

Couple therapy with parents: Results from a pragmatic randomized controlled trial testing the Integrative Brief Systemic Intervention (IBSI)

Joëlle Darwiche PhD¹  | Jean-Philippe Antonietti PhD¹ |
Cindy Eira Nunes PhD²  | Nicolas Favez PhD³ |
Esther Liekmeier MSc¹  | Yves de Roten PhD⁴

¹Family and Development Research Center, Faculty of Social and Political Sciences, University of Lausanne, Lausanne, Switzerland

²Faculty of Psychology and Education Sciences, Université Libre de Bruxelles, Bruxelles, Belgium

³Faculty of Psychology and Education Science, University of Geneva, Geneva, Switzerland

⁴Department of Psychiatry, Institute of Psychotherapy, Lausanne University Hospital and University of Lausanne, Lausanne, Switzerland

Correspondence

Joëlle Darwiche, Family and Development Research Center, Faculté des Sciences Sociales et Politiques, Géopolis, 1015 Lausanne, Switzerland.
Email: Joelle.Darwiche@unil.ch

Funding information

Schweizerischer Nationalfonds zur Förderung der Wissenschaftlichen Forschung, Grant/Award Number: 159437

Abstract

This study aimed to compare the effectiveness of the Integrative Brief Systemic Intervention (IBSI), combining therapeutic work on marital and coparenting relationships with brief systemic therapy (BST-as-usual) for parent couples. Couples were randomly assigned to the IBSI ($n = 51$) or BST ($n = 50$). Both treatments were six-session interventions and lasted about 6 months. Questionnaires on individual, marital, coparenting and family-related functioning were completed before and after therapy, and at 6-month follow-up. A significant improvement in all areas of functioning was observed after treatment and maintained at follow-up for both IBSI and BST-as-usual treatments. No significant differences in outcomes were found between the treatments. Additionally, women reported more distress overall than men, and this distress was reduced more significantly after therapy. Last, BST-as-usual couples requested more additional sessions compared to IBSI couples. This study extends the literature on couple therapy with parents.

KEYWORDS

coparenting, couple therapy, marital, randomized controlled trial

INTRODUCTION

Couple therapy provides help to partners who are facing overwhelming difficulties in their relationship, including general communication problems, sex issues, or arguments over more specific areas of their relationship, such as finances or division of labor (Doss et al., 2015). When partners are also responsible for raising children, couple therapy can assist them in addressing potential child and family issues that are affecting their relationship. Parent couples are bound by two types of relationships: marital (romantic) and coparenting. The marital relationship involves the two adults and is dyadic. The coparenting relationship refers to the way partners function together in fulfilling their parental role and is considered a family-level construct as it includes the child/children (McHale & Irace, 2011). Studies have shown that these two relationships are correlated but do not overlap (Van Egeren, 2004) and that the coparenting relationship has a more proximal effect on children's socio-emotional development, compared to marital quality (Bonds & Gondoli, 2007).

Couple therapy and family-related outcomes

Largely, the efficacy and effectiveness of couple therapy have been demonstrated with medium to large effect sizes on overall relationship satisfaction (Roddy et al., 2020) and small to medium effect sizes on specific domains of the marital bond, such as emotional intimacy, observed communication, or relationship cognitions (Wittenborn & Holtrop, 2022). It is also effective in improving individual mental and behavioral disorders and health conditions (e.g., Von Sydow et al., 2010).

However, the impact of couple therapy on family-related outcomes, such as coparenting satisfaction, parenting functioning, and family functioning, has rarely been assessed (Darwiche & de Roten, 2015; MacIntosh & Butters, 2014). In an article on evidence-based therapeutic interventions for couples and their effect on relationship distress, Doss et al. (2022) reviewed 37 studies published between 2010 and 2019. In examining the studies from this review, we found that the demographic descriptions of samples in 10 studies did not specify whether the couples were parents, and 21 provided this information but only in a descriptive manner. Only 6 out of the 37 studies integrated this information into their analyses. Three of them (Doss et al., 2012, 2015; Nowlan et al., 2017) tested whether being a parent predicted the amount of change in relationship satisfaction after couple therapy for military veterans and found that it did not. The other three studies (Klann et al., 2011; Roesler, 2020; Wong et al., 2018) included this information and assessed the effect of treatment on family-related variables. Wong et al. (2018) assessed the impact of an adaptation of emotionally focused therapy on family functioning, among other outcome variables, in a sample of 23 Chinese couples. The total score of family functioning was significantly improved after the group intervention. The two other studies were conducted in Germany with samples of 230 (Klann et al., 2011) and 554 couples (Roesler, 2020) to assess the effectiveness of marital counseling in real-world settings. Their design addressed dissatisfaction in the parent-child relationship and conflict over childrearing in addition to measures of individual and couple distress. Being a parent was associated with

better couple relationship functioning compared to couples without children (Roesler, 2020), but marital counseling had no effect on the family-related variables (Klann et al., 2011). The results obtained from these six studies were heterogeneous and so were the designs they employed in terms of the type of family variables and the importance assigned to them. Thus, further studies that purposefully and systematically include family-related variables in their design are needed.

Based on this and other reviews and meta-analyses (e.g., Roddy et al., 2020), we note that studies appear to consistently include measures of relationship satisfaction. Although many of them include measures of individual symptomatology or distress, few cover coparenting, and other family-related outcomes, even though ample evidence shows that conflict between parents impacts children (Teubert & Pinquart, 2010). Their inclusion would provide unique and valuable knowledge for understanding whether and how couple therapy can benefit family functioning and child well-being.

Targeting the coparenting relationship

The clinical models used in couple therapy generally provide a framework and techniques for identifying and changing general dysfunctional communication or interaction patterns (Scheinkman & DeKoven Fishbane, 2004). However, some authors suggest that “it will likely be important for therapists to target specific domains of relationship functioning in addition to improving the overall satisfaction of the couples [...]. Given that improvement in parenting children has been shown to improve couple relationship satisfaction (Sanders, 1999), it might be important to target parenting roles when working with couples as appropriate” (Klann et al., 2011, p. 206). Thus, controlled studies that evaluate the effect of couple therapy on coparenting and family-related variables and further our knowledge of the methods and potential benefits of targeting the coparenting relationship in couple therapy are needed.

One prominent finding that emerged from the empirical literature on coparenting concerns the spillover dynamics between coparenting and marital relationships (McHale, 2007). Previous results showed that they influence each other reciprocally (Morrill et al., 2010) and are associated across time (Le et al., 2016). Therefore, distress in the marital relationship influences how parents mutually support each other, which further reduces their emotional availability toward their children (Pedro et al., 2012). Difficulties in the coparenting domain also appear to affect the marital relationship (Cui & Donnellan, 2009). Positive spillover effects can also occur when satisfaction in one relationship improves the other (Pedro et al., 2012). As coparenting is considered a multidimensional construct (Feinberg, 2003), these spillover effects are assessed in terms of coparenting support, coparenting conflict (i.e., undermining the other parent through criticism or blame), and child triangulation (i.e., coalition formation between one parent and the child; Teubert & Pinquart, 2010). Exploring couples' marital and coparental functioning in therapy can provide a more nuanced understanding of the overall couple relationship. It may reveal different spillover effects and distinct relational dynamics in the two domains.

