Strengthening Defence and veteran couple relationships through relationship education: supplementary report

Evidence on Australian programs

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Views expressed in this report are those of the individual authors and may not reflect the views of the Australian Institute of Family Studies or the Australian Government.

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Glossary and abbreviations

## Glossary

|  |  |
| --- | --- |
| Term | Description |
| Blinding | Blinding is the term used to describe the concealment of group allocation in a randomised controlled trial. Blinding reduces bias in a study as it prevents differential treatment and occurrences of the placebo effect. In the most robust study designs, participants, those providing treatment, those collecting data and those analysing data are all blinded. |
| Current serving member | Person currently serving in the ADF. |
| Intention-to-treat analysis | An intention-to-treat analysis includes all participants who were randomised to either the treatment or control group, regardless of whether they participated in the treatment or withdrew from the study. An intention-to-treat analysis measures the outcomes of offering an intervention, rather than the outcomes of completing an intervention. |
| Relationship education programs | Programs designed to provide individuals and couples with the knowledge and skills required to build positive and lasting relationships and prevent and minimise relationship distress. |
| Veteran | Person who has served at least one day of continuous full-time service in the ADF. |

## Abbreviations

|  |  |
| --- | --- |
| ADF | Australian Defence Force |
| AIFS | Australian Institute of Family Studies |
| BAP | Becoming a Parent Program |
| CC | Couple CARE Program |
| CCP | Couple CARE for Parents Program |
| CCR | Couple CARE and RELATE Program |
| CRE | Couple relationship education |
| Defence | Department of Defence |
| DVA | Department of Veterans’ Affairs |
| IPV | Intimate partner violence |
| JBI | Joanna Briggs Institute |
| NA | Not applicable |
| PICO | Population, Intervention, Comparison, Outcome |
| PTSD | Post-traumatic stress disorder |
| REA | Rapid Evidence Assessment |
| UK | United Kingdom |
| US/USA | United States/United States of America |

Overview

This report examines the effectiveness of relationship education programs developed or delivered in Australia, based on evidence from high quality evaluations published in the last 20 years. It is part of a broader research project examining how relationship education programs may be adapted to meet the needs of Australian military and veteran couples.

Key messages

There have been 8 evaluations of Australian relationship education programs undertaken over the last 20 years examining the efficacy or effectiveness of couple relationship education. These evaluations cover the RELATE program and multiple versions of the Couple CARE program, including a version previously trialled with Australian Defence Force couples (Couple CARE in Uniform).

Published evaluations found these programs typically led to small to moderate improvements in couple outcomes on at least one measure, when compared to other programs or no intervention. However, improvements have been small or non-significant for some groups in some studies (e.g. where couples reported high levels of satisfaction at baseline) and have generally reduced over time in studies with longer follow-ups.

One of the 8 published studies, which evaluated delivery of an adapted version of Couple CARE for Parents to high-risk couples in the USA, found no evidence of positive effects and some evidence of contra (negative) effects.

These – majority positive – findings are largely consistent with those found in the initial review for the more established US programs.

Differences in the research design, target populations and outcomes measured make it difficult to draw conclusions about the relative effectiveness of the different programs covered in this review. However, there is substantially more evidence on the Couple CARE program than the RELATE program, and existing studies show better outcomes for couples who receive both as a combined intervention.

1. Introduction
   1. Background and objectives

Current and ex-serving Australian Defence Force (ADF) members face a range of pressures that may affect their capacity to build and maintain strong relationships.

Relationship education can be an effective early intervention for promoting strong relationships and preventing relationship deterioration and distress. Typically designed as an early intervention for couples who are happy and satisfied with their relationship or facing minor issues, relationship education aims to build the relational skills required to better navigate challenges.

These programs have previously been offered to newly married couples and targeted at, and adapted for, those who face additional strains due to their social or economic environments.

In late 2023, AIFS completed a research project examining evidence on the effectiveness of relationship education programs in strengthening couples relationships, and how these programs might be adapted to meet the specific needs of Australian military and veteran couples (see [Final report: Strengthening Defence and veteran couple relationships through relationship education (openarms.gov.au)](https://www.openarms.gov.au/sites/default/files/2023-10/aifs-report-relationship-education.pdf).

This research included a quick scoping review and stakeholder consultations to identify key relationship issues experienced by current and ex-serving members, and a Rapid Evidence Assessment (REA) to identify existing relationship education interventions available in Australia and internationally and assess evidence of their effectiveness.

The scoping review and consultations identified several military-related challenges for couples including:

* frequent separation of members and their partners due to members’ absence on military deployments and training, and relationship readjustment issues when they return
* frequent relocation of members to new postings, which can require partners to disrupt their lives to accompany the member or to choose to live separately for extended periods
* mental and physical health impacts of service on members and their families, including due to deployment and combat experience, cultural issues and work stress spillover
* stress around transition and adjustment to civilian life, including financial stress, loss of identity and community (for members and partners) and role adjustment.

Deriving from these challenges, the following issues were found to be experienced in the relationships of current and ex-serving members more often than in the general population:

* feelings of isolation, lack of intimacy and lack of support due to time apart and/or relocation to areas where couples have few extended support networks
* fears and concerns around trust, infidelity and lack of commitment
* feelings of resentment due to impact of service on families, partner’s employment and domestic load, especially where couples share care of dependent children or one partner provides care to the other
* management of physical and mental health issues (such as post-traumatic stress disorder (PTSD)), substance abuse and intimate partner violence.

The REA examined evidence of effectiveness for couple relationship education programs in Australia and internationally, and their suitability for a military and veteran population. It identified 4 US-based programs that were promising to trial with Australian military and veteran couples due to there being a moderate level of evidence of their effectiveness and suitability for a military population.

Due to the time frames for study selection and the strict criteria for determining the standard of evidence required for the program to be included in the review (i.e. at least one high quality randomised control trial within the review period), a detailed assessment of Australian programs was not undertaken. Coupled with the practical barriers of accessing and delivering programs from other countries, the aim of this project is to now broaden the original review, and to provide an expanded set of evidence on Australian programs.

The purpose of the review is to:

* inform knowledge on the types of relationship interventions the Department of Veterans’ Affairs (DVA) and/or the Department of Defence (Defence) could consider providing for current and ex-serving members and their partners – considering both evidence of effectiveness and the applicability (and feasibility) of delivering them in this context
* assist with selecting and tailoring an appropriate relationship education program.

### Research questions

The project was guided by the following key research question:

* Supplementary to the findings in ARP2210, what other current evidence exists within the literature to support the effectiveness of relationship education programs in improving couple outcomes within a civilian and current and ex-serving military population?

*It should be noted that this question was then adapted and modified for this report to draw out findings on programs developed or delivered in Australia.*

Key sub-questions that guided the synthesis and write-up of findings included:

* What does the evidence tell us about the effectiveness of Australian relationship education programs?
* Which Australian programs have been found to be effective in improving relationship outcomes for a civilian and current and ex-serving military population?
* What is the strength of evidence in support of each program?
* What evidence exists on how best to tailor these programs for the current and ex-serving military population?
  1. Methods

The review used a Rapid Evidence Assessment (REA) methodology, which is a form of knowledge synthesis for which the steps of a systematic review are streamlined or accelerated to produce evidence in a shortened time frame (Tricco et al., 2017). We followed the guidelines set out by Varker and colleagues (2014), described in detail in the original report (Hughes et al., 2023).

### Selection of studies

This section sets out how studies were selected for inclusion in this review, and how they were adapted from the original review criteria.

#### Original review criteria

The original review included:

* all evaluations of couple relationship education programs in Australia, New Zealand, the USA, Canada and the United Kingdom (UK) (studies with a control group) published between January 2012 and July 2022 that had used experimental or quasi-experimental designs
* evaluations of couple relationship education programs undertaken with other methodologies (i.e. inclusive of qualitative, process/implementation, satisfaction) that included military and veteran populations (within the same countries and time frames).

To be included in the initial review, the evaluation had to be examining a couple relationship education program, where this was defined as a program aiming to enhance couples’ relationship skills and focused on prevention or early intervention. This was to distinguish couple relationship education from couples therapy, which is typically designed for couples experiencing and seeking to address specific issues (noting that some relationship education programs draw on some principles of couples therapy).

We excluded programs designed for or specifically targeted towards individuals or couples experiencing specific or significant relationship challenges such as violence or substance abuse.

Two searches were undertaken to identify relevant studies: the first was limited to studies using experimental designs and not restricted to military or veteran population, while the second was limited to studies with a military population or cohort but included any study design.

The following databases were searched: Medline, Australian Family and Society Abstracts, Australian Public Affairs, Cochrane Database of Systematic Reviews, Psychology and Behavioural Sciences Collection, SocIndex, and the Directory of Open Access Journal; and could include peer reviewed articles, other published studies and dissertations.

A study screening and selection process was then undertaken, with inclusion criteria that specified that at least 50% of the program content had to be focused on the couple relationship. For a study with a non-military/veteran population to be in scope for the review, the study needed to report on one or more of the following outcomes: changes in relationship satisfaction, quality, strength, stability, communication, interaction, connection, conflict resolution or prevention of violence.

For a study with a military and/or veteran population to be in scope, it had to report on at least one of the above outcomes and/or on client satisfaction, acceptability or other process evaluation measure. (See original report for further details of PICO framework, search strategy, etc.).

#### Supplementary review criteria

To expand the evidence, this review re-ran the above search to pick up additional articles meeting the criteria and published between January 2010 and December 2011, and between July 2022 and June 2024 (extending the time frame covered by this review to January 2010 to June 2024 inclusive).

