships.

Generally, the focus on the overt factors of marital and family distress have been blamed as the main limitation of cognitive-behavioral marital therapy (CBMT). Its focus on cognitive components of marital and family distress does not allow extensive probing into related areas of marital and family distress such as personal/family background and other deep emotional problems (Ampuni, 2004: 10-11). Accordingly, clients with highly emotionally-induced marriage and family challenges cannot get the needed therapeutic assistance from CBMT. This is because the emotionally unstable client cannot probe the personal chain of thoughts, behaviors, and feelings that create and sustain the identified marital and family distress. Failure to engage in this initial exercises of CBMT means that clients cannot acquire new patterns of thoughts, behavior, and emotions that will enable them to positively alter their situations (Baheti, Bakshi, Gupta, & Gehdoo, 2017: 468). Regardless of this limitation, CBMT remains the most applied model of therapy among Ghanaian marriage counselors. As a way of enhancing marriage counseling in Ghana, the current study ascertains the impact of CBMT on marital distresses among married couples in Ghana. A significant impact coefficient value will mean the

DOI: 10.21522/TIJPY.2016.04.01.Art004
ISSN: 2518-8852

therapy is an effective model for marriage and family counseling in Ghana, despite its limitation. An insignificant coefficient value will mean it is ineffective and must be rejected a s a model of marriage and counseling therapy in Ghana.

Literature review

The Cognitive-behavioral Marital Therapy (CBMT)

The origin of CBMT can be traced to three main precursors. These are philosophical concepts, behavioral therapy, and cognitive therapy. Some studies connect the beginnings of CBMT with some elements of stoic philosophy (Richard & Huprich, 2009: 284). Stoicism refers to the philosophical belief that "truth" is a matter of "feeling" and for that matter, no absolute standard for determining "truth" exists (Richard & Huprich, 2009: 284). It holds that while humanity has no power over happenings in life, it possesses impressions of those life occurrences. Thus, by controlling one's thoughts about life events, one gains the ability to manage one's behavior and feelings. Though some aspects of Socrates' thought are often linked to stoicism, Zeno is considered the "founder" of this philosophical movement. The main connection between stoicism and CBMT lies in the notion that problems in intimate relationships are caused by individuals' perception of the behaviors of other parties (Richard & Huprich, 2009: 284). Accordingly, modifications in the pattern of thought and behavior of an individual will exert a positive attitude towards other parties in the intimate relationship thereby inducing satisfaction in the relationship.

Some studies trace the beginnings of CBMT to behavioral therapy (Mahoney, 1974: 9). The basic assumption of behavioral therapy is that individual thoughts and behaviors are affected by events within the social environment (Baucom & Epstein, 1990: 318). As such changes in the social environment of the individual automatically influence individual cognition and subsequent behavior (Hill, 2001: 248). Ivan Pavlov and John Watson's classical conditioning, B. F. Skinner's operant conditioning, and Edward Thorndike's connectionism were instrumental in the development of behavioral therapy. Based on the "psychological" theory of "associationism" (Roeckelein, 2006: 292), Pavlov and Watson contended that changes in behavior and thoughts occur using "transfer of association" (Tracey & Morrow, 2017: 235). Focusing on four main principles[1], Thorndike called attention to factors that affected individual patterned behavior. According to him, the dynamics of current behaviors "influence" subsequent behaviors (Jordan, 1998: 146). Building on Pavlov and Watson's ideas, Skinner sought to explain the effect of outcomes on the action of an individual (Tracey & Morrow, 2017: 43).[2] In light of this, Skinner observed that individuals would continue to perform actions that yield positive rewards and "avoid" or reduce actions that produce undesired outcomes (Naour, 2009: 82). Building on Robert Weiss and Richard Stuart's ideas on Behavioral Marital Therapy (BMT), Gayla Margolin and Neil Jacobson were among the first to apply social exchange theory to marital therapy (Bevilacqua & Dattilio, 2000: 9; Margolin & Jacobson, 1979; Stuart, 1969: 675-676; Vincent, Weiss, & Birchler, 1975: 476-477).

