Prevention of Couple Distress and Implications for Child Well-Being:

State of the Art and Future Directions

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Abstract

After innumerable scientific studies have documented the link between children's violence victimization (CVV) and a wide range of medical, emotional, psychological and behavior disorders, we need to develop and implement effective interventions to treat but also to prevent the negative outcomes of victimization. With regard to prevention, there is growing evidence that CVV is linked to intimate partner violence between parents (IPV) as well as to couple conflict and separation/divorce in general. Children, growing up in high conflict families, are at a heightened risk for child mental health problems over time. Moreover, witnessing IPV increases the children's risk for being maltreated themselves. Therefore it seems promising to focus on couple functioning when thinking about how to prevent CVV. Fortunately, there are efficacious prevention programs for relationship distress. The following review provides an overview of the definition and prevalence of CVV and its impact on the individual as well as on society. After synthesizing the most important research findings on the link between CVV, IPV, and couple conflict, evidence-based prevention programs for couples are introduced. Afterwards estimations regarding the availability of couple prevention are reported, followed by a description of dissemination challenges. Recommendations for future research, policy, and dissemination are discussed.

Key words: Family policy; child maltreatment; intimate partner violence; prevention; relationship education; public health approach

Highlights

- Of all children 25 to 50% are maltreated during childhood and adolescence
- Child maltreatment is linked to substantial economic, social, and individual costs
- Violence between parents increases a child's risk for being maltreated itself
- Of all children who witnessed violence between parents, 40% show behavior problems
- Interventions to protect children should focus on supporting healthy marriages

Definition and prevalence of children's violence victimization

Epidemiological research has shown that a substantial number of individuals are exposed to various forms of violent victimization during childhood and adolescence. Violent victimization is defined as personal exposure to acts of intentional harm (Gilbert et al., 2009). Moreover several major subtypes of children's violence victimization (CVV) need to be distinguished: (a) physical maltreatment/assault (e.g., beating, punching, strangling, burning, poising), (b) sexual maltreatment/assault (e.g., attempted or completed sexual act, touching of the genitalia, breast or buttocks, watching sexual acts, being filmed, prostitution) and (c) bullying (repeated patterns of harmful interactions between juveniles) as well as (d) neglect and (e) exposure to domestic violence (witnessing visually or aurally, actual or threatened physical or sexual assault between parents or other caregivers).

The definitions used in studies estimating the prevalence of CVV are varied. However, the prevalence figures are staggering: International studies demonstrate that, depending on the country, one-quarter to half of all children report severe and frequent physical abuse; approximately 20 percent of females and 5 to 10 percent of males report sexual abuse as children. The extent of emotional abuse such as witnessing intimate partner violence (IPV) and neglect are more difficult to assess (Gonzales & MacMillan, 2008). In their comprehensive review of population-based studies undertaken in developed countries, Gilbert and colleagues (2009) concluded that 5 to 35 percent of children are physically abused during childhood. For sexual abuse, the prevalence is estimated to be between 5 and 30 percent, while 10 to 20 percent witnessed domestic violence. In the context of the *WHO World Mental Health Surveys* Kessler et al. (2010) report prevalence rates of 5.3 to 10.8 percent for physical abuse and 4.2 to 7.8 percent for family violence. These results were similar for high-, middle-, and low-/lower-middle income countries. With regard to severe child maltreatment and neglect, prevalence rates of 15 percent are reported for Germany (Häuser, Schmutzer, Brähler,

& Glaesmer, 2011). Furthermore, Noll (2005) reports an increased risk of sexual abuse for children whose mothers have been a victim of sexual violence themselves. Thus, CVV not only affects the current victims but also the future generation. After having neglected the consequences of CVV in research for a long time, today we know about the varied negative effects. In the following those effects are briefly summarized.

Impact of children's violence victimization

Impact on the individual

From a psychological point of view, CVV is primarily regarded as an important risk factor for the development of mental health, emotional, and behavior problems in children and adolescents. Approximately 20% of children in western, industrialized countries experience the symptoms that constitute internalizing or externalizing DSM–IV disorders (Belfer, 2008; O'Connell, Boat, & Warner, 2009; Patel, Fisher, Hetrick, & McGorry, 2007). Many children, who are exposed to multiple types and repeated episodes of maltreatment, develop severe behavior problems, and DSM-IV disorders as a reaction, e.g., mood, anxiety, or substance-use disorders, dissociation, post-traumatic stress disorder symptoms and social problems (Felitti et al., 1998; Lansford et al., 2002). Compared to non-exposed children, they also have an increased risk for comorbidity, recurrent and persistent disorders as well as for poor treatment responses in psychotherapy (see Moffitt et al., in press). Results of the *WHO World Mental Health Surveys* show that childhood adversities account for 29.8% of all disorders across countries (Kessler et al., 2010). Moreover in a representative German study, for women CVV has been identified to be the strongest predictor for being severely maltreated by their intimate partner in later life (Schröttle, 2008); thus, CVV somehow seems to increase the vulnerability to repeated victimization. Additionally, domestic violence can become part of an *intergenerational cycle of violence*. Research findings indicate that children

and adolescents who witnessed IPV and were victimized by their parents were more likely to become perpetrators of violence themselves than those who were not exposed (Osofsky, 2003). When witnessing violence, children learn that violence (a) is part of family relationships, (b) is an appropriate way to resolve conflicts, (c) is a way of controlling people and that (d) perpetrators in intimate relationships are rarely disciplined.

