Proceedings of the 5th International Conference on Social Psychology and Humanity Studies
DOI: 10.54254/2753-7048/2027.38433

Cognitive-Behavioral Couple Therapy for Relationship Distress: How Maladaptive Beliefs Shape Relationship Functioning and Psychological Well-Being

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Abstract. Relationship distress is associated with poorer psychological well-being, including heightened stress, anxiety, and depressive symptoms. Cognitive-Behavioral Couple Therapy (CBCT) focuses on couples' relationship cognitions and interaction patterns; however, few existing reviews have synthesized the effects of specific relationship beliefs and attribution processes on relationship functioning and individual psychological outcomes. This literature review examines how hostile attributions, mind-reading expectations, catastrophizing, aversion to disagreement, and rigid destiny beliefs contribute to relationship distress, and how CBCT may modify these processes. Recent meta-analyses, randomized controlled trials, longitudinal studies, and large-scale relationship research published primarily from 2020 onward are synthesized. The evidence indicates that CBCT-informed interventions can improve relationship satisfaction, communication, and selected indicators of individual well-being. Collaborative communication and reduced maladaptive attributional processing are plausible mechanisms, although causal evidence is still limited. CBCT appears most useful when cognitive restructuring is paired with behavioral practice and communication skills. Clinical interpretation should nevertheless account for cultural variation, contextual stress, unequal access, and the need for safety assessment when coercion or abuse is present.

Keywords: Cognitive-behavioral couple therapy, relationship distress, maladaptive beliefs, relationship satisfaction, psychological well-being

1. Introduction

Quality of romantic relationships is one of the central issues of health psychology research because it is related to the individual well-being, health, and longevity of the relationship itself. A meta-analysis revealed that people usually experience declines in satisfaction in the early years of a relationship; however, these trajectories vary by age and relationship length [1]. There is also large-scale longitudinal data suggesting that the sense of commitment, appreciation, sexual satisfaction, satisfaction of the partner, and conflict are better predictors of the quality of the relationship than many demographic and individual difference factors [2]. Poor relationship quality is characterized by recurrent conflict, insecurity, negativity, and anxiety or depressive symptoms.

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CBCT is relevant to the topic in question because it involves an interpretation of events happening within relationships, instead of assuming that the event has a single and obvious meaning. Attributions about the cause of a problem, knowledge expected from one's partner, and expectations about the possibility of change in a relationship influence emotions, communication, and behaviors. However, a central gap remains in integrating specific relationship beliefs, attributional processing, and interaction patterns with both relationship quality and individual well-being. Evidence that a treatment improves outcomes does not establish whether cognitive change precedes better communication or whether either process causes those benefits. Findings also require synthesis across types of external stress, because the same belief may have different implications when couples have fewer resources or face health-related demands. The current review seeks to identify which types of cognitive and relational schemas contribute to distress, how different kinds of stressors in the social, economic, developmental, and health domains impact these associations, and by what means CBCT could enhance satisfaction, communication, and individual well-being. Narrative synthesis focuses primarily on meta-analyses, randomized controlled trials, longitudinal designs, and large collaboration-based data sets. A distinction is made between CBCT-specific evidence and broader evidence on cognitive-behavioral and skills-based interventions.

2. Relationship distress and psychological well-being

2.1. Conflict, rejection, criticism, betrayal, and chronic stress

Relationship distress involves repeated conflict, criticism, rejection, betrayal, withdrawal, and problems coordinating reactions to ongoing stress. Relationship distress is a pattern in which interactions are perceived as threatening, unfair, and difficult to repair. In their life span meta-analysis of relational distress, Bühler, Krauss, and Orth noted that, based on 165,039 individuals, satisfaction dropped roughly between ages 20 and 40, rose until old age, and followed a different trajectory once relationship length was included in the analysis [1]. Relationship distress is more likely to occur in young adulthood. These periods may therefore be useful windows for preventive support, although the findings do not establish an optimal intervention age or imply that every young couple will experience distress.

