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Marriage and Relationship Education and Couples and Marriage Therapy: What's the Difference?

Research Brief

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The views expressed in this research brief are those of the authors and do not necessarily reflect the views of the National Healthy Marriage Resource Center (NHMRC). The inclusion of key researchers and professionals is not meant to be a comprehensive list of all individuals that have contributed to the field of marriage/relationship education and/or couples therapy. Any omissions in the text are not intentional.

Marriage and Relationship Education and Couples and Marriage Therapy: What's the Difference?

Introduction

There has long been confusion about the difference between marriage and relationship education (MRE) and couples and marriage therapy (CMT) and whether these are the same as “marriage counseling.” Some people—including professionals, public officials and the media—use these terms interchangeably. The public’s confusion is understandable when professionals themselves often use the terms so loosely.¹ Some people are genuinely not aware of any differences. Others argue that any differences that may have once existed are increasingly becoming blurred and hence don’t really matter.

This Brief aims to explore the various claims made about the commonalities and differences between these two fields, in the hope of bringing more clarity to the way these fields are represented and discussed. While acknowledging the many elements these fields have in common, fundamental philosophical and practical differences between them also need to be recognized as they have important implications for policymakers.

It’s important to note that marriage and relationship education and couples and marriage therapy are currently separate professional sub-fields within a broader field. Each has its own professional education/training programs, national membership associations (see Resources), operates in somewhat

different practice settings, and is paid for differently. CMT is established with national standards, licensing exams and some state regulation whereas MRE does not have this infrastructure in place.

These two fields share roots in the marriage counseling movement which began in the United States in the 1930s. This movement flourished for three to four decades, but has since taken a back seat to MRE and CMT.

This research brief includes a short description of the growth and development of the marriage counseling movement to illustrate how it evolved into the separate but related contemporary fields of MRE and CMT. The brief defines MRE and CMT and discusses the extent to which the fields share similar goals, research, and theory foundations. It also explores how the two fields increasingly are working with similar content and approaches. The brief points out, however, that the driving values, mission, and direction of their advocacy efforts are clearly distinct. This discussion leads the author to conclude that professionals may think about these two fields as representing points along a continuum, with a good deal of overlap and movement by individual practitioners, as opposed to being sharply different from one another.

However, when the public/consumers’ perspective is considered, there do appear to be several rather clear

¹ For example, in the Berger and Hannah (Eds.) (1999) volume called *Preventive Approaches in Couples Therapy*, as the editors themselves note, using both “preventive” and “therapy” in the same title appears contradictory. Academic articles often avoid clearly defining or distinguishing these terms, grouping under the term “premarital counseling programs” face-to-face pastoral counseling sessions and group education for engaged couples (e.g., Schumm et al., 2010). In a meta-analysis of the effectiveness of marriage education, couples therapy and couples education programs may be lumped together (Reardon-Anderson, et al., 2005). A similar lack of clarity exists in the policy arena. Several states reduce the costs of marriage license fees to couples who show evidence of “premarital counseling” or “premarital preparation” which is interpreted by county clerks to mean participating in a list of approved general relationship and marriage education programs. <http://www.healthymarriageinfo.org/policy/legislation.cfm>.

differences between MRE and CMT. Such differences can affect how these fields are perceived, used, and experienced by consumers and have implications for public policy. The difference between MRE and CMT is perhaps best encapsulated by noting that consumers of marriage and relationship education are identified as “participants” or “customers,” whereas consumers of couples and marital therapy and counseling are described as “clients” or “patients.”

The Marriage Counseling Movement

For centuries, individuals and couples sought advice and help from family, friends, community “matchmakers,” and clergy when looking for a suitable mate or experiencing marital stress or disruption. It was not until the early 20th century, however, that people began to turn to self-defined “experts” for help with their marriages. This was in large part a response to the massive social, cultural, and technological changes which challenged the stability and shook the foundations of traditional marriage.²

The first marriage counseling clinics were set up in the United States in the 1930s. The National Council of Family Relations (NCFR) was established in 1938 and the American Association of Marriage Counselors (AAMC) was established in 1942. (In 1978, the AAMC changed its name to the American Association of Marriage and Family Therapy). Key leaders in the marriage counseling movement in the 1930s included

By mid-century, marriage counseling became widely provided by family service agencies, but these agencies were not numerous and did not reach disadvantaged or minority populations.