As the extended search identified a large volume of additional international material but little additional evidence on Australian programs,[[1]](#footnote-2) a decision was made to limit this review to published studies of relationship education programs developed and/or implemented in Australia that had been evaluated with at least one experimental trial during the review period. For all programs that met these criteria, we would review all published evidence (regardless of the methodology used).

A subsequent search was then undertaken to identify additional published studies on Australian programs via a web search and a search of reference lists of included studies. This generated 5 additional articles covering several additional studies. This report synthesises the findings from these studies, alongside the findings on Australian programs from the initial REA.

### Data extraction

Data for each new article were extracted using the template designed for the initial study, which included:

* lead author, year of publication, country
* study design
* study aim
* outcome measures
* sample characteristics
* intervention design (e.g. length of intervention)
* key findings for all outcomes.

Where there were multiple publications with an overlapping sample (i.e. the same study population), these studies were grouped together, and only key data were extracted from the additional publications for each study. Supplementary studies are summarised in the results.

### Quality assessment and risk of bias – for individual studies

A quality appraisal was undertaken of each new study to assess the quality and risk of bias. As for the previous project, the level of evidence for each study was categorised based on the following:

* Level I: A systematic review of RCTs
* Level II: An RCT
* Level III-1: A pseudo-randomised controlled trial
* Level III-2: A comparative study with concurrent controls
* Level III-3: A comparative study without concurrent controls
* Level IV: Case series with either post-test or pre-test/post-test outcomes (Varker et al., 2014).

All studies using randomised controlled trials (RCTs) or quasi-experimental designs were then assessed using the Joanna Briggs Institute (JBI) quality appraisal tools (JBI, 2020a, 2020b) for studies using these designs. As there is no JBI appraisal tool for mixed methods studies, the Mixed Methods Appraisal Tool (MMAT) 2018 version (Hong et al., 2018) was used for these studies.

Quality appraisal was conducted by one reviewer and a sample of results checked by another reviewer, any conflicts discussed, and consensus sought from a third reviewer where conflicts could not be agreed.

Synthesis and evaluation of evidence

As for the previous project, an evaluation of the evidence for programs identified in the review was undertaken using the 5 criteria in the FORM framework for assessing and grading a body of evidence (Hillier et al., 2011; Varker et al., 2014). They are:

* the strength of the overall evidence base, in terms of the quality and risk of bias, quantity of evidence and level of evidence (based on the study designs)
* the direction of the results in terms of positive, negative or null findings
* the consistency of the results
* the generalisability of the body of evidence to ADF couples
* the applicability of the body of evidence to the Australian context and DVA and Defence social services contexts.

In the initial study a FORM assessment was only undertaken for programs that had at least one level II study (RCT) with a low risk of bias. In this supplementary review an assessment was made of programs with at least one level II study, regardless of the results of the risk of bias assessment. This allowed us to consider a broader set of evidence on Australian relationship education programs.[[2]](#footnote-3) The risk of bias in the different studies is still summarised in this report, to compare and draw conclusions about the overall strength of the evidence base for different programs.

This report synthesises the available evidence on the programs that met the inclusion criteria. It highlights the strengths and weaknesses of the evidence in support of each program, and how applicable the program is to the Australian military context.

To draw out what evidence exists on how best to tailor relationship education programs for the Australian current and ex-serving military population, we also summarise specific characteristics of programs found to be especially effective with military populations, and /or factors that moderate the effect of relationship education that may be relevant to military and veteran couples (e.g. whether intimate partner violence (IPV), PTSD evident at baseline).

1. Results

This chapter presents findings form the studies reviewed. We begin with a summary of the studies and the programs they cover; then assess the quantity and quality of evidence available, and finally synthesise the findings on the efficacy of these Australian relationship education programs.

* 1. Summary of studies and interventions

This supplementary review covered 10 articles reporting on 8 studies exploring the efficacy or effectiveness of couple relationship education, one follow-up study (returning to trial participants to assess longer term effects) and one analysis of the presenting characteristics of those attending one of the programs.[[3]](#footnote-4)

The programs reported on in the articles were:

* Couple CARE online
* Rainbow Couple CARE
* Couple CARE in Uniform
* Couple CARE for Parents
* Couple CARE for Parents of Newborns – American version
* RELATE
* RELATE with Couple CARE.

Table 1 summarises key information about these programs (Table A1 in Appendix A: Evidence profile provides further detail at individual study level). Almost all were versions of the Couple CARE program.

Developed by Halford and colleagues, the Couple CARE program is a curriculum or ‘skills-based’ manualised relationship education program that provides information and training for couples in key relationship skills such as positive communication, conflict management, self-change, intimacy and caring, managing differences, and adapting to change (Halford et al., 2010).

Designed in a flexible delivery format that allows couples to work through the program in their own time (e.g. online or via take home audio-visual materials), couples typically watch short videos and complete a series of tasks individually and together each week, then have a weekly session with a therapist to review their progress and troubleshoot any issues.

The program has been adapted for delivery with different target groups. Studies included here examined versions adapted for new parents (Petch et al., 2012; Halford et al., 2010), same-sex couples (Pepping et al., 2020), and Australian military couples (Couple CARE in Uniform) (Bakhurst et al., 2017).

While the different versions cover the same original 6-unit structure and content areas and principles, adapted versions have additional content added – for example, Couple CARE for Parents has a combination of couple and parenting information, and Rainbow Couple CARE has additional topics on internalised stigma, discrimination, disclosure of sexual orientation and discussing non-monogamous relationships. Other content adaptations include modifications to make examples and images more suitable to specific target groups (same-sex couples, military couples).

Programs also vary in delivery method. For example, rather than delivering one unit a week over 6 weeks, in the Rainbow Couple CARE trial the program is delivered intensively across 2 days. All programs include around 12 hours of time commitment in total, with combined programs such as Couple CARE for Parents involving a longer time commitment (e.g. 17 hours in the trial reported by Halford et al., 2010).

The other program evaluated during the study, the ‘RELATE’ program, was compared to Couple CARE in 2 of the review studies (Halford et al., 2010; Halford et al., 2015, 2017) (or rather – RELATE was compared against RELATE plus Couple CARE, where some couples received only RELATE and other couples received both interventions).

RELATE is a brief couple relationship education intervention using an assessment and feedback approach. This comprises an inventory-based assessment of the couple’s relationship strengths and challenges followed by a feedback session with a relationship educator who informs the couple of their current relationship strengths and weaknesses and develops goals for them to work on (and may offer some coaching).

In contrast to curriculum-based programs such as Couple CARE, which were initially designed for couples who are currently satisfied with their relationship (primary prevention), assessment and feedback programs are often targeted to couples experiencing minor issues (secondary prevention). (For further discussion of these different approaches see Hughes et al., 2023).

Table 1: Summary of Australian programs included in the review and supporting evidence

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Intervention | Studies | Curricula/Content | Delivery characteristics | Population | Key outcomes | Evaluation of evidence |
| Couple CARE Online | Kysely, 2022 | Curriculum-based relationship education program that covers the following 6 topics: self-change, communication, intimacy and caring, managing differences, sexuality and managing life changes (Halford et al., 2010) | Self-directed online learning  Includes 6 units, each of which couples complete in about a week  Includes: (a) a DVD that presents key ideas and models core relationship skills; (b) a guidebook that presents structured tasks that allow the couple to apply the key ideas to their relationship and (c) development of individual self-change plans by each partner. | General population | Relationship adjustment  Relationship satisfaction  Marital Happiness | Low strength (1 x Level II study with high risk of bias)  Positive direction  Consistency NA  Generalisable (population similar to target)  Applicable to Australia |
| Rainbow Couple CARE | Pepping et al., 2020 | Adapted from Couple CARE to depict same-sex couples and including topics on internalised stigma, discrimination, disclosure of sexual orientation, and specific tailoring for gay men regarding extra dyadic sex | Included 6 units covering communication, conflict resolution, sex and sexuality, dyadic coping  Tested in a face-to-face workshop format over 2 days (unit 1 vs remaining 5 units). Couples received follow-up phone call from relationship educator 2 weeks following workshop. Relationship educators were qualified clinical psychologists and postgraduate clinical psychology students. | Same-sex couples | Relationship satisfaction  Relationship commitment | Low strength (1 x Level IV study with high risk of bias)  Positive direction  Consistency NA  Generalisability hard to judge (population different)  Applicable to Australia |
| Couple CARE in Uniform | Bakhurst et al., 2017 | Couple CARE adapted for use with Australian military population | Couple CARE adapted to include military examples and terminology. Delivered by postgraduate students in clinical psychology trained in Couple CARE and the distinctive needs of military couples  Couples sent program DVD and workbook by mail and asked to complete one of the six units each week before one-hour session with educator, conducted using Internet based videoconferencing (2 hours per week in total for approx 6 weeks). | ADF couples | Relationship satisfaction  Communication | Low strength (1 x Level II study with high risk of bias)  Positive direction  Consistency NA  Generalisable (same population)  Applicable to Australia |
| Couple CARE for Parents | Halford et al., 2010; Petch et al., 2012 | Couple CARE adapted for couples in transition to parenthood | Couple Care for Parents (CCP) is a 6-unit couple relationship and parenting education program focusing on positive couple adjustment to parenthood and prevention of future relationship deterioration.  Combines information and skill training in a mix of face-to-face group workshops and home-based, self-directed learning. Incorporates relationship and infant care/parenting information. Unit 1 delivered in a 6-hour face-to-face antenatal workshop for small groups of couples. Remaining units completed in couples’ homes. Total time commitment about 17 hours across 6 months, including 12 hours of professional contact time | Couples expecting their first baby | Relationship satisfaction  Communication | Low strength (2 x Level II studies with high risk of bias)  Positive direction  Consistent  Generalisable (similar population)  Applicable to Australia |
| Couple CARE for Parents of Newborns | Heyman et al., 2019 | Couple CARE adapted for high-risk US couples in post-natal period | Adapted version of CCP for low-income, unmarried parents in the US. 8 sessions delivered during baby’s first 8 months. Sessions 1 and 4 were home visits, others typically conducted via 30-to-60-minute telephone calls.  Sessions began when newborns were less than 3 months old and scheduled 1–3 weeks apart. Material adapted to simplify language and concepts; added content addressing conflict escalation and IPV, and suitable for post-natal rather than prenatal delivery. | Couples who have just had a baby (<3 months) at elevated risk of intimate partner violence | Relationship Satisfaction  Communication (Behavioural Self-regulation)  Psychological and physical abuse | Low strength (1 x Level II study with high risk of bias)  Negative direction  Consistency NA  Generalisability hard to judge (different population)  Applicable with caveats |
| RELATE | Halford et al., 2010; Halford et al., 2015; Halford et al., 2017 (follow-up) | Couples undertake assessment of their current relationship strengths and challenges in domains such as relationship satisfaction, communication and conflict management. They then receive feedback from educator who helps them with their specific relationship enhancement goals. | RELATE is a 271-item self-assessment of relationship strengths and challenges accessed online (based on self and partner reports). In the intervention, couples complete then read a 13-page report providing an overall couple relationship profile based on each partner’s strengths and challenges.  Couples then called over the telephone by a relationship educator who speaks to them in a semi-structured conjoint interview about the report for around 45–60 minutes. | Heterosexual couples predominantly in early to mid-forties, with higher incomes and education levels compared to the general Australian population | Relationship Satisfaction  Communication | Low strength (2 x Level II studies with high risk of bias)  Positive direction  Consistent  Generalisable (similar population)  Applicable to Australia |
| RELATE Plus Couple CARE | Halford et al., 2010; Halford et al., 2015; Halford et al., 2017 (follow-up) | In RELATE plus Couple CARE, couples did the Couple CARE program after the RELATE assessment and feedback. | In the RELATE plus Couple CARE program the couples undertake the RELATE intervention, followed by Couple CARE. In the semi structured interview, the relationship educator makes connections between content of the Couple CARE program relevant to the couple’s specific issues (identified in the RELATE assessment). | Heterosexual couples predominantly in early to mid-forties, higher incomes and education levels compared to the general Australian population | Relationship Satisfaction  Communication | Low strength (2 x Level II studies with high risk of bias)  Positive direction  Consistent  Generalisable (similar population)  Applicable to Australia |