In addition to the consequences of CVV for psychological functioning, research has begun to focus on possible consequences of CVV for children's physical health, as well. In the context of the retrospective *Adverse Childhood Experiences* (ACE) study, Felitti and his colleagues (1998) already reported that CVV increased the risk for certain physical disorders, e.g., cardiovascular diseases, cancer, stroke, bronchitis, and diabetes. Moreover a link between ACE and a heightened risk of premature mortality was found (Brown et al., 2009). In two long-running cohort studies, the Dunedin study in New Zealand (from 1972 onward) and the Environmental-Risk study in England (from 2000 onward), serious stressful experiences in each child's life and mental health have been assessed repeatedly in large, longitudinal study designs. At the same time, certain biomarkers which are known to be associated with higher risks for negative mental and physical health-outcomes as well as for behavior problems during the course of life have been assessed (e.g. Caspi et al., 2002; Caspi et al., 2003). These biomarkers include inflammatory and epigenetic factors, indicating that CVV is linked to long term changes in immune system functioning with elevated inflammation levels, telomere erosion, changes in gene expression and behavior, and a series of changes in the size, volume, and function of specific brain structures (see Moffitt et al., in press). First results show that an amplified immune response and chronic inflammation, resulting from child maltreatment, for example, are linked to significant tissue damage, which in turn is associated with age-related diseases such as cardiovascular diseases, type 2 diabetes, and dementia (Danese, Pariante, Caspi, Taylor & Poulton, 2007). Concerning telomere erosion, it is known

that a telomere is a region of repetitive nucleotide sequences at each end of a chromosome to protect it from deterioration. Telomeres are consumed during cell division; this process is called telomere erosion. The length of a telomere is a marker for biological aging and predicts lifespan. Shalev et al. (2012) found that CVV leads to faster telomere erosion from 5 to 10 years of age.

Accordingly, apart from its effects on mental health, stressful experiences in childhood can also lead to biological alterations that are known to be associated with an elevated risk to develop long-term physical health issues. Although we know about the varied negative effects of CVV on children's well-being, health care services for maltreated children and especially for mental health disorders are lacking – not only in the U.S., but in Europe in general. In fact, a fifth of the countries in the European Region lack mental health programs for children and adolescents. Even where services are available, 75% of the parents of affected children and adolescents do not make use of counseling or treatment options, indicating that CVV and mental health problems are being inadequately addressed (Ravens-Sieberer et al., 2008).

Impact on society

Not only are the victims themselves adversely affected by exposure to violence; there is a high burden on society as well. On the one hand, there are direct costs, that is, those costs associated with the immediate needs of victimized children, e.g., for hospitalization, mental health care, and child welfare services as well as law enforcement; on the other hand, indirect costs, that is, those costs associated with the long-term and/or secondary effects, need to be taken into account, too, e.g., special education, juvenile delinquency, mental health and health care, adult criminal justice system, and lost productivity to society. In the U.S. overall costs associated with child abuse and neglect have been estimated to be over $94 billion per year in 2001 (Fromm, 2001) and increased to over $103 billion per year in 2007 (Wang & Holton, 2007). For Australia overall costs of $11 billion are reported (Taylor et al., 2008), whereas in

Germany the costs for CVV have been estimated to be over €11 billion (about $13 billion; Habetha et al., 2012).

Conclusion

The economic, social, and individual costs of child maltreatment are substantial; it seems worthwhile to improve our preventive and therapeutic interventions to reduce these costs. Because of the complexity of the occurrence of CVV and its consequences described above, different approaches not only for the treatment but for the prevention of CVV need to be considered to reduce the likelihood of future generations being exposed to violence. Given that most children live within some family context, the role of couple functioning as a modifiable risk factor and as one focus of intervention is worth exploring.

Prevalence of children's violence victimization in the family

Research has shown that the younger a child is, the more victimization is perpetrated by parents (Finkelhor, 1997). That is because young children are mostly dependent on and usually spend most of the time with their fathers and especially mothers. In 2005 nearly 900,000 cases of child maltreatment were reported in the United States (U.S. Department of Health and Human Services, 2007). In most of these cases, the mother is acting alone (40 percent) in perpetrating the maltreatment; she is acting with the father 17 percent of time, whereas fathers act alone only in roughly 18 percent of cases. The risk for children's violence victimization by their parents is highly dependent on whether there is intimate partner violence (IPV) in the family or not. Taylor, Guterman, Lee, and Rathouz (2009) report that mothers who experience IPV are at a heightened risk of maltreating their children compared to mothers who do not experience IPV. In her review on the research of children exposed to domestic violence, Øverlien (2010) outlines that 30 up to 60 percent of children who are exposed to IPV, are also themselves physically abused. Moreover they have an elevated risk

for sexual abuse, as well. Osofsky (2003) found that the rate of physically abused and neglected children of those having witnessed domestic violence is 15 times higher compared to the U.S. national average. He reports that in families where the wife is battered, 60 to 70 percent of children are battered as well. Besides, children are also at risk for direct injury when they intervene in an event of intimate partner violence. In those cases, there may be violence to the child of an unintended nature (Øverlien, 2010). Juveniles whose first victimization occurred at a young age are vulnerable to repeated physical or sexual abuse (Stevens, Ruggiero, Kilpatrick, Resnick, & Saunders, 2005).

Concerning IPV, we know that in the U.S., approximately 12.5 percent of men are physically aggressive towards their wife, as defined by slapping, pushing, hitting, or grabbing (Holtzworth-Monroe, Smutzler, Bates, & Sandin, 1997). Approximately 1.5 to 2 million U.S. women are severely assaulted by their husbands per year. Yet these data may underestimate the extent of IPV because of a high number of unreported cases. For Germany, a representative sampled study of 16 up to 85 year old women found prevalence rates of 23 percent for physical abuse perpetrated by the intimate partner and 7% for sexual abuse (Schröttle & Müller, 2004). Of those women who reported physical or sexual abuse, 31 percent reported having been victimized only once, 36 percent having been victimized two up to ten times, and 33 percent had been victimized ten to 40 times. For men, a German pilot study showed that about 27 percent reported physical abuse by their current or previous partner (Forschungsverband “Gewalt gegen Männer”, 2004). In their representatively sampled study conducted in the United States, Smith Slep and O’Leary (2005) reported prevalence rates of 49 percent for IPV, with 24 percent of families reporting severe physical aggression (e. g., kicked, chocked, beat up, slammed against a wall, hit with an object, or burned). Furthermore, physical violence often occurs along with other forms of interspousal aggression (e.g., throwing objects/doors, kicking furniture) and psychological maltreatment (e. g., insults, threats, silent treatment for days or weeks) which may also cause

negative affect and distress in children in the same way as direct interspousal aggression. Concerning the number of children being exposed to violence, it is estimated that approximately 30 percent (15.5 million) of U.S. children live in families in which some form of IPV has occurred; 13 percent of juveniles experienced at least one incidence of severe partner violence during the past year (McDonald, Jouriles, Ramisetty-Mikler, Caetano, & Green, 2006). Furthermore, of those children witnessing IPV, 40 to 50 percent show extreme behavior problems (Jouriles, Mahoney, Norwood, McDonald, & Vincent, 1996).

