

Couples therapy: effectiveness of treatment and long-term follow-up

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Most couples therapy theories are developed and tested in the USA. In this clinical study, we investigated such therapies in a Swedish context. Over 300 couples were enrolled in the study of whom just under half completed the end-of-treatment assessment and just over 40 per cent a two-year follow-up. At the start, the study group displayed severe problems in marital adjustment, dyadic interactions and psychiatric symptoms. A relatively short treatment was used and 50 per cent of the couples attended less than nine sessions. Outcomes of treatment showed significant improvements in relationship matters, individual mental health and enhanced coping abilities. At long-term follow-up, all results remained the same and in some aspects improved for both sexes. This study confirms the effectiveness of such therapies in a Swedish context.

Introduction

In Sweden, most couples therapy is based on approaches developed and tested in the USA (Gurman and Jacobson, 2002). Most theories of couples therapy have been developed in the context of research therapy or treatment used in private practice (Shadish *et al.*, 1995). We were interested in investigating how these theories and methods work in Swedish culture performed within a clinical context. Shadish and Baldwin (2003, p. 561) note: '[t]he effects of marriage and family interventions in clinically representative conditions have not been studied much.' This is also true in Sweden. Swedish culture is different in many ways in comparison with the USA, in particular in different attitudes to equality between the genders. There is also a difference in therapeutic resources for couples available in Sweden. Couples therapy, guaranteed by law, is part of the social welfare system (family counselling).

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Research supports the effectiveness of couples therapy in enhancing marital satisfaction (Johnson and Lebow, 2000; Shadish and Baldwin, 2003). In addition, recent research supports the effectiveness of couples therapy addressing 'individual' problems such as depression or anxiety, and it is seen as a context where partners can help each other grow and promote resilience (Baucom *et al.*, 1998; Byrne *et al.*, 2004; Leff *et al.*, 2000). Many researchers have assessed various methods of treatment and have compared various models. In these comparisons, it has not been possible to verify measurable differences between therapy approaches (Dunn and Schwebel, 1995; Shadish *et al.*, 1993, 1995).

Meta-analyses assessing couples therapy outcomes (Hazelrigg *et al.*, 1987; Shadish *et al.*, 1993; Shadish and Baldwin, 2003) have unanimously concluded that this form of treatment increases marital satisfaction more than no treatment at all. Many couples entering couples therapy change positively in marital satisfaction/individual symptomatology, but not all of them will become 'symptom-free' (Gurman and Fraenkel, 2002). Various versions of couples therapy produce moderate and statistically significant effects (Jacobson and Addis, 1993; Gurman and Jacobson, 2002; Shadish and Baldwin, 2003). Overall, for the most commonly studied methods of treatment, couples therapy helped 60 to 75 per cent of the couples. Statistically significant change from distressed to non-distressed levels in marital satisfaction has reached an average level of 35 to 50 per cent. All couples therapies that have been reasonably well tested have been empirically proven to be effective. The durability of change is also important, but empirical tests have not been extensive. At this stage, it may be assumed that a significant number of couples may relapse over time. Some couples may, of course, experience negative effects as a result of treatment, which leads to deterioration.

Few studies have tested the effects of couples therapy long term after termination of treatment; the longest follow-up was a four-year study (Snyder *et al.*, 1991). The follow-up studies performed showed diminishing effects of 30 to 60 per cent over time (Jacobson *et al.*, 1987; Snyder *et al.*, 1991; Johnson and Lebow, 2000).

The context of the present study

In Sweden, evaluation of couples therapy has concentrated primarily on consumer satisfaction with few empirical studies examining outcomes in such therapies. Because of this, neither the situation of these couples nor the results of their treatment, whether short or long

term, can be properly evaluated. The need to obtain a deeper understanding of the requirements for treatment and prevention is reinforced by the increases in family distress and family disruptions and the importance of this from a public health perspective due to the associated health risks for both the couple and their children (Levenson *et al.*, 1993; SCB, 1995; Willén and Thuen, 2002; Hetherington and Elmore, 2003).

