THESIS

THE EFFECT OF PARTNER DIFFERENCES REGARDING DYADIC ADJUSTMENT AND EMOTION WORK ON COUPLE THERAPY OUTCOME

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Debra Wallace

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WE HEREBY RECOMMEND THAT THE THESIS PREPARED UNDER OUR SUPERVISION BY DEBRA WALLACE ENTITLED THE EFFECT OF PARTNER DIFFERENCES REGARDING DYADIC ADJUSTMENT AND EMOTION WORK ON COUPLE THERAPY OUTCOME BE ACCEPTED AS FULFILLING IN PART REQUIREMENTS FOR THE DEGREE OF MASTER OF SCIENCE.

Committee of Graduate Work

Robert C. Sim

Alicia Skinner Cook

Adviser

Clifton E. Barber

Department Head

ABSTRACT OF THESIS

THE EFFECT OF PARTNER DIFFERENCES REGARDING

DYADIC ADJUSTMENT AND EMOTION WORK

ON COUPLE THERAPY OUTCOME

Differences between partners on various relational aspects and the possible effects on couple therapy outcome have been unexplored. This study utilizes a database and effectiveness research to examine whether differences between the partners' perceptions of dyadic satisfaction and emotion work affects couple therapy outcome. The measures used are the Dyadic Adjustment Scale, Emotion Work Scale, Client Satisfaction Questionnaire and Client Termination Information Form. Multiple regression analyses were conducted to examine the effect of the predictor variables on various aspects of couple therapy outcome. Results indicate that differences between partners' dyadic satisfaction as well as their overall perceptions of dyadic satisfaction and emotion work do predict couple therapy outcome, yet which outcome variables and the direction of the prediction seems to vary by gender. Both systems theory and social role theory are used to explain the results. Limitations and recommendations for future research are addressed.

Debra A. Wallace
Department of Human
Development and Family Studies
Colorado State University
Fort Collins, CO 80523
Fall 2003

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TABLE OF CONTENTS

INTRODUCTION.....1

LITERATURE REVIEW

Effectiveness Research History.....4

Dyadic Satisfaction.....7

Emotion Work.....8

Therapy Outcome.....8

Theoretical Considerations.....11

Hypotheses.....18

METHOD

Participants.....20

Procedure.....22

Measures.....23

Data Analyses.....26

RESULTS

Descriptive Statistics of Key Variables.....29

Hypothesis One.....32

Hypothesis Two.....39

DISCUSSION

Partner Differences and Therapy Outcome.....50

Partners' Total Scores and Therapy Outcome.....53

Clinical Implications.....55

Research Implications.....56

Limitations.....57

Future Research.....59

Summary.....60

REFERENCES.....62

APPENDIX A - Treatment and Release Form 72

APPENDIX B - Client Summary Form (A).....74

APPENDIX C - Dyadic Adjustment Scale.....78

APPENDIX D - Emotion Work Scale.....82

APPPENDIX E- Client Satisfaction Questionnaire 84

APPENDIX F- Client Termination Information Form (excerpt) 87

CHAPTER ONE

Introduction

In most intimate relationships, couples at times experience some degree of dissatisfaction due to both internal and external factors (Sprecher, 2001). They can each be dissatisfied with some of their partners' behaviors, or dissatisfied with certain relational aspects or with the relationship as a whole. Dissatisfaction or "communication problems" is a common motivating factor for couples to seeking therapy. When couples have considerable differences in perceptions regarding certain relational aspects, the process of couple therapy may be potentially hindered, resulting in poorer outcomes.

Understanding possible effects on treatment outcome is important for many reasons. For one, managed behavioral health care companies have a growing influence on how therapists treat their clients. These companies are prominent because they are more affordable for employers. Managed care is exerting pressure on therapists to rely on effective brief therapeutic models to obtain successful outcomes (Brown, Dreis, & Nace 1999; Goldfried & Wolfe, 1998). A successful outcome concerns both the therapist and the couple's perception of positive change (Hampson, Prince, & Beavers, 1999) and how content each are with the effects of the change. Comparing data from assessments is one way to evaluate the potential effectiveness of therapy outcomes.

Managed behavioral health care organizations have found ways to determine which cases will lead to successful outcomes and which are at risk for poor outcomes. This is done through the use of database outcome management. Studies pertaining to

database outcome management can potentially increase effectiveness and efficiency by guiding administrators in actively managing cases at high-risk for poor outcomes. This type of study can also enable clinicians to use outcome information to monitor and improve their services (Brown et al., 1999). Database outcome management is in its infancy and has relied on data from individual clients, not couples. Therefore, there is a need to investigate the usefulness and validity of database outcome management with couples therapy. This study will use a database compiled with four years of data from couples who requested the services of a couple and family therapy center. The database will be used to determine if differences between partners influence the effectiveness of couple therapy within that center.

The added pressure for the accountability of psychotherapists has raised concern regarding the external validity of effectiveness research designs (Goldfried & Wolfe, 1998; Pinsof, Wynne, & Hambright, 1996). Most outcome research in couples and family therapy (CFT) is efficacy based. In efficacy studies, couples are 1) randomly assigned to treatment and control groups; 2) there is a predetermined number of sessions and; 3) a treatment manual is used (Pinsof et al., 1996). In contrast, effectiveness studies do not use random assignment and therapy is minimally constrained (Pinsof et al.). Although there are advantages to both, critics argue that effectiveness research can build a stronger bridge between clinicians and researchers and provide more clinically valid research (Goldfried & Wolfe).

Determining how to operationalize therapy outcome is another important consideration in evaluating success in couple therapy treatment (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Pinsof et al., 1996; Whisman & Snyder, 1997).

Typically, outcome data was achieved by administering self-report measures regarding dyadic satisfaction at various times of treatment (Baucom et al., 1998; Hampson et al., 1999; Whisman & Snyder). Self-report is not always valid or extensive enough to assess all the problems couples have (Whisman & Snyder).

Researchers have explored dyadic satisfaction extensively. Emotion work can influence dyadic satisfaction for each partner (Duncombe & Marsden, 1993; Levinger, 1964; Kiston & Holmes, 1992, Holm, 1999). Gender has been found to influence emotion work and dyadic satisfaction (Erickson, 1993; Higgins, 1997; Tingey, 1993). Because dyadic satisfaction scales are often used as a measurement of change in outcome studies, it is possible that the same variables that influence dyadic satisfaction will also affect therapy outcome.

Interestingly, when couples have divergent goals and contradictory views of marriage they do not fare well in traditional behavior therapy (Jacobson & Christiansen, 1996). Yet, few studies examine how differences in characteristics between partners influence therapy outcome, regardless of treatment ideology. Do differences between partners in these variables predict poorer therapy outcome? More specifically, does the difference in the scores on the assessments measuring dyadic satisfaction and emotion work predict poorer outcome? Do the partners' scores on these assessments predict an expanded operational definition of therapy outcome? Do any of the predictions depend on the gender of the partner? These are the questions this research project attempts to answer.

CHAPTER TWO

Literature Review

Effectiveness Research History

The effectiveness of therapy has always been important knowledge for researchers and clinicians. However, more recently, effectiveness research has become of greater interest to policy makers and insurance companies (Brown et al., 1999; Goldfried & Wolfe, 1998). Policy makers and insurance companies cater to the consumers rather to any particular psychotherapy theory, model, or treatment ideology (Brown et al., 1999). There is increased pressure on managed behavioral health care organizations (MHBOs) to reduce cost of services without sacrificing outcomes (Brown et al., 1999).

Advancements in technology have enabled MHBOs to manage the demand of reducing costs without losing effectiveness. Human Affairs International (HAI) is one of the largest MHBO in the nation. They have devoted considerable time and resources to developing a system for collecting and assessing individual clients' responses to treatment (Brown et al., 1999). They have found a way, by means of database outcome management, to predict which cases will lead to successful outcomes and which are at risk for poor outcomes. Database outcome management studies found that (a) outcome of therapy is highly variable; (b) that using a specific and empirically validated treatment ideology does not improve treatment outcome; (c) there are significant differences in effectiveness between individual providers and entire clinical delivery systems; and (d)

response to treatment in the first few sessions is highly predictive of outcome (Brown et al.). However, these findings pertain to individual clients and not couples.

The methodologies guiding psychotherapy outcome research have evolved since it began over a half a century ago (Goldfried & Wolfe, 1998). First, researchers were interested in whether psychotherapy was effective in producing personality changes (Goldfried & Wolfe). Then researchers started comparing which methods were best for certain problems (Goldfried & Wolfe). More recently, there has been a shift toward the medical model (Goldfried & Wolfe). Medical model research is most commonly efficacy research. This type of research targets the clinical populations, which are tied to universities and/or medical schools, and aims to study specific DSM diagnoses (Goldfried & Wolfe, 1998; Pinsof, Wynne, & Hambright, 1996). It is more controlled than effectiveness research because participants are randomly assigned to defined and controlled treatments (Pinsof et al., 1996). The therapists are required to restrict the number of sessions, adhere to a particular treatment ideology and use a therapy manual (Goldfried & Wolfe; Pinsof et al.).

Critics argue that the constraints of efficacy research compromise external validity (Goldfried & Wolfe, 1998; Pinsof et al., 1996). An alternative is effectiveness research where therapy outcome is studied in the natural context, such as in a private practice setting. The clients are not randomly assigned and therapy is minimally constrained (Pinsof et al.). Unfortunately, therapeutic theories without manuals, like integrative therapy approaches, are seldom empirically tested. Integrative therapy approaches combine therapies from different orientations. They have revealed clinical promise but need outcome data to confirm effectiveness (Goldfried & Wolfe).

Although efficacy and effectiveness research exits on a continuum, most couple and family therapy (CFT) outcome studies tend to rely on efficacy research methods (Boddington & Lavender, 1995; Pinsof et al., 1996). It has been conservatively estimated that only 7% of studies in CFT outcome studies were conducted in real world clinic settings (Shadish, Ragsdale, Glaser, & Montgomery, 1995). Goldfried and Wolfe (1998) encourage researchers to break away from random assignment, fixed number sessions, the use of treatment manuals, and the uses of theoretically pure therapies. Instead, researchers should collaborate with clinicians and study theoretically integrated treatments (Goldfried & Wolfe; Spenkle, Blow, & Dickey, 1999). There is a strong need to include more CFT studies that fall closer to the effectiveness side of the continuum (Pinsof et al.; Shadish et al.).

This study is an attempt to do effectiveness research. Although it is done in a clinical setting associated with a university, clients are not randomly assigned to treatment or control groups. There is no limit to the number of sessions. The therapists are not required to use treatment manual or follow a strict treatment ideology. In fact, the therapists use an integrated approach that combines interventions from various theories.