* 1. Quantity and quality of evidence

While the Couple CARE program has been evaluated most often, for most versions of the program, no more than 2 studies had been undertaken during the review period. There were also 2 studies covering the RELATE program during the review period (Halford et al., 2010 and Halford et al., 2015, 2017).

Seven of the 8 studies used experimental (RCT) designs, and one used a pre-post assessment with no control group (Rainbow Couple CARE, described by the Pepping et al., 2022 as a ‘preliminary’ assessment of program effectiveness).

Among the 7 RCTs, a variety of controls or comparisons were used:

* One RCT compared Couple CARE Online to the face-to-face version of Couple CARE (Kysely et al., 2022).
* One RCT compared Couple CARE plus RELATE (CCP) to RELATE only (Halford et al., 2010).
* One RCT compared CCP and RELATE against an active control (self-directed reading) (Halford et al., 2017, 2015).
* One RCT compared Couple CARE in Uniform against an active control (self-directed reading) (Bakhurst et al., 2017).
* Both RCTs of the Couple CARE for Parents (CCP) program compared CCP against the Becoming a Parent (BAP) program (described as a ‘standard prenatal program for new parents in Australia’ (Petch et al., 2012)).
* The RCT of Couple CARE for Parents in the US used a waitlist control (Heyman et al., 2019).

Sample sizes for studies ranged from 12 to 250 couples and sample characteristics varied. In addition to variations based on target population (same-sex couples, military couples, couples who have just become parents), some trials included couples that reported high relationship satisfaction or adjustment at baseline (e.g. Bakhurst et al., 2017; Petch et al., 2012) whereas others focused on couples experiencing mild relationship distress (Kysely et al., 2022) or significant risk of intimate partner violence (Heyman et al., 2019).

Most Australian trials included a disproportionate number of highly educated couples from Caucasian or Anglo-Celtic backgrounds; however, the American trial of the Couple CARE for Parents Program included disadvantaged high-risk couples from a variety of cultural backgrounds. All studies included baseline and post-program assessment of relationship functioning (using one or more measures), with some studies including additional follow-up assessment periods ranging from 3 to 28 months.

The most common outcome measure assessed in studies was relationship satisfaction (included in almost all studies). Many also included measures of couple communication using a mix of self-report and observational approaches. A couple of studies included measures of relationship aggression and/or intimate partner violence but only one reported on these outcomes.

All RCTs examined in the review were rated as having a high risk of bias on at least one criterion (using the JBI tool for assessing the quality of RCTs). As in the previous review, one of the most common quality problems was the lack of blinding, or insufficient reporting on the blinding process, for participants, those providing treatment or those assessing outcomes. While blinding may not be possible in all study designs, particularly when participants need to be informed of the likelihood they will receive an intervention, blinding of those who receive or deliver the program and its consequences, was insufficiently discussed or reported. Insufficient reporting of blinding was not considered a critical quality issue; however, this did result in a high number of ‘unclear’ ratings.

Another common issue was insufficient reporting of any similarity between treatment and control groups at baseline and/or due to loss of participants throughout the study. As differences between intervention and control groups and differences between those who remain in a study could account for differences in outcomes, studies that did not provide this information were assessed as having a higher risk of bias.

Another issue was the lack of use of Intention-to-Treat (ITT) analysis. ITT analysis includes all participants who were randomised to either the treatment or control group, regardless of whether they participated in the treatment or withdrew from the study (Gupta, 2011). Using an ITT analysis provides a realistic estimate of the effect of the intervention, whereas analysing only participants who completed treatment or remained in the study is likely to result in a measure of effectiveness that cannot be replicated in a real world setting (Gupta, 2011).

While not all studies included in this review used ITT analysis, we did not consider this a critical quality issue. These studies typically used other approaches that used all available data, including that of couples who dropped out throughout the study period and therefore had missing data (i.e. they included everyone for whom baseline data were collected at point of randomisation, with analysis undertaken based on the groups to which they were initially allocated).

* 1. Efficacy: direction and consistency of findings

Seven of the 8 evaluations included in this review had positive findings regarding outcomes from the relationship education – that is, they found small to moderate improvements on at least one of the measures used in the study, from pre- to post-intervention and /or follow-up, at significant or at trend level.

Only one study, the trial of Couple CARE for Parents adapted for delivery in the US, had results going in the opposite direction, suggesting that participation in the relationship education program may have led to worse outcomes for couples. The authors (Heyman et al., 2019) noted various possible explanations for this inconsistency. These included the focus on a high-risk population who were all at elevated risk for intimate partner violence (a quarter also reported clinically significant levels of stress at baseline); socio-economic and cultural differences (the Australian trials included predominantly white middle-class couples, while the American study had a racially diverse and economically disadvantaged cohort) and intervention differences (e.g. in the US study the program commenced after the birth of the baby rather than during pregnancy).

In the evaluations with positive findings that used RCTs or a comparison group, people in the relationship education program ‘treatment group’ typically had larger improvements in relationship outcomes than seen in the comparison group. Overall, however, the improvements in relationship outcomes were quite small, and effects reduced over time in studies with longer term follow-ups (e.g. Halford et al., 2017).

Analysis of moderating characteristics in some studies also found benefits for only some subgroups. Several studies examined the moderating effect of a couple’s level of relationship satisfaction at baseline; and found relationship education was more effective (or potentially only effective) for couples with initially low levels of satisfaction (Halford et al., 2015, 2017).

These findings indicate that relationship education may not be effective for all couples, with mixed findings for highly satisfied couples and couples with significant distress or safety issues.[[4]](#footnote-5)

### Which programs have the most evidence of efficacy?

It is difficult to draw conclusions about the relative effectiveness of the programs evaluated here, including the different versions of Couple CARE, due to differences in the target populations, study research designs and outcomes measured. However, there is more evidence on the effectiveness of Couple CARE and Couple CARE plus RELATE as a combined intervention than there is for the RELATE program alone.

The Australian studies reviewed here found no differences in outcomes between the online and face-to-face version of Couple CARE (Kysely et al., 2022). This is again consistent with the broader research, which suggests that relationship education delivered online and or through self-directed learning is just as effective at improving core relationship outcomes as more traditional face-to-face methods (Hughes et al., 2023, p. 23).

This has been further validated since the initial review was conducted. A meta-analysis of online couple relationship education (CRE) concluded effect sizes for online CRE compared favourably to the effect sizes reported in a meta-analysis of traditional couple relationship education (Megale, 2022).

As the different versions of Couple CARE programs examined here covered the usual 6-unit content areas, there was little difference in the overall program ‘dose’ received across programs, except that the Couple CARE for Parents program was longer to incorporate the parenting elements.

The Couple CARE for Parents program had positive and significant findings in 2 comprehensive Australian studies, providing solid evidence of the effectiveness of this program for new parents, despite the contra findings from the American version. The trials of adapted versions of the program for same-sex and military couples suggest Couple CARE can also be potentially adapted for these groups.

The findings were smaller and less consistent, and not significant (beyond trend level) for Rainbow Couple CARE, or for Couple CARE in Uniform, when compared to the comparison group[[5]](#footnote-6). But this may be because they were both small and underpowered studies – that is, they require further testing with larger samples and different comparison groups.