In conclusion, couples generally seek therapy for difficulties of various origins, and the priority is to work on the (marital) difficulties that have brought the partners to therapy. For parent couples, however, specific work on the coparenting relationship may be an additional target. Thus, Integrative Brief Systemic Intervention (IBSI)—a therapy model that targets both marital and coparenting relationships in the context of couple therapy—has been developed

(Darwiche et al., 2022). The present study evaluates the effects of this model on several individual and relationship outcomes.

Objectives and hypotheses

The effectiveness of IBSI with regard to the individual (symptomatology, depression, and anxiety), marital (marital satisfaction, dyadic coping, and partner's controlling and critical behavior), coparenting (coparenting support, conflict, and triangulation), and other family-related outcomes (child, parental, and family functioning) was compared to brief systemic therapy-as-usual (BST-as-usual), a non-manualized intervention for couples. IBSI is a manualized intervention specifically meant for parent couples. According to treatment guidelines, IBSI therapists consistently work on the coparenting relationship in combination with the marital relationship, whereas BST-as-usual therapists may or may not target the coparenting relationship, depending on, for example, the couple's request for therapy; furthermore, BST-as-usual therapists generally do not use interventions that specifically articulate the two relationships when addressing couple difficulties. Therefore, given that improving the coparenting relationship can positively spill over into the marital relationship, we expected IBSI to be more effective for marital, coparenting, and other family outcomes. However, we expected both treatments to be similar in terms of their impact on individual outcomes. Finally, to estimate cost-effectiveness, we compared the total duration (number of sessions) of the two treatments at follow-up.

MATERIALS AND METHODS

Participants

Clients

The clients were 101 heterosexual couples recruited from several consultation centers in French-speaking Switzerland. A research coordinator or the therapists themselves informed eligible couples about the study. In case of interest, the couples were contacted by a member of the research team, who provided a detailed explanation of the study and asked them to sign a consent form. The couples were then randomly assigned to one of the two conditions using a block randomization method with randomly selected block sizes, and their therapist was informed of their participation.

The eligibility criteria for participation were: (1) being parents of at least one child aged 0–16 years and (2) being engaged in a couple relationship (married or not). In total, 447 couples were contacted by the research team; out of these, 346 were excluded from the study as they refused to participate, withdrew their request for therapy before allocation, were unreachable, were included as pilot cases, or participated in fewer than four therapy sessions. Finally, 101 couples were randomly allocated to one of the two conditions (IBSI = 51; BST-as-usual = 50). Couples' allocation to the conditions and their flow through the study are depicted in Figure 1. Analyses of sociodemographic characteristics revealed no differences between participants who continued with the study and those who dropped out.

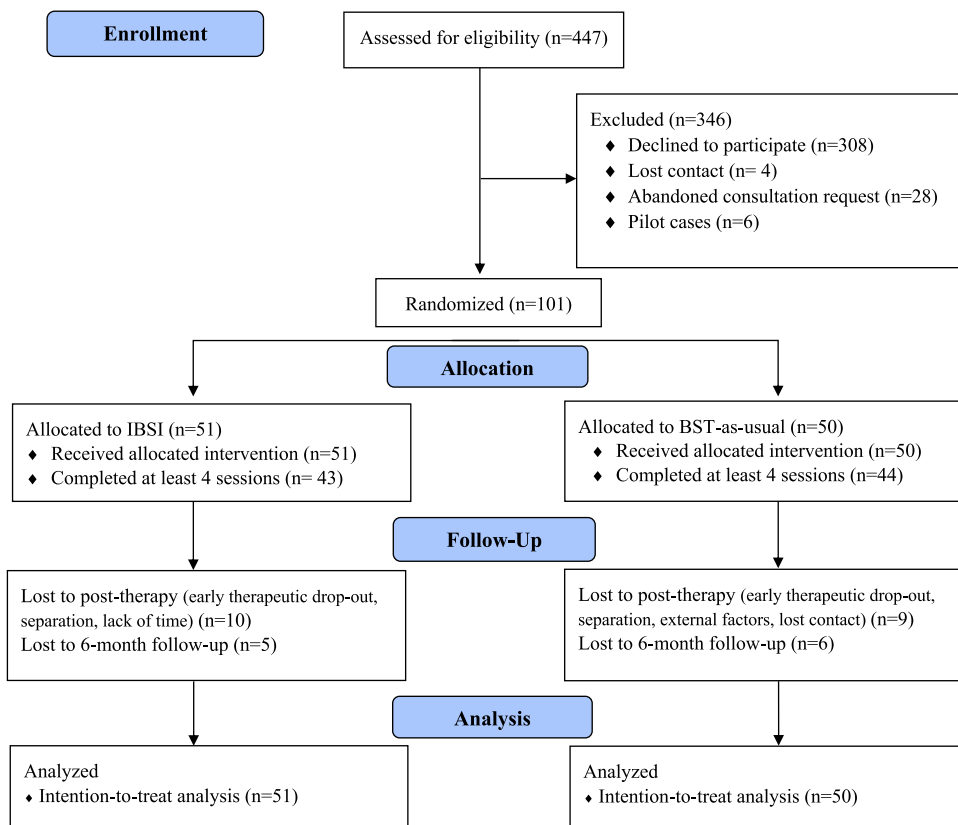


FIGURE 1 Consort flow diagram [Color figure can be viewed at [wileyonlinelibrary.com](https://onlinelibrary.wiley.com/doi/10.1111/jmft.12525)]

Table 1 contains summary data for the participants regarding demographic characteristics by the two treatment conditions, IBSI and BST-as-usual. No significant differences were found in demographic characteristics between the groups, except for the men's age (men in the IBSI group were older than men in the BST-as-usual group, $t(94) = -2.73$, $p = 0.008$).

Therapists

Thirty-three therapists (28 women) at the eight participating sites were recruited to the project, of whom 19 were IBSI therapists (16 women) and 14 were BST-as-usual therapists (12 women). The therapists' characteristics are provided in Supporting Information 1. No significant differences were identified in completion or near completion of the systemic programs and in the years of clinical experience between IBSI and BST-as-usual therapists.

The IBSI therapists had completed two, 2-day didactic workshops on IBSI (32 h in total) before taking part in the study. Moreover, they had undergone two supervised rounds of IBSI therapy and had at least 1 year of clinical experience with IBSI. During the study, they took part in monthly IBSI group supervision. The BST-as-usual therapists underwent regular systemic supervision during the study by designated systemic psychotherapy supervisors. The research group met the BST-as-usual therapists thrice during the study to answer questions they had about the research and to discuss potential issues related to the implementation of the research

TABLE 1 Preintervention demographic characteristics for clients by intervention group