Variables of Interest

Research on effectiveness tends to focus on the therapeutic relationship between the couple and the therapist, the individual characteristics of the therapist and treatment ideology, as well as the demographics and functioning of the couple (Snyder, Mangrum, & Wills, 1993). Traditional behavior therapy is found to be most successful for couples with high commitment and emotional engagement, greater flexibility in their gender roles, and convergent goals for the marriage (Jacobson & Christiansen, 1996). More

favorable outcomes also occur when couples have higher degrees of openness and a shared partnership (Hampson et al., 1999). High levels of marital affect, poor problem-solving skills, low psychological resilience, high levels of depression, and low emotional responsiveness lead to poorer outcomes (Snyder et al.). In general, researchers have found that the strongest predictors of couple therapy outcome are: (a) age; (b) depressive symptomatology; (c) gender roles; (d) pretreatment level of relationship distress; (e) relationship commitment and (f) spousal affection and intimacy (Whisman & Snyder, 1997).

Few studies examine how differences within characteristics between partners affects therapy outcome, regardless of treatment ideology. Snyder et al. (1993) pointed out that the more distressed the couple is at the beginning of treatment, the less likely couple therapy will be effective. Distress may be caused by differences in perceptions between partners. Thus, greater differences may influence the outcome of therapy. Scales that measure dyadic adjustment or dyadic satisfaction are commonly used as indicators of a couples' distress. There is extensive research regarding variables that influence dyadic satisfaction.

Dyadic Adjustment/Satisfaction. Dyadic adjustment is a process whereby partners in a dyad consciously or unconsciously changes or do not change in order to accommodate the relationship. Dyadic satisfaction can be defined as an intrapersonal evaluation of one partner's feelings about his or her partner, about certain relational aspects, and about the relationship as a whole (Rusbult, 1983). Couple therapy researchers tend to "agree that the couple's overall marital adjustment or marital satisfaction at the end of therapy is an important index of the treatments impact"

(Baucom et al., 1998, p. 54). Across three clinical studies (e.g. Baucom, 1982; Hahlweg, Revenstorf & Schindler, 1982; Margolin & Weiss, 1978), positive changes in marital satisfaction depended on one partner's scores in about 40% of the improved couples (Jacobson, Follette, & Revenstorf, 1984). This means that only one of the partners was more satisfied after therapy than before. Thus, there is a need to further explore the factors influencing dyadic satisfaction and therapy outcome between partners.

Emotion Work. Emotion work is the act of trying to change degree or quality of an emotion in one's private life (Hochschild, 1979, 1983). It consists of the energy invested in a relationship to support and enhance a partner's well being (Hochschild, 1990; Erickson, 1993) as well as the efforts partners make to understand each other and to empathize with other's situation and feelings (England & Farkas, 1986). Previous research demonstrates that there is a relation between emotion work and dyadic satisfaction. Carlson (1999) found that emotion work is a significant predictor of dyadic satisfaction for both partners. The performance of emotion work has been more strongly linked to dyadic satisfaction than has household labor for married couples (Duncombe & Marsden, 1993; Levinger, 1964; Kiston & Holmes, 1992). Men and women's dyadic satisfaction increases if the amount of emotional work within the relationship is perceived as equal (Holm, Werner-Wilson, Cook, & Berger, 2001). There is no research exploring the possible link between emotion work and couple therapy outcomes.

Therapy Outcome. A therapy outcome concerns both the therapist and the client's perception of change (Hampson, Prince, & Beavers, 1999). Therapists and researchers rely on a variety of resources to obtain outcome data. For individual therapy, outcome data can be gathered from a variety of sources: (a) the client, (b) the client's significant

other, (c) the payer of treatment, and (d) the therapist (Brown et al., 1999). However, in couple therapy the sources are limited. A researcher cannot ask significant others because they too are clients. The payer of treatment is most likely the clients or insurance companies. Insurance companies restrict diagnoses to individuals, not couples, so it is not possible for them make assessments based on dyadic interactions. There are also confidentiality issues. As a result of these limitations, the clients and therapists are the best evaluators of therapy outcome.

Research on the effectiveness of couple therapy seems to rely exclusively on client self-report measures to determine the effectiveness of therapy outcome (Hampson et al., 1999). Self-report is not always reliable due to clients' tendency to inflate their responses (Hunsley, Vito, Pinsent, James, & Lefebvre, 1997). In couple therapy, individuals may be influenced by their partner to respond a certain way. Yet, it has been found that researchers can trust partners' self-report about ordinary aspects of their relationship (Hunsley et al.). Boddington and Lavender (1995) recommend that a broader range of assessment procedures be used along with self-report measures. Therapists or other observers should gather observational information about the couples' interactions and behaviors as well as demographical data (e.g. relationship status) (Boddington & Lavender).

It may seem logical to rely on the therapists' observations and assessments. However, such information is difficult to interpret. Therapists tend to distort information due to their dependence on third parties for payment (Brown et al., 1999) or out of concern for negative consequences on their clients. Because self-report and therapist assessments are not reliable sources independently, combining them should increase

overall reliability and validity. Hampson et al. (1999) reported the need to supplement self-report measures by the client with observational or behavioral measures assessed by the therapist.

Commonly, clients' ratings of dyadic satisfaction have been used as a measure of outcome (Brown et al., 1999; Whisman & Snyder, 1997). When treating marital distress, most CFT researchers believe that dyadic satisfaction is a reliable indicator of therapy outcome (Baucom et al., 1998). The Dyadic Adjustment Scale (DAS; Spanier, 1976) is the most commonly used measure of outcome (Whisman & Snyder). Jacobsen, Follette, and Revenstorf (1984) operationalized the concept of a "clinically significant change" to include the following: (a) a client's score makes a reliable change from pre- to post-treatment, such that his or her score might improve more than would be expected by chance and (b) the post treatment score is on the functional rather than dysfunctional side of criterion (as cited in Christensen, 2000).

Markman (1992) believes couples researchers have become reliant on dyadic satisfaction as a sole outcome measure, and neglect the importance of other outcome variables like love, conflict tactics, and commitment. Brown et al. (1999) highlight that "there is no reason to believe that a high degree of satisfaction is necessarily a sign of successful outcome" (p. 395). A couple may still be dissatisfied with the relationship and break up as a result of therapy, but believe that was a positive outcome for them. This would be considered as negative in most effectiveness studies, yet that assumption is not necessarily valid.

Some outcome studies involve multiple dependent measures, including marital adjustment and marital satisfaction. Dunn and Schwebel (1995) did a meta-analysis of

marital therapy outcome. They argue that more outcome studies need to look beyond increasing general satisfaction, but consider change across many specific areas like intimacy and problem solving. They decided to assess effectiveness by looking at the change in scores in the measures that related to four specific areas: spouses' relationship behavior, cognitions, affect, and general assessment of the relationship and its quality. Baucom et al. (1998) address the concern "that results across various measures are not always consistent" (p. 54). Researchers should decide which dependent measures are relevant and find a way to interpret findings that are contradictory across measures (Baucom et al., 1998). Therefore, studies should explore and interpret other relational aspects that may influence outcome rather than solely relying on dyadic satisfaction.

Theoretical Considerations

General Systems Theory. One way of conceptualizing current interactions within the context of a dyad is through general systems theory (Bertalanffy, 1968). The core assumptions of systems theory are the following (Boss, Doherty, LaRossa, Schumm, & Steinmetz, 1993):

- A system must be understood as a whole
- Human systems are self-reflexive which requires a higher level of communication that enables humans to examine their systems and establish goals

Systems theory emphasizes the wholeness and the organization of elements within a living system (Greenberg & Johnson, 1998). A system is a "set[s] of elements standing in interrelation among themselves and with the environment" (Bertalanffy, 1975a, p. 159). If a part of a system changes, then inevitably the system as a whole will change. An

intimate dyad is usually a subsystem of a larger extended family, consists of two partners, and the relationship is considered a separate entity (Warden & Warden, 1998).

A vital concept to systems theory regarding couple interaction is *circular causality*. This means that each partner's actions influence multiple current reactions as well as future reactions, yet neither partner were wrong or right (Warden & Warden, 1998). Therefore, the couple is stuck in a cyclical, dysfunctional pattern in which attempts to decrease negativity re-ignites the cycle. "They have simply evolved a pattern in their relationship that is mutually dissatisfying" (Warden & Warden, p. 104). Another important concept is *boundaries*. Boundaries are emotional barriers that protect and enhance the integrity of a subsystem (Warden & Warden, 1998). The dyadic system can be influenced by the emotional states of the partners.

Couples may be located at different points on a continuum regarding these concepts (Boddington & Lavender, 1995). When partners are rigid on any of these dimensions, the dyadic system is predisposed to having difficulties responding to certain demands (Boddington & Lavender). Too much difference can lead to distance and rigid boundaries (Katherine, 1991). Interactions across boundaries are governed by implicit rules and patterns (Minuchin, 1985).

A common circular interaction is the pursuer-distancer cycle. Typically, when disagreements arise, women pursue their male partners in order to discuss and resolve the issue. However, men may feel pressured, unable to communicate their feelings, and/or want to avoid change, so they will withdraw from the situation. Usually, this upsets the women and causes them to pursue more and the men to withdraw more. This is a negative interaction pattern that is mutually dissatisfying to both partners. This

interaction pattern has been reliably identified and reported by couples, and is negatively correlated with dyadic adjustment (Klinetob & Smith, 1996; see Christensen & Heavey, 1993; and Heavey, Layne, & Christensen, 1993). As both partners become aware of their differences, each partner may change their cognitions or behaviors to adjust for the difference. Hence there is less need for a pursuer. If a partner should need to pursue, each partner may have learned more effective ways to express or deal with their differences. Therefore there is less need to withdraw.

Couples may become trapped in unsatisfactory patterns of interaction when they are unable to manage their differences and express their emotions to one another. Unsatisfactory patterns of interaction are perceived as the safest solution to dealing with the couples' differences yet often leads to distress (Boddington & Lavender, 1995). "Interactions and behaviors may be prescribed in order to weaken or strengthen boundaries, or to alter the power balance in the dyadic system" (Boddington & Lavender, p.75), therefore alleviating distress and increasing dyadic satisfaction. "It takes excellent communication and very clear boundaries to have intimacy when many differences exist" (Katherine, 1991, p.67-68). The greater differences are between the partners, the more difficult the process of couples therapy becomes. This is due to the fact that the partners would need to invest more energy to learn the skills necessary to defuse the disagreement.

Systems theory also provides a "framework for viewing gender inequalities and differences within the larger societal structure" (Warden & Warden, 1998, p. 105) because it operates much like a telescope. The influence of gender on a couple is embedded within families of origin, communities, and society; thus the therapist or

researcher can choose the level of the system on which to concentrate (Warden & Warden). Systems theory is the foremost conceptual influence on couple and family therapy and continues to evolve.