In this study, couples therapy was conducted in family counselling agencies in Sweden, which falls under the responsibility of municipal social welfare (SOU, 1994). To encourage low-income participation, costs are kept low. Most couples are self-referred. This is the only counselling in public health services that addresses couples who do not have special diagnosis. The counselling aims to perform couples therapy, but many also attend for other reasons: to obtain information about legal and social benefits; for mediation between separated couples; or for guidance and support about relational matters for those attending treatment on their own. Psychosocial treatment is the primary mode of treatment. Treatment is mostly short term, usually less than ten sessions, each extending to about one hour. The study used a multi-site design within six family counselling agencies (Lundblad and Hansson, 2005).

Aims

The study investigates the differences between before treatment and after treatment and at two-year follow-up. Results of the couples therapy are presented in the form of marital satisfaction, family climate, symptoms, sense of coherence and expressed emotion. In addition, this study examines how theories and methods developed elsewhere may be adapted to Swedish culture.

Method

Design

The study is in the form of a multi-centre non-randomized single group clinical study. The couples completed self-rating forms assessing the severity of relational and individual problems as well as individual resources before and after treatment, and two years after attending couples therapy. Results from all three assessments will be presented.

Participants and procedure

Over a two-year period (1998–2000), couples living together and attending family counselling agencies together were asked to participate in the study (consecutive sampling). Figure 1 shows the numbers attending the clinics and those taking part in the study.

A total of 317 couples agreed to participate. The inclusion criteria were: adequate knowledge of Swedish and an agreement to attend at least three joint counselling sessions as a couple (Lundblad and Hansson, 2005). Approximately 30 per cent of all those attending the participating clinics met the criteria for the study and just over half of these agreed to take part in the study. Each participant completed the self-rating forms individually (usually during the first visit). Sixteen therapists (fourteen women, two men) participated in the

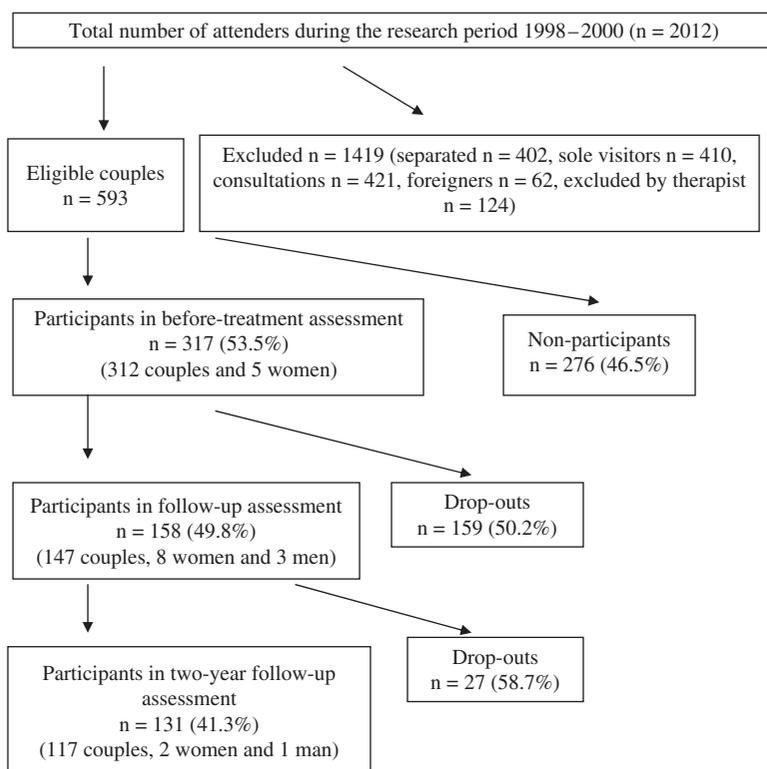


Figure 1. Attenders, participants and drop-outs from the study

study. The number of treated cases by each therapist varied between six and thirty-six. The median number was twenty cases. We assessed 158 (49.8 per cent) couples after treatment. Two years after attending family counselling a total of 131 (82.9 per cent of those completing treatment or 41.3 per cent of the original cohort) couples completed the long-term follow-up.