Ernest Groves³, Paul Popenoe⁴, Abraham Stone⁵, and Emily Mudd⁶. These and other leaders brought marital counseling to the attention of medical, social service and faith-based professionals.

Initially, the marriage counselors gave advice based primarily on their own experience and common sense. Their clients typically were not couples but individual women who sought their help. The wives, in turn, were often expected to take responsibility for “saving” their marriages. Soon, the movement began to be influenced by the ideas of social scientists such as Ernest Burgess⁷ and Lewis Terman⁸. Based on their studies of marital compatibility, personality characteristics and related research, several temperamental inventories were developed to measure and predict marital success—these were the forerunners of premarital inventories and computer-based matchmaking. Marriage counselors also began to work increasingly with psychiatrists and psychoanalysts who introduced psychological concepts of intrapsychic and family-of-origin conflicts that influence marital stress and adjustment.

- 2 This section draws heavily upon two new books by social historians who provide a history of the growth and evolution of the marriage counseling movement: *Making Marriage Work* by Kristin Celello (2009) and *More Perfect Unions* by Rebecca L. Davis (2010).
- 3 Sociologist who documented the decline of marriage by monitoring demographic trends.
- 4 Botanist and eugenicist who founded the American Institute of Family Relations in Los Angeles; he also became editor of the *Journal of Heredity*.
- 5 Physician and birth control advocate who with his wife, Hannah, founded a clinic in New York.
- 6 Social worker who with her husband founded the Philadelphia Marriage Council; she became one of the nation’s foremost marriage counseling experts.
- 7 Sociologist who studied marital compatibility.
- 8 Psychologist who assessed personality characteristics.

Definitions of MRE vary, but most will agree that marriage and relationship education provides general information and teaches skills, attitudes and behaviors to help individuals and couples achieve long-lasting, successful marriages and intimate partner relationships.

By mid-century, marriage counseling became widely provided by family service agencies, but these agencies were not numerous and did not reach disadvantaged or minority populations. In the 1950s and 1960s, some of the secular psychological tools and approaches began to be integrated into faith-based marital counseling. More Americans encountered premarital and marriage counseling from clergy than from any other source. The clergy had a captive audience: in 1940, it was estimated that three-fourths of all marriages were officiated by a rabbi, priest or minister. At the time, between one-half and two-thirds of Americans belonged to a church or synagogue. Marriage counseling continues to be offered to this day, especially by clergy and licensed professional counselors. Clergy are generally more accessible to the public, more familiar, and generally do not charge for their services (Davis, 2010).

In the late 1970s, marriage counseling began to lose ground to the next generation of marriage interventions: marriage and relationship education and couples and relationship therapy.

Marriage and Relationship Education (MRE)

Definition

Definitions of MRE vary, but most will agree that marriage and relationship education provides general information and teaches skills, attitudes and behaviors to help individuals and couples achieve long-lasting, successful marriages and intimate partner relationships (Halford, Markman & Stanley, 2008). This includes making wise partner choices and avoiding or leaving abusive relationships. Most MRE programs choose to use, and may adapt, one of a handful of highly-structured and widely tested curricula. These are usually offered in a group (classroom/workshop) format. MRE is not defined as a clinical practice and puts emphasis on prevention of the relationship problems, not their “treatment.”

Roots

With roots in research conducted in the 1940s, MRE as a field began in the 1950s and 1960s and grew out of the premarital education classes and counseling offered to engaged couples (primarily by religious organizations) to help them prepare for marriage. Premarital education then became more secular with the addition of research-based premarital inventories (PREPARE/ENRICH, FOCCUS, and RELATE). Marriage enrichment weekends and courses began to be offered to married couples who wanted to make their marriage stronger (Guerney, 1998).

In the 1970s and 1980s, clinical psychologists began to integrate ideas from family therapy and cognitive and behavioral therapy laboratory-based marital inter-



action research to develop psycho-educational program models designed to prevent marital distress and dysfunction. With education and structured groups as the delivery approach (as opposed to private one-on-one counseling sessions) they developed, tested, and refined their curricula over a number of years (Berger & Hannah, 1999). Among the best known of the university-developed programs were Bernard Guerney's⁹ Relationship Enhancement (RE), Sherod and Phyllis Miller's¹⁰ Couples Communication (CC), and Howard Markman and Scott Stanley's¹¹ Prevention and Relationship Enhancement Program (PREP) (See Sollee, 1998).