Social Role Theory. The premise of social role theory is that differences in the behavior of men and women exist due to the distributions of men and women into social roles (Eagly, 1987, 1997b). When these sex differences are manifested in behavior, they are more likely to conform to gender roles and stereotypes (Eagly, Wood, & Diekman, 2000). "This theory argues that the beliefs that people hold about the sexes are derived from observations of the role performances of men and women and thus reflect the sexual divisions of labor and gender hierarchy of the society" (Eagly et al., p. 124). Therefore, gender roles can induce sex differences in behavior in the absence of any intrinsic, inborn psychological differences between men and women (Eagly et al.).

The differences between the sexes are a result of the differing balance of activities associated with gender roles, typically revolving around family and economics (i.e. provider and homemaker; Eagly et al., 2000). Women have a stronger tendency to accommodate to the domestic role, which fosters a pattern of interpersonally facilitative and nurturing behaviors that can be termed as *communal* (Eagly et al.). *Agency* generally characterizes the male gender role resulting in more assertive and independent behaviors because they usually have to accommodate to the employment role (Eagly et al.).

Incorporating classic concepts such as *self-fulfilling prophecy* (Jussim, 1986; Merton, 1948) and *normative influence* (Beutsch & Guard, 1955) generally, "people are assumed to communicate their expectations to others through verbal and non-verbal behaviors and to react positively if their expectations are confirmed" (Eagly et al., 2000,

p. 144). This communication process operates at a relatively automatic level. Consequently, partners are not necessarily aware of their expectations or that they are conveying these expectations to others (Vorauer & Miller, 1997). Likewise, their partners may not be necessarily aware of the expectations placed on them or their influence on their partner (Vorauer & Miller). Although everyone receives implicit and explicit messages regarding gender roles, some individuals internalize their gender role more so than others (Eagly et al.). "The internalization of gender-stereotypic qualities results in people adopting gender-typed norms as personal standards for judging their own behavior" (Eagly et al., p. 150) and the behavior of others. Partners may desire non-gendered behaviors of themselves and their partners but unconsciously infer and send messages that provoke gender role behaviors. Gender roles and internalized gender identities may stand as roadblocks to intimacy as well as each partners' perception of dyadic satisfaction (Warden & Warden, 1998).

Gender Roles in Intimate Relationships. Couple differences often reflect gender stereotypes (Jacobson & Christensen, 1996). Based on traditional gender roles, men tend to have more power in relationships and women tend to focus on maintaining, building, and nurturing relationships and perform more emotion work than men (Tingey, 1993; Worden & Worden, 1998). "Women do more of the work involved in keeping the partner in a positive mood and are more supportive of their partners' speaking than men are in relation to their women partners" (Huston & Ashmore, 1986; as cited in Maccoby, 2002, p. 94). Women are well practiced in verbalizing thoughts and feelings in close relationships, whereas men tend to dismiss their feelings or keep them to themselves

(Worden & Worden). A common finding is that relationship concerns influences women's overall affect more so than men's affect (Snyder & Mangrum, 1996).

In healthy and satisfying relationships, emotional intimacy is valued by both partners and is made up of mutual love and respect (Worden & Worden, 1998). However, these concepts can mean very different things to men and women. Married men generally report greater dyadic satisfaction than married women (Fowers, 1991). The existence of communication about a couple's relationship, perception of spousal support, and emotional expressiveness are relational aspects that tend to influence women's dyadic satisfaction (Acitelli, 1992; Bradbury, Campbell, & Fincham, 1995; Harper & Elliott, 1988; Kitson & Holmes, 1992; Levinger, 1966; as cited in Holm et al., 2000, p. 10). "When dissatisfaction in the marriage increases, it is most likely the female who feels intensely and who will try to confront the problem, but at an emotional and physical cost to herself" (Worden & Worden, p. 44). Gender influences the relation between emotion work and dyadic satisfaction (Erickson, 1993; Higgins, 1997). Women's dyadic satisfaction seems to be positively influenced by the amount of emotion work their partners do (Erickson). Men and women seem to experience different interactions between emotion management and dyadic satisfaction (Higgins-Kessler, Werner-Wilson, Cook, & Berger, 1997).

Traditionally, women are socialized and viewed as submissive and dependent. However in the context of an intimate relationship, women seem to become more aggressive with their male partner than with others (Maccoby, 1998). Women also seem to nag and confront more while men tend to withdraw and stonewall (Gottman & Silver, 1999). Maccoby (2002) suggests that these behaviors could result because men are

uncomfortable using the confrontational tactics they use with men with women, and are less skilled in negotiating and talking about conflict. "In resolving differences, men, poorly trained in expressing and confronting intimate issues and more quickly physically aroused in a negative exchange, respond to intimate conflict by attempting to control or withdraw from the partner" (Worden & Worden, 1998, p. 45). If gender differences can influence a couple's relationship, then is it possible for these differences influence therapy outcome, and if so, how is therapy outcome affected?

Summary of Literature Review

The increased pressure from managed care systems on therapist to provide more externally valid and brief treatment interventions support the need for more effectiveness research. The use of an existing database of couples' scores on various relational aspects can provide outcome management to determine which relational aspects predict successful therapy outcome. Partners' perceptions of emotion work in their relationship influences men and women's dyadic satisfaction differently. However, no studies have compared differences between partners regarding specific relational aspects and how these differences influence therapy outcome.

Although there have been many studies exploring therapy outcome, they tend to operationalize outcome as change in dyadic satisfaction and do not combine self-report with therapist observations. For the purposes of this study, the partners' perceptions about dyadic satisfaction and the therapeutic process, as well as the therapists' observations will quantify outcome. The partners' scores on the initial and final administration of the scale measuring dyadic satisfaction (the DAS) and emotion work (EWS) will be compared. It is important that dyadic satisfaction is not the only dependent variable influencing

outcome. The self-report measure regarding outcome consist of items that pertain to whether the partners' needs have been met and if they learned to effectively solve their problems due to the process of therapy. The therapists' observations are based on their assessment of prognosis.

Hypotheses

1. Differences between partner' scores on scales measuring dyadic satisfaction and emotion work at pre- and post-test will predict poorer outcomes.
    a. Differences between partners' scores on scales measuring dyadic satisfaction and emotion work at pre- and post-test will predict less favorable therapists' estimate of prognosis.
    b. Differences between partners' scores on scales measuring dyadic satisfaction and emotion work at pre- and post-test will predict smaller changes in each partners score on scale measuring dyadic satisfaction.
    c. Differences between partners' scores on scales measuring dyadic satisfaction and emotion work at pre- and post-test will predict less favorable evaluations of getting needs met and receiving help to deal with problems.
2. The partners' score on scales measuring dyadic satisfaction and emotion work at pre- and post-test will predict all outcome measures.
    a. The partners' score on scales measuring dyadic satisfaction and emotion work at pre- and post-test will predict favorable therapists' estimate of prognosis.
    b. The partners' score on the scale measuring emotion work at pre- and post-test will predict changes in each partners score on scale measuring dyadic satisfaction.

c. The partners' score on scales measuring dyadic satisfaction and emotion work at pre- and post-test will predict each partners' evaluations of getting needs met and receiving help to deal with problems.

CHAPTER THREE

Method

Participants

The participants are couples who have utilized and completed all the necessary paper work for the Center for Couple and Family Therapy at Colorado State University from 1997-2001. The frequencies of the demographical information are reported in Table 1. There were 92 individual participants in a total of 46 couples with a majority of them living together but not married and all being heterosexual. Of those who responded (n = 21), the average length of their relationship was 4.5 years. On average, the age of the participants was 26 ranging from twenty to forty-six years old, their highest level of education was undergraduate, and their income typically fell between $10,000- $20,000. About a third of the participants were students at the university and the remaining specified a range of occupations (see Table 1). Fifty-five percent of the participants had previous therapy. The average number of sessions was 10 and ranged from three to 28 sessions. The therapists (n = 45) recorded up to three presenting problems for each of the couples: *Premarital counseling* was recorded for 67% of the couples, *communication* for 29 %, and *other emotional differences* for 11%. The couples were referred through the university's faculty, other professionals, community agencies, or were self-referred.

Table 1

Frequencies for Demographical Information of Sample

Demographic	N	n
Relationship Status	92	
Married		14
Living Together		52
Single		10
Committed Partnership		7
Divorced		7
Other		2
Education	90	
1-12		18
Undergraduate		50
Graduate M.S./M.A.		11
Post Graduate Ph.D		5
Other		6
Income	92	
1-10,000		35
11-20,000		21
21-30,000		9
31-40,000		9
41-50,000		7
> 50,000		11
Occupation	81	
Student		23
Managerial/Professional		15
Other		13
Service		10
Technical, sales, administrative		8
Farming, forestry, or fishing		4
Unemployed		4
Production, craft or repair		2
Operator, fabricator, or laborer		2

The therapists were graduate students in a Human Development and Family Studies program with an emphasis in MFT and were primarily female. Therapists were supervised by American Association of Marriage and Family Therapy (AAMFT) approved supervisors. The therapists employed an integrative therapy approach by selectively borrowing principles from various family theories. The therapists (n = 42) recorded up to three theoretical approaches that they used for the majority of their sessions with the couples: 50% used solution-focused, 43% used constructivist, and 19% used feminist models. Solution-focused interventions are meant to change the way the couple "languages" their problems and focuses on the couple's resources and successes (Nichols & Schwartz, 2001). Therapists do not impose their own solutions yet collaborate with the couple to find solutions that are satisfactory for both partners (Nichols & Schwartz). Constructivism asserts that therapists should not consider what they are seeing in the couple objectively real, but rather a product of their assumptions and interactions with the couple (Nichols & Schwartz). Therefore, interventions must apply to the meanings that the couple has constructed for their problems or interactions. A feminist perspective examines inherent power differentials that typically exist within couples and between therapists and clients as well as empowers clients to integrate all aspects of self into their relationships (Haddock et al., 2000). Therapists and couples collaborate on what their goals are and what will help them reach those goals.

Procedure

Couples who came to the Center for Family and Couple Therapy were required to sign a *Treatment and Release Form* (see Appendix A), fill out a *Client Summary Form (A)* (see Appendix B), and complete a battery of assessments at the initial session. The

couple assessment included the Dyadic Adjustment Scale (DAS) and Emotion Work Scale (EWS). When therapy ended, each partner completed the DAS and the EWS again, as well as an assessment regarding the process of therapy, entitled Client Satisfaction Questionnaire (CSQ). At the end of therapy, therapists recorded in the couple's file what their estimate of prognosis is for the couple. This prognosis is used to supplement the self-report measures with the therapists' observation.