The behavioral therapeutic component of CBMT flows out of the assumption that behavioral changes borne out of the interaction between marriage couples in therapy aid in producing sustainable positive attitudes in the thought, behavior, and emotional patterns of individuals in the marital relationship. This assumption is further enforced by the idea that positive attitudes in marriage individuals occur when the therapy provides new ways by which spouses perceive themselves, their spouses, marriage, and the world. Accordingly, CBMT employs some approaches that aim at modifying the behaviors of individuals in marital relationships (Fischer & Fink, 2014: 14). Paramount among these approaches are "self-monitoring," "exposure therapy," and "behavioral experiments" (Wedding & Corsini, 2014: 253).

Some studies have connected the development of CBMT with some cognitive theorists. Foremost among these theorists are Aaron Beck and Albert Ellis (Rathus & Sanderson, 1999: 23). Ellis, for example, suggested that one's perception of actual events affects one's behavior. Donald H. Baucom

[1] These are the principle of "Effect," the principle of "readiness," the principle of "identical elements," and the principle of "exercise" (Tracey & Morrow, 2017: 235).
[2] Skinner's processes were "positive reinforcement," "negative reinforcement," "punishment," and "extinction" (Schmidt & Wrisberg, 2008: 292; Rutledge, 2008: 53).

and Norman Epstein incorporated earlier research on the role cognition plays in marital satisfaction into marital therapy (Baucom & Epstein, 1990: 89). According to them, five main cognitive factors interact within the marital relationship to determine the level of satisfaction. These cognitive factors are "perception," "attributions," "expectancies," "assumptions," and "standards" (Baucom & Epstein, 1990: 47, 49, 79, 123, 315). From this perspective, then, the cause of marital dissatisfaction is the negative perception of one or both spouses concerning the marital relationship, the other spouse, or himself/herself. The cognitive component of CBMT focuses on ways by which the therapy can modify individual perceptions about the marriage, the other spouse, or oneself (Ampuni, 1998: 6).

Marital and family counseling formally began in the United States of America during the 1930s. Its initial approach was psychoanalysis. The development of this specialized therapy saw the utilization of various counseling approaches to marital and family distress. Foremost among these were insight-oriented, behavioral, solution-focused, and cognitive-behavioral approaches. Cognitive-behavioral Marital Therapy (CBMT) was developed in the 1980s. In recent times, CBMT has gained increasing recognition as one of the functional approaches in dealing with marital and family distress. As a therapeutic theory, CBMT can explain why individuals and members in marital and familial relationships have problems. It also addresses the needed change(s) that ought to take place for individuals in marital and familial relationships resolve or cope with their marital and family distress.

Some assumptions of CBMT indicate this capacity inherent in the therapy. One underlying assumption of CBMT is that the thinking, behavior, and feeling pattern of individuals affect other members of the marital and familial relationship. Usually, negative responses from significant others within the group adversely affects in-group cohesion, thereby causing dissatisfaction in the relationship. To help clients to heal, CBMT assumes that the therapist aids clients to gain self-understanding of their cognition-- "perceptions, attributions, assumptions, expectations, and standards" (Baucom & Epstein, 2013: 47). Through such understanding, clients can move on to alter their distorted thoughts concerning other members of the relationship as well as their perception of the whole relationship. The positive effect of such modification is the termination of distorted patterns of affective and interpersonal interactions within the marriage and family.

Unlike other approaches to marriage and family therapy, CBMT is yet to crystallize its procedures or sessions. Accordingly, individual CBMT therapists self-dictate procedures and sessions according to the interaction between the therapeutic atmosphere and the dynamics within the holistic experience of clients. In this study, Robert Friedberg's six-part structure is instructive for the determination of a suitable procedure for CBMT. Friedberg's six-part structure consists of "mood check in, homework review, agenda setting, processing session content, homework assignment, and feedback/summaries" (Friedberg, 2006: 161).

Though Friedberg is silent on part one- the mood check-in, it is generally expected that activities in this part would involve the first interview. Among other things, this interview will concentrate on understanding the background of clients, the presenting problem(s), as well as goal setting for therapy. In part two, homework, clients are pyscho-educated on ways by which they could provide evidence of their thought patterns. The therapist provides clients with insights on how clients could study their emotions and behaviors in the marital or familial setting. Part three, agenda setting, is where actual counseling begins for Friedberg. Here, the therapist probes individual thoughts concerning other members of the marital and familial relationship as well as individual perception about the relationship itself. Also, the therapist aids clients to reflect on personal feelings concerning other members of the relationship as well as the relationship itself.