Of the participating couples, 60 per cent were younger than 40 years, 25 per cent were between 40 and 49 years old, and 15 per cent were older than 49. Eighty-five per cent had children under the age of 18 years. We classified the couples according to their occupational status, and the study group was shown to be comparable to Swedish statistical norms for adults (ages 18 to 64 years) on this dimension.

Therapy methods

In Sweden, therapists commonly use integrative treatment approaches. In this research, treatment was not performed according to a manual, but a careful investigation of the treatment methods normally used by the therapists was done at the outset of the study. The therapists were asked to identify their working methods using self-assessments about their choice of five selected methods and videotaping of therapy sessions. The therapists identified and defined some of their commonly used therapy methods. From this we concluded that systems theory was used as a meta-theory to identify and clarify interactions and problems. This included communication training and problem-solving activities. Psychodynamic techniques were also used with a mixture of insight-oriented and emotionally focused methods. These methods were used to focus on understanding and expressing feelings in the present relationship, linking these to earlier experiences and unsatisfied needs. Educational methods were used to inform couples about common relationship problems, stressors connected to life-cycle changes, and training of special skills. Cognitive techniques were used to clarify personal dysfunctional interpretations of couple interactions and linking these to behaviours and emotions. Solution-focused methods (e.g. asking questions about miracles, exceptions and scaling techniques) were used to strengthen resources and focus on progress. We found (from the therapists' descriptions and from external assessments of the videotapes) that the therapists' methods appeared to be consistent across the group. Techniques derived from systems theory were used for around 27 per cent of the time, solution-focused techniques 20 per cent,

cognitive approaches 19 per cent, educational techniques 19 per cent and psychodynamic interventions 15 per cent. There were no statistically significant differences between the therapists' use of different methods either individually or by agency (X^2 -test).

Instruments

Couples entering therapy experience problems in various domains (Burman and Margolin, 1992; Gottman and Notarius, 2000; Kiecolt-Glaser and Newton, 2001), and the assessment, therefore, included measures of individual (Psychiatric Symptoms and Sense of Coherence), relational (Dyadic Adjustment Scale and Expressed Emotion), and family (Family Climate Scale) functioning.

The Dyadic Adjustment Scale (DAS) is a measure of marital satisfaction (Spanier, 1976). The scale consists of thirty-two items with sub-scales about dyadic consensus, dyadic satisfaction, dyadic cohesion and affectional expression. The score varies from 0 to 151 with higher scores indicating greater satisfaction. The total scale and the sub-scales may be considered as measures of different aspects of marital satisfaction. The Swedish version has a satisfactory Cronbach's alpha (.87–.93) (Kaslow *et al.*, 1994). In this study, Cronbach's alpha ranged between .86 and .91.

Questions about Family Members (QAFM) is a self-rated measure of 'expressed emotion' (EE) (Hansson and Jarbin, 1997). It consists of thirty items that describe a dyadic relationship with another family member. The questionnaire has been homogenized by factor analysis, resulting in four factors: two factors about 'given EE' (critical remarks (CR)) and emotional over-involvement (EOI)), and two factors about 'perceived EE' (perceived criticism (PC) and perceived emotional involvement (PEI)). Expected differences between clinical and non-clinical groups have been found. Cronbach's alpha for CR was .87, for EOI it was .81, for PC it was .73, and for PEI it was .69. In this study Cronbach's alpha were between .68 and .84. In this study, we have used the two sub-scales that are conceptually closest to the commonly used observational ratings of Expressed Emotion: critical remarks and emotional over-involvement (Butzlaff and Hooley, 1998).

The Family Climate Scale (FCS) is a list of eighty-five adjectives that are selected to reflect different aspects of the emotional atmosphere in the family (Hansson *et al.*, 1994). The family climate affects not only the adults in the family but also the health and personal growth of the children (Hetherington and Elmore, 2003). Four independent factors

have been identified: Closeness (CL), Distance (DI), Expressiveness (EX), and Chaos (CH). An index was calculated for each of the factors. Cronbach's alpha for CL was .98, for DI it was .91, for EX it was .71, and for CH it was .92. In this study, Cronbach's alpha was between .97 and .78. In this study, we excluded the factor expressiveness.