The law in the state of Colorado mandates therapists to keep full records of clients for five years. In accordance with this law, the center has maintained couples' data and has entered their responses from the DAS, EWS, and CSQ into a confidential database. This research project accessed the files and database in order to compare each partner's scores from the DAS and EWS and determine if differences influence the couple's and the therapist's perception of the therapeutic outcome.

Measures

Dyadic Adjustment Scale. Dyadic adjustment is operationalized as a process in which the outcome is determined by the degree of: 1) troublesome dyadic differences; 2) interpersonal tensions and personal anxiety; 3) dyadic satisfaction; 4) dyadic cohesion; and 5) consensus on matters" (Spanier, 1976, p. 17; see Appendix C). The DAS specifically measures the dyadic satisfaction, dyadic cohesion, dyadic consensus and affectional expression in dyadic adjustment (Spanier). The DAS contains 32 items that are answered on various Likert-type scales, for example ranging from *always agree* to *always disagree*, *all the time* to *never*, or *extremely unhappy* to *perfect*. Total DAS score range from 1-150 with individuals scoring below 101 classified as *relationally distressed* while those scoring above 102 are considered to be *relationally nondistressed* (Spanier).

Spanier carefully created an assessment that could be employed with both married and non-married couples.

The subscale for dyadic satisfaction (DS) measures the amount of tension in the relationship as well as how seriously the respondent has considered ending the relationship (Holm, 1999). The dyadic cohesion subscale (DCoh) examines the couple's sense of sharing positive connections with each other (Prouty, Karkowski, & Barnes, 2000). Dyadic consensus (DCon) addresses the facets of a relationship that deal with a partner's individual perception of the couple's agreement on a variety of relationship issues (Prouty et al.). Dyadic affectional expression (AE) measures the amount of the couple's agreement on the demonstration of affection within the relationship (Prouty et al.).

Validity and reliability studies of the DAS are compelling. When Spanier (1976) first created the scale, he inspected the validity. Spanier concluded that the scale has high content validity because items were only included if three judges agreed that the items were the following: a) relevant measures of dyadic adjustment for contemporary relationships; b) consistent with nominal definitions suggested by Spanier and Cole (1974); and c) carefully worded with appropriate fixed choice responses. The criterion-related validity is significant ($p < .001$) (Spanier) when the criterion was marital status. Each item differed significantly for married versus divorced partners. Spanier also provided evidence of the construct validity. He correlated the DAS with the Locke-Wallace Marital Adjustment and found an .86 correlation among married couples and .88 correlation among divorced respondents.

Spanier (1976) also reported the scale's total score reliability (α = .96) and the subscales reliabilities: DS, α = .94; DCoh, α = .86; DCon, α= .90; and AE, α = .73. The high reliability results were also confirmed by Sharply and Cross (1982), Spanier (1988), and Kazak, Jarmas, and Snitzer (1988) (see Prouty et al., 2000). Carey, Spector, Lantinga, and Krauss (1993) found high internal consistency within the overall DAS (α = .95) and for each of its subscales: DS, α = .87; DCoh, α = .83; DCon, α= .91; and AE, α = .70 (Prouty et al., 2000). Kurdek (1992) also validated the scale's reliability and validity with heterosexual and homosexual couples (Prouty et al.).

Emotion Work Scale. In this study, the scale measuring emotion work contains 12 items in which respondents rate how frequently they invest energy in the emotion management of their relationship (see Appendix D). In researching the construct of emotion work, there is a distinction made between emotion work and emotion labor. Hochschild (1983) purports that emotion work addresses the energy one invests to manage their emotions and enhance the well being of others in their private life whereas emotion labor should pertains to emotion management that is done for a wage. The concept *emotion work* has been expanded since Hochschild's original description to include emotional support and expressiveness (Erikson, 1993; Tingey, 1993).

Blumstein and Schwartz (1983) included a series of relationship questions in a couples' survey that unintentionally related to emotion work. Tingey (1993) then used eight of these questions to assess how much effort the respondent devotes to emotion work in his or her relationship, and later, four more questions were added. The responses range on a five-point Likert-type scale from 0 (never) to 4 (very frequently). Higher scores on this scale indicate more self-reported performance of emotion work within the

relationship (Holm, 1999). Werner-Wilson and Zimmerman (1997) found moderate internal-consistency reliability with an alpha coefficient of .74, and this alpha was confirmed with this study's sample, who were on average Caucasian, not married, heterosexual, younger couples. Higgins-Kessler et al. (1997) established the face validity of this measure.

Client Satisfaction Questionnaire. Each partner fills out a CSQ assessment that asks eight questions about their opinions regarding the services received (see Appendix E). For the purposes of this study, only items three and six were assessed. Item 3 asks, "To what extent has our program met your needs?" Partners rate from "almost all my need have been met" to none of my needs have been met." Item 6 asks, "Have the services you received helped you deal more effectively with your problems?" Partners rate from "Yes, they helped a great deal" to "No, they seemed to make things worse." Therapists report on a client termination information form when the prognosis is not well (1) to very well (5) (see Appendix F). The higher the score, the more likely the therapist believed therapy ended successfully. There are no data regarding the reliably and validity of this measure.

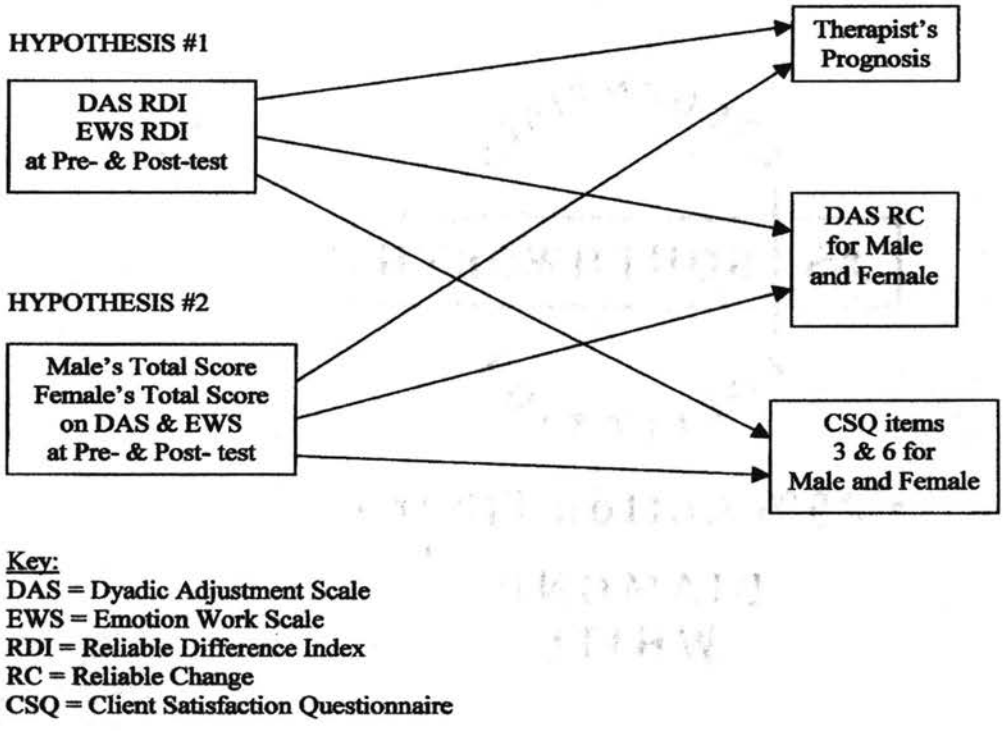
Data Analysis

This study proposes that there are several predictors, the size of differences on each of the measures that may predict poorer outcomes of therapy. The primary interest is to determine how differences between partners' total scores on the DAS and EWS influence the outcome of therapy. Due to missing data on EWS items and the limited number of items on this instrument, the total score was determined by calculating the mean of only 10 of the responses.

A difference score between the partners was determined by using a Reliable Difference Index (RDI) and is derived from Jacobson et al. 's (1984) *reliable change index, RCI* = $(x_2 - x_1)/SEM$. The RDI consist of subtracting one partner's score from the other partner's score and is then divided by the standard error of measurement. The difference may result in either a positive or negative prediction depending on whether the male or female had the higher score. A RDI was computed for each measure and correlated with the three different measures of therapy outcome: change in DAS score, CSQ scores, and therapist prognosis. The change in the DAS scores for males and females was calculated using the reliable change index. The *SEM* for the DAS was determined by using the standard deviation (*SD* = 28.3) and the reliability (α = .96) of Spanier's (1976) initial analysis of the DAS. Yet for the EWS, the *SEM* was determined by calculating the standard deviation (*SD* = .45) and the reliability (*r* = .74) from this study's sample because the EWS has not been standardized on a population. Using and adapting Jacobson et al.'s formula enhances the reliability of clinical significance by taking into account the variance in change of scores that would naturally occur with repeated measures as well as indicating whether the change reflects more than the fluctuations of an imprecise scale.

To determine if differences between partners' scores on scales measuring dyadic satisfaction and emotion work at pre- and post-test predicts poorer outcomes, a multiple regression with simultaneous entry was used to test the prediction of DAS RDI and EWS RDI at pre- and post-test on each of the outcome variables (refer to Figure 1.1). Testing hypothesis one resulted in seven regressions. For example the predictors, which are the DAS RDI and EWS RDI at pre- and post-test were entered and a regression analysis was

computed with therapist's prognosis. Then, the same predictors were entered for a regression analysis with each of the male and females' RCI, and finally, with the male and females' evaluation of needs being met (CSQ item 3) and dealing with problems (CSQ item 6). To determine if each partners' total score predicted therapy outcome a multiple regression with simultaneous entry of the predictors of the males' DAS total scores and EWS mean scores at pre- and post-test with outcome variables was run. The same was done with females' DAS and EWS scores and outcome variables. Testing the second hypothesis resulted in 21 regressions.



Note. Single arrow represents a set of predictors for each outcome

Figure 1.1 Conceptual diagram of hypotheses

CHAPTER FOUR

Results

Descriptive Statistics for Key Variables

The data for the descriptive statistics are reported in Tables 2, 3, and 4. The mean score for females on the EWS slightly decreased from pre- to post-test and the males' increased. Multiple paired *t*-tests were run for males and females' scores on the EWS and DAS separately to test if significant change occurred overtime. A paired *t*-test showed that the females' decrease in mean EWS score was not significant, however the males' increase was significant ($t = 3.48, p = .001$). Examination of the DAS RDIs at pre- and post-test revealed that many of the couples had significantly different scores: at pretest: 30% of the couples had RDIs greater than ± 1.96 and 15% at post-test. A RDI larger than ± 1.96 would be unlikely to occur ($p < .05$) without actual difference between the partners (Jacobson et al., 1984). The sample sizes are different for the DAS results because a total DAS score could not be computed if there were missing data within any of the subscales. Thirty-seven percent of the couples EWS RDIs were greater than ± 1.96 at pre-test and 35% were greater at post-test.