Conclusion

IPV is part of the everyday life of many children and puts children's safety at risk: on the one hand, it significantly increases the risk for parent-child aggression; on the other hand, witnessing IPV alone already puts children at a higher risk to develop emotional and behavior problems in childhood and adolescence. Given these findings, future approaches, aiming to decrease the prevalence of CVV, should include interventions, focusing on strengthening couples and their relationships. That is, by decreasing the prevalence of IPV, the number of children witnessing violence could be reduced simultaneously, along with a decrease in the children's risk for being victimized themselves (Kavemann & Kreyssig, 2006). In the following, the most important research findings on the link between IPV, couple conflict, and children's outcomes are summarized to better understand the underlying mechanisms.

Marital/couple conflict and child well-being

The belief that couple relationships are critically related to child development and outcome has been a cornerstone of clinical and scientific literature throughout the 20th century (e.g. Erel & Burman, 1995). Couple conflict between the partners can take many forms, and may have positive and negative elements. It is healthy to discuss relationship conflicts in constructive ways (e.g., I-statements, expression of feelings and needs, open ended questions). By contrast, avoidance or withdrawal from couple or family conflict may be even

more detrimental than engaging in openly angry and hostile heated arguments. Discussion of differences in opinion can be helpful and useful if the argument lead to conflict resolution and adaptive problem solving. However, destructive couple conflict, e.g., verbal aggression, personal insult, defensiveness, withdrawal, nonverbal hostility, and physical aggression, constitute a family risk factor and predicts child behavior problems more accurately than marital apathy and covert tension do (Grych & Fincham, 1992; Hahlweg, in press).

The impact of the parents' own relationship as a couple on their child's well-being results from several factors (Repetti, Taylor, & Seeman, 2002): (a) after parents argue with each other, each parent is more likely to be negative in interacting with the child; (b) parents who argue with each other struggle to work together as a team to parent their child; and (c) frequent arguments between parents create a broad negative environment in which the child is raised.

These findings indicate that couple conflict and aggression are linked with multiple negative influences and pathways to children's development. The negative effects are brought about not only by the direct exposure to couple conflict but also through changes in parenting and other related parent risk factors such as depression or alcohol problems (Cummings & Davies, 2010; Troxel & Matthews, 2004; Krishnakumar & Buehler, 2000). Three meta-analysis by Buehler et al. (1997), Gershoff (2002), and Krishnakumar and Buehler (2000) document the empirical evidence for the associations between interparental conflicts, the quality of the parent child relationship, and children's MEB disorders. Effect-sizes are moderate, ranging from $d = .32$ to .62 (see Figure 1).

Marital conflict/divorce and child adjustment

Couple conflict is a common occurrence even in harmonious and stable relationships and most children, even from high conflict homes, do not develop behavior problems. Zimet and Jacob (2002) summarized the studies of the impact of divorce on child functioning and

came to the conclusion that marital conflict and discord are more significant to child maladjustment than family intactness/divorce, and that process dimensions (e.g., parent hostility) explain a greater amount of negative child-outcome variance than structural dimensions. In order to understand the complexities of influences associated with relations between children and marital conflict, Cummings and Davies (2010) provided a framework for a process oriented approach (see Figure 2), focusing on the "Emotional Security Theory EST" as a guiding conceptualization.

"Illustrating a "direct pathway" of influence (path 2 in Figure 2), exposure to destructive intraparental conflict increases children's vulnerability to psychological problems by undermining their emotional security in the interparental relationship – that is, children's confidence in their parent's ability to manage discord, and to preserve family and marital stability. (...) The erosion of children's confidence in their parents as sources of protection and support within the attachment relationship accounts for many of the deleterious effects of parenting difficulties (e. g., unresponsiveness, intrusiveness, low warmth) on children's psychological adjustment (paths 1, 4). (...) In addition, the effects of marital conflict may be moderated by the operation of other family processes, such as family conflict or cohesion (path 5)" (Cummings & Davies, 2010, p. 31-32).

Child negative outcomes have included externalizing problems (e.g., conduct disorder, aggressiveness, delinquency, antisocial behavior), internalizing problems (e.g., depression, anxiety, withdrawal), as well as poor social skills often characterized by hostility and sibling or peer social problems. Couple conflict is also linked with poor school grades and problems in intellectual achievements. These school problems may be due to children's attention difficulties and sleep problems as a result of ongoing parental conflict (Cummings & Davies, 2010; Grych & Fincham, 1992). When analyzing the association between marital conflict and

child development, it seems to be important to document those elements of conflict that specifically contribute to negative outcomes (Zimet & Jacob, 2002):

Frequency. The more children are exposed to conflict, the more likely they show distress, disturbed behavior, and heightened reactivity when exposed to future conflicts. *Intensity*. High intensity conflict, particularly when physical violence is involved, strongly contributes to emotional problems, social skill impairments, and behavior problems. *Content*. Certain conflict topics may be more threatening to children. When the topic pertains to the child, he/she is more likely to experience feelings of helplessness, fear, dysphoria, shame, and negative self-evaluation. Children may feel responsible for the parent's arguments, because they perceive themselves as the source of tension. Child-related content has been more often linked with internalizing outcomes. *Resolution*. Consistently less negative reactions have been observed in children who experienced their parents as having resolved their conflicts. When anger between parents is unresolved, children experience distress and anger, and perceive the event as far more negative than when anger is resolved (Cummings & Davies, 2010).

Divorce/separation

About 55 percent of American, and 40 to 45 percent of Australian, English, German, or Swiss first marriages end in divorce (for an overview, see Hahlweg, Baucom, Grawe-Gerber, & Snyder, 2010). About 50 percent of the divorces occur in the first seven years of the marriage. In 2011, about 187.000 couples got divorced in Germany (Statistisches Bundesamt, 2011). Many other couples, about 10 to 25 percent (for Germany: 1.6 to 4 million), live in stable but unhappy relationships for various reasons, e.g., personal and cultural expectations about divorce, the presence of children, financial implications of divorce, or because no alternative partner was available. As painful as the experience of divorce is for many people, about 75 percent of divorced men and 66 percent of divorced women remarry within three years. Unfortunately, the divorce rate in second marriages is even higher than in first marriages.