In the 1980s and 1990s, several prominent family therapists became aware that most highly distressed, divorcing couples came to therapy either too late or not at all. Hence, therapists such as John Gottman¹²,

Philip and Carolyn Cowan¹³, William Doherty¹⁴, and Diane Sollee¹⁵ became interested in developing preventive psycho-education approaches to reach larger numbers of couples at earlier stages in their relationship. They played seminal roles in conducting couples research and in the development of relationship and marriage education curricula. Under the leadership of Diane Sollee, with Guerney, Miller, Stanley, Markman and others, the Coalition for Marriage, Family and Couples Education (CMFCE) was founded in 1996 as an umbrella organization designed to promote and support the field of MRE (Sollee, 1998).

Some consider MRE to be an academic subfield which, along with parent education, exists within family life education, situated in the family studies and human ecology departments in universities (Doherty, 1995) and now practiced widely within the cooperative extension movement (see National Extension Relationship and Marriage Education Network, NER-MEN). However, most of the founders and leading curricula developers and researchers of MRE were initially trained as psychologists (also known as "prevention scientists") who focus their research on risk and protective factors. Many of them also practiced as mental health clinicians offering individual and couple therapy.

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- 9 Professor in counseling psychology and human development/family studies at Penn State University; directed the National Institute of Relationship Enhancement in Bethesda, MD.
 - 10 CEO of Interpersonal Communication Programs, Inc.; part of research and development team of Couple Communication at the University of Minnesota Family Study Center along with Daniel Wackman, and Elam Nunnally. Phyllis Miller, PhD joined the organization in 1986 and is the president of ICP.
 - 11 Professors of Psychology and the Co-Directors of the Center for Marital and Family Studies at the University of Denver; conduct research program on the prediction and prevention of relationship discord and divorce and the effects of destructive conflict and relationship distress prevention on mental health.
 - 12 Known for his research on marital stability and divorce prediction, thirty-five years of breakthrough research on marriage and parenting; co-founder of the Gottman Relationship Institute.
 - 13 Conducted longitudinal studies that include randomized clinical trials of couples group interventions; among the founding members of the Council on Contemporary Families.
 - 14 Professor and Director of the Marriage and Family Therapy Program in the Department of Family Social Science, College of Education and Human Development, at the University of Minnesota.
 - 15 Founder and director of the Coalition for Marriage, Family and Couples Education (CMFCE) and director of the annual Smart Marriages/Happy Families® conference; she also spent ten years at the American Association for Marriage and Family Therapy (AAMFT) as Associate Executive Director for Professional Education and Public Information.

Content and Format

MRE programs vary considerably in format and content, but at the core of most MRE curricula are communication skills, problem-solving skills, and the management of conflict and negative emotions (see Blanchard et al., 2009; Halford, Markman and Stanley, 2008). Some programs include ways to protect and reinforce the positive connections in the relationship. Research identifies all of these areas as being associated with marital success and failure. In addition, many other specific content areas (such as commitment and avoiding violent and abusive relationships) have been added over the years in response to new research. Similarly, to reach and serve more racially- and economically-diverse populations, some programs have been modified to include content on financial management. Some MRE programs offer opportunity for follow-up (booster sessions) and/or referrals to treatment and other services.

MRE programs may include a mixture of didactic teaching, interactive discussion, couple exercises, role playing, video excerpts, and homework exercises. Humor and laughter are often key elements and the experience is meant to be enjoyable as well as instructive. The sharing and interaction among peers both inside and outside the sessions provides support, insight, and helps to normalize many of the issues discussed in MRE. The workshops are often led by a male-female pair. While personal examples and stories are often shared voluntarily, the leader does not call on participants to discuss their personal problems or situations in any depth.

Currently, there are over 100 different marriage education curricula which vary in length, setting, target populations, and content (Dion, 2005). A recent federal government publication listed around

60 low-cost MRE curricula (ACF, 2009). Importantly, only a handful of these program curricula have been rigorously evaluated and have been found to have moderate positive effects (see Halford, et al., 2003 & 2008; Hawkins & Ooms, in press). Curricula have been written or adapted for couples from diverse ethnic, racial and economic backgrounds as well as for adoptive parents, stepfamilies, and prison inmates (Ooms, 2007).