The Symptom Check List (SCL-90) (Derogatis *et al.*, 1973) is a widely used measure that contains ninety items referring to expressions of psychosomatic and emotional distress. A low score on this questionnaire indicates 'good mental health'. This questionnaire has been standardized to Swedish conditions (Fridell *et al.*, 2002). Cronbach's alpha was .89. In this study, Cronbach's alpha was .95.

The Sense of Coherence (SOC) instrument measures a person's stress-resilience capacity, and as such becomes a health-promoting factor (Antonovsky, 1993). In theory, Antonovsky (1985) viewed this variable as a relatively stable trait, but later research has shown that it may be sensitive to change (Smith *et al.*, 2003). SOC consists of twenty-nine items with seven alternatives for each item. The scores vary between 29 and 203. In earlier studies, this instrument has shown a satisfactory validity and reliability (Cronbach's alpha was .89) (Antonovsky, 1993; Hansson and Olsson, 2001). In this study, Cronbach's alpha was .91.

Statistical methods

In this study, the statistical methods used were paired t-test for differences between dependent groups (pre-treatment, post-treatment and at two-year follow-up). Paired t-test were limited to those individuals who participated in after-treatment assessment and follow-up participants respectively. X^2 was used for frequency differences and ANOVA for differences between independent variables. Effect size ($ES = d$) was estimated by calculating differences between the mean post-test score and the mean pre-test score, divided by the pooled standard deviation (Cohen, 1988). It was calculated to get an estimate of the magnitude of change after treatment and at follow-up regardless of the particular measure being used. Cohen (1988) suggests that effect sizes may be interpreted as follows: $d = .20$ to $.40$ small; $d = .50$ to $.70$ medium; and $d = .80$ and over large, although caution is needed, since ES are calculated in different ways in different studies and do not provide an absolute measure of change.

Results

A total of 158 couples were assessed after treatment. From these, 131 couples were followed up two years after attending counselling (Figure 1). Nine divorced women and two divorced men also filled in the instruments. A total of thirty-six (27.5 per cent) couples were separated at the two-year follow-up. The DAS and FC were excluded in the after-treatment assessments for separated persons because these forms assume that the parties are living together. The average number of counselling sessions was 8.8 (SD 5.1), and 50 per cent of the couples attended fewer than nine (three to eight) sessions. The range of sessions varied from three to twenty-five. The most frequent number of sessions was five.

Attrition analysis

At the end of treatment, differences between those couples who took part in the post-treatment assessment (study completers) and those who did not (study drop-outs) were analysed with regard to study group variables (one-factor ANOVA), agencies, and therapist variables (X^2 -test). There were no differences in the initial values on any of the self-ratings between eventual study completers and study drop-outs. However, study completers attended significantly more treatment sessions than did study drop-outs ($t = 5.86$, $p < .001$).

Marital satisfaction (DAS)

Table 1 shows the changes in marital satisfaction as assessed by the Dyadic Adjustment Scale (DAS).

TABLE 1 DAS: assessment of the study group before treatment (1), post-test (2) and long-term follow-up (3), together with statistical differences and effect size (ES)

	Before	Post-test	Follow-up	Diff. 1-2		ES	Diff. 1-3		ES
	W. n = 316 M. n = 310	W. n = 105 M. n = 102	W. n = 94 M. n = 93	t	p	(d)	t	p	(d)
DAS	M (sd)	M (sd)	M (sd)						
W	88.6 (19.3)	103.9 (21.7)	103.0 (21.4)	-7.16	.0001	.75	-4.97	.0001	.71
M	94.5 (18.8)	107.3 (18.1)	108.2 (20.3)	-6.49	.0001	.69	-4.19	.0001	.70

Note: W = women, M = men.

In the study group, both genders initially presented very low scores on marital satisfaction (dyadic adjustment). Women initially rated their marital adjustment significantly than did men ($t = -5.733$ and $p < .0001$). After treatment (women; $t = -7.16$, $p < .0001$, men; $t = -6.49$, $p < .0001$), and at long-term follow-up (women; $t = -4.97$, $p < .0001$, men; $t = -4.19$, $p < .0001$), there were significant improvements for both genders compared with values prior to treatment. For women, there was a statistically significant difference between the post-test assessment and at long-term follow-up ($t = 2.15$, $p < .03$), showing some deterioration two years after treatment, although this was not the case for men.