Often, the public and researchers have taken a pathogenic view of divorce and have focused on the stresses and adverse outcomes associated with marital breakup. However, it should also be recognized that divorce can offer an escape from an unhappy, abusive, conflictual, or demeaning marriage and an opportunity to build new, more harmonious, fulfilling relationships, and increased personal growth and individuation (see Hahlweg et al., 2010). All the same, according to a representatively sampled German study, women, whose parents had separated during their daughter's childhood, reported to have witnessed IPV between their parents significantly more often than women, whose parents did not split up (Schröttle, 2008).

The extent of the social problems posed by destructive couple conflict and the following separation/divorce is staggering. Approximately half of all children in the U.S. will experience parental divorce. However, across the U.S. and Europe, the separation rate of unmarried parents is higher than the divorce rate of married parents (Kiernan, 2003). In an analysis of family breakdown amongst 14.600 parents with five year old children using data from the U.K. Millennium Cohort Study, Callan and his colleagues (2006) found that 9 percent of *married* parents, 26 percent of *cohabiting* parents and 60 percent of self-described *closely involved* parents had split up before their child's fifth birthday. Combining the latter two categories means 35 percent of *unmarried* couples split up during this period of time. These data are alarming, taking into account that children and adolescents who experience parental divorce tend to have poorer social, educational, cognitive, emotional, and behavioral short- and long-term outcomes (see Baldridge, 2011; Brown, 2010).

Conclusion

Not only IPV but couple conflict in general as well as separation/divorce put children at a higher risk for long-term negative health outcomes. Moreover research has shown that IPV, couple conflict, and separation/divorce are highly intercorrelated. Improving couples functioning, e.g., in terms of enhancing couples communication, problem solving, and stress

management skills, seems promising as one focus of intervention to reduce the likelihood of children being exposed to violence. In the following discussion, different evidence-based programs for the prevention and treatment of couple conflict are reviewed.

Prevention of couple conflict and divorce

Over the last 30 years, approximately 100 clinical trials have demonstrated the efficacy and effectiveness of couple therapy and interventions to prevent relationship distress and divorce (for an overview see Hahlweg et al., 2010). While couple therapy programs seem to be effective in reducing marital distress, the data on long-term outcome indicate that in many cases, therapy is undertaken too late to repair the damage of years of destructive conflict.

A viable alternative to treating marital distress is to provide preventive interventions while the couple is still happy or at least in the early stages of distress. Based on a cognitive-behavioral approach, the working model of intervention assumes that the couple's communication difficulties, e.g., the inability to handle negative emotions and to solve conflicts underlie the deterioration of a relationship. Consequently, the goal of most preventive efforts is to decrease the frequency of negative and increase the frequency of positive exchanges during conflict discussions and to solve relationship issues more effectively. Within the context of couple prevention, the following approaches need to be distinguished:

Universal preventive interventions

Universal preventive interventions target an entire population, e.g., all couples planning to marry, rather than focusing on high-risk groups. There are a number of well researched and effective preventive programs, including:

- "Premarital Relationship Enhancement Program PREP" (Markman, Floyd, Stanley, & Stoorasli, 1988)

- "Ehevorbereitung - Ein Partnerschaftliches Lernprogramm EPL" (Premarital Preparation - A Couples' Learning Program; Hahlweg, Markman, Thurmaier, Engl, & Eckert, 1998; Thurmaier, Engl, & Hahlweg, 1999)
- Freiburger Stress Präventions Programm FSPP (Couples Coping Enhancement Training (CCET, see Bodenmann, 2004).

These programs can be delivered individually or in groups, either in 6 weekly sessions of approximately 2.5 hr duration or at a weekend meeting (typically Saturday to Sunday afternoon). Group sizes vary from three to five couples with two trainers for each group. The couples meet as a group for the lecture portions of the sessions but meet alone and work with a trainer for all other aspects of each session.

Enhanced Triple P (level 5). Even though the primary goal of the Triple P – Positive Parenting Program is to enhance parent's parenting competencies (see Sanders, Markie-Dadds, & Turner, 2003), the impact of marital communication on parent-child interaction is also taken into account. *Enhanced Triple P* is an indicated level of intervention for families with additional risk factors that have not changed as a result of participation in a lower level of intervention. Partner Support is one of different modules, designed for two-parent families with relationship adjustment or communication difficulties. It helps partners to improve their communication, increase consistency in the use of positive parenting strategies, and provide support for each other's parenting efforts. Parents are taught positive ways of listening and speaking to one another, supporting each other, and solving problems.

Efficacy/Effectiveness of universal prevention programs. There is a general finding that most couples who complete pre-marriage education programs generally report high satisfaction with the programs. The Giblin, Sprenkle, and Sheehan (1985) meta-analysis of 85 relationship education and enhancement programs found an average effect size of $d = 0.44$ across all programs and relationship outcome measures, which corresponds to a moderate

effect size. Hahlweg and Markman (1988) included seven controlled studies in their meta-analysis, which all focused on relationship skills training. They found a large mean effect size of $d = 0.79$ for cognitive-behaviorally oriented education programs relative to controls. In another meta-analysis, Hawkins, Blanchard, Baldwin, and Fawcett (2008) examined the efficacy of marriage and relationship education on relationship quality and communications skills in 117 studies. For experimental designs, the effect sizes ranged from $d = .30$ to .36, while the communication skills effect sizes were somewhat larger and ranged from $d = .43$ to .45. Although only a handful of studies included follow-up assessments, at 12 month or longer, there was not much evidence of diminishing effects. In a recent meta-analysis, the efficacy of premarital education programs was investigated (Fawcett, Hawkins, Blanchard, & Carroll, 2010). Including unpublished results, a total of 47 studies were coded. For control-group studies, the authors found that premarital education programs had no significant effect on relationship quality/satisfaction ($d_{qua/sat} = .22$) but a significant moderate effect on communication ($d_{com} = .45$). If analyses were limited just to published control-group studies, the overall effect size became significant for both outcome measures ($d_{\text{qua/sat}} = .58$; $d_{com} = .99$), suggesting a certain publication bias.