With regards to outcome variables, thirty-nine percent of the females' DAS RCI and 26% of males' DAS RCI were greater than ± 1.96. Because RCIs greater than ± 1.96 would be unlikely to occur without actual change, significant change in dyadic satisfaction did occur for about a third of the participants, but the mean RCIs are not overall indicative of this change. The means for the CSQ items were similar for males

and females and ranged from 3.49 to 3.81. This scale ranges from 1 to 4 with most partners reporting that most of their needs have been met and that they received great deal of help for dealing effectively with their problems. The mean therapist prognosis is a 4.07, which represents "well." The sample sizes vary due to missing items.

Table 2

Descriptive Statistics for Predicting Variables

	Emotion Work		Dyadic Adjustment Scale	
	Pre-test	Post-test	Pre-test	Post-test
Females				
Mean	2.8	2.7	107.85	116.43
SD	.39	.42	13.4	10.2
Range	1.84	2.58	49	45
N	46	46	39	40
Males				
Mean	2.5	2.7	108.48	116.02
SD	.46	.5	13.0	11.4
Range	2.17	2.33	55	48
N	46	46	40	43

Table 3

Descriptive Statistics for Outcome Variables

	DAS RCI	Needs Met	Deal w/Problems	Prognosis
Females				
Mean	1.33	3.55	3.81	4.07
SD	2.22	.59	.55	.92
Range	10	2	3	3
N	36	42	42	45
Males				
Mean	1.02	3.49	3.63	
SD	1.92	.55	.54	
Range	8.42	2	2	
N	38	43	43	

Table 4

Descriptive Statistics of Reliable Difference Index on Emotion Work Scale and Dyadic Satisfaction Scale

	EWS RDI		DAS RDI	
	Pre-test	Post-test	Pre-test	Post-test
Mean	-1.16	-.10	.11	-.10
SD	2.25	2.35	2.0	1.4
Range	10.87	8.73	8.07	7.54
N	46	46	37	39

Hypothesis One: Differences between the partners' scores on the DAS and EWS at pre- and post-test will predict poorer outcome

Correlations between the predictors were run because males and females are not independent and to assess multicollinearity. The correlations of the predictors for hypothesis one are reported in Table 5. A moderate positive relation was found between the DAS RDIs at pre- and post-test ($r = .45, p < .01$) and between the EWS RDIs at pre- and post-test ($r = .48, p < .01$). A positive relation was also found between the EWS RDI at pre-test and the DAS RDI at post-test ($r = .38, p < .05$).

Table 5

Intercorrelations Between the Reliable Difference Index for DAS and EWS Scales at Pre- and Post-test

Scales	1	2	3	4
Pre-test				
1. DASRDI	-	.28	.45**	.01
2. EWSRDI		-	.38*	.48**
Post-test				
3. DASRDI			-	.27
4. EWSRDI				-

Note. $*p < .05$. $**p < .01$.

The results of the regression analysis for the reliable difference index (RDI) on the DAS and EWS at pre- and post-test predicting therapy outcome variables are reported in Tables 6 a through 6d. The RDIs on the DAS and EWS at pre- and post-test significantly combine to predict the females' DAS RCI ($p = .008$). More specifically, the DAS RDI at pre-test ($p = .002$) and post-test ($p = .003$) are the strongest predictors on the females' RCI (see Table 8). There are no other significant predictions amongst the DAS RDI and EWS RDI at pre- or post-test and the outcome variables.

Table 6a

Simultaneous Regression Analysis for Reliable Difference Index on DAS and EWS at Pre- and Post-test Predicting Therapists' Prognosis (N = 31)

Variable	*B*	*SE B*	β
Pre-test			
DASRDI	0.05	0.10	0.10
EWSRDI	-0.31	0.10	-0.07
Post-test			
DASRDI	-0.03	0.14	-0.04
EWSRDI	0.09	0.08	0.23

Table 6b

Simultaneous Regression Analysis for Reliable Difference Index on DAS and EWS at Pre- and Post-test (N = 32)

Variable	*B*	*SE B*	β
	Predicting Males' DAS RCI		
Pre-test			
DASRDI	-0.32	0.21	-0.33
EWSRDI	-0.11	0.20	-0.11
Post-test			
DASRDI	0.12	0.28	0.09
EWSRDI	-0.07	0.17	-0.08
	Predicting Females' DAS RCI		
Pre-test			
DASRDI	0.69	0.21	0.60**
EWSRDI	-0.11	0.20	-0.09
Post-test			
DASRDI	-0.88	0.28	-0.55**
EWSRDI	-0.07	0.17	-0.07

Note. $^{**}p < .01$.

Table 6c

Simultaneous Regression Analysis for Reliable Difference Index on DAS and EWS at Pre- and Post-test (N = 29)

Variable	*B*	*SE B*	β
	Predicting Males' Evaluation of Needs Being Met		
Pre-test			
DASRDI	-0.01	0.06	-0.02
EWSRDI	-0.03	0.05	-0.13
Post-test			
DASRDI	0.11	0.07	0.32
EWSRDI	0.06	0.05	0.06
	Predicting Females' Evaluation of Needs Being Met		
Pre-test			
DASRDI	-0.03	0.06	-0.13
EWSRDI	-0.04	0.06	-0.16
Post-test			
DASRDI	-0.06	0.08	-0.18
EWSRDI	0.02	0.05	0.09

Table 6d

Simultaneous Regression Analysis for Reliable Difference Index on DAS and EWS at Pre- and Post-test (N = 29)

Variable	*B*	*SE B*	β
	Predicting Males' Evaluation of Dealing with Problems		
Pre-test			
DASRDI	0.05	0.06	0.20
EWSRDI	0.01	0.05	0.03
Post-test			
DASRDI	0.11	0.07	0.33
EWSRDI	-0.08	0.04	-0.36
	Predicting Females' Evaluation of Dealing with Problems		
Pre-test			
DASRDI	-0.06	0.05	-0.28
EWSRDI	0.05	0.05	0.26
Post-test			
DASRDI	0.04	0.07	0.15
EWSRDI	0.01	0.04	0.05

Due to the strong relation between the females' DAS RCI and DAS RDI at pre- and post-test, post hoc analyses were performed to determine which DAS subscales of the female partners' DAS RCI that the DAS RDI at pre- and post-test predict. The results of this regression are reported in Table 7. The DAS RDI at pre-test positively predicts females' RCI on the dyadic consensus (DCon) subscale ($\beta = .70, p < .001$) and dyadic

satisfaction (DS) subscale (β = .41, p = .034) as well as negatively predicts at the same subscales at post-test (DCon: β = -.57, p = .001; DS: β = -.43, p = .025). The DAS RDI at post-test also negatively predicts females' RCI on the dyadic cohesion (Dcoh) subscale (β = -.58, p = .001). The DAS RDI doe not seem to predict females' RCI of dyadic affectional expression because there were no significant results

Table 7

Post Hoc Simultaneous Regression Analysis Reliable Difference Index on Pre- and Post-test of DAS

Variables	*B*	*SE B*	β
Predicting Females' Reliable Change Index on Consensus Subscale			
Pre-test DAS RDI	.47	.10	.70***
Post-Test DAS RDI	.55	.14	-.57**
Predicting Females' Reliable Change Index on Cohesion Subscale			
Pre-test DAS RDI	.23	.15	.30
Post-Test Das RDI	-.70	.21	-.58***
Predicting Females' Reliable Change Index on Dyadic Satisfaction Subscale			
Pre-test DAS RDI	.38	.17	.41*
Post-Test Das RDI	-.58	.24	-.43*
Predicting Females' Reliable Change Index on Affectional Expression Subscale			
Pre-test DAS RDI	.17	.11	.29
Post-Test Das RDI	-.15	.16	-.18

Note. *$p < .05$. **$p < .01$. ***$p < .001$.

Hypothesis Two: The partners' score on DAS and EWS at pre- and post-test will predict outcome

Correlations between the predictors were run to assess multicollinearity. The correlations of the predictors for hypothesis two are reported in Table 8. The males' scores on the DAS and EWS are all moderately to highly positively correlated with each other. The females' DAS and EWS pre- and post-test scores are moderately positively correlated and there is also a positive correlation between EWS pre-test mean score and DAS post-test total score.

Table 8

Intercorrelations between Total DAS Scores and Mean EWS Scores at Pre- and Post-test

Variable	1	2	3	4
	Males' Scores			
Pre-test				
1. DAS Total	-	.56**	.61**	.40**
2. EWS Mean		-	.45**	.65**
Post-test				
3. DAS Total			-	.63**
4. EWS Mean				-
	Females' Scores			
Pre-test				
1. DAS Total	-	.14	.44**	.20
2. EWS Mean		-	.36*	.51**
Post-test				
3. DAS Total			-	.06
4. EWS Mean				-

Note. $*p < .05$. $**p < .01$.

The results of the regression analysis for males' total score on DAS and mean score on EWS at pre- and post-test predicting therapy outcome are reported in Tables 9a through 9d, and females' scores in Tables 10a through 10d. Both males' and females' total DAS scores and mean EWS scores at pre- and post-test significantly combine to predict therapists' estimate of prognosis (Males: $p = .011$; Females: $p = .026$; see Tables 9a and 10a) and each other's DAS RCI (Males: $p = .005$; Females: $p = .002$; see Tables 9b and 10b). Their DAS scores at pre-test (Males: $\beta = -.81, p = .001$; Females: $\beta = -.48, p = .018$) and at post-test (Males: $\beta = .60, p = .018$; Females: $\beta = .53, p = .004$) are the strongest predictors for each other's DAS RCIs. Both males' and females' EWS scores at pre- test negatively predict their own DAS RCI (Males: $\beta = -2.26, p = .009$; Females: $\beta = -2.59, p = .017$; see Tables 9b and 10b) and at post-test positively predict their own DAS RCI (Males: $\beta = 2.05, p = .014$; Females: $\beta = 2.31, p = .027$). Their DAS scores at post-test are the strongest predictors for prognosis (Males: $\beta = .53, p = .019$; Females: $\beta = .44, p = .022$) and for their own evaluation of needs being met (Males: $\beta = .71, p = .002$; Females: $\beta = .42, p = .037$; see Tables 9c and 10c). The males' DAS score at pre-test negatively predicts the females' evaluation of needs being met ($\beta = -.50, p = .028$; see 13c), and at post-test positively predicts ($\beta = .60, p = .018$). The females' DAS score at post-test negatively predicts males' evaluation of receiving help to effectively deal with problems ($\beta = -.47, p = .026$; see Table 10d). Males' EWS score positively predicts their partners' evaluation of receiving help to effectively deal with problems ($\beta = .63, p = .034$; see Table 9d).