Variable	IBSI ^a		BST-as-usual	
	Women (<i>n</i> = 50)	Men (<i>n</i> = 50)	Women (<i>n</i> = 50)	Men (<i>n</i> = 50)
Age, <i>M</i> (<i>SD</i>)	38.32 (7.71)	41.58 (8.84)	36.56 (7.19)	37.16 (7.26)
Nationality, <i>n</i> (%)				
Swiss	34 (68.0)	37 (74.0)	42 (84.0)	36 (72.0)
European	12 (24.0)	8 (16.0)	7 (14.0)	11 (22.0)
Other	4 (8.0)	5 (10.0)	1 (2.0)	3 (6.0)
Highest educational level, <i>n</i> (%)				
Elementary school	5 (10.0)	5 (10.0)	3 (6.0)	7 (14.0)
Vocational school	9 (18.0)	13 (26.0)	9 (18.0)	20 (40.0)
High school	5 (10.0)	5 (10.0)	7 (14.0)	4 (8.0)
University	24 (48.0)	19 (38.0)	22 (44.0)	15 (30.0)
Other	7 (14.0)	8 (16.0)	9 (18.0)	4 (8.0)
Marital status, <i>n</i> (%)				
Married/common law	37 (74.0)	37 (74.0)	32 (64.0)	33 (66.0)
Single	8 (16.0)	11 (22.0)	15 (30.0)	13 (26.0)
Separated/divorced	5 (10.0)	2 (4.0)	3 (6.0)	4 (8.0)
Duration of current relationship (years), <i>M</i> (<i>SD</i>)	11.46 (6.99)		10.97 (6.95)	
Duration of difficulties, <i>M</i> (<i>SD</i>)	4.13 (4.11)	3.25 (2.56)	3.44 (3.32)	2.72 (2.57)
Area of main issues, <i>n</i> (%)				
Marital issues	40 (80.0)	40 (80.0)	35 (70.0)	34 (68.0)
Coparenting issues	6 (12.0)	8 (16.0)	10 (20.0)	13 (26.0)
Marital and coparenting issues	4 (8.0)	1 (2.0)	4 (8.0)	2 (4.0)
Missing	0 (0)	1 (2.0)	1 (2.0)	1 (2.0)
Number of cohabiting children, <i>M</i> (<i>SD</i>)	1.68 (0.74)		1.90 (0.95)	
Age of youngest child, <i>M</i> (<i>SD</i>)	5.47 (4.65)		4.32 (4.23)	

Abbreviations: BST-as-usual, brief systemic therapy-as-usual; IBSI, Integrative Brief Systemic Intervention.

^aThe total IBSI intent-to-treat sample is *n* = 51, but demographic characteristics are missing for one couple.

in their practice. Both groups of therapists were able to obtain specific feedback on their clients' progress data upon request, but only after the study was completed.

Procedure

After being randomly assigned to one of the two treatment conditions, to which they were blinded, each couple was assigned a therapist in the consultation center that they initially

contacted for couple therapy. The research meeting was planned before the first therapy session. The couples received the consent forms and a set of questionnaires to complete before the first research meeting. The questionnaires assessed individual, marital, coparental, and other family functioning variables. The couples were asked to complete the questionnaires at three stages: before therapy, immediately after the last therapy session, and at 6-month follow-up. Each couple received 200 CHF for their participation once their follow-up measures were completed. The study was approved by the appropriate Ethics Committee.

Therapeutic interventions

IBSI

IBSI is a manualized brief systemic couple intervention intended for parents seeking couple therapy. It aims to address the couple's presenting problem, considering its specific impact on the marital and coparenting domains (Darwiche et al., 2022). The intervention is divided into three phases. The first session is dedicated to creating a therapeutic space and to the joint development of minimum objectives. The intermediate sessions (2–5) allow for work on the couple's objectives. To promote change during these sessions, therapists use various techniques borrowed from empirical research on coparenting and systemic treatment models (e.g., structural, strategic, transgenerational, and solutionist models; see Darwiche et al., 2022 for more details). The last session is dedicated to reflecting on the intervention and possible follow-up. This session also allows the therapist to further address possible relapses and help the partners anticipate their reactions when facing future difficulties.

BST-as-usual

BST-as-usual is a non-manualized brief systemic intervention for couples. Systemic therapy is what is usually provided to couples seeking therapy in the French-speaking Swiss community where the study took place. BST-as-usual focuses primarily on the marital relationship to enhance positive behavior and improve the couple's communication and problem-solving using concepts and techniques from different schools of systemic therapy.

Both IBSI and BST-as-usual are brief, consisting of approximately six sessions over 6 months ($M = 5.83$, $SD = 0.59$ for IBSI and $M = 5.98$, $SD = 0.84$ for BST-as-usual). The brief format is discussed with the couple at the start of therapy, and a wrap-up session is scheduled around the sixth session. However, depending on the couple's needs, additional sessions may be scheduled. The number of additional sessions and their format is decided by both the therapist and the couple.

Therapist adherence

Therapist adherence was monitored using an adherence scale (Imesch et al., 2019), assessing general systemic attitudes (one item) and IBSI-specific strategies (eight items). The items were rated on a 6-point Likert scale (from less adherence to more adherence); four points were the threshold. Two independent coders trained in the administration of this scale coded 20 therapy

sessions (10 IBSI therapy sessions and 10 BST-as-usual therapy sessions) drawn at random (25% of the total sample). The raters had good inter-rater reliability (overall intraclass correlation coefficient = 0.82, range = 0.5–1.00). As expected, the overall systemic attitude was similar in both groups ($t(18)=0.19$, $p = 0.850$), but IBSI therapists used the IBSI-specific strategies more than BST-as-usual therapists ($t(18) = 3.03$, $p = 0.007$).

Instruments

Individual functioning

Individual symptomatology

The partners' overall symptomatology was assessed with the Outcome Questionnaire (Lambert et al., 2004). This self-report questionnaire comprises 10 items rated on a 5-point Likert scale (0 = *never* to 4 = *almost always*). Answers can be summed into a composite score ranging from 0 to 40. Higher scores correspond to higher levels of individual symptomatology; scores of 12 or more indicate symptoms of clinical significance (Seelert et al., 1999). In our sample, the internal consistency across the three time points was $\alpha = 0.84$ –0.92 for women and $\alpha = 0.76$ –0.88 for men.

Depression

We used the Patient Health Questionnaire (Spitzer et al., 1999) to assess partners' depression. This scale comprises nine items resulting in a total score ranging from 0 to 27. The following score categories are used to interpret the level of depression: 0–4 minimal depression, 5–9 mild depression, 15–19 moderate depression, and 20–27 severe depression (Spitzer et al., 1999). In our sample, the internal consistency across the three time points was $\alpha = 0.83$ –0.84 for women and $\alpha = 0.83$ –0.88 for men.

Anxiety

Anxiety was measured with the State-Trait Anxiety Inventory (Spielberger et al., 1983). This questionnaire comprises 20 items that assess an individual's propensity toward anxiety. The composite score can range from 20 to 80, with higher scores corresponding to higher anxiety; scores of 54 and above indicate symptoms of clinical significance (Kvaal et al., 2005). The internal consistency across the three time points was $\alpha = 0.89$ –0.91 for women and $\alpha = 0.87$ –0.94 for men.

Marital functioning

Dyadic adjustment

The quality of the marital relationship was assessed with the Dyadic Adjustment Scale (Spanier, 1976). This self-report questionnaire includes 32 items. Composite scores range from 0 to 151, with higher scores indicating a higher-quality marital relationship; scores of 97 or below indicate couple distress (Jacobson & Truax, 1991). In this study, the internal consistency across the three time points was $\alpha = 0.92$ –0.94 for women and $\alpha = 0.89$ –0.92 for men.

Dyadic coping

The partners completed the joint dyadic coping subscale of the Dyadic Coping Inventory (Bodenmann, 2008). This subscale contains five items that assess joint coping with external stressors faced by the couple. Composite scores are means and range from 0 to 5. Higher means correspond to higher levels of dyadic coping. In our sample, the internal consistency across the three time points was $\alpha = 0.82$ – 0.90 for women and $\alpha = 0.80$ – 0.85 for men.