Expressed emotion (QAFM)

Our analysis of this self-report measure (Table 2) has focused on the two dimensions (critical remarks and emotional over-involvement) that most closely resemble the original dimensions of observational ratings of Expressed Emotion (Butzlaff and Hooley, 1998).

Differences between women and men were initially found on both sub-scales (CR $t = 11.592$, $p < .0001$, EOI $t = 4.029$, $p < .0001$). Men were more often the receivers of critical remarks (CR) expressed by the women while women seemed to be more affected by emotional over-involvement (EOI). After treatment (women; CR $t = 8.49$, $p < .0001$, EOI $t = 6.08$, $p < .0001$, men; CR $t = 5.75$, $p < .0001$, EOI $t = 4.41$, $p < .0001$) and at long-term follow-up (women; CR $t = 6.85$, $p < .0001$, EOI $t = 6.81$, $p < .0001$, men; CR $t = 5.95$, $p < .0001$, EOI $t = 7.26$, $p < .0001$), there were significant improvements for both sexes in both dimensions compared with values before treatment.

TABLE 2 *QAFM: assessment of the study group before treatment (1), post-test (2) and long-term follow-up (3), together with statistical differences and effect size (ES)*

QAFM	Before	Post-test	Follow-up	Diff. 1-2		ES	Diff. 1-3		ES
	M (sd)	M (sd)	M (sd)	t	p	(d)	t	p	(d)
	W. n = 316	W. n = 127	W. n = 121						
	M. n = 311	M. n = 121	M. n = 115						
CR. W	2.81 (.71)	2.36 (.73)	2.30 (.78)	8.49	.0001	.62	6.85	.0001	.68
EOI. W	2.92 (.62)	2.56 (.73)	2.39 (.68)	6.08	.0001	.53	6.81	.0001	.81
CR. M	2.34 (.64)	2.03 (.67)	1.89 (.69)	5.75	.0001	.48	5.95	.0001	.68
EOI. M	2.74 (.62)	2.50 (.68)	2.23 (.61)	4.41	.0001	.37	7.26	.0001	.83

Notes: W = women, M = men, CR = critical remarks, EOI = emotional over-involvement.

Comparing post-test assessments and long-term follow-up for both sexes, there was a significant difference in the dimension of EOI (women; $t = 2.48$, $p < .01$, men; $t = 3.47$, $p < .0007$), which showed further improvements in this area. The assessment of the levels of CR showed no change from end of treatment to follow-up.

Family climate (FC)

Table 3 shows ratings at the three assessment times on another measure of couple functioning: the family climate (FC). At the start of treatment both women and men rated themselves low on closeness (CL) and high on distance (DI) and chaos (CH).

After treatment (women; CL $t = -8.20$, $p < .0001$, DI $t = 5.63$, $p < .0001$, CH $t = 4.10$, $p < .0001$, men; CL $t = -6.67$, $p < .0001$, DI $t = 5.37$, $p < .0001$, CH $t = 5.21$, $p < .0001$) and at long-term follow-up (women; CL $t = -6.56$, $p < .0001$, DI $t = 4.49$, $p < .0001$, CH $t = 4.08$, $p < .0001$, men; CL $t = -4.23$, $p < .0001$, DI $t = 3.49$, $p < .0008$, CH $t = 4.32$, $p < .0001$), there were significant improvements for both sexes on all three FC measures compared to pre-treatment values. There were no significant differences between post-treatment and long-term follow-up.

Psychiatric symptoms (SCL-90)

This questionnaire was used to assess psychological and emotional symptoms. Table 4 shows the changes in the overall score of the SCL (GSI).

Both women and men initially reported high levels of symptoms with women having significantly higher scores than men (GSI $t = 5.644$, $p < .0001$). Both sexes expressed highest scores in depression, obsession-compulsion and anxiety (for further details, see Lundblad and Hansson, 2005). At post-test (women; $t = 9.18$, $p < .0001$, men; $t = 5.44$, $p < .0001$) and at long-term follow-up (women; $t = 8.12$, $p < .0001$, men; $t = 7.37$, $p < .0001$), there were statistically significant improvements for both sexes compared to values prior to treatment. Comparing post-treatment result with follow-up, there was a statistically significant improvement in overall symptoms (GSI) for men ($t = 2.04$, $p < .04$) but not for women.