In the Halford and colleagues (2010) study, couples in the RELATE program showed significant improvements in communication over time but significantly less improvement in communication than those who participated in the combined RELATE and Couple CARE program. Neither study found significant (within group) improvements in relationship satisfaction for those in the RELATE program but there was an improvement in relationship satisfaction for those in the combined RELATE Plus Couple CARE program.

Not surprisingly, and consistent with the previous review, these studies suggest the largest improvements (effect sizes) result from programs that incorporate key elements of both approaches – assessment and feedback and skills-based information and training (Hughes et al., 2023, p. 32).

### Who benefits most?

Among the different programs evaluated, effects (mostly measured over a short time frame) tended to be larger for couples with low satisfaction or functioning prior to the program, or higher relationship distress or risk. This was evidenced in studies that included analysis of how outcomes were moderated by level of couple satisfaction or risk at baseline (Halford et al 2017; Petch et al 2012); as well as studies that did not moderate but included samples of couples who were highly satisfied at baseline and found small effects (e.g. Bakhurst et al., 2017; Pepping et al., 2020).

None of the studies looked at how outcomes varied for military and veteran couples. In a secondary analysis that compared 90 military couples to 642 civilian couples, covered in the initial review, Salivar and colleagues (2020) found similar rates of program satisfaction but lower completion rates in the military group. They further found comparable improvements at post-treatment and follow-up on the relationship measures but the military couples made fewer gains on measures of intimate partner violence.

Unfortunately, none of the Australian studies examined how outcomes from relationship education vary for couples experiencing other issues commonly reported to be concerns for military and veteran couples – such as infidelity, PTSD and IPV. How relationship education affects couples experiencing these specific issues has been explored more extensively in the US literature.

The remainder of this chapter provides a more detailed breakdown of the findings for each of the programs evaluated in this review.

* 1. Findings on specific programs

### Couple CARE Online

In the trial comparing Couple CARE Online to the face-to-face delivery of Couple CARE (Kysely et al., 2022) participants in both groups experienced statistically significant increases in relationship satisfaction over time – assessed post-intervention and at a 3-month follow-up – and there were no significant differences between the intervention and active control group, suggesting that Couple CARE is equally effective when delivered online or face to face.

Couples in the study were experiencing mild relationship distress; however, couples were excluded if they were experiencing clinically significant relationship distress, severe psychiatric disorders or substance use problems (Kysely et al., 2022). This intervention used an experimental setting to reduce the potential for differences in setting – couples completing the online intervention did so in a private room in a therapist’s office.

The limitations of this study include its short follow-up period (3 months), small sample size and experimental (i.e. not real world) setting.

### RELATE and RELATE plus Couple CARE

The RELATE program, and a combined version of Couple CARE plus RELATE (CCR), were evaluated in 2 different RCTs in Australia during the review period. One study compared 28 newlywed couples receiving the RELATE assessment with feedback intervention against 29 newlywed couples receiving Couple CARE plus RELATE (Halford et al., 2010).

The other study (Halford et al., 2015, 2017) compared 62 couples receiving RELATE with 62 couples receiving Couple CARE plus RELATE against an active control (58 couples instructed to do self-directed reading). In the latter study, the randomised couples were recruited via advertising and social media and included married or cohabiting couples in a committed relationship for at least 6 months.

Both studies included pre- and post-intervention assessments of relationship satisfaction and a 12-month follow-up. The former study additionally tested impacts on couple communication, while the latter study only assessed impacts on relationship satisfaction. However, the latter study included additional longer follow-up assessments at 18, 30 and 48 months post-intervention.

The former study included analysis of how intervention effects were moderated by gender and the latter included an analysis of how intervention effects were moderated by couples’ level of relationship satisfaction at baseline.

In the first study, at the 12-month follow-up, couples in both the RELATE only and Couple CARE with RELATE showed improved communication. However, across the 3 measures, there was consistently more improvement in communication from pre to post for couples receiving CCR, rather than just RELATE, for at least one gender.

Relative to RELATE, in CCR there was a large decline in negative affect (conflictual communication) for men (*d* = 0.79) (not women); a moderate decline in negative listening among women (*d* = 0.62) (and a trend to decline in men (*d* = 0.27)), and a small to moderate decline in negative speaking among women (*d* = 0.38) (but not men).

In terms of impacts on relationship satisfaction, women in the combined program (CCR) showed a reliably larger increase in satisfaction (with a mean of 30.4 at 12 months) than women in the RELATE-only condition (*d* = 0.42 – a moderate effect size), who showed little change. For men, there was no reliable increase in relationship satisfaction over time and no difference between conditions, with the authors concluding the combined program (CCR, relative to just RELATE) benefited women but not men.

The authors note that due to the absence of a no-intervention control, this study provided no information on whether RELATE assessment and feedback had a beneficial effect compared to no intervention and noted that most research finds that satisfaction declines in recently married couples, whereas the couples receiving RELATE in the current study showed no such decline.

In the trial comparing RELATE with Couple CARE plus RELATE against an active control group, Halford and colleagues (2017) found no change in relationship satisfaction for RELATE versus control couples but a small to medium positive effect for CCR compared to the control (*d* = 0.45, 95% CI [0.18, 0.69]).

Moderator analysis showed that for high satisfaction couples, neither intervention increased relationship satisfaction at any time point. For low satisfaction couples, Couple CARE plus RELATE increased relationship satisfaction more than the control, with a medium to large effect (*d* = 0.62, 95% CI [0.09, 1.16]). This difference held at the 6-month follow-up, and there was a trend in the same direction at 12 months, but there were no reliable differences from 2 years onwards. The authors concluded that there was a clear intervention effect for CCR with low satisfaction couples that reduced over time.

### Couple CARE for Parents

Couple CARE for Parents (CCP) was evaluated with 2 different RCTs in Australia including an RCT comparing CCP participants with an active control group – those receiving the program were compared against those who participated in the Becoming a Parent (BAP) program, described as the standard perinatal program for new parents in Australia (Halford et al, 2010; Petch et al., 2012).

The first study (Halford et al., 2010) included 80 couples (40 in intervention and 40 in the control group); the second included 250 couples (125 in the intervention and 125 in the control group). The first included post-intervention assessments at 5 and 12 months post-partum; and the second included post-intervention assessments at 6,16 and 28 months post-partum.

In both studies, couples were recruited from public metropolitan hospitals in their third trimester. In both studies, couples were high in relationship adjustment at baseline (Halford et al., 2010) and both studies under-represented couples with low education and non-English speaking backgrounds. In the second study, Petch and colleagues (2022) tested whether the effect of CCP on relationship outcomes was moderated by risk of future adjustment problems (using a cumulative measure based on the number of factors including parental divorce in the woman’s or man’s family of origin, lack of university education in either partner, annual household income of AUD$50,000 or less, unplanned pregnancy and presence of intimate partner violence).

The first study found that participants in the CCP intervention experienced a significantly greater reduction in negative couple communication from pre- to post-intervention than those in BAP, though there was partial attenuation of these effects over time (at 12 months post-partum). The finding of attenuation of CRE effects over time has been found in previous research, leading authors to conclude the program is effective in the short term but additional intervention might be required to sustain affects (i.e. booster sessions) (Halford et al., 2010).

The first study also found CRE prevented significantly greater decline in women's, but not men's, relationship adjustment from pre-intervention to follow-up. Halford and colleagues (2010) posit that this may be because parenthood predicts a greater decline in relationship adjustment among women than among men, although previous American studies have found CRE prevented decline in relationship adjustment in both genders when compared to no intervention controls.

They conclude the evidence demonstrated that CRE can help prevent deteriorating relationship adjustment across the transition to parenthood and has additional benefits beyond that of currently available best practise antenatal and perinatal support (Halford et al., 2010).

The second study, which included moderator analysis by risk, found that relative to BAP, CCP women decreased their negative communication, irrespective of risk level.[[6]](#footnote-7) The effect of treatment condition on relationship satisfaction was moderated by risk. At follow-up, there was no association between treatment condition and outcome for low-risk women (x2(1, *N* = 167) = 0.36, *p* > 0.05) or men (x2(1), *N* = 167) = 0.17, *p* > 0.05).

However, high-risk women receiving CCP reported higher relationship satisfaction, and less decline in satisfaction across time, than high-risk women receiving BAP (x2(1, *N* = 83) = 3.87, p < 0.05). And high-risk men in CCP showed a trend (x2(1, *N* = 83) = 3.53, *p* = 0.06) for higher relationship satisfaction relative to high risk men in BAP. Petch and colleagues (2012) conclude it is a useful intervention that primarily benefits high-risk women.

### Couple CARE in Uniform, Rainbow Couple CARE

The evaluations of the adapted versions of Couple CARE for ADF couples and same-sex couples both found small but significant or trend-level improvements over time in relationship outcomes in the intervention group (*d* = 0.22 for relationship satisfaction and 0.19 for relationship functioning for Rainbow Couple CARE (Bakhurst et al., 2017; Pepping et al., 2020), but no evidence of benefits relative to a control (the evaluation of Rainbow Couple CARE did not include a control group, and the trial of Couple CARE in Uniform included a control group but found no differences in outcomes between treatment and control).

Participants in the Couple CARE in Uniform intervention experienced a modest increase in relationship satisfaction and decrease in negative communication from pre-education to the 6-month follow-up but no difference was found in the extent of change (pre- to post-intervention) between Couple CARE in Uniform and the control group (who undertook self-directed reading).

Both authors noted that small improvements in functioning are not surprising given the sample participants had high relationship satisfaction to begin with – given other studies have concluded that the benefits of relationship education for satisfied couples tend to be in maintaining functioning over time, rather than shorter term improvements in satisfaction or reductions in distress. These were also both small underpowered studies, which make it harder to pick up intervention effects.