2.2. Associations with stress, depressive symptoms, anxiety, negative affect, and reduced quality of life

Relationship quality is associated with individual psychological functioning, supporting its relevance to health psychology. The study of 43 datasets conducted by Joel and colleagues also found an association between relationship quality and individual well-being. In 11,196 couples, predictors like relationship factors as reported by actors accounted for 45 percent and 18 percent of variance in baseline and follow-up satisfaction respectively while individual differences made a lower contribution. Among the most significant predictors were perception of commitment, appreciation, sexual satisfaction, partner satisfaction, conflict, life satisfaction, negative affect, depression, and insecurity [2].

Social resources could moderate the link between partner blame and dissatisfaction. In their study using a socioeconomically poor sample of newlyweds across different ethnicities, Nguyen et al. noted that attributing relationship problems to partners' traits was associated with lower satisfaction [3, 4]. This effect was enhanced in samples with low social network resources and a low proportion of married individuals in networks in cases of wives. Lack of financial strain among the couples

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themselves did not moderate the link. This sample therefore expands attribution studies to a sample of mainly poor couples, while the findings highlight the relevance of network resources as situational factors.

Beliefs also moderated relationship processes during a public health crisis. For example, in a study of 382 emerging adults across the COVID-19 pandemic, Figueroa et al. showed that daily criticism was a significant predictor of reduced satisfaction in the future ($\beta = -.23$); on the other hand, COVID-19 fear and beliefs did not have a direct connection to satisfaction [5, 6]. The beliefs about growth mediated the relationship between criticism and satisfaction: criticism was linked to reduced satisfaction for individuals low in beliefs about growth but not for those high in beliefs about growth.

Access is another aspect of distress relevant to health. Poor couples may experience difficulties regarding transportation, childcare, scheduling, and finances. In a national randomized controlled trial, Doss et al. divided 742 poor couples into the groups of Our Relationship, ePREP, and a waitlist control group [7]. Intervened couples showed significant improvements in relation to the control group in five areas of the relationship with the median effect size of about .46; improvements lasted four months but interventions did not lower separation rates after six months. This distinction matters because satisfaction, communication, and relationship continuation are separate outcomes. The trial supports accessible relationship support, but does not show that short-term improvement guarantees relationship stability.

3. Cognitive patterns underlying unhealthy relationship experiences

3.1. Maladaptive relationship beliefs: mind-reading expectations, aversion to disagreement, destiny beliefs, and growth beliefs

Evidence for lay beliefs is also more nuanced than the general catalog of irrational thoughts implies. Zagefka and Bahul examined 253 participants in the United Kingdom and 132 in Hungary. In both samples, intolerance of disagreement was associated with lower satisfaction, while mind-reading and destiny beliefs were not [5]. The dysfunction in disagreement arises because disagreement is seen as evidence of the failure of the relationship and hence cannot be repaired due to its avoidance. There may be other relevant beliefs in other situations, which would have to be investigated. Longitudinal studies differentiate destiny and growth beliefs. According to Gander et al., high levels of destiny beliefs were linked with high levels of initial satisfaction; however, growth beliefs predicted slower decline in satisfaction [7, 8]. Mismatched growth beliefs were associated with low satisfaction. A couple consisting of individuals who both had high destiny beliefs declined most steeply. Satisfaction was also found to predict increases in growth beliefs.

The same was observed by Figueroa et al. Beliefs in growth were not correlated with satisfaction during the pandemic but were able to mitigate the negative relation between criticism and satisfaction [6]. This might be due to the fact that a growth mindset could motivate couples to view challenging situations as something that can be solved instead of a sign that they are incompatible. Rigid beliefs, by contrast, tend to exacerbate such dichotomous thinking.