Sense of coherence (SOC)

See Table 5. Initially, women and men had low sense of coherence scores, although men scored significantly higher than women

TABLE 3 FC: assessment of the study group before treatment (1), post-test (2) and long-term follow-up (3), together with statistical differences and effect size (ES)

FC	Before		Post-test		Follow-up		Diff. 1-2		ES		Diff. 1-3		ES
	W. n = 295	M. n = 291	W. n = 102	M. n = 98	W. n = 92	M. n = 92	t	p	(d)	t	p	(d)	(d)
	M (sd)	M (sd)	M (sd)	M (sd)	M (sd)	M (sd)							
FC 1. W	.73 (.73)		1.60 (1.00)		1.52 (.98)		- 8.20	.0001	1.00	- 6.56	.0001	1.00	.92
FC 2. W	.93 (.76)		.51 (.72)		.52 (.67)		5.63	.0001	.57	4.49	.0001	.57	.57
FC 3. W	1.51 (1.28)		.81 (1.21)		.66 (1.08)		4.10	.0001	.56	4.08	.0001	.79	.72
FC 1. M	.82 (.80)		1.52 (.98)		1.50 (1.01)		- 6.67	.0001	.79	- 4.23	.0001	.79	.75
FC 2. M	.84 (.76)		.40 (.64)		.35 (.61)		5.37	.0001	.63	3.49	.0008	.63	.71
FC 3. M	1.45 (1.23)		.70 (1.07)		.63 (.94)		5.21	.0001	.65	4.32	.0001	.65	.75

Notes: W = women, M = men, FC 1 = closeness, FC 2 = distance, FC 3 = chaos.

TABLE 4 SCL-90: assessment of the study group before treatment (1), post-test (2) and long-term follow-up (3), together with statistical differences and effect size (ES)

	Before	Post-test	Follow-up	Diff. 1-2	ES	Diff. 1-3	ES
	W. n = 311 M. n = 308	W. n = 129 M. n = 118	W. n = 127 M. n = 118				
SCL-90	M (sd)	M (sd)	M (sd)	t	p	(d)	t
				p		(d)	p
GSI W	85.6 (47.6)	54.7 (44.6)	52.3 (40.1)	9.18	.0001	.67	8.12
GSI M	67.5 (46.4)	45.4 (43.7)	39.5 (33.4)	5.44	.0001	.49	7.37

Notes: W = women, M = men, GSI = Global Severity Index.

TABLE 5 SOC: assessment of the study group before treatment (1), post-test (2) and long-term follow-up (3), together with statistical differences and effect size (ES)

	Before	Post-test	Follow-up	Diff. 1-2	ES	Diff. 1-3	ES
	W. n = 317 M. n = 311	W. n = 128 M. n = 125	W. n = 128 M. n = 120				
SOC	M (sd)	M (sd)	M (sd)	t	p	(d)	t
				p		(d)	p
Women	132.4 (23.2)	138.8 (22.3)	141.1 (22.4)	- 5.60	.0001	.28	- 4.85
Men	139.1 (21.6)	146.0 (22.0)	147.3 (21.6)	- 4.54	.0001	.32	- 4.68

Notes: W = women, M = men.

($t = -4.19, p < .0001$). After treatment (women; $t = -5.60, p < .0001$, men; $t = -4.54, p < .0001$) and at long-term follow-up (women; $t = -4.85, p < .0001$, men; $t = -4.68, p < .0001$), there were statistically significant improvements for both genders compared with pre-treatment values. These scores did not change significantly during the follow-up period.

Comparison of outcome between therapists and treatment agencies

No differences were found on any of the outcome measures between the different therapists and treatment agencies, suggesting that even if the treatment approaches varied to some degree, the differences were not significant enough to lead to differences in treatment outcome.

Discussion

Most theories and methods of couples therapy have been developed and tested in the USA in the context of research or in private practice.