Marriage and relationship education is offered to individuals and couples across various life stages including teens, single adults and dating, cohabiting, engaged, married, divorced, separated or remarried couples. Participants learn about these programs from other couples, from community PSAs, or are referred by health or social service professionals or the faith community. MRE participants come to the programs voluntarily (sometimes through referral) in order to learn how to deal successfully with normal relationship challenges.

Currently, MRE is offered to individuals and couples across various life stages.

Typically, MRE is offered in a structured group situation—classes, workshops, or special events/retreats—provided in a community or institutional setting (such as schools, churches, campuses, social service agencies, or prisons). Some programs also offer individualized premarital or marital inventories; others match up couples with mentor married couples. Since MRE is not defined as a clinical practice—unlike couples therapy or counseling—it is increasingly being provided to the general public through written materials, websites, DVDs, self-guided Internet courses and other vehicles. Media



campaigns can also provide useful public health information messages about healthy marriage and relationships.

MRE programs offered in the private or faith-based sectors generally charge moderate fees. These fees can vary. Some programs charge \$10 per session. Community-based programs conducted over six to eight weeks may charge hundreds of dollars. For a weekend retreat in a luxurious resort, \$800 or more may be the fee. Unlike couples therapy, these fees are not considered reimbursable by medical insurance. Increasingly, MRE programs are offered at no charge in the community (especially when funded by federal or state dollars) or in institutional settings such as schools. To help make them more accessible to low-income couples, some programs provide a meal, child care, transportation or other modest incentives and supports.

Professional Qualifications

The individual MRE facilitators, educators, or workshop leaders come from a wide variety of backgrounds. They may have graduate degrees in a mental health profession, pastoral counseling, or they

may have certification as family life educators. Others may not have any professional training. Studies have shown that those who are not mental health professionals are as effective in the instructor role (Markman et al., 2006). Currently, there are no national or state credentials required to practice relationship and marriage education. There is, however, a national family life education credentialing process administered by the National Council on Family Relations (NCFR) where one can become a Certified Family Life Educator (CFLE). This includes a component on relationship education. MRE instructors are often certified to teach a particular curriculum by the curriculum developers; the developers typically provide a short, 1-2 day training. Some curricula are self-directed and require no special training to use (called “out-of-the box”).

Couples and Marriage Therapy (CMT)

Definition

It is generally agreed that couples and marriage therapy is a customized service couples may seek when they are seriously distressed, unhappy in their relationship, have a high degree of conflict, and/or at least one partner is questioning his or her commitment to the other. CMT, which grew out of the marriage counseling movement, is now a subfield of family therapy. The American Association for Marriage and Family Therapy (AAMFT) website (www.aamft.org) states that marriage and family therapists “treat a wide range of serious clinical problems including depression, marital problems, anxiety, individual psychological problems and child-parent problems. The AAMFT site also contends that marriage and family therapy is brief, solution-focused and specific, with attainable therapeutic goals and designed with “the end in mind.”

Roots

Couples and marriage therapy derives from two fields. First, CMT grew out of family therapy, a branch of psychotherapy that works with families as whole systems. Family therapy has some early roots in the child guidance movement and in marriage counseling. The field took off and became formalized in the 1960s when several independent psychiatrists and researchers (including Gregory Bateson¹⁶, Don Jackson¹⁷, Jay Haley¹⁸ and Theodore Lidz¹⁹) started to study and treat schizophrenic patients together with other members of their family. Child psychiatrists (several of them trained psychoanalysts) such as Nathan Ackerman²⁰ and Salvador Minuchin²¹ also played an important role in the field's development.

The core belief of family therapists is that changing the current interactions among members of the couple/family is necessary for the ill/dysfunctional patient to heal. A number of distinct schools of family therapy emerged, initially drawing on psychoanalysis, social psychiatry, communications and systems theory, learning theory and cognitive behavior therapy (Guerin, 1976). Minuchin's structural family therapy approach—which became widely used especially in the public sector—arose from his experience with, and commitment to, working with low-income families. Family therapists began to work with couples as an outgrowth of their work with family dysfunction.