3.2. Cognitive distortions and maladaptive attributions: catastrophizing, overgeneralization, hostile interpretations, and social stress

Whereas cognitive distortions and maladaptive attributions have many similarities, there are distinctions between them. Cognitive distortions refer to the manner of making the appraisal.

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Catastrophizing refers to the overestimation of a probable outcome, overgeneralization refers to the expansion of an incident into a general rule, and mind reading involves assumptions about another person's thoughts. On the other hand, attributions involve the explanation of the causes behind an event and determine whether the partner's behavior was driven by his/her personality or situation [3, 4]. A delayed response may be interpreted as meaning that the partner is going to leave, or that the partner deliberately ignored the issue. The process can cause accusations or withdrawal and can lead to negative expectations.

Relationship cognitions are an integral part of larger functional theories. According to Spencer and Anderson, online interventions affected relationship-specific cognitions as well as anxiety, depression, satisfaction with one's health, and quality of life [9]. Related couple relationship education programs also target many of the behavioral skills used in CBCT. Megale et al., in a review of nine studies involving more than 2,000 couples, found that online relationship education commonly addressed communication, problem-solving, emotional expression, and conflict resolution [10]. However, these programs represent relationship education rather than conjoint CBCT. These interventions are not CBCT, but their content illustrates how cognitive and behavioral interventions can be integrated: partners rethink a problem, practice new ways of interacting, and adjust expectations.

4. CBCT mechanisms and evidence of change

4.1. Cognitive restructuring and behavioral experiments

The first mechanism of CBCT is cognitive restructuring. It involves identifying the automatic thoughts and interpretations of couples, differentiating between observation and inference, exploring alternate explanations, and formulating a balanced appraisement. Behavioral experiments are conducted to assess the accuracy of these appraisals as couples ask for something directly, express vulnerability, or respond to conflicts differently. As indicated in Gregory's meta-analysis of 14 randomized clinical trials, the random-effects Hedges' g statistic before outlier deletion was .490 and .421 after exclusion of one trial; the latter result was homogeneous and statistically significant [3].

4.2. Behavioral change: communication training, collaborative problem solving, and homework practice

The other strategy is behavioral practice. Communication training focuses on making specific requests, reflective listening, validation, and problem solving in limited time rather than criticism, mind reading, or withdrawal. Homework exercises this skill set beyond sessions. Doss et al.'s study showed that both ePREP and OurRelationship programs enhanced functioning in five areas compared to the waitlist control group [7]; however, OurRelationship resulted in somewhat greater decreases in conflict (d = .24). Structured practice can thus operate through several pathways, although improved functioning did not lead to fewer breakups six months later.

4.3. Evidence from meta-analyses and trials

Overall efficacy findings support the advantages of relationship interventions but need differentiation in the type of treatments and their effects. In Gregory's meta-analysis of 14 randomized CBCT experiments, Hedges' g between groups was 0.49, which fell to 0.42 after an outlier was excluded [3]. As for the online relationship education, the within-treatment pre-post

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differences for satisfaction (d = 0.47), communication (d = 0.36), anxiety (d = -0.56), depression (d = -0.44), and quality of life (d = 0.57) were demonstrated by Spencer and Anderson [9]. Such figures do not reflect superiority over control groups. Megale et al. also described successful relational and individual changes in different online interventions [10]. The review by Megale and the meta-analysis by Spencer both refer to the study by Doss and are not independent replications [6, 9, 10].

Indirect support is provided by neuroimaging instead of any proven CBCT process. Marwood et al. found reduced activity in the anterior cingulate/paracingulate gyrus, inferior frontal and insula after psychotherapy for depression/anxiety where activity in the cuneus at the start predicted later improvements. These results relate to individual psychotherapy within heterogeneous studies. They could help frame hypotheses regarding emotional processing, but not specific neural pathways involved in couples therapy or the causes of cognitive change.