In part four, the processing content, clients are provided with exercises or assignments to be completed out of the therapeutic setting. These exercises include "self-monitoring, self-motivation, rational analysis, and behavioral enactment" (Friedberg, 2006: 161-162). Generally, these exercises aim at enhancing clients' consciousness about personal thoughts, behavior, and feelings. Again, they aim at inducing desire for positive adjustments in clients' thoughts and relational skills. Accordingly, clients are made to record their activities within the marital or familial setting. These recordings are mainly discussed in part five.

In the last part, "feedback and summaries," the therapist assist clients in recognizing areas in the marital or familial relationship in which there is a general agreement or disagreement. This feedback

DOI: 10.21522/TIJPY.2016.04.01.Art004
ISSN: 2518-8852

and summaries enable the therapist to acquire insight into the client's perception of individual therapy and the entire therapeutic process. For Friedberg, adherence to this structure promises high potency for CBMT.

Among the myriad approach to marriage and family counseling, cognitive-behavioral marital therapy (CBMT) has wider recognition. Compared with other approaches in marriage and family counseling, CBMT is less costly, and it has relatively shorter sessions. Except for marital and family distress that may call for between 6-8 sessions, CBMT normally ranges from 10 to 20 sessions. Its flexibility enables the therapist to apply it in any context. Additionally, CBMT has realistic goals that readily connects to the cognitive, behavioral, and affective framework of clients (Patterson, 2014: 142). In the end, clients own the processes of CBMT themselves. This is because CBMT assisted them both to come to terms with factors that cause and sustain their challenges as well as develop a newer pattern of thoughts, behavior, and affect that aids them to resolve or cope with their marital and family distress (Baucom & Epstein, 1990: xi).

Marital Distress

Feelings of unhappiness within the marital relationship has been referred to as marital distress (Reis & Sprecher, 2009: 344; Halford, 2003: 3). Among the negative results it induces are physical, emotional, and mental "disorders" (Barlow, 2014: 703; Fincham & Beach, 1999: 48, 49; Greene & Burleson, 2008: 149; Carlson & Dermer, 2017: 1008; Lebow, Chambers, Christensen, & Johnson, 2012: 146). Inadequate "communication" among married couples is one of the causes of marital distress (Cox & Brooks-Gunn, 2014: 52; Jacob, 2013: 147). At other times, the style or pattern of the communication that occurs among married couples is the real cause off marital distress (Salamon, 2008: 113). Also, challenges in having quality time for each other as well as financial constraints in the marital relationship have been indicated as other causes of marital distress (van Acker, 2017: 21).

According to Chris Segrin and Jeanne Flora, poor problem resolution skills as well as inability to relate well with each other may cause marital distress in the marital relationship (Segrin & Flora, 2011: 252). Spouse's "perceptions" of reality, "attributions," "expectancies," "assumptions" about the intersection of reality and life activities, as well as "beliefs or standards" have been found to either cause or sustain the presence of marital distress in the marital relationship (Baucom & Epstein, 2013: 47). Irving E. Sigel and Gene H. Brody place marital distress into a fourfold category. These are "physically aggressive, verbally aggressive, withdrawn, and nonaggressive"(Sigel & Brody, 1990: 197). This study employs a threefold categorization of marital distress. These are mild (from 47 to 42, RDAS), moderate (from 41 to 32, RDAS), and severe marital distress (below 31, RDAS).

Methodology

The quantitative study uses the descriptive-correlational-experimental design to ascertain the effect of Cognitive-behavioral Marital Therapy (CBMT) on 50 married couples sampled by the proportionate stratified random sampling technique. This technique was used so all essential traits of the participants will be include in the study. A pre-testing screening was conducted on clients of a counseling clinic in Accra. Clients who obtained a score of 47 or below on the RDAS were included in the study. Three categories emerged from the screening: severe (70 clients); moderate (16 clients) and mild (14 clients). Individuals totaling 50% from each category were randomly selected to participate in the study. An eight-session CBMT therapy was designed for the research group. The level of marital distress for each participant was measured in the first session through the RDAS. The entire duration of the CBMT treatment was eight weeks. Each session was between 50-110 minutes. In a follow-up exercise two weeks after CBMT treatment had ended, participants completed the RDAS and the SPOM-C instruments.