For the reason that the most meaningful index of the efficacy of relationship education is its long-term effects, the results of some selected studies are described next. At a 3-year follow-up (Markman et al., 1988), couples who had participated in the PREP reported higher relationship satisfaction than control couples who showed the predictable decline that occur in most relationships over time. Furthermore, PREP couples were more satisfied with their sexuality, had lower levels of problem intensity, and reported significantly fewer instances of spousal physical violence than control couples. At the 4-year follow-up, there was a significantly lower dissolution rate among the PREP couples relative to controls (but no

differences in divorce rate); also, PREP couples showed more positive and less negative communication than control couples (Markman, Renick, Floyd, Stanley, & Clements, 1993).

The EPL, too, was evaluated in a longitudinal prospective study (Hahlweg et al., 1998; Thurmaier et al., 1999). At the 5-year follow-up, the *divorce rates* differed significantly: 16 percent in the control versus 4 percent in the EPL group. EPL couples also demonstrated significantly greater use of positive verbal and nonverbal behavior than control couples. Control-group couples displayed significantly greater use of negative verbal behavior (e.g., criticism, disagreement), and nonverbal negative behavior than EPL spouses.

The results of these two prospective longitudinal studies demonstrate a significant impact of the universal interventions on couples' functioning over a 5-year period. The German findings replicate those of Markman and his colleagues (1993) cross-culturally and demonstrate the possibility of preventing relationship distress and dissolution through a short-term intervention focused on building skills in functional communication and conflict management for satisfied couples early in their relationship.

Selective preventive interventions

Selective preventive interventions target subgroups of the population who have an elevated risk for developing a problem. One example is to provide premarital relationship enhancement programs only to those couples in which one or both partners come from a divorced family and are, therefore, at elevated risk for developing marital problems.

Halford, Sanders, and Behrens (2001) conducted a randomized controlled trial of a skills-based relationship education program, including an assessment of relationship satisfaction and stability data at four year follow-up. The evaluated relationship education program was Self-PREP which is similar in content to PREP supplemented with a self-regulation component. On the basis of negative family-of-origin experiences (parental divorce or inter-parental violence) the couples were divided into a high- and a low-risk group for relationship problems. In general,

couples completing Self-PREP were found to have significantly higher relationship satisfaction at 4-year follow-up than couples in a control condition, but this effect was only evident for couples at high risk of relationship problems. This finding and the possibility that relationship education may have differential effects for low- and high-risk couples needs further exploration.

Indicated prevention interventions

Indicated prevention involves selecting couples who self identify with some symptoms of distressed relationships but who do not identify themselves as maritally distressed and in need of therapy. In an EPL-study by Kaiser, Hahlweg, Fehm-Wolfsdorf, and Groth (1998), couples with a minimum partnership duration of three years, of whom 70% were dissatisfied with their relationship, were recruited and randomized to EPL or a no intervention control group. The EPL couples reported significantly fewer relationship problems after the intervention and also showed greater skills in positive verbal and nonverbal communication (namely self-disclosure, positive solution, and acceptance of partner) and fewer negative verbal communication behaviors (criticism and justification) than control couples. Recently, an 11-year follow-up interview of this study was conducted (Hahlweg & Richter, 2010). Divorce rates in those couples who had attended the EPL were 26 percent whereas 56 percent of the controls had separated. For those couples still together, in both groups, the rate of happy relationships was 80 percent - thus, there is optimism for older couples who are willing to focus on improving their relationships. The response rate after 11-years was 93 percent.

Implications for future research

Couples entering marriage and similar committed relationships are heterogeneous with respect to their relationship education needs, yet there has been little research on tailoring programs to the individual needs of couples. In the future, adaptations of existing universal, selective, and indicated prevention programs are needed to address specific subgroups as well as particular topics, e.g., stepfamilies and couples in which a partner has a psychological

disorder (see Baucom, Whisman, & Paprocki, in press; Halford & Casey, 2010 and Markman & Rhoades, 2012). Future research should also focus on the needs of couples at different stages and not just on the transition into a relationship. For example, couples making the transition into parenthood or facing health crises (see Baucom, Kirby, & Kelly, 2010; Halford & Casey, 2010; Heinrichs, Conrath, Degen, & Snyder, 2012), may benefit from specialized relationship education.

Are couple interventions widely available?

In the U.S. and Australia, the percentage of couples receiving some form of universal preventive interventions (relationship education) is about 30 percent (see Doss, Carhart, Hsueh, & Rahbar, 2010). Samples collected in religious organizations have considerably higher participation rates given that most churches require premarital counseling in order to get married in church. Representative data for Germany and Switzerland are not available. Yet, in a study by Lösel, Schmucker, Blanckensteiner, and Weiss (2006) the dissemination of relationship education provided by German family centers was investigated. Out of the 200,000 events offered to the public per year, only about 1,500 were focused on relationship enhancement; of those, 65 percent were self-developed by the provider, only about 7 percent had a cognitive-behavioral background, and only 1.4 percent used some form of broader empirical evaluation. These findings implicate the need to think of new approaches to dissemination and evaluation.

Challenges for couple prevention and intervention

Although approximately one third of intact couples are distressed, the vast majority of people suffering from relationship difficulties do not seek help, and those who do primarily

seek assistance in physicians' offices. Less than 15 percent of intact couples seek couple therapy (Doss et al., 2010).

What prevents couples from accessing appropriate interventions? Some couples may be unaware of risk factors in their relationships (Doss, Atkins, & Christensen, 2003). Those who have not yet begun to self-evaluate as distressed often have low motivation to seek treatment while severely distressed couples often believe it is too late for their relationship to improve. Further barriers include lack of confidence in the outcome, a preference to solve problems on one's own, unwillingness to share their private life, a fear of being stigmatized, a lack of awareness of resources, treatment costs and logistical challenges such as a lack of time or childcare (Doss, Benson, Georgia, & Christensen, in press). All these barriers illustrate the need for interventions that have the ability to reach individuals, couples, or families who might otherwise not seek intervention or not have readily available access to care. To achieve this goal, it is necessary to make progress in new ways of delivering services to victims and those at risk for IPV (Kazdin & Blase, 2011).