Table 9a

Simultaneous Regression Analysis for Males' Total DAS Score and Mean EWS Score Predicting Therapists' Prognosis (N = 36)

Variable	*B*	*SE B*	β
Pre-test			
DAS Total	0.02	0.01	0.28
EWS Mean	-0.36	0.42	-0.20
Post-test			
DAS Total	0.04	0.02	0.53*
EWS Mean	-0.40	0.41	-0.22

Note. $*p < .05$.

Table 9b

Simultaneous Regression Analysis for Males' Total DAS Score and Mean EWS Score

Variable	*B*	*SE B*	β
	Predicting Females' DAS RCI *(N = 32)*		
Pre-test			
DAS Total	-0.14	0.04	-0.81***
EWS Mean	0.66	1.26	0.12
Post-test			
DAS Total	0.14	0.05	0. 63**
EWS Mean	-0.90	1.13	-0.18
	Predicting Males' DAS RCI *(N = 37)*		
Pre-test			
DAS Total	-	-	-
EWS Mean	-2.26	0.81	-0.58**
Post-test			
DAS Total	-	-	-
EWS Mean	2.05	0.79	0.54*

Note. Dashes indicate coefficients are less than .001. *$p < .05$. **$p < .01$. ***$p < .001$

Table 9c

Simultaneous Regression Analysis for Males' Total DAS Score and Mean EWS Score

Variable	*B*	*SE B*	β
Predicting Males' Evaluation of Needs Being Met *(N = 33)*			
Pre-test			
DAS Total	-0.01	0.01	-0.17
EWS Mean	-0.001	0.28	-0.001
Post-test			
DAS Total	0.04	0.01	0.71**
EWS Mean	0.06	0.27	0.06
Predicting Females' Evaluation of Needs Being Met *(N = 34)*			
Pre-test			
DAS Total	-0.02	0.01	-0.50*
EWS Mean	0.39	0.31	0.31
Post-test			
DAS Total	0.03	0.01	0. 60**
EWS Mean	-0.32	0.33	-0.27

Note. $*p < .05$. $**p < .01$.

Table 9d

Simultaneous Regression Analysis for Males' Total DAS Score and Mean EWS Score

Variable	*B*	*SE B*	β
Predicting Males' Evaluation of Dealing with Problems (N = 33)			
Pre-test			
DAS Total	0.01	0.01	0.11
EWS Mean	0.27	0.36	0.24
Post-test			
DAS Total	-0.01	0.01	-0.14
EWS Mean	-0.17	0.34	-0.16
Predicting Females' Evaluation of Dealing with Problems *(N = 34)*			
Pre-test			
DAS Total	0.01	0.01	0.26
EWS Mean	-0.36	0.30	-0.31
Post-test			
DAS Total	-0.02	0.01	-0.47
EWS Mean	0.69	0.31	0.63*

Note. $*p < .05$.

Table 10a

Simultaneous Regression Analysis for Females' Total DAS Score and Mean EWS Score Predicting Therapists' Prognosis (N = 34)

Variable	*B*	*SE B*	β
Pre-test			
DAS Total	0.02	0.01	0.23
EWS Mean	-0.33	0.45	-0.13
Post-test			
DAS Total	0.04	0.02	0.44*
EWS Mean	-0.37	0.42	-0.15

Note. $*p < .05$.

Table 10b

Simultaneous Regression Analysis for Females' Total DAS Score and Mean EWS Score

Variable	*B*	*SE B*	β
	Predicting Males' DAS RCI *(N = 32)*		
Pre-test			
DAS Total	-0.07	0.03	-0.48*
EWS Mean	-0.84	0.99	-0.16
Post-test			
DAS Total	0.10	0.03	0. 53*
EWS Mean	1.05	0.84	0.21
	Predicting Females' DAS RCI *(N = 35)*		
Pre-test			
DAS Total	-	-	-
EWS Mean	-2.59	1.03	-0.42*
Post-test			
DAS Total	-	-	-
EWS Mean	2.31	1.00	0.38*

Note. $*p < .05$.

Table 10c

Simultaneous Regression Analysis for Females' Total DAS Score and Mean EWS Score

Variable	*B*	*SE B*	β
Predicting Males' Evaluation of Needs Being Met *(N = 32)*			
Pre-test			
DAS Total	-0.003	0.01	-0.07
EWS Mean	0.02	0.30	0.01
Post-test			
DAS Total	0.06	0.01	0.31
EWS Mean	0.11	0.29	0.08
Predicting Females' Evaluation of Needs Being Met *(N = 32)*			
Pre-test			
DAS Total	-0.002	0.01	-0.04
EWS Mean	0.03	0.28	0.02
Post-test			
DAS Total	0.02	0.01	0.43*
EWS Mean	0.17	0.27	0.12

Note. $*p < .05$.

Table 10d

Simultaneous Regression Analysis for Females' Total DAS Score and Mean EWS Score

Variable	*B*	*SE B*	β
Predicting Males' Evaluation of Dealing with Problems *(N = 32)*			
Pre-test			
DAS Total	0.001	0.01	0.10
EWS Mean	-0.11	0.27	-0.08
Post-test			
DAS Total	-0.02	0.01	-0.47*
EWS Mean	0.34	0.26	-0.26
Predicting Females' Evaluation of Dealing with Problems *(N = 32)*			
Pre-test			
DAS Total	0.01	0.01	0.19
EWS Mean	-0.09	0.25	-0.07
Post-test			
DAS Total	-0.02	0.01	-0.39
EWS Mean	0.41	0.24	0.33

Note. $*p < .05$.

Summary of Results

The results of this study support the hypotheses to some degree. For hypothesis one, differences between the partners on the DAS only predicted the females' increase in dyadic satisfaction, which predicted a favorable outcome. Differences on DAS did not predict any of the other outcome variables and differences on the EWS did not predict any outcome variables. Thus, my results do not support hypothesis one. There was

support for the second hypothesis. The partners' scores on the DAS and EWS at post-test did predict some of the outcome variables, yet which variables and the direction of the prediction seems to vary by gender.

CHAPTER FIVE

Discussion

Partner Differences and Therapy Outcome

The first hypothesis for this study is that difference between partner' scores on scales measuring dyadic satisfaction and emotion work at pre- and post-test will predict poorer outcome. The results for hypothesis one indicate that the greater the difference between the partners' dyadic satisfaction at the initial session and the smaller the difference at the final session, the more the females' dyadic satisfaction increased. Therefore, partners' differences regarding dyadic satisfaction predicted a favorable outcome with regards to females' dyadic satisfaction. The differences between the partners' perceptions of emotion work did not predict any outcome variables in this study.

The results regarding differences and change in dyadic satisfaction seem reasonable considering social role theory. Both the male and female partners have received messages regarding their gender roles that in turn lead to different behaviors and expectations. Each partner implicitly or explicitly conveys their expectations to their partner. Female gender roles are typically characterized as communal whereby they acquire superior interpersonal skills, ability to communicate non-verbally (Eagly et al., 2000), and tend to take on more responsibility for maintaining intimate relationships. Men are less socialized to express feelings, especially regarding relational issues, and possess more assertive and independent behaviors. If women are more skilled with non-

verbal communication, then there is a potential that they have more implicit expectations. Men are less aware or are unable to perceive implicit expectations and do not confirm their partner's needs; thus, the women become more dissatisfied. Also, men typically have more power in relationships and these imbalances usually benefit men and disadvantage women (Davidson, 1984; Peterson, 1990) and because relational issues tend to affect women more, women have more cause to be dissatisfied. Therefore, if a woman were dissatisfied with the relationship, then the difference between the partners would be greater at the initial session. Yet through the therapeutic process, the females' dyadic satisfaction increases and the differences between the partners at the final session decreases. The results seem to reflect the instrumental role women tend to play in maintaining intimate relationships.

With respects to systems theory, the couple unit acts as a system, so if one member is dissatisfied it affects the overall quality of the relationship. The dissatisfied partner, usually a woman, initiates the process of therapy. Women may be more aware of and affected by disagreements because "women's overall level of affect is more strongly influenced by relationship concerns" (Snyder & Mangrum, 1996, p. 317). In this study, the average dyadic satisfaction score of both partners at the initial session is slightly above relationally distressed (Spanier, 1976). It seems both partners are slightly dissatisfied with the relationship, with the women being more dissatisfied. The process of therapy enables the partners to examine their system, the relationship dyad, and establish goals as well as improve communication. It cultivates awareness of their differences as well as teaches each partner to manage and appropriately express their emotions surrounding their differences. These expressions and new skills may create or re-ignite a

positive connection between the partners, which satisfies the women's needs. The couple recognizes their cycle of interaction and as one or both partners make changes to their cognitions or behaviors, a pattern of interaction that is mutually satisfying results. The need for a pursuer or a distancer decreases because each partner discovers other ways to effectively manage their differences and get their needs met.

The fact that strength of the differences between partners' dyadic satisfaction predicted females' increase in dyadic satisfaction led us to conduct post hoc analyses to determine which DAS subscales the differences from pre- and post-test predicted. The partners' differences regarding dyadic satisfaction at the initial session predicted the increase in score of the dyadic consensus subscale (Dcon) and dyadic satisfaction (DS) subscale. The prediction was strongest for Dcon, thus the greater difference between the partners at the initial session, the increase in dyadic satisfaction for females was most likely due to the change in their perception of dyadic consensus. The results also show that as the differences between the partners' dyadic satisfaction at the final session decreases, the females' score on dyadic cohesion subscale (Dcoh) increases. Dcoh measures the partner's sense of sharing positive connections with their partner.

Gender differences influence how men and women physiologically and psychology respond to distress within the relationship (Gottman & Silver, 1999). Where as women tend to confront relational issues, men avoid or increase the negativity, and over time this pattern will lead to emotional disconnection (Gottman & Silver). Gottman and Silver discovered that in the happiest, most stable marriages, husbands did not resist power sharing and decision-making, and when disagreements arose "these husbands actively searched for common ground rather than insisting on getting their way" (p. 101).

Considering gender role theory and systems theory, emotional disconnection could explain why differences between partners' dyadic satisfaction were stronger predictors of the females' perception of agreement and connectedness in the relationship.