The research adapted two instruments. The first was the Session Process and Outcome Measures-Client version (SPOM-C). Four sub-scales defined the SPOM-C- the Helping Skills Measure (HSM-C, with 13 items), Session Evaluation Scale-Client Version (SES-C, with 4 items), and the Relationship Scale-Client Version (RS-C, with 4 items).

The 21-item HSM-C employs a five-point Likert scoring scale from strongly disagree (1) to strongly agree (5). Scoring is by accumulation. Higher scores mean therapy was effective and lower scores means the opposite. Reliability alpha coefficient values of 0.73, 0.71, and 0.82 was recorded

for all the stages of the treatment process measured by the HMS-C Kellems (2002). Validity alpha coefficient values were r=0.43, p, <0.001, r=0.44, p<0.001, and r= 0.60, p<0.001 for all the stages of the treatment measured by the HSM-C.

The Revised Dyadic Adjustment Scale (RDAS) was the second research instrument (Spanier, 1976: 15; Busby, Christensen, Crane, & Larson, 1985: 289-290). Initially, it determined the level of distress of each participant. It uses a 14-item on a 5- or 6-point scale to access marital adjustment about consensus, satisfaction, and cohesion. The overall score of the RDAS is 69. Scores of 48 means greater stability in marriage while 47 or below indicates the existence of instability in the marital relationship. Average scores in this study determined the level of marital distress of each participant. Non-distress/distress free score is 48 and above, average score of 47 -42 is mild, average score of 41-32 is moderate, and average score of 31 and below is severe. The reliability alpha coefficient value of the RDAS is ".90" with "construct validity of .68 (p<.01)" (Busby, Christensen, Crane, & Larson, 1985: 290; Crane, Middleton, & Bean, 2000: 53). Several studies have confirmed the efficiency of the RDAS as far as concerns assessing marital distress (Anderson et al., 2014: 530; Turliuc & Muraru, 2013: 49; Hollist et al., 2012: 348).

The Predictive Analytics Software (PASW) 18 Guide to Data Analysis was used in the disparity analysis. The level of distress of participants were measured by descriptive frequencies. The paired t-test was used to measure the mean values within the sample. The Pearson correlation coefficient measured the correlation between the outcome of therapy for CBMT and level/type of marital distress.

In adherence to Principle V ("Responsibility to research participants") of the code of ethics of the American Association for Marriage and Family Therapy (AAMFT), the researcher ensured indicated the voluntary nature of participating in the research. In effect, participants were told that they could terminate their participation by their own choice. Participants were also assured of their privacy.

Results and discussion

Table 1.1. Distribution of Marital Distress before and after therapy for CBMT

Type of Marital Distress	Before		After	
	Frequency	Percent	Frequency	Percent
Severe	35	70.0	-	-
Moderate	8	16.0	13	26.0
Mild	7	14.0	37	74.0
Total	50	100.0	50	100.0

Table 1.1 presents distribution scores and frequencies for the three types of marital distress for both the before and after therapy for the comparison group. Frequencies and scores for before therapy was: severe was 35 (70%); moderate was 8 (16%), and mild was 7 (14%). Frequencies and scores for after therapy were: severe was 0 (0%); moderate was 13 (26%), and mild was 37 (74%). Table 4.7b indicates a significant impact of therapy on the status of marital distress for the participants who reported severe marital distress.

Table 1.2. Type of marital distress and therapy outcome for CBMT

Variable	Obs	Mean	Std. Err	Std. Dev.	[95% Conf. Interval]	
After therapy	9	39.44	0.2939	0.882	38.77	40.12
Before therapy	9	26.44	1.608	4.824	22.74	30.15
Difference	9	13	1.633	4.899	9.23	16.77

Marital Distress = Severe to moderate

Mean (diff) = mean (Marital distress after therapy - Marital distress before therapy) t = 7.96
Ho: mean (diff) = 0 degrees of freedom = 8
Ha: mean (diff) < 0 Ha: mean (diff) ≠ 0 Ha: mean (diff) > 0

DOI: 10.21522/TIJPY.2016.04.01.Art004
ISSN: 2518-8852

Pr (T < t) = 1.0000 Pr (|T| > |t|) = 0.0000 Pr (T > t) = 0.0000

The analysis indicates the marital distress for nine (9) participants moved from the severe state to the moderate state with a mean difference of 13 from before and after therapy provision.