Conclusion

Over the past years, a great deal has been learned about the prevention and alleviation of couple distress, and a variety of prevention programs has been developed. Research analyzing the efficacy and effectiveness of these programs has demonstrated that skills based relationship trainings, in particular, succeed to improve and maintain relationship satisfaction und stability over time. However in practice, evidence-based programs are rarely offered and if they are, many couples do not make use of them. Based upon such findings, we now are at a point where careful thought and planning can reap fruitful results in a national program to prevent marital distress.

Recommendations for dissemination and policy in the couple area

In order to develop a comprehensive, national scope prevention strategy, a number of steps are necessary (Baucom, 1998; Hahlweg, 2004): In order to reach a broad range of couples who have different needs and who will be receptive to different levels of intervention, a multilevel set of couples' interventions must be developed. For example, Sanders (1999) and his colleagues have created such a multilevel set of interventions for parenting which can serve as a conceptual framework for a focus on couples. Adapting from Sanders' terminology, several different levels of intervention can be differentiated according to the intensity of intervention: (a) universal couples' interventions based on a public health model with no direct couple contact; (b) primary care for couples who want to address their own relationship without direct contact; (c) active skills training and education for couples involving direct contact with trained interventionists; and (d) couple therapy or counseling for distressed couples.

Universal couples' interventions

Many couples do not wish to focus directly on their marital relationships in a concentrated manner, attending workshops or counseling sessions. Yet, minimal intervention might be of assistance to a wide variety of couples when considered from a public health perspective. In the arena of child behavior problems, Sanders, Montgomery, and Brechman-Toussaint (2000) have demonstrated that a professionally produced television series in an infotainment format is watched by a large number of parents with high levels of consumer satisfaction. A similar set of television segments focusing on couples, either within a larger series devoted to the family or as a standalone series, could reach a large segment of the population; also adolescents without an intimate partner might be interested. In addition to assisting couples on its own right, such a series might open discussion among partners about their own relationships and make them more motivated to seek additional assistance if it is needed.

Primary care focusing on a couple's own relationship

Whereas the above strategy provides general information about marriage including universally relevant themes and information, additional intervention strategies are needed for couples who want to focus on their own relationships in a more detailed manner. Again, the couple intervention field could draw upon the work of Sanders and his colleagues, who have produced a series of Tip Sheets with information that parents can request about specific aspects of parenting relevant to their own situations. A series of videotapes elaborating upon these themes also is available (Sanders, Turner, & Markie-Dadds, 1996). A similar strategy can be employed focusing on couples. Already there is a wealth of information about marriage and communications skills that has been produced in a variety of formats for couples, including handouts and self-help books for couples that can be employed and adapted for such purposes. The availability of such materials can be advertised through the above television series, newspaper advertisements, television and radio announcements, and brochures in primary health care settings.

In addition to the use of television programs, videotapes, and printed materials, recent advances in technology provide additional opportunities for reaching couples without direct, ongoing intervention. The increasing widespread use of computers provides at least two additional mechanisms for reaching couples. One of the strengths of the computer is its ability to provide access to extremely large data bases within the context of one's own home. This can be useful to individuals who are in more remote settings or who for a variety of reasons are not comfortable discussing relationship issues with persons outside of the family. One mechanism for providing such information is through the Internet. Thus, a web page with a variety of information about couples, married life, links to other sites, and information about agencies and groups to contact if the individual desires direct contact might reach segments of the population who are unlikely to contact professionals initially.

Another strategy for using the computer to assist couples is through the development of interactive DVDs or web-based programs (see Casey & Halford, 2010; Halford & Casey, 2010; Engl & Thurmeier, 2010). Such computer programs could be purchased or accessed by the individual couple and used on their home computers. The current storage capacities of these devices provide great flexibility regarding the types of materials that can be presented, along with interactive strategies. Although not all couples would be comfortable with such a format, a number of couples might actually find it to be preferable. For example, most requests for couple therapy or family problems come from women; men are known to seek assistance from the mental health field less frequently than women. Thus, a modality that allows men to stay within their homes might be appealing. Second, a significant number of men are captivated by the technology of computer programs, and thus might be receptive to such a medium.

Active skills training and education from trained interventionists

The hallmark of the above interventions is that they involve little or no direct contact between the couple and professionals in the couple field. These strategies need to be supplemented with interventions that allow a couple to work directly with persons trained to assist couples with their marriages. Existing programs for couples can be categorized as (a) information-based educational programs that do not involve teaching skills to couples and (b) skills-based education programs. Both basic research and treatment research point to the importance of skills-based programs for couples. The results of skills-based couples' programs such as PREP (Markman et al., 1988), EPL (Hahlweg et al., 1998; Thurmaier et al., 1999), or FSPP (Bodenmann, 2004) demonstrate that these interventions have promise in assisting couples. The application of such prevention programs in multiple countries including Germany, U.S., Australia, and Holland provide a wealth of information and experience upon which to draw in establishing a broad network of active skills-based programs for couples.

Couple therapy for distressed couples

The above strategies are designed to help prevent the development of couple discord or provide assistance as distress is developing. In addition, assistance is needed for couples who are currently distressed. At present, there are several approaches to couple therapy (i.e., cognitive-behavioral, integrative-behavioral, insight-oriented, and emotion focused couple therapy) that have received empirical support for their effectiveness. The most researched and well validated approach is a cognitive-behavioral intervention that is consistent with the skills-based prevention programs described above. In order to help couples avoid the multiple complications resulting from divorce for both parents and children, it is important that care continue to be provided for these distressed couples.

Conclusion

As can be seen, in order to develop a comprehensive program to support and assist couples at different levels of need and with different levels of comfort in seeking assistance, a wide variety of intervention strategies is needed. The first two levels of intervention described above rely upon a variety of media strategies to reach couples who do not wish or need to work directly with a trained interventionist in the couple field. The creative use of a variety of media can greatly extend the outreach to couples in the community. Yet, some of these interventions are likely to be less effective than in-person therapy; but strong effect sizes (ES) are not always the first consideration (Kazdin & Blase, 2011). An intervention with a larger ES is not invariably better than one with a smaller one. An intervention with a weak but reliable effect that can reach a large number of individuals or couples with little cost would be worth having and could only be displaced by another intervention with a greater ES that addressed the same population, cost, and so on. Also, it is quite possible, even in this context that both treatments are kept because they reach a slightly different group among those in need. Summing up, small effects on a large scale provide an important complement to other

models of delivery. The task is not to have one intervention to reach everyone. In order to successfully develop, coordinate, and disseminate such a variety of offerings, an organizational strategy and structure on the national level is needed.