A second important strand in CMT is empirically-

based behavioral couple therapy, which has been shown to have a positive and large effect on the reduction of marital distress (Shadish and Baldwin, 2005). Other approaches that have also received empirical support include cognitive-behavioral couples therapy, integrative behavioral couples therapy, and emotion-focused couples therapy (Gurman, 2008).

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Content and Format

In couples or marital therapy, the couple typically is interviewed together by the therapist in an office (but may sometimes be seen individually) on a once-a-week or bi-weekly basis for a number of weeks. Very occasionally, couples will be seen together with other couples in a group therapy format. (CMT may also be a component of inpatient treatment for mental illness, substance abuse and other disorders.) Couples self-refer, but are also often referred by health care professionals, social service agencies and other couples. (In the 1970s and 1980s, marriage and family therapy was offered in community mental health centers to disadvantaged populations. Sometimes sessions were held in families' homes; often there were

16 Conducted research on communication that began in 1952 that became the origin for the majority of the interactional approaches to psychotherapy; his delineation of the philosophical framework for family therapy has been crucial in the field's development.

17 Acknowledged as a principle founder of Interactional Theory and Conjoint Family Therapy.

18 One of the founders of family therapy; he was Director of Family Therapy Research at the Philadelphia Child Guidance Clinic and Co-Founder of the Family Therapy Institute of Washington, D.C.

19 Professor and chief of clinical services in psychiatry and built the Department of Psychiatry at Yale University; best known for his many articles and books on the causes of schizophrenia and on psychotherapy with schizophrenic patients and their families.

20 Founded the first family therapy journal, *Family Process*, and organized the first discussion on family diagnosis; established the Family Mental Health Clinic in New York City and opened the Family Institute (later renamed the Ackerman Institute for the Family).

21 Family therapist, author of *Families and Family therapy* discussing his structural family theory; served as the director of the Philadelphia Child Guidance Clinic and later established Family Studies, Inc., in New York.

co-therapists). The focus of CMT sessions typically is on exploring the presenting symptom (problem behaviors) and understanding the patterns of communication and interaction between the couple (and sometimes other members of the family) that need to change. The therapist provides an assessment, advice, encouragement, direction and therapeutic challenge in a supportive environment where coaching and teaching are key ingredients. The sessions may be experienced as stressful and painful but also as supportive, validating and helpful.

Working with couples constitutes about one quarter of an MFT's practice and the majority of MFT's work in private practice settings (Doherty, 1996). The cost of couples therapy varies depending on the qualifications of the therapist. It can range from \$60-\$80 per hour for a marriage and family therapist to \$150 per hour and up for a psychologist. Both private practitioners and community and university clinics often offer sliding scale fee schedules. When couples therapy is provided by a licensed mental health professional, the cost can sometimes be partially offset by medical insurance. The large majority of states license or certify marriage and family therapists.

Professional Qualifications

Couples and marriage therapy can be provided by any one of the five core mental health professionals (as approved by the federal government)—psychiatrists, psychologists, social workers, psychiatric nursing, and marriage and family therapists (MFT). However, according to William Doherty, many therapists see couples without any significant training specific to working with couples (2002). He adds that only therapists trained in the profession of marriage and family therapy have required coursework in marriage therapy and they may not have significant clinical training specifically with couples, just with family units of some kind.

Marriage and Relationship Education and Couples and Marriage Therapy: What's the Difference?

CMT Professions Overview

Psychiatrists must complete 4 years of medical school plus a 4-year psychiatric residency where they undergo hospital training.

Psychologists must earn a doctoral degree for independent and clinical practice.

Social workers may have a bachelor's degree in social work (BSW) or Master's degree in social work (MSW), which is typically required for health, school settings and clinical work. Most states also require licensure of clinical social workers.

Marriage and Family Therapist (MFT) is a two-year post-graduate degree; around one-third are dual-licensed as a psychologist, social worker, etc.

Psychiatric-Mental Health Nursing (PMHN) is a specialty in nursing requiring a Master's degree. They provide a full range of primary mental health care services to individuals, families, groups and communities; they function as psychotherapists, educators, consultants, advanced case managers, and administrators.