Participants in both programs also reported high satisfaction with the program (and significantly higher than the control in the trial of Couple CARE in Uniform). In the absence of no intervention controls, it is not possible to conclude definitively whether the programs had a positive effect when compared to no intervention, with both authors concluding that relationship education ‘may’ enhance relationship functioning for these cohorts and the need for further research.

1. Summary and conclusions

This report has examined the evidence on the effectiveness of Australian relationship education programs, drawing on evidence published over the last 20 (plus) years. It supplements a previous review that considered evidence on Australian and international programs for a narrower review period.

The initial review concluded that, relative to other social programs, relationship education programs have an extensive evidence base, having been tested in many large randomised controlled trials over many years, predominantly in the USA. Studies of the well-established programs identified in the initial review found these programs typically lead to small to moderate improvements in a range of couple outcomes.

Improvements are typically larger for couples facing minor issues in their relationship or at greater risk of relationship challenges due to personal characteristics or social context. Where studies have included medium- to long-term follow-up of participants, there is inconsistent evidence of sustained effects. For this reason, previous scholars have concluded couples are likely to benefit from repeat interventions to refresh and reinforce learnings (Stanley et al., 2014).

The previous review found 4 US programs that have been successfully adapted and delivered to military couples in the USA that are promising for delivery in the ADF context (e.g. ePREP), which varied in their approach, delivery characteristics and target groups (primary vs secondary intervention). These programs had also been tested (and found to be promising for potential delivery) with different population groups including low-income couples, same-sex couples and couples experiencing less severe forms of intimate partner violence.

The previous review concluded that which of these programs was likely to lead to the greatest engagement and improvements for current and ex-serving ADF members and their partners may vary depending on a couple’s specific circumstances and needs. Larger dose programs have been found to have larger effects. However, not all couples need or will have time to commit to the more intensive programs, and short interventions have been found to be effective with some couples.

On balance, the evidence of positive improvements was strongest for the hybrid OurRelationship program, which combined key features of the different programs (i.e. couple relationship assessment and feedback with curriculum-based training).

While the initial review included programs delivered in Australia, due to lack of high-quality evaluations and trials in the review period, Australian programs were not among the 4 programs identified as promising.

This supplementary review examined additional evidence on Australian programs over an expanded time frame, covering 10 published articles on 8 studies of RELATE, various versions of Couple CARE, and a combined version of Couple CARE plus RELATE. The RELATE and Couple CARE programs have similar characteristics, and draw on similar content and evidence approaches, to the respective US assessment and feedback versus curriculum-based programs (Halford et al., 2015).

All these studies shared some limitations and were rated as having a high risk of bias due to at least one study design issue, such as lack of information about blinding or a reliance on self-report measures. Nonetheless, 7 of the 8 evaluations – and all evaluations of Australian programs trialled in Australia (one was a trial of an Australian program in the USA) – had generally positive findings.

All studies found small to moderate improvements in at least one of the measures used in the study, from pre- to post-intervention and/or follow-up, at significant or trend level. In the RCTs (evaluations including a comparison group), people in the ‘treatment group’ typically had larger improvements in relationship outcomes than the comparison group.

The improvements in relationship outcomes were small for some subgroups, and effects attenuated over time; consistent with findings from the previous review. These patterns were again consistent with the conclusion drawn in our previous report (Hughes et al., 2023) that there is evidence of benefits in relationship education programs in the short to medium term for generally happy couples, and especially for those with minor issues, or those at risk of issues due to their social or work environments.

Overall, Couple CARE is the Australian program with the most substantial evidence base, with various versions having been tested in multiple experimental trials. While the trial of Couple CARE with ADF couples found no significant additional benefit against an active comparison group, it found significant improvements over time for the military couples who participated, and high levels of program satisfaction among those who completed it, suggesting Couple CARE is worthy of further trial and investigation.

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Appendix A: Evidence profile

Table A1: Studies evaluating relationship education programs developed or delivered in Australia