Creation of an organization and structure to oversee the development and dissemination of couple interventions

The exact nature of the organizational structure necessary to provide the interventions described above will require a great deal of thought by various parties involved. However even at present, at least one major recommendation is appropriate: any organizational structure that is developed should draw heavily from both public agencies and universities. The actual delivery of prevention/intervention programs is likely to be based within a variety of public agencies, and their involvement from the beginning is essential (see Hahlweg et al., 2010). These agencies know how they operate, who their personnel are, the populations they serve, and regional factors that will either contribute to or deter effective dissemination. Thus, not only do these agencies have a great deal of firsthand experience in the delivery of services, but it is also critical that they have a sense of involvement and ownership of programs that are developed. Widespread development, dissemination, and success of couple programs are unlikely if agencies experience that the programs are being thrust upon them from the outside.

Equally essential in the organizational efforts is the presence and leadership of university faculty having experience in conducting basic research on couples and in developing and evaluating couple treatment and prevention programs. These scholars can help to insure that changes proposed to the intervention due to cultural factors, regional preferences, etc. do not disrupt the basic integrity of the programs and are consistent with basic research findings. University faculty are also likely to be integral in developing and

evaluating the training programs to ensure that those delivering the program meet certain criteria. Similarly, university faculty will likely be central in conducting the ongoing evaluation of the intervention programs, including the design of the evaluation components, data analysis, and interpretation of findings.

First efforts to implement and evaluate couple interventions on a large scale

In recent years, first efforts to support couples on the large scale emanate from the United States. Such efforts include the *Supporting Healthy Marriage* (SHM; Hsueh et al., 2012) initiative, founded in 2003 at an expense of $500,000,000 to evaluate the effectiveness of a skills-based relationship education program for low-income married parents. The aim of SHM is to help couples strengthen their relationships and, in turn, to support more stable and more nurturing home environments as well as more positive outcomes for parents and their children. The evaluation was made possible by the *Administration for Children and Families* (ACE) within the U.S. Department of Health and Human Services. First results showed that after 12-months, the SHM program produced a consistent pattern of small positive effects on multiple aspects of couples' relationships: Across outcomes and data sources, the program group couples showed higher levels of marital happiness, greater warmth and support, more positive communication, and fewer negative behaviors and emotions in their interactions with each other, relative to the control group. Moreover men and women in the program group reported less psychological abuse in their relationships as well as less psychological distress. However, at the 12-month follow-up point, the program did not significantly affect whether couples stayed married or not.

Another example of a large scale approach is Building Strong Families (BSF), a 9-year, multisite demonstration program, that has also been funded by the ACF (Dion et al., 2008). BSF is structured to promote strong relationships between couples with a new baby or who are about to have a child together and to support couples who desire marriage to achieve

it. Given different programs, BSF provides group as well as individual and family support. A recently conducted 5-year follow-up found no overall effects on couples' relationship quality or the likelihood that they remained together or got married (Wood, McConnell, Moore, Clarkwest, & Hsueh, 2012).

In 2011 the ACF additionally announced the availability of funding for four discretionary grant awards totaling $150,000,000 for *Healthy Marriage* and *Responsible Fatherhood* grants. These grants aim to assist married couples or those considering marriage in building strong relationships with each other and their children, and to help fathers to meet their parenting and financial responsibilities to their children.

All these broad initiatives are promising, and the SHM study already provides some encouraging evidence that couple based interventions can yield positive effects when delivered on a large scale. However, the importance of those findings will depend on whether the initiatives will succeed to have positive impacts on marital stability and parents' and children's well-being over time.

Summary

The review illustrates that in daily life, an alarming number of children and adolescents are exposed to different forms of violence. Violence victimization in turn is a scientifically accepted explanation of emotional, psychological, and behavior disorders (e.g., mood disorders as well as anxiety, behavior, and substance-use disorders). Moreover, recent findings suggest that CVV can also lead to certain biological alterations that are known to be associated with an elevated risk for cardiovascular diseases, immune diseases, stroke, and even dementia. Thereby CVV not only has an enormous impact on the individual but also on society, resulting in extensive costs for health care services and other services and systems that are related to behavior, emotional, and psychological disorders as well as to physical

health outcomes. Because of the complexity of the occurrence of CVV and its effects on child well-being, different approaches not only for the treatment but for the prevention of CVV are needed to reduce the likelihood of future generations being exposed to violence.

Because children's risk for being victimized is highly associated with IPV between parents, one approach to decrease the prevalence of CVV should focus on increasing couple functioning and satisfaction, along with a decrease of IPV. In order to assist couples at different stages, at different levels of need and of comfort in seeking assistance, a wide variety of interventions as well as an extensive dissemination strategy is needed. Based on these findings, different approaches to prevent and treat couple distress were discussed. However in order to develop, coordinate, and disseminate such a variety of offerings successfully, an organizational strategy and structure on the national level is needed, which should incorporate both public agencies and universities. Accordingly, the future challenge is to successfully integrate the existing knowledge of effective interventions and a conceptual framework.

Concerning research, future studies should investigate the effectiveness of the dissemination of evidence-based couple programs on a large scale basis. In the context of those studies, the researchers should focus on the long-term effectiveness as well as on assessing different strategies of delivery to reduce dissemination costs. Moreover, adaptations of evidence-based programs should be developed and evaluated to address specific subgroups as well as particular topics.

Given the strong association between couple functioning and child well-being, extensive and well planned advancements might be the only strategy to achieve essential changes on a large-scale basis and, therefore, to decrease the burden of couple conflict, family violence, and separation/divorce on individuals, families, and society on the whole.