Partners' Total Scores and Therapy Outcome

The second hypothesis of this study was that the partners' score on scales measuring dyadic satisfaction and emotion work at pre- and post-test will predict all outcome measures. Dyadic satisfaction and emotion work were both positive and negative predictors of couple therapy outcome, depending on which session and gender. The results suggest that the less satisfied both partners are with their relationship at the initial session and the more satisfied they are at the final session, the more their partners' dyadic satisfaction increased from the initial to final session. Also, the more satisfied both partners were with their relationship at the final session, the more each partner said that their own needs were met and the higher the therapists rated the couples' prognosis. These results suggest that a favorable therapy outcome depends on both partners' dyadic satisfaction as well as getting needs met and the importance of including prognosis as an outcome variable.

Males' dyadic satisfaction at the final session positively predicted their partners' report that they got their needs met. Interestingly, it seems that as females became more satisfied with the relationship, their partners were less likely to report that they received help to deal with *all* their problems. This may be a result of males' internal confusion of maintaining status quo along with having to manage new expectations for their relationship. Males were more satisfied with the relationship at the onset because they liked the status quo and were less desirous of change. The process of therapy may have

highlighted power differentials that led the females to notice more unmet needs and the males to perceive these needs as new problems.

Only one positive prediction occurred between emotion work and outcome. It seems that the more males invested in emotion work at the final session, the more females' response to their evaluation of receiving help to deal with problems was favorable. Considering social role theory, if women tend to assume the burden of emotion work in intimate relationships, then they will feel helped when their partners do more emotion work. This finding suggests the importance of addressing emotion work in therapy. Overall, this study had more favorable **outcomes and emotion work did not** seem to be a strong predictor. This could result due to the construct validity of the EWS or the lack of consensus of what emotion work is within and between partners.

Previous research suggests that too much difference can lead to distance and rigid boundaries (Katherine, 1991). Research also demonstrates that couples with flexible gender roles have successful outcomes with traditional behavior therapy (Jacobson & Christiansen, 1996). Yet, even if both partners are flexible in their gender roles, they may unknowingly internalize and conform to some aspects of gender roles. Gender roles can induce sex differences in behavior as well as influence partners' expectations. The behaviors used to express each partner's expectations can lead to disagreement and disconnection. Unsatisfactory patterns of interaction may result which causes distress and a need for therapy.

Couples beginning therapy may not be fully aware of what exactly is causing their distress and dissatisfaction. They may be able to point to certain behaviors that make them unhappy, but are unconscious of the automatic processes at work. Therapy not only

sheds light on the differences between the partners' perceptions and behaviors regarding a myriad of relational aspects, but highlights the underlying processes as well. If therapy is effective, then each session provides the partners with an objective observer and interpreter of their behaviors, emotions, and needs. A safe and objective therapeutic setting enables each partner to learn new behaviors and cognitions in order to better manage their differences as well as grow closer in the process.

Clinical Implications

The results of this study suggest that the differences between partners' and the partners' perceptions of dyadic satisfaction do play a role in couple therapy outcome. The findings also emphasize the importance of both partners getting their needs met through the process of therapy and their evaluation of dealing with problems, which was predicted by each partners' perceptions of dyadic satisfaction and emotion work. Therefore, therapists should examine the differences between partners on the assessments they administer to the couples. Dyadic satisfaction and emotion work should be included in the battery of assessments. Therapists should not only look at the difference between the total scores on couple assessments, but compare individual items as well. It is important to know which partner is more or less dissatisfied and with what relational aspects so that the interventions can be tailored to meet the needs of each partner. Previous literature purports that the person wanting change and/or who is the most dissatisfied tends to confront, and the partner wishing to maintain status quo withdraws. Thus, therapists would need different techniques to evoke positive responses for partners experiencing either position.

The feminist critique of couple therapy has noted that when therapists do not consider the role of gender between therapist and the couple as well as within the couple, they are implicitly accepting gender stereotypes and ignoring the power differentials that exist between women and men in a patriarchal society (Hare-Mustin, 1994; Knudson-Martin & Mahoney, 1996). The therapists in this study had completed feminist oriented coursework and were aware that power differentials typically benefit men. The results of this study seem to weigh more on the females scores, which may have resulted from the therapists' awareness of power differentials. Because the males scores also improved, it would seem the therapists were able to compensate for the power differential yet attend to the males' needs as well. Therapists should not assume that they are able to assess their clients' behavior without considering social norms and cultural discourses, especially regarding gender (Harris, Moret, Gale, & Kampmeyer, 2001)

Research Implications

This study is an example of effectiveness research. The clients were not randomly assigned to treatment or control groups, there was no limit to the number of sessions, and the therapists were not required to use a treatment manual or follow a strict treatment ideology. A database of partners' responses regarding dyadic satisfaction, emotion work, and satisfaction with the therapy process was used to determine how differences between the partners influenced the effectiveness of therapy. The use of a database seems to provide a useful way to assess outcome management for couple therapy, however better tracking is recommended to insure validity of the database. This study serves as an example of how to combine self-report and clinical observational measures regarding various variables, and find ways to interpret findings that may be contradictory across

dependant variables. Expanding and utilizing the reliable change index (Jacobson et al., 1984) provides a standardized criterion for determining significant changes for each partner and differences between the partners. Also, this study offers outcome data that suggest that the integrative approach used at the Center for Couple and Therapy at Colorado State University is effective due to the significant increase in dyadic satisfaction and favorable evaluation of needs being met and prognoses.

Limitations

The most obvious limitation of this study pertains to generalizabilty. Because this study uses data from a center where therapists were in training, the findings cannot be generalized to all marriage and family practices. The sample size is small and homogeneous, which further limits the findings generalizabilty. Also, a pre-post design with no comparison group makes it impossible to assess regression to the mean or time-related or event-related changes other than therapeutic change. Along with these limits, the sample only represents approximately 20% of the clients that used the Center during 1997-2001 due to incomplete assessments and poor tracking. The differences between couples who stay in therapy compared to those who drop out must also be considered. Research has found that couples who have been referred to therapy, had previous therapy, have presenting problems regarding individual or parenting issues, or have a novel therapist are more likely to drop out of marital counseling (Allgood & Crane, 1991). Therefore, results are based on a skewed sample and must be considered when interpreting the generalizations and implications of this study.

Another limitation is the reliability of therapy outcome measures. For one, the items regarding evaluation of needs and effectiveness, as well as the therapists' prognosis

were extracted from other assessments, which may affect their reliability. Secondly, this study relies on self-report measures of progress. The partners do fill out the assessments individually, yet they are with each other in a small room. The partners may respond more favorably due to the presence of their partner. Although therapists also comment on prognosis, therapists may be biased as well, especially at such an early stage of therapeutic development. Also, the couples are aware that their therapist can read their responses regarding satisfaction with therapy process so they may not respond honestly. The therapist can potentially examine the partners' responses on all the assessments given at the final session before they make their estimate of prognosis, which may influence their prognosis.

There are more limitations regarding the scales. The scale measuring emotion work was created by taking parts of other scales that did not necessarily pertain to emotion work, so it may not be an accurate scale for measuring emotion work in personal relationships. The concept of emotion work has also evolved and has changed how different fields conceptually define it. The EWS may measure one conceptual definition of emotion work but not the definition intended or best for this study. A more valid and reliable scale of emotion work may reveal that differences between partners' perceptions of emotion work are a strong predictor for therapy outcome.

In order to test all the relations proposed in this study, numerous multiple regressions were computed. As noted earlier, the sample sizes varied for each of the regressions, which affect the power of the results. "Using multivariate correlational procedures in studies with low subject-to-variable ratios will inevitable lead to unstable results" (Snyder & Mangrum, 1996). Thus, due to the small sample size and large

number of predictions, the results of this study are preliminary at best. Some findings may be due to error and would need to be validated with larger and more heterogeneous samples.

Future Research

Although the findings did not support the hypothesis that greater differences would predict poorer therapy outcome, differences between partners' dyadic satisfaction did predict the females' change in dyadic satisfaction, especially regarding dyadic consensus and cohesion. Future research could survey what aspects of a relationship contribute to males versus females' dyadic satisfaction and study those differences. Because the outcomes in this study were more favorable and the differences were small between partners, then it would seem likely that smaller differences may predict more favorable outcomes. This prediction, along with the one found in this study regarding differences, could be advanced if researchers compared couples with significant differences to couples without significant differences.

Previous research demonstrates a link between emotion work and dyadic satisfaction, and results from this study expands this link to include partners' evaluation of needs met and effectiveness of therapy. Future research should explore the extent to which dyadic satisfaction and emotion work predict evaluation of needs and dealing with problems. Although measuring emotion work needs further investigation, in this study, as females' perception of emotion work decreased from initial to final session while males' perception of emotion work increased. Also, the partners' greatly differed on their perceptions of emotion work investment at the initial session. These results suggest that there may be different processes influencing both partners' perceptions of emotion work.

It seems further examining these findings may add new insight to emotion work literature and couple therapy outcome research. Future studies should further explore this connection with larger and more heterogeneous samples.

Employing effectiveness research and databases provides new insight to couple therapy outcome studies. Researchers are not constrained by length of treatment, therapeutic orientation, or random assignment, and the data are more representative of a natural clinical setting. Also, expanding the typical outcome variable of dyadic adjustment or satisfaction to include evaluation of needs, effectiveness, and prognosis enhances the depth of the outcome study. More outcome studies should expand the operationalization of therapy outcome as well as use effectiveness research methodologies and databases.

Summary

Overall, the differences between the partners' scores at the initial and final sessions regarding dyadic satisfaction and emotion work did not predict poorer outcome, yet the outcome measures reveal favorable outcomes, with dyadic satisfaction increasing significantly. Thus, when the differences between partners are small then dyadic satisfaction tends to improve, both partners believe their needs were met, and the therapists rate the couples' prognosis as "well." The difference between the partners' dyadic satisfaction is a stronger predictor for the females' increase in satisfaction, especially regarding consensus and connection. A partner's increase in dyadic satisfaction also seems to predict: their partners' dyadic satisfaction, whether their needs were met through the therapy process, and the therapist's prognosis. This study's use of an effectiveness research methodology and a database suggests that the integrative

approach used by the therapists at the Center for Couple and Family Center at Colorado State University is potentially successful.

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Appendix A

Treatment and Release Form

Colorado State University
Marriage and Family Therapy Clinic
Treatment and Release Form

TREATMENT:

I consent to mental health treatment recommended by the CSU Marriage and Family Therapy Clinic.

Because this is a graduate training program, matters of litigation (i.e. child custody, court testimony, evaluations, etc.) are beyond the scope of our mission. Therefore, clients with legal concerns should not seek these services from the CSU Marriage and Family Therapy Clinical Staff. Instead, such clients should seek other professional services within the community. Referrals are available upon request.

RELEASE FOR:

VIDEO/AUDIO TAPING:

I authorize the CSU Marriage and Family Therapy Clinic to video and/or audio tape my therapy sessions. I understand that these tapes and the information shared in sessions may be used under direct supervision for educational purposes, as explained by my therapist.