Coparenting functioning

Coparenting support

Coparenting support was assessed with the Parenting Alliance Measure (Abidin & Konold, 1999). This self-report questionnaire comprises 20 items that assess coparenting support. Composite scores range between 20 and 100, with higher scores corresponding to higher coparenting support. For our sample, the internal consistency across the three time points was $\alpha = 0.94$ – 0.96 for women and $\alpha = 0.94$ – 0.95 for men.

Coparenting conflict

We assessed coparenting conflict with two scales: (1) the conflict subscale of the Coparenting Inventory for Parents and Adolescents (Teubert & Pinquart, 2011) and (2) the conflict subscale of the Perceptions of Coparenting Partner Questionnaire (PCPQ; Stright & Bales, 2003). The CI-PA subscale comprises eight items that assess coparenting conflict, with a mean ranging from 0 to 5. In our sample, the internal consistency across the three time points was $\alpha = 0.76$ – 0.82 for women and $\alpha = 0.78$ – 0.82 for men. The PCPQ subscale comprises seven items and is summarized into a mean score ranging from 1 to 5. For this subscale, the internal consistency across the three time points was $\alpha = 0.79$ – 0.89 for women and $\alpha = 0.80$ – 0.84 for men. For both subscales, higher means correspond to higher levels of conflict.

Coparenting triangulation

Coparenting triangulation was measured with two different scales: (1) the triangulation subscale of the Coparenting Inventory for Parents and Adolescents (Teubert & Pinquart, 2011) and (2) the “Nuclear Family Triangulation” subscale of the Personal Authority in the Family System Questionnaire (Bray et al., 1984). The CI-PA subscale comprises eight items that assess coparenting triangulation, with a mean ranging from 0 to 5. In our sample, the internal consistency across the three time points was $\alpha = 0.84$ – 0.87 for women and $\alpha = 0.82$ – 0.87 for men. The “Nuclear Family Triangulation” PAFS-Q subscale comprises eight items and is summarized into means ranging from 1 to 5. In our sample, the internal consistency across the three time points was $\alpha = 0.64$ – 0.76 for women and $\alpha = 0.66$ – 0.75 for men.

Family-related functioning

Parents' perception of child's adjustment

Both partners completed the Strengths and Difficulties Questionnaire (Goodman, 1997) to assess their youngest child's difficulties and prosocial behaviors. This hetero-report questionnaire comprises 20 items measuring the child's difficulties, such as emotional problems, peer problems, hyperactivity, and behavioral problems. Difficulties can be summed into a composite

score ranging from 0 to 40. Higher scores correspond to more difficulties, with scores of 17 and above considered abnormal (Goodman, 1997). The SDQ also comprises five items concerning children's prosocial behaviors, which can be summarized into a composite score ranging from 0 to 10. Separate analyses were thus conducted on the child's difficulties and prosocial behavior. In our sample, the internal consistency of the difficulty subscales across the three time points was $\alpha = 0.78$ – 0.88 for women and $\alpha = 0.78$ – 0.84 for men. For the prosocial subscale, the internal consistency ranged from $\alpha = 0.75$ – 0.83 for women and $\alpha = 0.73$ – 0.85 for men.

Parenting

We used a self-report measure called Being a Parent (McCarty & Doyle, 2001) to assess both parents' perceptions of their own efficacy and satisfaction in parenting. This questionnaire comprises 12 items. The composite scores are means ranging from 1 to 7. Higher mean scores correspond to higher levels of parental self-esteem. In our sample, the internal consistency across the three time points was $\alpha = 0.79$ – 0.86 for women and $\alpha = 0.78$ – 0.82 for men.

Family

Family functioning was assessed with the Family Assessment Device (Epstein et al., 1983). We used three subscales of this self-report measure: problem-solving, emotional responsiveness, and overall functioning. These subscales were summarized into a mean score ranging from 0 to 5. Higher mean scores correspond to higher levels of family dysfunction. In our sample, the internal consistency across the three time points was $\alpha = 0.92$ – 0.95 for women and $\alpha = 0.91$ for men.

Data analysis

Analyses were conducted using R statistical software (R Core Team, 2021). The baseline equivalence of the two groups was verified with the *jmv* package (Selker et al., 2020). Mixed-effects models were computed with the *lme4* package (Bates et al., 2015), and Cohen's *d* effect size estimates from the mixed-effects models were calculated with the *EMAtools* package (Kleiman, 2017). Finally, we conducted survival analyses on the total number of therapy sessions at follow-up with the *survival* package (Therneau, 2015).

First, we performed multivariate analyses of variance to test the equivalence of the two groups before therapy. These analyses indicated group equivalence in all the variables, except for child adjustment (subscale difficulties). We, therefore, controlled for child adjustment before therapy for all the subsequent statistical analyses.

To explore between-group differences in the outcomes, we conducted three-way mixed model analyses of variance using the Satterthwaite method to calculate degrees of freedom (Kenny & Kashy, 2011). For each variable, we tested the same mixed model, including time as a within-subject factor (pre/post/follow-up), and the intervention group (IBSI/BST-as-usual) and gender (male/female) as between-subject factors. We also explored second-degree interactions between the predictors (Time $\times$ Group; Time $\times$ Gender; Gender $\times$ Group). For the estimation of the time effect, we established the contrast between pre–post and post–follow-up changes to differentiate between changes that occur immediately after therapy and those that occur in the longer term. To account for the initial difference between the two intervention groups, we controlled for the impact of this difference on the mixed models by systematically including the child's pretherapy difficulties as a control variable. Mixed models also have the advantage of

accounting for the fact that each participant is nested in a couple which is a distinguishable dyad, where each participant is distinguished by gender. This analytical approach allows us to estimate individual development over time while considering that the data of the two partners in the same couple are likely to be correlated. We, therefore, accounted for the random effect of gender in the couple in our estimates.

We also conducted survival analyses (R. G. Miller, 1981) to explore differences between the two groups in the total number of therapy sessions completed by the couples. We estimated survival curves using the Kaplan–Maier method (R. G. Miller, 1981) for each intervention group for this categorical variable.

All analyses were conducted using an intention-to-treat approach. We, therefore, based our analyses on all available data at the pretest, posttest, and follow-up.

Missing data

The rate of missing data per variable was generally less than 5% among the 100 couples who participated in the pretherapy assessment, less than 5% among the 82 couples who participated in the posttherapy assessment, and less than 10% among the 62 couples who participated in the 6-month follow-up.

RESULTS

Correlations between our variables are presented in Supporting Information 2. They show that, for both women and men, the correlations between measures of the same variable across the three time points were strong and significant overall.

Mixed-effects analyses revealed a main effect of time on most variables, as evident in Table 2. Time effects were significant for 12 of the 15 outcomes, with effect sizes generally being medium to large. Improvements concerned all areas of functioning (individual, marital, coparenting, and other family-related outcomes). Table 3 displays the time effects, showing that improvements occurred after treatment, with no significant change from posttherapy to 6-month follow-up. Regarding the child's adjustment, the parents perceived that their child had fewer difficulties at the 6-month follow-up only, while the child's prosocial behaviors had already improved at the posttest. Between posttherapy and follow-up, the child's prosocial behaviors significantly decreased; however, follow-up scores remained significantly higher than pretherapy scores.