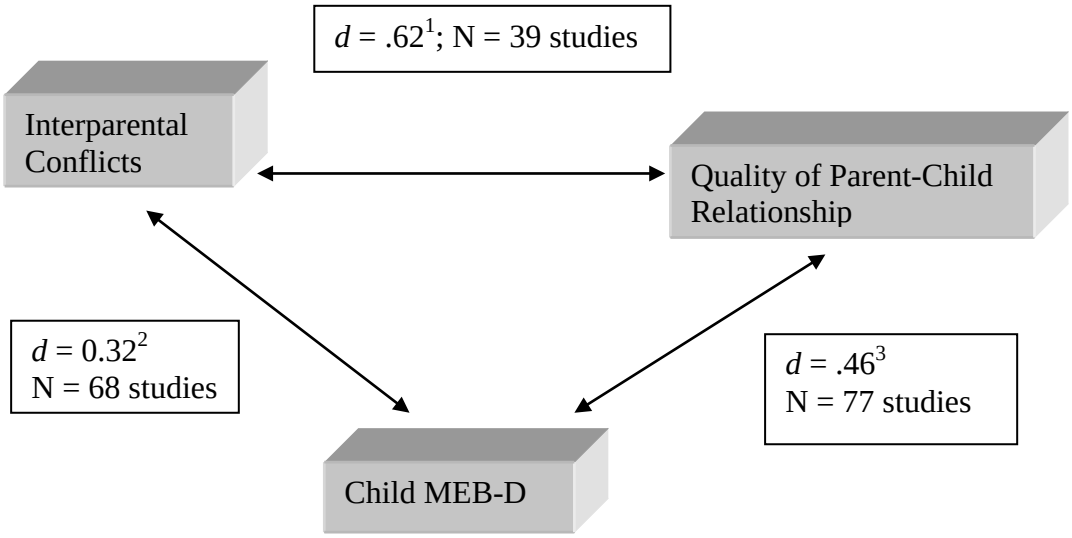

Figure 1. Meta-analyses: Association of parental variables and child mental, emotional, and behavioral disorders (MEB-D) [1]Krishnakumar & Buehler (2000); [2]Buehler et al. (1997); [3]Gershoff (2002).

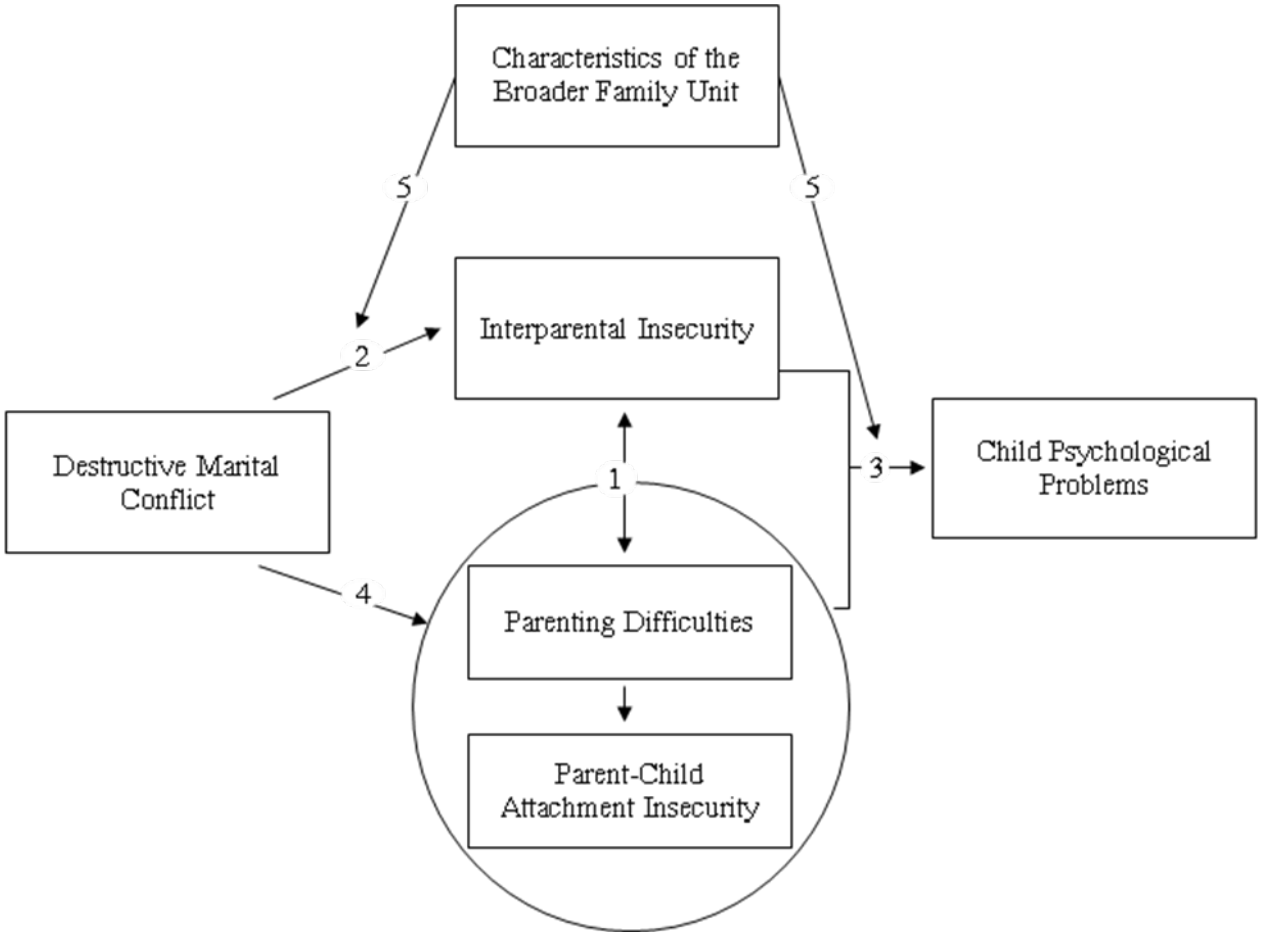

Figure 2. Multiple pathways underlying associations between destructive marital/couple conflict and child psychological problems (Cummings & Davies, 2010).

Acknowledgements

This manuscript is based on a paper presented at the third Think Tank Meeting by the Klaus-Grawe-Foundation in Zuoz, Switzerland, June, 2012.

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