Variable	Obs	Mean	Std. Err	Std. Dev.	[95% Conf. Interval]	
After therapy	20	44.3	0.377	1.688	43.51	45.09
Before therapy	20	27.7	0.649	2.90	26.34	29.059
Difference	20	16.6	0.782	3.50	14.96	18.238

Marital Distress = Severe to Mild

Mean (diff) = mean (Marital distress after therapy - Marital distress before therapy) t = 21.20
Ho: mean (diff) = 0 degrees of freedom = 19
Ha: mean (diff) < 0 Ha: mean (diff) ≠ 0 Ha: mean (diff) > 0
Pr (T < t) = 1.0000 Pr (|T| > |t|) = 0.0000 Pr (T > t) = 0.0000

The analysis indicates the marital distress for twenty (20) participants moved from the severe state to the mild state with a mean difference of 16.6 from before and after therapy provision.

Variable	Obs	Mean	Std. Err	Std. Dev.	[95% Conf. Interval]	
After therapy	6	50.16	0.872	2.13	47.924	52.41
Before therapy	6	29.33	0.760	1.861	27.37	31.29
Difference	6	20.83	1.33	3.250	17.42	24.244

Marital Distress = Severe to Distress free

Mean (diff) = mean (Marital distress after therapy - Marital distress before therapy) t = 15.69
Ho: mean (diff) = 0 degrees of freedom = 5
Ha: mean (diff) < 0 Ha: mean (diff) ≠ 0 Ha: mean (diff) > 0
Pr (T < t) = 1.0000 Pr (|T| > |t|) = 0.0000 Pr (T > t) = 0.0000

The analysis indicates the marital distress for six (6) participants moved from the severe state to distress state with a mean difference of 20.83 from before and after therapy provision.

Variable	Obs	Mean	Std. Err	Std. Dev.	[95% Conf. Interval]	
After therapy	5	44.2	0.735	1.64	42.16	46.24
Before therapy	5	36.2	1.281	2.86	32.64	39.75
Difference	5	8	1.949	4.35	2.58	13.41

Marital Distress = Moderate to Mild

Mean (diff) = mean (Marital distress after therapy - Marital distress before therapy) t = 4.10
Ho: mean (diff) = 0 degrees of freedom = 4
Ha: mean (diff) < 0 Ha: mean (diff) ≠ 0 Ha: mean (diff) > 0
Pr (T < t) = 0.9926 Pr (|T| > |t|) = 0.0148 Pr (T > t) = 0.0074

The analysis indicates the marital distress for five (5) participants moved from the moderate state to distress free state with a mean difference of 8 from before and after therapy provision.

The effects of therapy for participants in the moderate to distress free and mild to distress free were not statistically different. The study found that the therapeutic effect of CBMT was great among

participants with severe marital distress under the research group that moved to distress-free state after the therapy application with a mean difference of 23.18. CBMT is not effective in helping clients who report moderate and mild marital distresses in Ghana. Its over reliance on cognition and thought patterns limits clients' chances of wider exploration to determine the web of factors that creates and sustains the marital distress (see Baheti, Bakshi, Gupta, & Gehdoo, 2017: 468; Ampuni, 2004: 10-11). As such, clients with varying marital distress, from the moderate through to the mild state, do not find CBMT as helpful as clients with severe marital distress do. While the results of the research partially confirm the affirmed limitation of the Cognitive-Behavioral Marital Therapy (CBMT), its significant impact on clients with severe marital distress suggest a deviation from the affirmed position. In the context of Ghana, CBMT is helpful to resolving the troubles caused by severe marital distress among married couples but unhelpful to those caused by moderate ad mild marital distresses.