No main effect of group was observed, except for children's prosocial behaviors, with parents in the BST-as-usual group reporting more prosocial behaviors overall than parents in the IBSI group ($F(1, 74) = 6.46, p = 0.013$). Last, a main effect of gender was observed. For instance, we found gender effects for several variables such as anxiety ($F(1, 81) = 4.38, p = 0.040$), with women (estimated marginal mean [EMM] = 45.2, standard error [SE] = 0.95) reporting significantly higher anxiety (EMM = 42.5, SE = 1.03), higher dyadic adjustment ($F(1, 64) = 17.53, p < 0.001$), greater dyadic coping ($F(1, 73) = 9.66, p = 0.003$), and more partner negative behaviors ($F(1, 71) = 7.32, p = 0.009$) than men. Men obtained significantly higher scores than women on the three marital-related variables (dyadic adjustment, dyadic coping, and partner's behavior). We also found a gender effect for coparenting support ($F(1, 75) = 16.84, p < 0.001$), with men (EMM = 80.9, SE = 1.15) reporting significantly more support than

TABLE 2 Estimated three-way mixed-model analysis of variance of target variables for individual, marital, coparenting, and family-related functioning

	Time				Time × Group				Time × Gender			
	<i>df</i>	<i>F</i>	<i>p</i>	<i>d</i>	<i>df</i>	<i>F</i>	<i>p</i>	<i>d</i>	<i>df</i>	<i>F</i>	<i>p</i>	<i>d</i>
Individual functioning												
OQ	(2, 247)	10.39	<0.0001	0.57	(2, 247)	1.43	0.240	0.12	(2, 249)	3.43	0.034	0.24
PHQ	(2, 240)	9.89	<0.0001	0.50	(2, 240)	2.11	0.123	0.17	(2, 241)	3.70	0.026	0.16
STAI	(2, 243)	8.19	<0.0001	0.50	(2, 243)	0.03	0.971	0.02	(2, 244)	1.44	0.238	0.04
Marital functioning												
DAS	(2, 192)	17.34	<0.0001	0.83	(2, 192)	2.36	0.097	0.28	(2, 204)	0.23	0.795	0.09
DCI	(2, 207)	20.05	<0.0001	0.73	(2, 207)	0.59	0.554	0.01	(2, 216)	1.57	0.210	0.14
Coparenting functioning												
PAM	(2, 245)	10.25	<0.0001	0.56	(2, 245)	0.37	0.691	0.06	(2, 251)	0.23	0.795	0.08
CI-PA conflict	(2, 236)	2.54	0.081	0.29	(2, 235)	2.13	0.121	0.21	(2, 236)	1.25	0.289	0.16
PCPQ	(2, 236)	1.13	0.325	0.18	(2, 236)	1.76	0.175	0.21	(2, 242)	0.39	0.677	0.00
CI-PA triangulation	(2, 237)	5.49	0.005	0.43	(2, 237)	0.09	0.091	0.05	(2, 243)	0.02	0.981	0.03
PAFS-Q	(2, 250)	0.54	0.585	0.05	(2, 250)	0.01	0.995	0.01	(2, 252)	0.31	0.734	0.07
Family-related functioning												
SDQ	(2, 318)	6.40	0.002	0.41	(2, 318)	1.73	0.179	0.08	(2, 297)	0.14	0.874	0.03
SDQ prosocial	(2, 229)	16.10	<0.0001	0.74	(2, 229)	1.30	0.275	0.09	(2, 235)	0.09	0.912	0.04
BP	(2, 240)	3.89	0.022	0.34	(2, 240)	0.59	0.556	0.02	(2, 244)	3.18	0.043	0.31
FAD	(2, 231)	9.73	<0.0001	0.50	(2, 231)	0.63	0.535	0.13	(2, 240)	0.24	0.788	0.09

Note: The main effect of Group and Gender as well as Group × Gender interactions were also conducted but are not presented in this table. *P* values less than 5% are indicated in bold.

Abbreviations: BP, Being a Parent; CI-PA, Coparenting Inventory for Parents and Adolescents; *d*, Cohen's *d*; DAS, Dyadic Adjustment Scale; DCI, Dyadic Coping Inventory; *df*, degree of freedom of the *F*-test; FAD, Family Assessment Device; OQ, Outcome Questionnaire; PAFS-Q, Personal Authority in the Family System Questionnaire; PCPQ, Perceptions of Coparenting Partner Questionnaire; PHQ, Patient Health Questionnaire; SDQ, Strengths and Difficulties Questionnaire; STAI, State Trait Anxiety Inventory.

women ($EMM = 75.7$, $SE = 1.35$), and coparenting conflict measured with the PCPQ ($F(1, 72) = 4.35$, $p = 0.041$), with women ($EMM = 1.93$, $SE = 0.07$) reporting significantly more conflict than men ($EMM = 1.78$, $SE = 0.06$).

Mixed-effects analyses revealed neither a significant Time × Group interaction nor a significant Gender × Group interaction. However, a Time × Gender interaction was observed for some variables, such as individual symptomatology and depression (Table 2). The interaction signaled that changes in terms of individual symptomatology and depression were significantly different from zero for women but not for men (PHQ; women pre-fu: $t(249) = 4.64$, $p < 0.001$; men pre-fu: $t(248) = 0.72$, $p = 0.754$). A significant Time × Gender interaction was also found for the parental self-esteem variable ($F(2, 244) = 3.18$, $p = 0.043$). Indeed, it appeared

TABLE 3 Estimated means and SD of target variables at each measurement time and pairwise differences by time

	Estimated marginal means (SE)			Pairwise differences		
	Pre	Post	Follow-up	Pre-post	Pre-fu	Post-fu
OQ	16.2 (0.50)	14.0 (0.54)	14.8 (0.56)	4.47***	2.81*	−1.42
PHQ	7.93 (0.43)	6.28 (0.45)	6.26 (0.47)	3.87***	3.73***	0.04
STAI	45.4 (0.80)	42.6 (0.85)	43.5 (0.88)	3.94***	2.61*	−1.13
DAS	90.8 (1.60)	97.8 (1.69)	95.6 (1.77)	−5.88***	−3.70**	1.67
DCI	2.39 (0.08)	2.74 (0.09)	2.80 (0.09)	−5.25***	−5.49***	−0.71
PAM	75.8 (1.17)	80.2 (1.24)	78.8 (1.28)	−4.43***	−2.85*	1.35
CI-PA conf	1.53 (0.06)	1.41 (0.06)	1.48 (0.06)	2.25	0.90	−1.23
PCPQ	1.90 (0.06)	1.83 (0.06)	1.84 (0.07)	1.37	1.19	−0.11
CI-PA tri	0.92 (0.07)	0.74 (0.07)	0.83 (0.08)	3.31**	1.49	−1.64
PAFS-Q	3.96 (0.05)	3.98 (0.05)	4.02 (0.05)	−0.41	−1.03	−0.63
SDQ	10.35(0.35)	11.02(0.41)	9.23 (0.42)	−1.45	2.34*	3.54**
SDQ Pro	7.12 (0.21)	8.34 (0.24)	7.67 (0.24)	−5.67***	−2.48*	2.92*
BP	4.75 (0.07)	4.88 (0.08)	4.86 (0.08)	−2.62*	−2.07	0.41
FAD	2.30 (0.04)	2.17 (0.04)	2.16 (0.04)	4.08**	4.13**	0.27

Abbreviations: BP, Being a Parent; CI-PA, Coparenting Inventory for Parents and Adolescents; DAS, Dyadic Adjustment Scale; DCI, Dyadic Coping Inventory; FAD, Family Assessment Device; OQ, Outcome Questionnaire; PAFS-Q, Personal Authority in the Family System Questionnaire; PAM, Parenting Alliance Measure; PCPQ, Perceptions of Coparenting Partner Questionnaire; PHQ, Patient Health Questionnaire; SDQ, Strengths and Difficulties Questionnaire; SE, standard error; STAI, State-Trait Anxiety Inventory.