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Authors & year | Design and data collection points | Intervention, comparison and participants | Quality assessment: Level I, II, III(1) or IV and risk of bias | Intervention summary and dose | Relationship outcomes measured | Characteristics of sample: Sample size, Mean age (SD), Relationship status % | Results (and comments, including caveats) |
| Kysely et al., 2022 | RCT  Baseline, post-program, +3 months | Couple CARE Online (*n* = 15 couples)  Couple CARE face-to-face (*n* = 15 couples) | Level II (1) study with high risk of bias (insufficient information provided about treatment and control groups at baseline, no analysis of group attrition) | Couple CARE is a 6-unit manualised psychoeducation intervention covering topics of self-change, communication, intimacy and caring, managing differences, sexuality and adapting to change. Couples watch short videos and complete a series of tasks individually and together each week. Couples then have a weekly session with a therapist to review progress and troubleshoot any issues.  In the test (videoconferencing) condition, both partners were in the same room in a clinic, and the therapist in another room (replicating couples accessing from a different location via videoconference). In the control condition (face-to-face), the couples were in the same room as the therapist (replicating traditional face-to-face therapy). | Relationship adjustment and satisfaction (Dyadic Adjustment Scale)  Areas of Change Questionnaire  Marital Happiness Scale | Couples experiencing mild relationship distress, excluded severe psychiatric problems or clinically significant relationship distress.  *N* = 30 couples  Mean age: 42.51 years | Participants in the Couple CARE Online intervention experienced statistically significant (pre-post) increases in relationship satisfaction/quality (η2 = 0.06, *p* = 0.002), desired and perceived change (desired change η2 = 0.02, *p* = .041; perceived change η2 = 0.06, *p* = 0.001) and marital happiness (η2 = 0.10, *p* = 0.006) over the course of the intervention, with small to moderate effect sizes.  There were no statistically significant differences between the intervention and active control group, suggesting that Couple CARE is equally effective when delivered online or face-to-face.  Positive findings are pre-post-test for each form of delivery condition. Study provides no assessment against a waitlist or no intervention control. |
| Pepping et al., 2020 | Pre-and post-test only (no control or longer term follow-up) | Rainbow Couple CARE (*n* = 12 couples) | Level IV study with high risk of bias (small sample size) | Adapted from Couple CARE, included 6 units covering communication, conflict resolution, sex and sexuality, dyadic coping. Adapted to depict same-sex couples and include topics on internalised stigma, discrimination, disclosure of sexual orientation, and specific tailoring for gay men regarding extra dyadic sex.  Tested in a face-to-face workshop format over 2 days (unit 1 vs remaining 5 units). Couples received follow-up phone call from relationship educator 2 weeks following workshop. Relationship educators were qualified clinical psychologists and postgraduate clinical psychology students. | 16-item couple Relationship Satisfaction index, Relationship dedication (or commitment) subscale from their Revised commitment inventory, client satisfaction questionnaire | 12 same-sex couples ranging in age from 20 to 56 years (*M* = 36.67, *SD* = 9.52).  3 male same-sex couples and 9 female same-sex couples.  Mean relationship duration = 4.02 years (*SD* = 3.78)  All but one cohabiting.  19/24 individuals reported Anglo-Celtic background.  Main couple satisfaction at baseline was similar to that reported for a large community sample of heterosexuals in couple relationships, reflecting the sample as satisfied overall. | Study examined feasibility, acceptability and preliminary effectiveness of Couple CARE adapted for same-sex couples.  Analysis compared change over time for those receiving the intervention and found significant improvements in mental health following the intervention but only trends for improvements in relationship outcomes (*d* = 0.22 for relationship satisfaction and 0.19 for relationship functioning).  Consumer satisfaction with program was high (*M* = 28.61, *SD* = 3.22, out of a possible 32)  Authors conclude that relationship education may enhance relationship functioning for same-sex couples. |
| Heyman et al., 2019 | RCT, Baseline, post-program & 2 follow-ups (child 8, 15 & 24 months) | Couple CARE for Parents of Newborns (*n* = 188) versus 24-month waitlist control (*n* = 180)  Moderator: risk of IPV  Setting: maternity units in 2 large hospitals in exurbs of New York City | Level IV study with high risk of bias (unclear blinding, no analysis of differences in groups due to attrition) | Adapted version of CCP for low-income unmarried parents in the USA. 8 sessions delivered during baby’s first 8 months. Sessions 1 and 4 were one-hour home visits, the others typically conducted via 30-to-60-minute telephone calls.  Sessions began when newborns were less than 3 months old and were scheduled 1–3 weeks apart with early sessions more closely spaced. Couples watched videos and completed activities from their workbooks prior to the session and discussed with coach at the next session.  Material adapted to simplify language and concepts; add content addressing conflict escalation and IPV, and to be suitable for post-natal rather than prenatal delivery. | Revised Conflict Tactics Scale (version 2) psychological and physical abuse subscales; 32 item Relationship Satisfaction index; 16 item Behavioural Self-Regulation for Effective Relationship Scale; Conflicts and problem-solving scales (4 subscales: collaboration, stalemate, avoidance-capitulation, & child involvement in conflict) | Couples at elevated risk for IPV (*n* = 368)  Mean age for men = 29.3 years (*SD* = 5.2)  Mean age for women = 26.8 years (*SD* = 3.8).  A mix of non-Latino African American, Hispanic Latino, non-Latino white, and non-Latino multiracial.  1/3 had undergraduate or advanced degrees.  59% married | Overall, CCP was not found to prevent physical or psychological IPV or improve relationship satisfaction, self-regulation or communication.  Regarding relationship functioning, the intervention had a significant (small to medium sized) negative impact on partners’ collaboration at 15-month follow-up.  CCP had no significant effect on preventing physical IPV (18.4% of CCP and 18.6% of control couples developed physical IPV).  Moderation analysis showed that, with one exception, cumulative risk did not modify the effects of CCP on IPV or other aspects of relationship functioning. CCP reduced male to female physical IPV for men with lower cumulative risk but increased it in men with high cumulative risk.  Whether or not the pregnancy was planned was a significant moderator of effect (LI: simple slope = -0.67, *p* = 0.04]; if unplanned, CCP may have resulted in increased IPV (LI: simple slope = 0.48, *p* = 0.09]. |
| Bakhurst et al., 2017 | RCT, Baseline, post-program and 6-month | Couple CARE in Uniform (*n* = 17)  Active control (self-directed reading:12 hours to a great marriage  (*n* = 15)  Moderator: Gender | Level II (1) study with high risk of bias (appropriate analysis, but small sample, unclear blinding, differences in groups at baseline (on one outcome measure), and differential attrition) | Couple CARE 6-unit flexible delivery program adapted for use with military couples. Content modified to include military examples and terminology. Delivered by postgraduate students in clinical psychology who were trained in Couple CARE and the distinctive needs of military couples. Couples sent program DVD and workbook by mail and asked to complete one of the six units in the workbook each week before one-hour session with their educator, conducted using internet-based videoconferencing (2 hours per week in total for approx 6 weeks).  Control couples sent a copy of *The Great Marriage Tune-Up Book* (Larson, 2003) and were instructed to read it over 6–8 weeks, with reminder call after 3 weeks. | 16 item Couple Relationship Satisfaction index; Relationship status inventory (stability), Psychological & physical aggression scales from Conflict Tactics Scale; Observational Communication (coded for positive & negative speaker & listener behaviour & affect), Consumer Satisfaction Questionnaire | *N* = Australian military couples (one or both partners in ADF)  50% Army, 31% Airforce, 19% Navy  Married or co-habiting for at least 6 months  Couples overall highly satisfied with their relationship at baseline  Neither partner receiving psychological therapy for an individual or couple related issue.  Mean age = 34.3 years for men and 32.8 years for women | Modest decrease in negative communication scores from pre to post education across both conditions at trend level only (z = 1.83, *p* = 0.07). No reliable difference between conditions in the extent of decline across time.  Significant but modest improvement in relationship satisfaction over time (x2(1) = 46, *p* < 0.05), and decrease in negative communication from pre-education to 6-month follow-up, but no reliable difference between conditions in extent of change from pre-intervention to follow-up.  In a recent meta-analytic review, Karantzas et al. (2023) stated the study found the program reduced physical aggression (*d* = 0.12) and conflict (*d* = 0.69) from baseline to follow-up, but Bakhurst (2015) reports that the floor effects prohibited examination of inter-partner aggression outcomes.  Couple CARE participants showed significantly higher consumer satisfaction with the program (*M* = 29.0, *SD* = 3.0) than the control group couples (*M* = 24.6, *SD* = 3.3) (F(1, 19) = 14.38, *p* = 0.001, *d* = 1.4. |
| Halford et al., 2017 | RCT, Baseline, post-intervention, 6-, 12-, 18-, 30-, and 48-month follow-up | RELATE assessment with feedback (*n* = 61 couples), Couple CARE with RELATE, (*n* = 62 couples)  Self-directed reading (*n* = 58 couples)    Moderators: relationship satisfaction at baseline | Level II (1) study with high risk of bias (no reporting or discussion of loss to follow-up, and no alphas reported) | RELATE assessment with feedback: Couples read a 13-page report providing an overall couple relationship profile based on each partner’s strengths and challenges, after which they discuss report with each other and relationship educator over the phone and identify relationship enhancement goals.  Couple CARE with RELATE: Couple CARE is a 6-unit flexible delivery program covering common relationship topics including communication, intimacy and managing differences. Units are provided in 15-min DVD segments with practical exercises in a guidebook. Couples complete one unit a week in their own time, either online or via take-home audio-visual materials. Couples then take a phone or video-call with a relationship educator who reviews their work and provides coaching support Time commitment is 2 hours per unit (12 hours in total).  Control couples sent a copy of *The Great Marriage Tune-Up* *Book* (Larson, 2003) and instructed to read it over 6–8 weeks, with reminder call after 3 weeks. | RELATE assessment of relationship strengths and challenges (domains of relationship satisfaction, stability, self-regulation, kindness & caring, effective communication, flexibility, conflict, conflict style, sexual intimacy, & problem areas) | *N* = 182 couples  Heterosexual couples in Australia (recruited via social media and advertisements) in a cohabiting or married relationship for at least 6 months (68% married)  Mean age: 40–45 years  Mean income and education levels higher than general Australian population  Mean length of relationship = 11–12 years.  30% born outside Australia | There was no change in relationship satisfaction in the RELATE or Control conditions but there was a small to medium positive effect size increase in relationship satisfaction for Couple CARE plus RELATE compared to control (*d* = 0.45, 95% CI [0.18, 0.69]).  Moderator analysis showed that for high satisfaction couples, neither intervention increased relationship satisfaction. For low satisfaction couples, RELATE plus Couple CARE increased relationship satisfaction (more than the control, with a medium to large effect (*d* = 0.62, 95% CI [0.09, 1.16]). This difference held post-assessment and at 6-month follow-up, and there was a trend in the same direction at 12 months; but there were no reliable differences from 2 years onwards. Thus, the authors conclude there was a clear intervention effective for CCR with low satisfaction couples, but that effect reduced over time.  Neither intervention had any change on mental health relative to the control condition. |
| Halford et al., 2015 | As above (same study) but examines immediate effects only | As above | Level II (1) study with high risk of bias (no reporting or discussion of loss to follow-up, incomplete blinding) | As above | As above | As above | The study found no difference in relationship satisfaction post intervention for couples receiving RELATE, when compared to the active control (self-directed reading) (x2(2) = 0.43, *p* = 0.08), overall, for those with low satisfaction at baseline.  Couples with initially low satisfaction receiving Couple CARE plus RELATE (CCR) showed a moderate increase in relationship satisfaction relative to the control (*d* = 0.50). In contrast, couples initially high in satisfaction showed little change and there was no difference between CCR and the control conditions.  They conclude that brief relationship education can assist somewhat distressed couples to enhance satisfaction and has potential to be a cost-effective way of enhancing the reach of couple interventions. |
| Halford, Wilson et al., 2010 | RCT, Baseline, post-intervention, 12-month follow-up | RELATE assessment with feedback (*n* = 28 couples), Couple CARE with RELATE (CCR) (*n* = 29 couples) | Level II (1) study with high risk of bias (lack of blinding of those delivering the program) | As above  Delivered by trained relationship educators with degrees in Human Services experience working with Relationship Australia Qld, and/or postgraduate clinical psychology students. | Observed couple communication; and RELATE assessment of relationship strengths and challenges (domains of relationship satisfaction, stability, self-regulation, kindness & caring, effective communication, flexibility, conflict, conflict style, sexual intimacy, & problem areas). | 59 newlywed couples (recruited from Qld register of marriages in July 2005 & June 2006)  Mean age = 36 years (*SD* = 10.7) for men and 34.2 (*SD* = 10.2) for women  Mean duration of premarital cohabitation = 35 months (*SD* = 23.2)  Predominantly Caucasian, well educated  Sample on average about 0.5/0.25 *SD* (women/men) more satisfied with their relationship at baseline than a population sample of cohabiting and recently married couples. | At 12-month follow-up, across the 3 measures, there was more improvement in communication from pre to post in CCR than in RELATE, for at least one gender.  Relative to RELATE, in CCR, there was a large decline in negative affect (conflictual communication) for men (*d* = 0.79) (not women); a moderate decline in negative listening among women (*d* = 0.62) (and a trend to decline in men (*d* = 0.27)), and a small to moderate decline in negative speaking among women (*d* = 0.38) (but not men).  Women in CCR showed a reliably larger increase in satisfaction (with a mean of 30.4 at 12 months) than women in the RELATE only condition (*d* = 0.42 – a moderate effect size) who showed little change (Mean of 28.4).  For this, authors concluded the combined program (Couple CARE plus RELATE, relative to just RELATE) benefited women but not men.  The authors further note that in the absence of a no-intervention control, this study provides no information on whether RELATE assessment and feedback had a beneficial effect compared to no intervention, and noted that most research finds that satisfaction declines in recently married couples, where the couples receiving RELATE in the current study showed no such decline (we cannot rule out that this is not a selection effect). |
| Petch et al., 2012 | RCT, Baseline (third trimester pregnancy) & 3 time points post-intervention (4, 16 & 28 months postpartum) | Couple CARE for Parents (CCP) (*n* = 125)  Becoming a Parent (BAP) program (*n* = 125)  Moderators: Risk for declining satisfaction | Level II (1) study with high risk of bias (groups differed at baseline on some measures despite randomisation, and insufficient analysis of whether reasons for attrition affected balance/profile of groups) | CCP is a 6-unit couple relationship and parenting education program focusing on positive couple adjustment to parenthood and prevention of future relationship deterioration. Combines information and skill training in a mix of face-to-face group workshops and home-based, self-directed learning. Includes relationship and infant care/parenting information.  Becoming a Parent Program (BAP) is an optimised version of standard available perinatal care in Australia. BAP provided information and support to the mother on topics such as birth expectations, breastfeeding, infant care and development  In this trial, interventions were delivered by trained midwives, supervised by registered psychologists. | Dyadic relationship adjustment scale (DAS) self-report measure of relationship satisfaction; observed couple communication (blind coded – for conflict, invalidation and negative affect), 36-item Parenting Stress Index | Sample size = 250 couples  All couples expecting their first child  Mean age for women = 28.7 years (*SD* = 4.9), Mean age for men = 30.6 years (*SD* = 5.8).  Mean relationship duration = 5.5 years (*SD* = 3.3)  Highly educated couples were over-represented, and Non-English speaking background couples under-represented, compared with the Australian population. | Relative to BAP, CCP women decreased their negative communication, irrespective of risk level (including on measures of conflict (*d* = 0.38) and invalidation (*d* = 0.44), but not negative affect).  There was no effect of treatment condition on relationship satisfaction, but an effect of risk, and a significant risk and condition interaction.  At follow up, there was no association between treatment condition and outcome for low risk women (x2(1, *N* = 167) =0.36, *p* > 0.05) for men (x2(1), *N* = 167) = 0.17, p > 0.05). However, high risk women receiving CCP reported higher relationship satisfaction, and less decline in satisfaction across time, in CCP than high risk women receiving BAP (x2(1, *N* = 83) = 3.87, p < 0.05) And high risk men in CCP showed a trend (x2(1, *N* = 83) = 3.53, *p* =.06) for higher relationship satisfaction than higher risk men in BAP. |
| Halford et al., 2011 | Same study as above but cross sectional analysis of prevalence & correlates of IPV among participating couples at baseline | Couple CARE for Parents (*n* = 250 couples) | NA | NA | Relationship satisfaction (32-item DAS), couple aggression (78-item conflict tactics scale 2nd edition –analysis includes subscales on injury and physical assault with a physical assault (self & partner report)), 16-item Self-regulation for effective relationship scale; 6-item Social Support questionnaire satisfaction subscale | 250 couples expecting their first child  Mean age = 28.7 years (*SD* = 4.9 years) for women and 30.6 years (*SD* = 5.8 years) for men  Main relationship duration was 5 years and five months (*SD* = 3 years and 3 months)  65% of couples were married and the remainder cohabiting | Using any report by either spouse to define the occurrence of IPV, the study found that IPV had occurred in the past year in about 1/3 (32%) of couples attending CRE, with just over 30% of women and 20% of men perpetrating at least one act of IPV.  7% reported at least one incident of severe violence (injured).  The vast majority of IPV was mainly minor (low level and reciprocal).  Logistic regressions were conducted to identify correlates or predictors of IPV. Only lower female relationship satisfaction was associated with risk of IPV. Marital status, unplanned pregnancy, low relationship self-regulation and low social support were unrelated to the occurrence of IPV. |
| Halford. Petch et al., 2010 | RCT, Baseline (last trimester of pregnancy) and 2 points post intervention (5 & 12 months postpartum) | Couple CARE for Parents (CCP) (*n* = 40)  Becoming a Parent (BAP) (*n* = 40) | Level II (1) study with high risk of bias (intention-to-treat analysis was not used, those delivering treatment not blinded) | CCP is a 6-unit couple relationship and parenting education program focusing on positive couple adjustment to parenthood and prevention of future relationship deterioration. Combines information and skill training in a mix of face-to-face group workshop and home-based, self-directed learning. Includes relationship and infant care/parenting information.  Unit 1 was a 6-hour face-to-face antenatal workshop for groups of 3–4 couples at a clinic. Remaining 5 units completed in couples’ homes. Units 2 and 3 involved 1.5-hour home visits. Units 4–6 were self-directed and involved a couple watching a 12-minute DVD, completing exercise and a 45-min telephone call with the educator to review unit and provide coaching. Total time commitment about 17 hours across 6 months, including 12 hours of professional contact time).  Delivered by registered clinical psychologist.  Becoming a Parent Program (BAP) is an optimised version of standard available perinatal care in Australia. BAP provided information and support to the mother on topics such as birth expectations, breastfeeding, infant care and development. | Observed couple communication (coded for conflict, invalidation and negative affect), 32-item Dyadic relationship adjustment scale (DAS); 16-item Self-Regulation for Effective Relationship scale (SRES), short form (36 item) Parenting Stress Index (PSI) | Sample size = 80  Couples in committed relationship for at least 12 months expecting first child  Couples high on relationship adjustment at baseline  Mean age of female participants was 28.7 years (*SD* = 4.9) and male was 30.6 years (*SD* = 5.6).  70% of couples were married and 30% cohabiting | Couples in the CCP intervention experienced significantly greater reduction in negative couple communication, from pre to post intervention, relative to those in BAP. Though there was partial attenuation of these effects overtime (from post-workshop, at 5 months post-partum, to post-intervention, at 12 months post-partum).  Multi-level modelling effect sizes (quadratic) for women (*r* = 0.51, *p* < 0.05, *r* = 0.76, *r* = 0.49, *p* < 0.05 for 3 measures), and men (*r* = 0.37, 0.81, 0.53, *p* < 0.05).  Women in the CCP intervention experienced significantly less decline in relationship adjustment than women in BAP, from pre-intervention to follow-up (6.5 points per year less) and self-regulation (4.2 points per year less), which are moderate to large effect sizes.  However, for men there was no difference between CCP versus BAP, in changes in relationship adjustment or self-regulation.  Parenting stress measures reflected positive adjustment to parenthood for intervention and control group participants with no differences between BAP and CCP. |