OBSERVATION:

I also give my permission to allow the supervisor and/or members of the therapy team to observe my session through the one-way mirror.

RESEARCH:

I also authorize the CSU Marriage and Family Therapy Clinic to use any and all information obtained during the time of therapy at the clinic for research purposes with the understanding that anonymity and confidentiality will be maintained at all times.

I UNDERSTAND THE ABOVE AND INDICATE MY AGREEMENT BY THE FOLLOWING SIGNATURE.

_____ _____
Client signature date

_____ _____
Client signature date

_____ _____
Client signature date

THERAPIST'S STATEMENT

I have thoroughly explained to my client(s) the purposes of taping sessions and allowing observations by the supervisor or team members.

_____ _____
Therapist signature date

Appendix B

Client Summary Form (A)

Colorado State University
Marriage and Family Therapy Clinic
Client's Information
Client Summary Form (A)

Case Number _____ Date: _____ _____

Please complete the following information about yourself. This information will be kept confidential. If you have any questions, please feel free to ask your therapist.

1. **Name** _____ **Birth date** _____

2. **Phone number(s)** Home: _____ Work: _____

3. **Address** _____
_____ Zip Code _____

4. **Please ( ) Marital Status**
_____ 1. Married _____ 4. Never Married
_____ 2. Separated _____ 5. Living Together
_____ 3. Divorced Other Please Specify: _____

If you are married what was your age when you married? _____
How many years have you been married? _____
Name and age of former spouse(s), if applicable:
_____ Age: _____
_____ Age: _____

5. **Please ( ) Your Occupation Category:**
_____ 1) Managerial or professional specialty.
_____ 2) Technical, sales, or administrative support.
_____ 3) Service occupation.
_____ 4) Precision production, craft or repair.
_____ 5) Operator, fabricator, or laborer.
_____ 6) Farming, forestry, or fishing.
_____ 8) Unemployed
9) Other Please Specify _____

6. **Please ( ) Your Predominant Ethnicity:**
_____ 1) White _____ 4) Asian
_____ 2) Black _____ 5) American (Indian, Eskimo, Aleut)
_____ 3) Hispanic Other Specify: _____

7. **Please ( ) Your Education (Highest-level):**
_____ 1) 1-12 _____ 4) Post Graduate Ph.D.
_____ 2) Undergraduate
_____ 3) Graduate M.S./M.A. Other Specify: _____

8. **Please ( ) Your Current Income Level:**
_____ 1) 1-10,000 _____ 5) 25,001-30,000
_____ 2) 10,001-15,000 _____ 6) 30,001-35,000
_____ 3) 15,001-20,000 _____ 7) 35,001-40,000
_____ 4) 20,001-25,000 _____ 8) Above 40,000

9. **Please (_) your religious preference:**

_____1) Catholic _____4) Jewish
_____2) Protestant _____5) None
_____3) LDS Other Specify:_____

10. **Which child in the family order were you? (i.e., 1st, 2nd, 5th...)** _____

11. **Number of children in the family in which your grew up as a child.** _____

12. **Have you had any previous therapy/counseling experience(s)? (Y / N)**

If so, please describe:_____
_____

13. **If you have children, please list:**

#1 Name:_____ Age:_____ Gender:_____
Relation to Family:_____

#2 Name:_____ Age:_____ Gender:_____
Relation to Family:_____

#3 Name:_____ Age:_____ Gender:_____
Relation to Family:_____

#4 Name:_____ Age:_____ Gender:_____
Relation to Family:_____

#5 Name:_____ Age:_____ Gender:_____
Relation to Family:_____

#6 Name:_____ Age:_____ Gender:_____
Relation to Family:_____

14. **How did you hear about the Marriage and Family Therapy Clinic at CSU?**

_____
_____

15. **Please list any past (or) current problems with chemical dependency (i.e., alcohol, drugs, etc.)**

_____
_____
_____

16. **Name, address, and phone number of someone who can be contacted in the event of an emergency:**

_____
_____
_____

17. **Briefly state your reason(s) for seeking therapy at this time:**

_____
_____
_____
_____
_____

MEDICAL INFORMATION:

18. **Please list any health or medical problems within the last five years?**

19. **Do you have seizures? (y / n)**

20. **Please list any medicines, prescribed or otherwise.**

21. **Do you drink coffee, tea, or cola? (Y / N)**
How much?

22. **Please list the type and amount of any (street) drugs used or in use.**

23. **Please list the type and amount of alcohol used.**

24. **Do you have any allergies? (Y / N)**
To what?

25. **Do you have a physician? (Y / N)**

Name:_____ Address:_____

_____

_____

Phone No._____

26. **When did you last see a physician?** _____

Appendix C

Dyadic Adjustment Scale (DAS)

Most people have disagreements in their relationships. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item based on the following scale:

5 = Always agree
4 = Almost always agree
3 = Occasionally disagree
2 = Frequently disagree
1 = Almost always disagree
0 = Always disagree

_____ 1. Handling family finances
_____ 2. Matters of recreation
_____ 3. Religious matters
_____ 4. Demonstrations of affection
_____ 5. Friends
_____ 6. Sex relations
_____ 7. Conventionality (Correct or proper behavior)
_____ 8. Philosophy of life
_____ 9. Ways of dealing with parents or in-laws
_____ 10. Aims, goals, and things believed important
_____ 11. Amount of time spent together
_____ 12. Making major decisions
_____ 13. Household tasks
_____ 14. Leisure time interest and activities
_____ 15. Career decisions

The following questions have different answers. Please read the questions and answers carefully. Now, please indicate below approximately how often the following items occur between you and your partner based on this scale:

0 = All the time
1 = Most of the time
2 = More often than not
3 = Occasionally
4 = Rarely
5 = Never

_____ 16. How often do you discuss or have you considered divorce, separation or terminating your relationship?
_____ 17. How often do you or your partner leave the house after a fight?
_____ 18. In general, how often do you think that things between you and your partner are going well?

_____ 19. Do you confide in your mate?
_____ 20. Do you ever regret that you married (or lived together)?
_____ 21. How often do you and your partner quarrel?
_____ 22. How often do you and your partner "get on each other's nerves?"

How often would you say the following events occur between you and your partner?

23. How often do you kiss your mate? (Circle your response)
    0 = Never
    1 = Rarely
    2 = Occasionally
    3 = Almost Every Day
    4 = Every Day

24. How many outside interests do you and your partner engage in together? (Circle your response)
    0 = None of them
    1 = Very few of them
    2 = Some of them
    3 = Most of them
    4 = All of them

How often would you say the following events occur between you and your partner, based on the following scale:

0 = Never
1 = Less than once a month
2 = Once or twice a month
3 = Once or twice a week
4 = Once a day
5 = More often

_____ 25. Have a stimulating exchange of ideas
_____ 26. Laugh together
_____ 27. Calmly discuss something
_____ 28. Work together on a project

There are some things about which couples sometimes agree and sometimes disagree. Indicate if either item below caused differences of opinions or were problems in your relationship during the past few weeks. (circle the number under yes or no)

Yes	No		
0	1	29.	Being too tired for sex.
0	1	30.	Not showing love.

31. The numbers on the following line represent different degrees of happiness in your relationship. The middle point, "happy." represents the degree of happiness of most relationships. Please circle the number which best describes the degree of happiness, all things considered, of your relationship.

0	1	2	3	4	5	6
Extremely Unhappy	Fairly Unhappy	A Little Unhappy	Happy	Very Happy	Extremely Happy	Perfect

32. Which of the following statements best describes how you feel about the future of your relationship?

5 I want desperately for my relationship to succeed, and would go to almost any length to see that it does.

4 I want very much for my relationship to succeed, and will do all I can to see that it does.

3 I want very much for my relationship to succeed, and will do my fair share to see that it does.

2 It would be nice if my relationship succeeded, but I can't do much more than I am doing now to help it succeed.

1 It would be nice if it succeeded, but I refuse to do any more than I am doing now to keep the relationship going.

0 My relationship can never succeed, and there is no more that I can do to keep the relationship going.

Appendix D

Emotion Work Scale (EWS)

Please indicate the response that best describes how frequently you invest energy in the following:

0 = Never
1 = Rarely
2 = Occassionally
3 = Frequently
4 = Very frequently

_____ 1. Make sure our household runs smoothly.
_____ 2. Confide inner-most thoughts and feelings to partner/spouse.
_____ 3. Try to bring partner/spouse out of a bad mood.
_____ 4. Express concern about partner/spouse's safety.
_____ 5. Do or say things to keep my partner/spouse's spirits high.
_____ 6. Praise partner/spouse.
_____ 7. Suggest a workable solution to our problem.
_____ 8. Act affectionately.
_____ 9. Raise problems we need to work on.
_____ 10. Apologize after a fight.
_____ 11. Express concern about financial matters.
_____ 12. Remind partner/spouse of what he/she needs to do.

Appendix E

Client Satisfaction Questionnaire (CSQ)

Please help us improve our program by answering some questions about the services you have received. We are interested in you honest opinions, whether they are positive or negative. Please answer all questions. We also welcome you comments and suggestions. Thank you very much; we really appreciate your help.

Circle your answer:

1. How would you rate the quality of service you have received?
   - 4 Excellent
   - 3 Good
   - 2 Fair
   - 1 Poor

2. Did you get the kind of service you wanted?
   - 4 Excellent
   - 3 Good
   - 2 Fair
   - 1 Poor

3. To what extent has our program met your needs?
   - 4 Almost all of my needs have been met
   - 3 Most of my needs have been met
   - 2 Only a few of my needs have been met
   - 1 None of my needs have been met

4. If a friend were in the need of similar help, would you recommend our program to him or her?
   - 1 No, definitely not
   - 2 No, I don't think so
   - 3 Yes, I think so
   - 4 Yes, definitely

5. How satisfied are you with the amount of help you received?
   - 1 Quite dissatisfied
   - 2 Indifferent or mildly dissatisfied
   - 3 Mostly satisfied
   - 4 Very satisfied

6. Have the services you received helped you to deal more effectively with your problems?
    4 Yes, they helped
    3 Yes, they helped a great deal
    2 No, they didn't really help
    1 No, they seemed to make things worse

7. In an overall, general sense how satisfied are you with the services you have received?
    4 Very satisfied
    3 Most satisfied
    2 Indifferent or mildly dissatisfied
    1 Quite dissatisfied

8. If you were to seek help again, would you come back to our program?
    1 No, definitely not
    2 No, I don't think so
    3 Yes, I think so
    4 Yes, definitely

Appendix F

Client Termination Information Form (excerpt)

Prognosis:_____

1-Not Well 2-Fairly Well 3-Average 4-Well 5-Very Well