Couples and Marriage Counseling

Individuals and couples can also seek help with their relationship problems from professional "counselors." The definition of the practice of professional counseling given on the American Counseling Association website (ACA) is "the application of mental health, psychological or human development principles,

through cognitive, affective, behavioral or systematic intervention strategies, that address wellness, personal growth, or career development, as well as pathology.” Although often referred to informally as therapists, professional licensed counselors are not generally considered to be members of the mental health professions. These counselors are considerably less likely, depending on the state, to receive insurance reimbursement for their services. Counseling derives from, and operates primarily within, social and community (not clinical) settings. Counseling typically focuses on helping persons resolve problems or issues related to work, school or family matters. “In this setting the counselor is a problem solver who through direct advice or non-directive guidance helps the client make rational decisions related to their personal situation” (see www.guidetopsychology.com/clin-cns).

In the United States, there are many different counseling specialties (for example, school, mental health, substance abuse, career, rehabilitation, etc.). Trained licensed counselors typically have at least a two-year post graduate degree in counseling psychology or a related specialty. However, many bachelor degree counselors work in salaried positions without a license. Counselors who have some special training in working with couples are generally pastoral counselors, mental health counselors, and marriage and family counselors (MFCC). Like couples and marriage therapists, counselors work face to face with individuals and couples to focus on the specific problems and challenges their clients bring to them.

Professionals’ Perspectives on Commonalities and Differences

This thumbnail sketch of the history, definition, and development of the fields of MRE and CMT illustrates

The most important distinction between MRE and CMT focuses on the goals and timing of the intervention.

the multiple strands of theory, research, and practice that are intertwined in these two fields (and, to some extent, the professional counseling field). These fields clearly share the goal of improving marital/couple relationships. They draw upon similar and overlapping theoretic, disciplinary and research roots. At this point in time, what can be said about their differences?

The most important distinction between MRE and CMT focuses on the goals and timing of the intervention. MRE is asserted to be a *preventive educational* approach based on the explicit assumption that the couple participating in MRE is not currently experiencing (or admitting to) significant problems in their relationship but desires to avoid stress and problems in the future. By contrast, in CMT, it is assumed that the couple already has some dysfunction or problem that needs to be diagnosed and treated, and that they seek therapy because they are somewhat aware of and concerned about the problem(s). This distinction between prevention and remediation/therapy is considered by some to be “the only clear distinction between therapy and preventive education,” (Markman et al., 2006).

Yet, even this distinction is becoming blurred as, increasingly, MRE is being provided to groups who are already in very fragile and often quite problematic relationships (for example, the unmarried parents enrolled in the federally-funded *Building Strong Families* programs). There are MRE programs designed for couples in distress and even on the brink of divorce, such as *Retrouvaille*, a world-wide marriage education program for seriously distressed couples. Some couples therapists do preventive work with engaged

couples who are basically happy with their relationship but want to work on some issues and establish a stronger foundation for their future together.

A second major distinction often made is that MRE and CMT operate from different theories about the most effective methods and approaches to creating behavior change. Although this distinction may have had some validity in the past, it is also beginning to blur. Contemporary couples and individual therapy has largely abandoned psychodynamic theories and methods such as exploring past history, probing for unconscious processes, releasing feelings, and developing insight. Increasingly, couples and family therapists employ evidence-based cognitive behavioral approaches by focusing on the here and now and re-framing thoughts and attitudes. They also may teach the communication and behavioral skills that are the building blocks of most evidence-based MRE curricula. A few MRE programs, such as Harville Hendrix's²² *Imago / Getting the Love You Want* and John Gottman's *Marriage Survival Kit*, combine education and therapy where integrating traditional therapeutic techniques and processes into the psycho-educational content.

The blurring of these alleged differences—prevention versus treatment and education versus therapy—suggest that a sharp distinction can no longer be drawn between learning at a cognitive level (“psycho-education”) and learning at an emotional level (“therapy”). The experience of participating in an MRE program clearly involves the emotions as well as the brain, as does the experience of therapy—though in different ways. The evolving science of emotional intelligence confirms the linkages (Goleman, 1995).

Similarly, there is probably a false dichotomy between

prevention and treatment in that almost every individual, however well-functioning, is presently struggling with some relationship problems and would like to do better. Even distressed individuals can learn how to prevent worse or repeated relationship problems in the future. David and Vera Mace made this point well when they outlined three levels of prevention and noted that “these preventive processes overlap and cannot be precisely distinguished from one another” (Mace, 1983).