Appendix B: Methodology

Evaluation of the evidence

Evaluation of the evidence was undertaken using the 5 criteria, below (Varker et al., 2014), which draw on the FORM framework for assessing and grading a body of evidence (Hillier et al., 2011). The evaluation focused on:

* the **strength of the evidence base**, in terms of the quality and risk of bias, quantity of evidence and level of evidence (based on the study designs)
* the **direction** of the study results in terms of positive, negative or null findings
* the **consistency** of the study results
* the **generalisability** of the body of evidence to ADF couples
* the **applicability** of the body of evidence to the Australian context and DVA and Defence social services contexts.

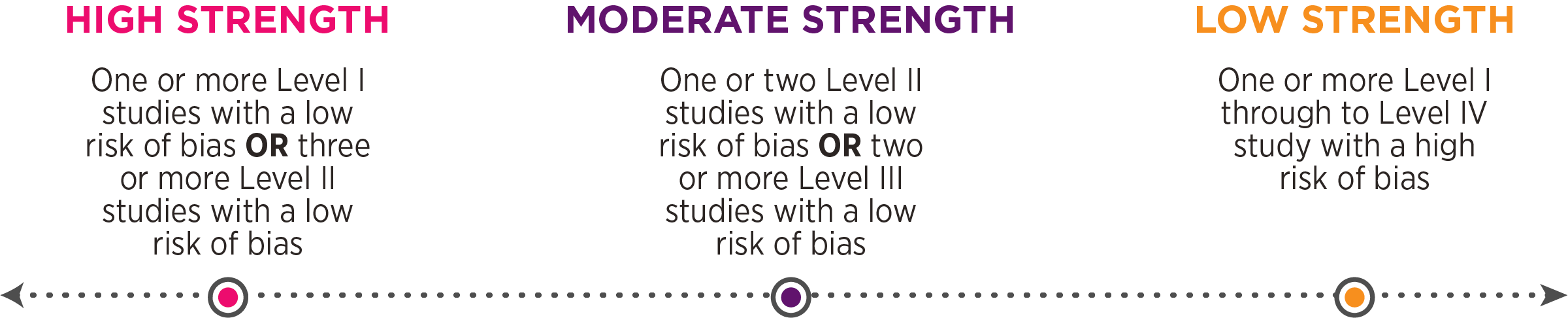
As a first step, each study was categorised based on the study design:

* Level I: A systematic review of RCTs
* Level II: An RCT
* Level III-1: A pseudo-randomised controlled trial
* Level III-2: A comparative study with concurrent controls
* Level III-3: A comparative study without concurrent controls
* Level IV: Case series with either post-test or pre-test/post-test outcomes (Varker et al., 2014).

Where there was at least one Level II study, the FORM assessment was undertaken. A full description of the FORM assessment can be found in the DVA guide to REAs (Varker et al., 2014). Each criteria is summarised below.

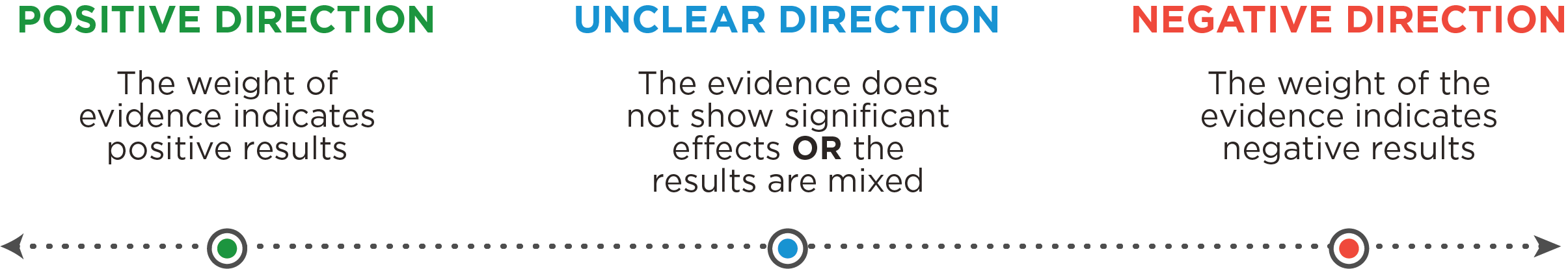
### Strength of the evidence base

The strength of the evidence base considers the quality of the study and its risk of bias, the quantity of evidence and the level of evidence.