* <0.05 ; ** <0.01 ; *** <0.001 . For pairwise differences the t -value was reported.

that only women reported improvements regarding parental self-esteem from pre- to posttherapy. These improvements were maintained at 6-month follow-up.

Survival analyses revealed a main group difference ($\chi^2(1) = 5.4$, $p = 0.02$), as couples in the BST-as-usual group tended to remain in therapy longer than IBSI couples. Figure 2 presents the survival curves for each intervention group. Post hoc analyses to determine whether there was a significant effect on follow-up scores when couples continued therapy sessions between the posttest and follow-up revealed no significant effect.

DISCUSSION

This study aimed to assess the effectiveness of IBSI, which combines therapeutic work on both marital and coparenting relationships. Contrary to our hypothesis, IBSI was not superior to BST-as-usual with regard to marital, coparenting, and other family-related outcomes. However, both treatments were effective in improving all measured dimensions, with effect sizes mostly varying from medium to large. Furthermore, these benefits were maintained at 6-month follow-up. Individual distress, in terms of global symptomatology, depression, and anxiety, significantly decreased at the end of therapy, consistent with the literature (Von Sydow et al.,

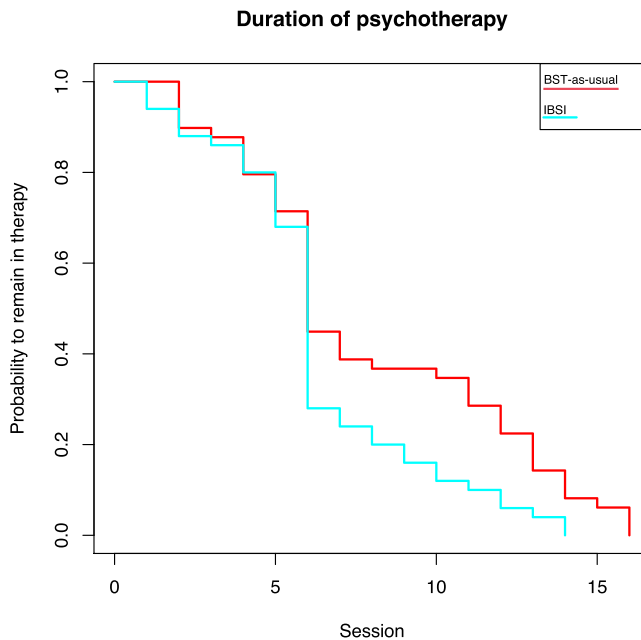


FIGURE 2 Duration of psychotherapy [Color figure can be viewed at [wileyonlinelibrary.com](https://onlinelibrary.wiley.com/doi/10.1111/jmft.12625)]

2010). We observed improvements in marital variables (marital satisfaction, dyadic coping, and conflict frequency), adding to the data on the effectiveness of systemic couple therapy in alleviating relationship distress (Doss et al., 2022). Our study also contributes to the still sparse literature on the effectiveness of couple therapy with regard to family variables, as both treatments were effective in enhancing the quality of coparenting and improving the other family-related variables (child's adjustment, parental functioning, and family functioning). Only one effect among all the examined variables emerged between the posttest and follow-up. This effect concerned the decrease in children's difficulties, which appeared only at follow-up. This may indicate a lagged effect of couple therapy on children's adjustment, implying that couple therapy has a direct effect on improving the partners' individual and joint functioning and that this improvement may have a delayed positive effect on the children.

Possible interpretations of the absence of differences in outcomes between treatments are as follows. First, IBSI was compared to BST-as-usual, which is considered the treatment of choice for couple therapy in French-speaking Switzerland. This renders it a high-quality treatment, not comparable to standard care that may include current best practices but also minimal services or to a control group (i.e., waiting list). Therefore, while the usual treatment intensity is typically low in psychotherapy trials (Munder et al., 2022), our study included a high-intensity comparison group, especially since it was offered by mental health experts. Therefore, the fact that both treatments had positive effects can be considered an important result in itself. Since both IBSI and BST-as-usual were systemic (i.e., considered not only the couple subsystem but also other family subsystems), it is likely that the mechanisms of change were similar, which may have reduced the evidence for differences in outcomes (Castonguay, 2002). Comparing IBSI with a treatment based on another theoretical approach would allow us to verify if there are more differences in outcomes, particularly for the coparenting relationship.

Second, coparenting scores in our sample were, on average, satisfactory even before therapy, with relatively high coparenting alliance and low coparenting conflict and triangulation scores. In comparison, the scores for individual symptomatology and marital quality were in the distressed range. We cannot exclude a selection bias in the recruitment: the couples who participated may have been the ones functioning best at the level of coparenting and family. More systematic inclusion of (co)parenting and family measures in couple therapy trials is needed to determine whether positive coparenting is a characteristic of our sample or, more generally, the case for couples entering couple therapy. Moreover, couples tend to minimize their level of coparenting and family distress by focusing on the marital problem that brought them to therapy. It can be difficult for a couple facing a crisis to identify and accept that both their marital and coparenting relationships are troubled, and they may need to minimize the difficulties in other areas of their relationship to be able to focus on their marital difficulties. This would be consistent with the clinicians' experience that partners were more readily able to discuss their coparenting disagreements at the end of therapy compared to the initial sessions. In this regard, further research is needed to test whether IBSI is more effective for parent couples who are experiencing (co)parenting distress in addition to marital distress. Finally, the absence of differences between treatments could be driven by whether there is a threshold of coparenting difficulty—which was not reached in our sample—at which a targeted intervention would become necessary. It would also be interesting to evaluate whether IBSI could be used as an adjuvant treatment in child and adolescent psychiatry. Therapists, or the parents themselves, sometimes consider couple treatment necessary, even when the main reason for the consultation is the child's symptoms. A treatment that incorporates coparenting and marital aspects, such as IBSI, could be helpful in this context.

Furthermore, the analyses revealed an interaction effect between time and gender, indicating that the levels of symptomatology and depression among women, but not men, had significantly reduced, and their parenting satisfaction had improved after therapy, with stability of these results at 6-month follow-up. This result is consistent with previous findings that suggest marriage and relationship programs lead to better outcomes in women compared to men (Javadivala et al., 2021). Previous findings also show that women are more likely to seek couple therapy than men and that they tend to report a greater number and severity of problems at the outset of therapy than men (R. B. Miller et al., 2003).

Finally, our results show that the total duration of psychotherapy differed between the two treatments, with couples in the BST-as-usual group tending to stay in therapy longer than the IBSI couples. However, this result should be interpreted with caution: the difference is small, and a cost-effectiveness analysis must consider all other costs for it to be conclusive, such as the time required to train clinicians in each group (Georgia Salivar et al., 2020).

Limitations of the study

First, the current study is limited by the homogeneity of the sample, which restricts the generalizability of the results. Replication of the results with a more diverse sample is, therefore, required. Second, although the effects of the interventions could be described at six-month follow-up, future research should evaluate longer-term outcomes to better establish the stability of the effects. Third, while the IBSI and BST-as-usual therapists were fully trained systemic therapists, the participating IBSI therapists would have had to adopt new strategies in their treatment of couples to follow the IBSI principles. With longer-term IBSI experience, it is

possible that this aspect of novelty may have worn off and rendered IBSI therapists more efficient in treating parent couples using this approach.