Even distressed individuals can learn how to prevent worse or repeated relationship problems in the future.

These three levels of prevention have been widely accepted by the mental health and public health communities and can be described for our purposes as follows (see Berger and Hannah, 1999):

1. **Primary (universal) Prevention:** The program is geared toward helping couples deal with normative challenges and problems such as life transitions (e.g., marriage, parenthood, geographical moves, and job loss) in a healthy, constructive way. Primary prevention activities are thus described as universal interventions.
2. **Secondary (at-risk) Prevention:** These programs are designed to prevent future dissatisfaction and the loss of desirable relationship characteristics such as passion and intimacy. Secondary prevention activities are described as selective interventions directed toward individuals or groups who demonstrate relatively significant risk for developing couple distress/dysfunction and conflict (e.g., very young couples, low income unmarried parents, military couples in war time,

22 Clinical counselor with a specialization in couples therapy; led to the development of Imago Relationship Therapy.

or when one partner is seriously depressed or ill).

3. **Tertiary (directed) Prevention:** These programs aim to keep existing serious couple problems from escalating and leading to further deterioration of the relationship. These programs typically aim to avoid marital breakup, unless safety is an issue.

There appears to be growing agreement that couple intervention models should be conceptualized by professionals as lying along a preventive continuum, with MRE placed along the primary prevention end of the continuum and CMT on the tertiary end and with considerable degree of movement along the continuum in both directions (Berger and Hannah, 1999). For a particular couple, both approaches may be provided and seen as complementary. Couples and marriage therapists sometimes refer their patients to MRE programs to experience the benefits of a more structured group experience. MRE educators may refer some couples to therapists for additional, more specialized help with their personal difficulties.

Professional Values

These two fields clearly share an interest in, and commitment to, strong, healthy couple relationships. Yet, the professional orientation, values and public philosophies of these two fields as a whole differ considerably. Those who self-identify primarily as couples and marriage therapists (and counselors) consider themselves to be members of the health care/social service systems. As professionals, their major concern is to ensure that individuals and couples have access to the therapy (counseling) they need *when they are in relationship distress*. Those who identify primarily as practitioners of MRE are generally more likely to subscribe to a “public health” prevention approach. A public health approach indicates that there is a universal problem—in this case, the breakdown of healthy marriages which negatively impacts

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child well-being. MRE practitioners continually seek new avenues and tools to reach larger numbers of the general public with their information and services. They believe that relationship skills and emotional intelligence are not necessarily inborn and are often not modeled well in childhood. Therefore, these skills may need to be learned.

The End-User Perspective on Commonalities and Differences

In spite of the blurring of some of the differences between MRE and CMT, there is growing evidence that potential end-users do perceive and experience clear differences between MRE and CMT. The main differences appear to be MRE’s public health marketing framework, the group format, and the structured, skills-based curriculum. These differences appear to have the greatest significance for policy. The evidence comes primarily from the lessons learned from the recent major expansion of MRE through the advent of government funding (see Hawkins and Ooms, in press).

It is well known that many individuals and couples are reluctant to seek therapy or mental health services of any kind. By the time they do, their problems are generally more severe and harder to address (Halford et al., 2003). The vast majority of divorcing couples have not consulted a therapist. It’s hard to admit that one has a problem, especially anything associated with personal failures and inadequacies. It’s even harder to talk with a stranger about the details of one’s

intimate, personal life. Couples seeking help under a mental health umbrella still experience, or believe they will experience, some stigma. For disadvantaged populations, additional barriers to seeking therapy can include cost (little insurance coverage), lack of services, and long waiting lists. African-American and other minority populations have a long history of resistance to, and distrust of, professional forms of help, especially when provided by white professionals who are not from their communities (Boyd-Franklin, 1989).

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The hope of marriage education proponents is that MRE will be seen as a more accessible service than couples and marriage therapy and become socially normalized, as child birth preparation has become among some populations in recent years. More people could therefore benefit from MRE and at an earlier stage in their lives or relationships, when they can more easily be helped. At the same time, there is concern about how to motivate people who are not yet having problems to attend these programs voluntarily. One strategy gaining interest is to focus on key life transitions, such as at the application for a marriage license or the birth of a baby.