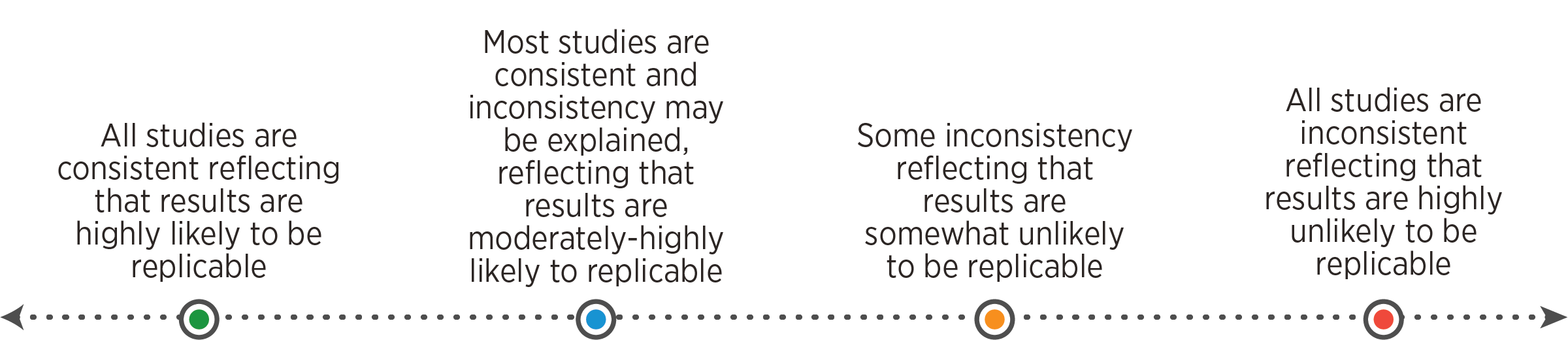
### Direction of evidence

Direction of evidence looks at whether positive or negative outcomes were found.



### Consistency

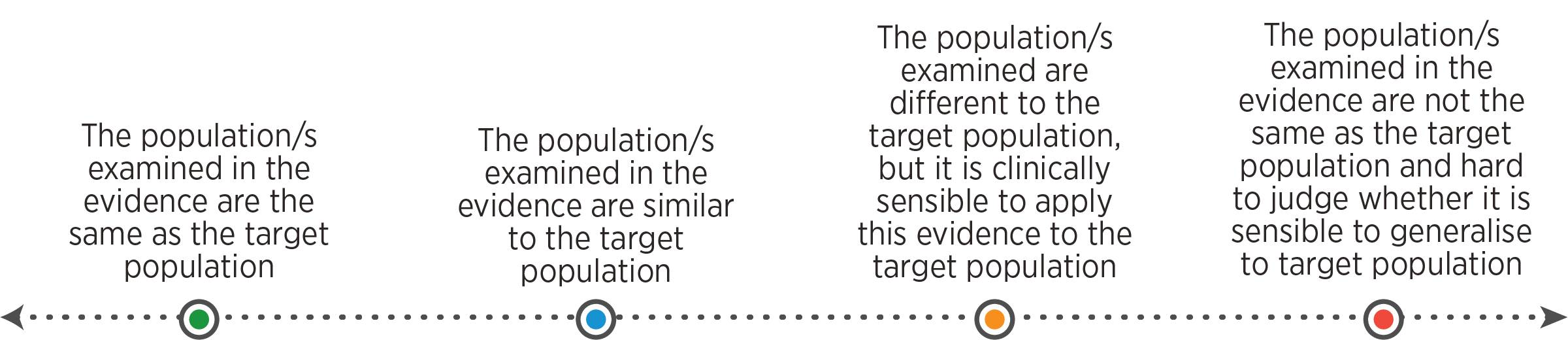
Consistency refers to whether the findings were consistent across the included studies (and are therefore likely to be replicable). Where there was only a single study, consistency was not assessed.



### Generalisability

Generalisability covers how the participants and settings of the included studies match the target population: Australian military and veteran couples. In applying these criteria in the original review, a study undertaken with an ADF population was considered ‘the same’, a study with a military population in another country (e.g. the USA) or broad population group in Australia was considered ‘similar’, a study with a broad population group in another country was considered ‘clinically sensible’, and a study in a particular location or with a particular age group or participants from a specific cultural background was considered ‘hard to judge’.

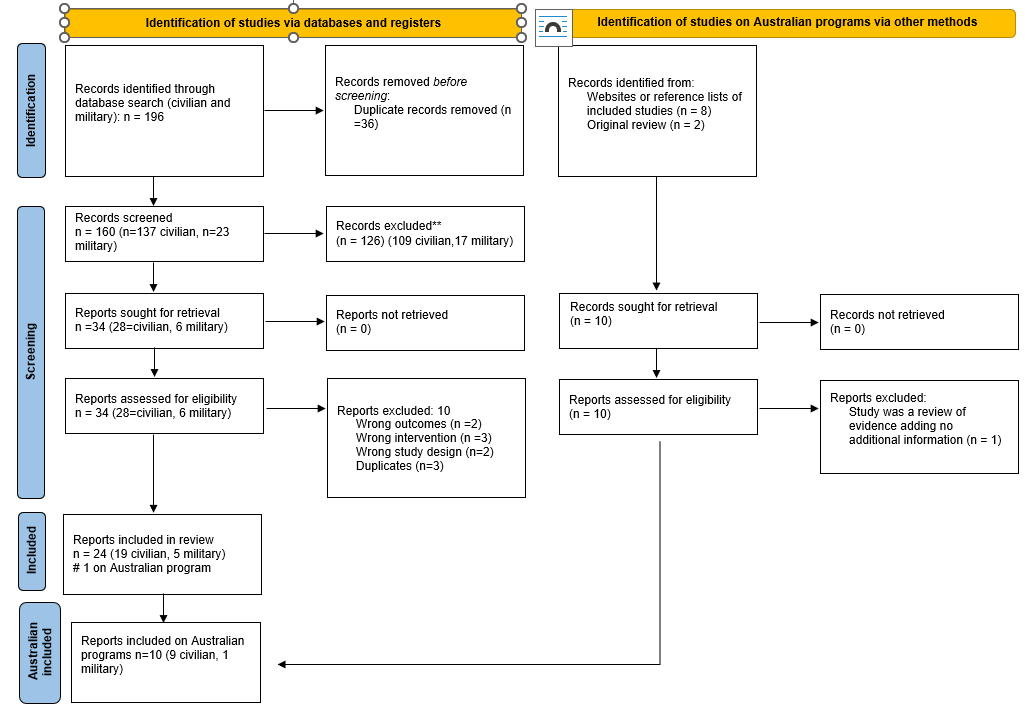
Other considerations that might influence the generalisability of the findings include gender age or ethnicity or issues such as the prevalence of shared conditions in the study population (Varker et al., 2014). To draw out any findings that are more relevant and generalisable to Australian military and veteran couples, in this supplementary review we have further upgraded studies undertaken with civilian participants whose characteristics are more common among Australian military or veteran populations (mental health PTSD, physical health, IPV) as ‘similar’.



### Applicability

The applicability criteria consider whether the evidence base is relevant to the Australian context, drawing on organisational and cultural factors. Drawing on Varker and colleagues (2014) and Hillier and colleagues (2011), our assessment of applicability considered factors such as staff qualifications, the replicability, accessibility and adaptability of the intervention and program content to an Australian context, and other organisational factors unique to the ADF context.

Appendix C: Flow diagram



1. The flow diagram in Appendix C depicts the number of records (articles or other published papers) included and excluded after the initial search and at each stage of the screening process, and the reasons for inclusions and exclusions. On completion of the screening process, a total of 24 articles were identified as in scope: 19 from the civilian and 5 from the military search. Of the 19 additional articles, only one was on a relationship education program designed or delivered in Australia. [↑](#footnote-ref-2)
2. Many programs were excluded from ranking in the original review due to the lack of a high quality RCT. The review found that while many randomised controls are undertaken, it is common for RCTs to have a number of methodological problems that introduce bias into the results (e.g. lack of blinding, high levels of participant attrition and failure to analyse how this affects study results). The vast majority of randomised controlled trial studies that we reviewed were deemed to have a high risk of bias or unknown risk of bias due to failure to report on details required to make this assessment. [↑](#footnote-ref-3)
3. This includes 2 articles that were in the original review (Halford et al., 2017; Kysely et al., 2022), one new article included as a result of the extended time frames (Halford et al., 2010) and 6 articles within the time frames for the original review that were excluded for other reasons, such as wrong outcomes (Petch et al., 2012), wrong issues (intimate partner violence - Heyman et al., 2019), non-significant results (Bakhurst et al., 2017), non- experimental studies (Pepping et al., 2020; Halford et al., 2011), or because it was an additional article on the same study presenting limited additional information on effectiveness (Halford et al., 2015). [↑](#footnote-ref-4)
4. In the trial of Couple CARE for Parents adapted for delivery in the US, where all couples were at elevated risk of IPV, Heyman and colleagues (2019) concluded that relationship education may not be effective as a standalone intervention for preventing intimate partner violence. However, other studies of relationship education in the US have found reductions in intimate partner violence for participants in similar programs (e.g. see Hatch and colleagues’ (2022) evaluation of Our Relationship). And in a recent meta-analytic review, Karantzas and colleagues (2023) found considerable evidence that relationship education can reduce couple relationship aggression and conflict behaviour. In all these programs, the content of the relationship education program had not been specifically developed to address IPV. Other programs specifically designed to address violence within couple relationships show promising evidence that these programs assist in reducing IPV (e.g. the Strength at Home program (Taft et al., 2022, 2024)). [↑](#footnote-ref-5)
5. In the trial of Couple CARE In Uniform, there were significant modest improvements in relationship satisfaction, and decreases in negative communication, from pre-education to 6 month follow up, but no reliable difference between conditions in the extent of change from pre intervention to follow up. [↑](#footnote-ref-6)
6. Including on measures of conflict (*d* = 0.38) and invalidation (*d* = 0.44), but not negative affect. [↑](#footnote-ref-7)