In this clinical study, performed within public health services, we investigated the applicability of these approaches in a Swedish context. As far as we know, this study is the most comprehensive assessment of couples therapy in family counselling agencies in Sweden.

There were three potential limitations to the study that need to be addressed before discussing the findings. First, self-report measures were used to assess all outcome variables which could have biased the results. However, the instruments used were mostly well-established measures with good psychometric properties and, in the case of the DAS and SCL-90, also with comparative data for a Swedish population.

Second, drop-out figures from post-treatment assessment were quite high, which is fairly common in psychotherapy research (Stanton and Shadish, 1997). In couples therapy, an additional factor is that both members of the couple need to agree to complete the treatment (and participation in the study). One of the participants might have been less interested or less content, or some external factor might be the reason for not completing the assessment. However, as in other psychotherapies, discontinuing treatment or participation in research does not necessarily indicate lack of effectiveness or dissatisfaction with treatment. The data from the study, showing that characteristics of the participants and the drop-outs did not differ significantly, increase confidence in our ability to generalize the findings about the effectiveness of the treatment.

The third possible limitation is that this was a single group study which did not use a wait-list control group or a randomized selection to determine treatment. We did not consider wait-list controls for ethical reasons. It has lately been questioned whether wait-list controls are essential in evaluating outcome research in couples therapy, as there is already good evidence from a large number of studies that distressed couples placed on waiting lists make no improvements during the waiting period (Baucom *et al.*, 2003). Randomization between different treatments requires different treatment methods to be available, but the therapists participating in the study all used relatively similar approaches which tended to be integrative. Couples therapy deals with behavioural, cognitive and emotional changes, and we felt that it was important to allow therapists the flexibility of addressing all these areas rather than limiting them to a more contained treatment model. Using a combination of methods we felt

was advantageous because therapists could be free to meet couples differently according to their specific problems.

Single group studies can overestimate outcome results compared to randomized studies (Wilson and Lipsey, 2001; Shadish and Baldwin, 2003). This means that our findings should be interpreted with caution, but given the consistency of the findings with all the assessments pointing in the same direction, it may be assumed that treatment had a significant impact upon the couples. It is also notable that the results were obtained with relatively short treatment.

Initially, both women and men rated their problems as serious in relational, individual and family domains. After treatment, significant improvements were attained. Both sexes scored normal values on 50 to 75 per cent in all variables. The magnitude of the improvements as shown by the effects sizes of change were moderate to large on all variables except on the variable sense of coherence, where improvement was smaller. At the two-year follow-up, the results remained largely the same or to some extent improved. We do not have information about any additional treatments (e.g. medication or individual therapy) during the two-year follow-up which could have potentially influenced the results.

Overall, this study underlines that in spite of the many and severe problems experienced by both the women and men attending the couple counselling, the outcomes of the treatment were clearly positive and maintained at follow-up. The results were comparable for both women and men. Notwithstanding the potential limitations of the study we would conclude that the couples therapy contributed significantly to improved relationships, individual mental health and enhanced coping abilities.

The aim of our study was to evaluate a couples treatment approach developed in a different cultural context and to compare the outcomes to other international studies. We also wanted to investigate if couples therapy performed as a public service (open to everyone) also results in positive outcomes. Our findings show that in spite of these differences the outcomes are comparable to other studies (Snyder *et al.*, 1991; Jacobson and Addis, 1993; Gurman and Fraenkel, 2002). Family counselling in Sweden is an activity meant for 'everyone' with easy access (by a telephone call to make an appointment) and it is available in every municipality. Costs are kept low and people from all social classes make use of it. This activity is also cost-effective for the care-givers. Most couples have short-term therapy, often not more than five sessions. Many of the couples gained positive benefits from

treatment, and this was seen as a way to help prevent more serious problems that could manifest at a later date.

These findings emphasize the diverse problems couples have when entering family counselling and the importance to reflect on ways to help these families receive appropriate and timely assistance; otherwise, family problems could become more severe and the family unit may dissolve. Enduring family problems as well as family transitions increase the risks for psychological and physical ill-health for all family members (Kiecolt-Glaser and Newton, 2001; Hetherington and Elmore, 2003). In addition, family counselling in the context of public health should consider taking more interest in preventive efforts to help Swedish couples.

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