Conclusion

This quantitative study assessed the impact of Cognitive Behavioral Marital Therapy (CBMT) on marital distresses among married couples in Ghana. Through a descriptive-correlational-experimental research design, 50 married couples were sampled through a proportionate stratified random sampling technique. Results showed that CBMT had significant impact on the severe marital distresses among married couples in Ghana. Participants who reported severe marital distress recorded moderate, mild, and distress free after therapy. This implies that CBMT is effective in treating clients who report severe marital distresses than those who report moderate or mild marital distresses in Ghana. In light of this, CBMT is recommended for use in treating clients who report severe marital distress in Ghana. However, Ghanaian marriage counselors may resort to other models of therapy in the event of helping clients who report moderate to mild marital distresses. Further studies in this direction will be a welcomed resolution to enhancing marital counseling in Ghana.

References

[1].Ampuni, S. (2004). Cognitive-Behavioral Marital Therapy: a Cognitive-Behavioral Approach for. Buletin Psikologi, 12(1), 1–15.

[2].Anderson, S. R., Tambling, R. B., Huff, S. C., Heafner, J., Johnson, L. N., & Ketring, S. A. (2014). The Development of a Reliable Change Index and Cutoff for the Revised Dyadic Adjustment Scale. Journal of Marital and Family Therapy, 40(4), 525–534.

[3].Baheti, D. K., Bakshi, S., Gupta, S., & Gehdoo, R. S. P. (Eds.). (2017). Symptom Oriented Pain Management (2nd ed.). New Delhi: The Health Sciences Publishers.

[4].Baucom, D. H., & Epstein, N. (1990). Cognitive-Behavioral Marital Therapy (4th ed.). Levittown: Brunner/Mazel.

[5].Baucom, D. H., & Epstein, N. (2013). Cognitive-Behavioral Marital Therapy. New York: Routledge.

[6].Bevilacqua, L. J., & Dattilio, F. M. (Eds.). (2000). Relationship Dysfunction: A Practitioner's Guide to Comparative Treatments. New York: Springer.

[7].Busby, D. M., Christensen, C., Crane, D. R., & Larson, J. H. (1985). A revision of the Dyadic Adjustment Scale for use with distressed and nondistressed couples: Construct hierarchy and multidimensional scales. Journal of Marital and Family Therapy, 21(289–308).

[8].Carlson, J., & Dermer, S. B. (Eds.). (2017). The SAGE Encyclopedia of Marriage, Family, and Couples Counseling, vol. 4. California: Sage.

[9].Cox, M. J., & Brooks-Gunn, J. (Eds.). (2014). Conflict and Cohesion in Families: Causes and Consequences edited by Martha J. Cox, Jeanne Brooks-Gunn. New York: Psychology Press.

[10]. Crane, D. R., Middleton, K. C., & Bean, R. A. (2000). Establishing criterion scores for the Kansas Marital Satisfaction Scale and the Revised Dyadic Adjustment Scale. American Journal of Family Therapy, 28(2), 53–60.

[11]. Curwen, B., Palmer, S., & Ruddell, P. (2005). Brief Cognitive Behavior Therapy. London: Sage.

[12]. David H. Barlow. (2014). Clinical Handbook of Psychological Disorders. (D. H. Barlow, Ed.) (5th ed.). New York: Guilford.