5. Discussion: limitations, safety, and future directions

The key issue that remains open in need of clarification pertains to the mechanism: the demonstration of more favorable outcomes is not necessarily an indication of the process through which cognitive and communicative change produces such benefits for relationships. The only mediation study identified examined sexual communication in a single clinical group, and no studies have directly tested the causal relation between changes in relationship beliefs and outcomes [3, 11]. The methodological limitations include heterogeneity of interventions and comparison arms. Gregory identified unclear randomization and concealment of allocation risk in 11 out of 14 studies [3]. Online relationship education programs cannot be compared with psychotherapy as an intervention, and the average differences in pre- and post-treatment measurements cannot distinguish the effect of the treatment from natural recovery [9, 10]. The present narrative review combines selected literature without conducting reproducible systematic searches and duplication of literature screening. Among measurement shortcomings is the fact that self-reported measures can connect perceived cognitive change with perceived satisfaction through the same reporting procedures [2, 9, 10]. Concerning follow-up shortcomings, there is the issue of durability because the effects of communication-mediated interventions are insignificant at six months' follow-up time and no fewer breakups have been identified in the study by Doss [6, 11]. Morland's study is not aimed at proving non-inferiority of formats of intervention delivery [12].

The evidence supports a reasonable but conditional explanation. The maladaptive attributional style and inflexibility of expectations are related to low relationship satisfaction especially where financial, social, developmental, or health stresses prevent adaptive functioning [4, 6]. At the same time, beliefs should not be viewed as uniformly negative or consistently predictive. Belief in conflict seems to have a more consistent effect than belief in mind reading or destiny, according to Zagefka and Bahul's study across nations [5]. Growth beliefs can act as a protection against criticism and slowing down satisfaction, while destiny beliefs can be high in cases where the level of satisfaction was high from the beginning [6, 8].

Issues related to safety and context must be considered boundary conditions, not optional extras. Some studies excluded violent or aggressive behaviors, fearfulness, and coercion; hence, the results do not generalize to couples for whom the conjoint intervention could pose a risk of increased harm. Couples must be screened prior to any partner-level cognitive intervention, and individual safety planning and appropriate referrals are necessary when issues of abuse or coercive control arise. Further research should include more heterogeneous couples, objective measures of interactional behavior and contextual stress, and longitudinal or cross-lagged designs to examine whether cognitive change predicts communication change and whether both mediate later well-being.

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Comparative testing of full versus brief CBCT, office- versus telehealth-delivered, and CBCT compared to credible active controls would help establish dose and mechanisms of action. Biological measures may be interesting, but these should be used in combination with relationship-level observations [12, 13].

6. Conclusion

The available evidence suggests that appraisals, emotions, partner behavior, and contextual demands interact when relationship problems arise. Maladaptive attributions and fear of conflict are related to relationship dissatisfaction, while the consequences of destiny and growth beliefs depend on the particular situation and time. Such diversity implies the need for flexibility in assessment rather than making assumptions about the equal significance of every dysfunctional belief. CBCT provides a perspective for analysis of beliefs and practicing constructive behaviors. Cognitive restructuring, behavioral experiments and communication skills practice can be used simultaneously, but there is no clear evidence about the sequence of their application. Thus, it is necessary to distinguish between treatment efficacy and its mechanisms. Online interventions based on different theories provide good results and expand opportunities for the use of CBCT. The effects of CBCT on psychological problems, relationship satisfaction, communication, and stability should be analyzed separately. The cultural norms, financial constraints, access barriers, and social limitations must be taken into account along with cognitive processes of the individual. It will be useful for future research to include diverse samples, multiple measurement points, valid comparison conditions, and longer follow-ups in order to determine whether there is a causal effect between cognitive and behavioral processes. For this reason, the clinical recommendation is necessarily conditional. CBCT should be available when both partners can receive treatment safely, and this may involve culturally, linguistically, economically, psychologically, and access-sensitive adaptations. Technology-based approaches are promising but need privacy and technical guarantees, as well as careful risk assessment.

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