CONCLUSION

This study was conducted with parent couples who sought couple therapy and were offered either a specific intervention targeting their marital and coparenting relationships or brief systemic couple therapy. The results showed no differences between treatments; however, there was an improvement in individual symptomatology and marital satisfaction traditionally assessed in couple therapy research and in family-related variables, which are rarely included in these trials. This study contributes to our knowledge about couple therapy for parent couples, an area that has received limited attention. The findings have implications for clinical practice and training as they raise awareness among couple therapists regarding the importance of coparenting as a key dimension of couple functioning. Identifying how marital and coparental roles dynamically influence each other in couples' daily lives and recognizing the best therapeutic strategies for addressing these dynamics during therapy can be a valuable extension of couple therapists' work.

ACKNOWLEDGMENT

This work was supported by the Swiss National Science Foundation under Grant SNF 159437. Our acknowledgments go to the couples as well as to all the therapists involved in this project.

ORCID

Joëlle Darwiche  <http://orcid.org/0000-0001-9802-3216>

Cindy Eira Nunes  <http://orcid.org/0000-0002-1614-9622>

Esther Liekmeier  <http://orcid.org/0000-0001-7604-6230>

REFERENCES

- Abidin, R. R., & Konold, T. R. (1999). *Parenting alliance measure: Professional manual*. Psychological Assessment Resources.
- Bates, D., Mächler, M., Bolker, B., & Walker, S. (2015). Fitting linear mixed-effects models using lme4. *Journal of Statistical Software*, 67(1), 1–48. <https://doi.org/10.18637/jss.v067.i01>
- Bodenmann, G. (2008). *Dyadisches coping inventar: Test manual [Dyadic Coping Inventory: Test manual]*. Huber.
- Bonds, D. D., & Gondoli, D. M. (2007). Examining the process by which marital adjustment affects maternal warmth: The role of coparenting support as a mediator. *Journal of Family Psychology*, 21(2), 288–296. <https://doi.org/10.1037/0893-3200.21.2.288>
- Bray, J. H., Williamson, D. S., & Malone, P. E. (1984). Personal authority in the family system: Development of a questionnaire to measure personal authority in intergenerational family processes. *Journal of Marital and Family Therapy*, 10(2), 167–178. <https://doi.org/10.1111/j.1752-0606.1984.tb00007.x>
- Castonguay, L. G. (2002). Controlling is not enough: The importance of measuring the process and specific effectiveness of psychotherapy treatment and control conditions. *Ethics & Behavior*, 12(1), 31–42. https://doi.org/10.1207/S15327019EB1201_2
- Cui, M., & Donnellan, M. B. (2009). Trajectories of conflict over raising adolescent children and marital satisfaction. *Journal of Marriage and Family*, 71(3), 478–494. <https://doi.org/10.1111/j.1741-3737.2009.00614.x>
- Darwiche, J., Carneiro, C., Vaudan, C., Imesch, C., Eira Nunes, C., Favez, N., & de Roten, Y. (2022). Parents in couple therapy: An intervention targeting marital and coparenting relationships. *Family Process*, 61(2), 490–506. <https://doi.org/10.1111/famp.12773>

- Darwiche, J., & de Roten, Y. (2015). Couple and family treatments: Study quality and level of evidence. *Family Process*, 54(1), 138–159. <https://doi.org/10.1111/famp.12106>
- Doss, B. D., Mitchell, A., Georgia, E. J., Biesen, J. N., & Rowe, L. S. (2015). Improvements in closeness, communication, and psychological distress mediate effects of couple therapy for veterans. *Journal of Consulting and Clinical Psychology*, 83(2), 405–415. <https://doi.org/10.1037/a0038541>
- Doss, B. D., Roddy, M. K., Wiebe, S. A., & Johnson, S. M. (2022). A review of the research during 2010–2019 on evidence-based treatments for couple relationship distress. *Journal of Marital and Family Therapy*, 48(1), 283–306. <https://doi.org/10.1111/jmft.12552>
- Doss, B. D., Rowe, L. S., Morrison, K. R., Libet, J., Birchler, G. R., Madsen, J. W., & McQuaid, J. R. (2012). Couple therapy for military veterans: Overall effectiveness and predictors of response. *Behavior Therapy*, 43(1), 216–227. <https://doi.org/10.1016/j.beth.2011.06.006>
- Epstein, N. B., Baldwin, L. M., & Bishop, D. S. (1983). The McMaster family assessment device. *Journal of Marital and Family Therapy*, 9(2), 171–180. <https://doi.org/10.1111/j.1752-0606.1983.tb01497.x>
- Feinberg, M. E. (2003). The internal structure and ecological context of coparenting: A framework for research and intervention. *Parenting*, 3(2), 95–131. https://doi.org/10.1207/S15327922PAR0302_01
- Georgia Salivar, E. J., Rothman, K., Roddy, M. K., & Doss, B. D. (2020). Relative cost effectiveness of in-person and internet interventions for relationship distress. *Family Process*, 59(1), 66–80. <https://doi.org/10.1111/famp.12414>
- Goodman, R. (1997). The Strengths and Difficulties Questionnaire: A research note. *Journal of Child Psychology and Psychiatry*, 38(5), 581–586. <https://doi.org/10.1111/j.1469-7610.1997.tb01545.x>
- Imesch, C., Carneiro, C., de Roten, Y., Fort, D., Eira Nunes, C., Faivre Vaudan, C., Duc Marwood, A., Michaud-Feinberg, J., & Darwiche, J. (2019). *IBSI Adherence Scale* [Unpublished manuscript].
- Jacobson, N. S., & Truax, P. (1991). Clinical significance: A statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology*, 59(1), 12–19. <https://doi.org/10.1037/0022-006X.59.1.12>
- Javadivala, Z., Allahverdipour, H., Asghari Jafarabadi, M., Azimi, S., Gilani, N., & Chattu, V. K. (2021). Improved couple satisfaction and communication with marriage and relationship programs: Are there gender differences? A systematic review and meta-analysis. *Systematic Reviews*, 10(1), 178. <https://doi.org/10.1186/s13643-021-01719-0>
- Kenny, D. A., & Kashy, D. A. (2011). Dyadic data analysis using multilevel modeling. In J. J. Hox & J. K. Roberts (Eds.), *Handbook for advanced multilevel analysis* (pp. 335–370). Routledge/Taylor & Francis Group.
- Klann, N., Hahlweg, K., Baucom, D. H., & Kroeger, C. (2011). The effectiveness of couple therapy in Germany: A replication study. *Journal of Marital and Family Therapy*, 37(2), 200–208. <https://doi.org/10.1111/j.1752-0606.2009.00164.x>
- Kleiman, E. (2017). *EMAtools: Data management tools for real-time monitoring/ecological momentary assessment data*. R package version 0.1.3. <https://CRAN.R-project.org/package=EMAtools>
- Kvaal, K., Ulstein, I., Nordhus, I. H., & Engedal, K. (2005). The Spielberger State-Trait Anxiety Inventory (STAI): The state scale in detecting mental disorders in geriatric patients. *International Journal of Geriatric Psychiatry*, 20(7), 629–634. <https://doi.org/10.1002/gps.1330>
- Lambert, M. J., Morton, J. J., Hatfield, D., Harmon, C., Hamilton, S., Reid, R. C., & Burlingame, G. B. (2004). *Administration and scoring manual for the OQ-45*. American Professional Credentialing Services.
- Le, Y., McDaniel, B. T., Leavitt, C. E., & Feinberg, M. E. (2016). Longitudinal associations between relationship quality and coparenting across the transition to parenthood: A dyadic perspective. *Journal of Family Psychology*, 30(8), 918–926. <https://doi.org/10.1037/fam0000217>
- MacIntosh, H. B., & Butters, M. (2014). Measuring outcomes in couple therapy: A systematic review and critical discussion. *Journal of Couple & Relationship Therapy*, 13(1), 44–62. <https://doi.org/10.1080/15332691.2013.836050>
- McCarty, C. A., & Doyle, S. R. (2001). *Parent-child communication*. <https://fasttrackproject.org/measure/parent-child-communication-parent/>
- McHale, J. P. (2007). When infants grow up in multiperson relationship systems. *Infant Mental Health Journal*, 28(4), 370–392. <https://doi.org/10.1002/imhj.20142>