How has this expectation of reaching large numbers with MRE played out? Over the past decade, the infusion of government funding has led to a considerable increase in the number and diversity of individuals and couples participating in MRE programs (NHMRC, 2010). A challenge in attracting couples to either secular-sponsored MRE or CMT is the general lack of understanding of what these programs are, as well

as stigma attached to seeking help for an intimate relationship. As a result, when publicly-funded MRE programs emerged, recruitment was initially a challenge. However, through various creative marketing efforts (some targeted to men) with a strengths-based approach, and removing the practical barriers to attendance faced especially by low-income couples (i.e., providing child care, transportation, etc.) many programs have overcome these challenges. (Hawkins and Ooms, in press).

Similarly, CMT has faced a perception problem (e.g., “We don’t *need* counseling”). Some couples therapists, however, report that nowadays many educated couples are comfortable with the idea of seeking therapy but are very uncomfortable with the idea of participating in MRE sessions, perhaps because they fear they will have to share their own intimate problems with others.

Anecdotal reports, formal process evaluations of MRE programs, and customer focus group feedback provide several insights into what aspects of MRE seem to be most important to participants. These are clearly different from the typical experience of patients receiving couples therapy (Hawkins and Ooms, in press) and indicate MRE is more accessible and less invasive than CMT. Here are some common themes that emerge as attractions to MRE programs:

1. **The universal (public health) framing and marketing.** Although the marketing may be directed towards specific “at-risk” groups, couples and individuals are encouraged to come to MRE programs voluntarily in order to learn how to enrich their relationships and deal successfully with normal relationship challenges. This is very different from a couple deciding to go to couples/marriage therapy to discuss and get help with their painful personal problems and distress.

2. **A supportive and normalizing group format.**

The experience of participating in a structured group setting with other couples is less personally threatening and generally more enjoyable and instructive than being in face-to-face therapy. The facilitator/instructor is not going to insist participants share their personal “baggage.” Participants also report that they highly value the peer learning and support provided by these programs. The interactive discussion with other couples seems to reassure participants that the relationship issues and challenges they are experiencing are “normal” and expected.

3. **Structured curriculum combined with fun activities appeals to couples and especially to men.** Working through a formal structured curriculum provides MRE participants with reassurance that a body of scientifically-based knowledge exists and that relationship skills can be learned. Participants clearly value learning skills they can put into practice right away and also enjoy the humor, fun exercises, and entertaining presentations by the instructors. The concrete skills, humor, and presence of other men has increased the ability of MRE programs to reach out to and engage men. MRE couples programs not only strengthen the couple’s relationship but have been found to be more effective in actively engaging fathers with their children than traditional fathers-only programs (Hawkins & Ooms, in press).

Conclusion

The terms marriage and relationship education and couples and marriage therapy continue to be used interchangeably. However, these fields are situated at different points along a continuum from prevention-oriented (MRE) to treatment-oriented services (CMT), although these fields can sometimes overlap. CMT

is focused on addressing, in a face-to-face setting, the personal, particular problems couples encounter in their relationship. By contrast, MRE is generally provided in a group setting and teaches a common set of skills, attitudes, and behaviors that strengthen couple relationships.

The fields complement each other and have evolved from a common background. They have different professional goals, training, and standards; these differences may not be obvious to the average consumer. As MRE becomes more commonplace, continues to be offered in a variety of communities, and the evidence-base of effective programs grows, the professionalization of the field is likely. Similarly, CMT professionals are now using more cognitive and skill-based strategies as part of therapy. As these fields continue to evolve, the distinctions may become even less clear.

Resources

American Association for Marriage and Family Therapy (AAMFT) www.aamft.org

American Association of Pastoral Counselors (AAPC) www.aapc.org

American Counseling Association (ACA) www.counseling.org

Association for Behavioral and Couples Therapy <http://abctcouples.org>

Association for Couples in Marriage Enrichment (ACME) www.bettermarriages.org

Coalition for Marriage, Family and Couples Education (CMFCE) www.smartmarriages.org

National Council on Family Relations (NCFR) www.ncfr.org

National Extension Relationship and Marriage Education Network (NERMEN) www.nermen.org

National Healthy Marriage Resource Center
www.healthymarriageinfo.org

National Registry of Marriage Friendly Therapists
www.marriagefriendlytherapists.com

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