DOI: 10.21522/TIJPY.2016.04.01.Art004
ISSN: 2518-8852

[13]. Epstein, N., & Baucom, D. H. (1989). Cognitive-Behavioral Marital Therapy. In A. Freeman, K. M. Simon, L. E. Beutler, & H. Arkowitz (Eds.), Comprehensive Handbook of Cognitive Therapy (pp. 491–593). Boston: Springer.
[14]. Fincham, F. D., & Beach, S. R. (1999). Conflict in Marraige: Implications for Working with Couples. Annual Review of Psychology, 50, 47–77.
[15]. Fischer, D. J., & Fink, B. C. (2014). Clinical Processes in Behavioral Couples Therapy. Psychotherapy, 51(1), 11–14.
[16]. Friedberg, R. D. (2006). A Cognitive-Behavioral Approach to Family Therapy. Journal of Contemporary Psychotherapy, 36, 159–165.
[17]. Greene, J. O., & Burleson, B. R. (Eds.). (2008). Handbook of Communication and Social Interaction Skills. New York: Taylor & Francis.
[18]. Halford, W. K. (2003). Brief Therapy for Couples: Helping Partners Help Themselves. California: Guilford.
[19]. Hill, G. (2001). A Level Psychology Through Diagrams. Oxford: Oxford University Press.
[20]. Hollist, C. S., Falceto, O. G., Ferreira, L. M., Miller, R. B., Springer, P. R., Fernandes, C. L. C., & Nunes, N. A. (2012). Portuguese Translation and Validation of the Revised Dyadic Adjustment Scale. Journal of Marital and Family Therapy, 38(1), 348–358.
[21]. Jacob, T. (Ed.). (2013). Family Interaction and Psychopathology: Theories, Methods and Findings. New York: Springer.
[22]. Jordan, J. S., ed. (1998). System Theories and A Priori Aspects of Perception. Amsterdam: Elsevier.
[23]. Lebow, J. L., Chambers, A. L., Christensen, A., & Johnson, S. M. (2012). Research on the Treatment of Couple Distress. Journal of Marital and Family Therapy, 38(1), 145–168.
[24]. Mahoney, M. J. (1974). Cognition and Behavior Modification. Michigan: Ballinger Publishing Co.
[25]. Margolin, G., & Jacobson, N. (1979). Marital therapy: Strategies based on social learning and behavior exchange principles. New York: Brunner/Mazel.
[26]. Naour, P. (2009). E.O. Wilson and B.F. Skinner: A Dialogue Between Sociobiology and Radical Behaviorism. Pella: Springer.
[27]. Patterson, T. (2014). A cognitive Behavioral Systems Approach to Family Therapy. Journal of Family Psychotherapy, 25(2), 132–144.
[28]. Rathus, J. H., & Sanderson, W. C. (1999). Marital Distress: Cognitive Behavioral Interventions for Couples. Maryland: Jason Aronson.
[29]. Reis, H. T., & Sprecher, S. eds. (2009). Encyclopedia of Human Relationships, vol. 1. California.
[30]. Richard, D. C.S., & Huprich, S. K., eds. (2009). Clinical Psychology: Assessment, Treatment, and Research. London: Elsevier Academic Press.
[31]. Roeckelein, J. E. (2006). Elsevier's Dictionary of Psychological Theories. Amsterdam: Elsevier.
[32]. Rutledge, L. S. (2008). Motivation and the Professional African American Woman. Bloomington: Authorhouse.
[33]. Salamon, M. J. (2008). Every Pot Has a Cover: A Proven System for Finding, Keeping and Enhancing the Ideal Relationship. Lanham: University Press of America.
[34]. Schmidt, R. A., & Wrisberg, C. A. (2008). Motor Learning and Performance: A Situation-based Learning Approach. Champaign: Human Kinetics.
[35]. Segrin, C., & Flora, J. (2011). Family Communication (2nd ed.). New York: Taylor & Francis.
[36]. Sher, T. G. (2011). Encyclopedia of Clinical Neuropsychology, vol. 1. New York: Springer.
[37]. Sigel, I. E., & Brody, G. H., eds. (1990). Methods of Family Research: Clinical populations. New York: Psychology Press.
[38]. Spanier, G. B. (1976). Measuring Dyadic Adjustment: New Scales for Assessing the Quality of Marriage and Similar Dyads. Journal of Marriage and the Family, 38, 15–28.
[39]. Stuart, R. B. (1969). Operant-Interpersonal Treatment of Marital Discord. Journal of Consulting and Clinical Psychology, 33, 675–682.
[40]. Tracey, D. H., & Morrow, L. M. (2017). Lenses on Reading, Third Edition: An Introduction to Theories and Models (Third). New York: The Guilford Press.
[41]. Turliuc, M. N., & Muraru, A. A. (2013). Psychometric Properties of the Revised Dyadic Adjustment Scale on a Sample of Married Adults. Journal of Psychological and Educational Research, 21(1), 49–76.

[42]. van Acker, E. (2017). Marriage and Values in Public Policy: Conflicts in the UK, the US and Australia. New York: Taylor & Francis.
[43]. Vincent, J. P., Weiss, R. L., & Birchler, G. R. (1975). A Behavioral Analysis of Problem Solving in Distressed and Nondistressed Married and Stranger Dyads. Behavior Therapy, 6, 475–487.
[44]. Wedding, D., & Corsini, R. J. (2014). Current Psychotherapies (10th ed.). Belmont: Cengage Learning.