- McHale, J. P., & Irace, K. (2011). Coparenting in diverse family systems. In J. P. McHale & K. M. Lindahl (Eds.), *Coparenting: A conceptual and clinical examination of family systems* (pp. 15–37). American Psychological Association. <https://doi.org/10.1037/12328-001>
- Miller, R. B., Yorgason, J. B., Sandberg, J. G., & White, M. B. (2003). Problems that couples bring to therapy: A view across the family life cycle. *The American Journal of Family Therapy*, 31(5), 395–407. <https://doi.org/10.1080/01926180390223950>
- Miller, R. G., Jr. (1981). *Survival analysis*. Wiley.
- Morrill, M. I., Hines, D. A., Mahmood, S., & Córdova, J. V. (2010). Pathways between marriage and parenting for wives and husbands: The role of coparenting. *Family Process*, 49(1), 59–73. <https://doi.org/10.1111/j.1545-5300.2010.01308.x>
- Munder, T., Geissbüsler, A., Krieger, T., Zimmermann, J., Wolf, M., Berger, T., & Watzke, B. (2022). Intensity of treatment as usual and its impact on the effects of face-to-face and internet-based psychotherapy for depression: A preregistered meta-analysis of randomized controlled trials. *Psychotherapy and Psychosomatics*, 91(3), 200–209. <https://doi.org/10.1159/000521951>
- Nowlan, K. M., Georgia, E. J., & Doss, B. D. (2017). Long-term effectiveness of treatment-as-usual couple therapy for military veterans. *Behavior Therapy*, 48(6), 847–859. <https://doi.org/10.1016/j.beth.2017.05.007>
- Pedro, M. F., Ribeiro, T., & Shelton, K. H. (2012). Marital satisfaction and partners' parenting practices: The mediating role of coparenting behavior. *Journal of Family Psychology*, 26(4), 509–522. <https://doi.org/10.1037/a0029121>
- R Core Team. (2021). *R: A language and environment for statistical computing*. R Foundation for Statistical Computing. <https://www.R-project.org/>
- Roddy, M. K., Walsh, L. M., Rothman, K., Hatch, S. G., & Doss, B. D. (2020). Meta-analysis of couple therapy: Effects across outcomes, designs, timeframes, and other moderators. *Journal of Consulting and Clinical Psychology*, 88(7), 583–596. <https://doi.org/10.1037/ccp0000514>
- Roesler, C. (2020). Effectiveness of couple therapy in practice settings and identification of potential predictors for different outcomes: Results of a German nationwide naturalistic study. *Family Process*, 59(2), 390–408. <https://doi.org/10.1111/famp.12443>
- Sanders, M. R. (1999). The triple P—Positive Parenting Program: Towards an empirically validated multi-level parenting and family support strategy for the prevention and treatment of child behavior and emotional problems. *Clinical Child and Family Psychology Review*, 2(2), 71–90. <https://doi.org/10.1023/a:1021843613840>
- Scheinkman, M., & DeKoven Fishbane, M. (2004). The vulnerability cycle: Working with impasses in couple therapy. *Family Process*, 43(3), 279–299. <https://doi.org/10.1111/j.1545-5300.2004.00023.x>
- Seelert, K. R., Hill, R. D., Rigdon, M. A., & Schwenzfeier, E. (1999). Measuring patient distress in primary care. *Family Medicine*, 31(7), 483–487.
- Selker, R., Love, J., & Dropmann, D. (2020). *Jmv: The “jamovi” analyses*. R package version 1.2.23. <https://CRAN.R-project.org/package=jmv>
- Spanier, G. B. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and the Family*, 38(1), 15–28. <https://doi.org/10.2307/350547>
- Spielberger, C. D., Gorsuch, R. L., Lushene, R. E., Vagg, P. R., & Jacobs, G. A. (1983). *Manual for the State-Trait Anxiety Inventory*. Consulting Psychologists.
- Spitzer, R. L., Kroenke, K., Williams, J. B., & Patient Health Questionnaire Primary Care Study Group. (1999). Validation and utility of a self-report version of PRIME-MD: The PHQ primary care study. *Journal of the American Medical Association*, 282(18), 1737–1744. <https://doi.org/10.1001/jama.282.18.1737>
- Stright, A. D., & Bales, S. S. (2003). Coparenting quality: Contributions of child and parent characteristics. *Family Relations*, 52(3), 232–240. <https://doi.org/10.1111/j.1741-3729.2003.00232.x>
- Teubert, D., & Pinquart, M. (2010). The association between coparenting and child adjustment: A meta-analysis. *Parenting*, 10(4), 286–307. <https://doi.org/10.1080/15295192.2010.492040>
- Teubert, D., & Pinquart, M. (2011). The Coparenting Inventory for Parents and Adolescents (CI-PA): Reliability and validity. *European Journal of Psychological Assessment*, 27(3), 206–215. <https://doi.org/10.1027/1015-5759/a000068>
- Therneau, T. (2015). *A package for survival analysis in S*. Version 2.38. <https://CRAN.R-project.org/package=survival>

- Van Egeren, L. A. (2004). The development of the coparenting relationship over the transition to parenthood. *Infant Mental Health Journal*, 25(5), 453–477. <https://doi.org/10.1002/imhj.20019>
- Von Sydow, K., Beher, S., Schweitzer, J., & Retzlaff, R. (2010). The efficacy of systemic therapy with adult patients: A meta-content analysis of 38 randomized controlled trials. *Family Process*, 49(4), 457–485. <https://doi.org/10.1111/j.1545-5300.2010.01334.x>
- Wittenborn, A. K., & Holtrop, K. (2022). Introduction to the special issue on the efficacy and effectiveness of couple and family interventions: Evidence base update 2010–2019. *Journal of Marital and Family Therapy*, 48(1), 5–22. <https://doi.org/10.1111/jmft.12576>
- Wong, T. Y., Greenman, P. S., & Beaudoin, V. (2018). “Hold Me Tight”: The generalizability of an attachment-based group intervention to Chinese Canadian couples. *Journal of Couple & Relationship Therapy*, 17(1), 42–60. <https://doi.org/10.1080/15332691.2017.1302376>

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: Darwiche, J., Antonietti, J.-P., Nunes, C. E., Favez, N., Liekmeier, E., & de Roten, Y. (2023). Couple therapy with parents: Results from a pragmatic randomized controlled trial testing the Integrative Brief Systemic Intervention (IBSI). *Journal of Marital and Family Therapy*, 49, 351–369. <https://doi.org/10.1111/jmft.12625>