Couples Research & Therapy *Newsletter*

The Newsletter of Couples Research & Therapy AABT–SIG Spring/Summer '03

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Notes from the Tr˙umvirate

SIG Co-Presidents' Column

EDUCATION, *n.* That which discloses to the wise and disguises from the foolish their lack of understanding. -Ambrose Bierce (1911), *The Devil's Dictionary*

Now that summer is upon us, we have an opportunity to turn to our scholarly endeavors from educating others to educating ourselves. We can now devote more time to knowing what we do not know. The research that our members are working on will, no doubt, help to reveal our lack of understanding of marriage and marital therapy.

To help our members with their "lack of understanding," the triumvirate has been working on bringing in a speaker for the preconference seminar who is likely to have a different perspective on marriage. During the SIG meeting in November various topics were considered for the preconference seminar, with several possibilities left on the table at the end of the meeting. In keeping with the idea of revealing our lack of understanding, the triumvirate has found a speaker who will present a workshop on sex. Specifically, Julia Heiman has agreed to give a talk (format TBD) on *Recent Developments in the Assessment and Treatment of Sexual Dysfunctions: Focus on Women*.

We will hold the event in the late afternoon on the Thursday preceding the conference. Please arrange your travel itinerary accordingly. We will schedule it to end before dinnertime, so that you will still be free to make plans for supper. More details about this event will follow in our fall newsletter.

Other happenings in the SIG include a request and reminder from Annmarie to update information about your research laboratory on the couple research graduate program list that she keeps on her website. You can go to the links page of http://www.science.wayne.edu/~acano to check on your listing or to see the format of new listings. Please email her at acano@wayne.edu if you'd like to edit your entry. She has received positive feedback from those who used the site. It seems to be a useful tool for prospective grad students and others interested in contacting colleagues. Annmarie noted that at least two labs have benefited from having prospective graduate students checking the site.

We continue to be one of the strongest SIGs in AABT. As such, we want to remind you to always be thinking about possible invited speakers. It is too late for invitations for this fall, but let's use some of our strength to bring in some relationship researchers as invited speakers in the future. It is not too early to start thinking of 2004.

As usual, please encourage your colleagues with research interests in intimate relationships to join the SIG (and AABT), and, more importantly, keep the SIG in mind as a resource for your research and clinical work involving intimate relationships.

Have a safe and enjoyable summer. We look forward to hearing from you and seeing you in the fall.

Annmarie Cano
Kristina Coop Gordon
Matthew D. Johnson

Treasurer's Update

Kathleen Eldridge

Hi there SIGers. November promises to bring another great conference. Our SIG membership continues to grow. We now have 92 nonstudent members and 83 student/postdoc members, for a total of 175 SIG members. This means we have increased our membership by 20 in the last year.

With so many members, we need larger rooms at AABT. Booking larger rooms requires strong paying membership. Since AABT does not recognize inactive (nonpaying dues) members as SIG members, we want to be able to reactivate any members who have not paid SIG dues for the last 2 years. That way we can continue to hold our meetings with sufficient seating and presentation space.

As usual, dues are $20 for faculty members/professionals and $5 for students/1st year postdocs. To reactivate your paying SIG membership by paying for the current 2002-2003 year, you may mail a check made out to Kathleen Eldridge, with "AABT Couples SIG" in the memo line, to the address below. I will send you a receipt of payment via mail or email.

Kathleen Eldridge, Ph.D.
AABT Couples SIG Treasurer
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Our treasury currently contains approximately $1200, which will be used to (a) pay for all of the SIG costs in November, (b) hold a pre-convention meeting before the conference, and (c) bring in a guest speaker.

Thank you to all of you who have consistently paid your SIG dues and remain paying members. And thanks in advance for renewing your paying SIG membership if you have not paid for the last 2 years. If you aren't sure if you have paid SIG dues in the last 2 years, email me at keldridg@pepperdine.edu and I will let you know.

Also, please email me with updates in your contact information and your student/nonstudent status, so I can update our membership list for the SIG website. This is particularly important for members who were not able to make the SIG meeting at AABT last November to provide updated information.

Everyone in the SIG may participate in the SIG listserve and have access to the SIG website. Feel free to contact me if for some reason you are not connected to one of these resources and would like to be.

See you in November!
Kathleen

Editor's Letter

Susan Stanton

Spring is the time for rain, flowers, more rain, graduations, and of course, premarital intervention programs before the onslaught of summer weddings. After two years of assisting with Don Baucom's annual premarital weekend (BOOST, an update of Howard Markman's PREP), I decided that I wanted a part of the fun. I dragged my fiancé to 12 workshops on different areas of relationship functioning. I had a rude shock as he dared to point out the skills I had not been following in our relationship. (Never fear, the wedding is on June 5, 2004!) I write this newsletter humbled, having learned a taste of what it is like for couples to try to keep track of all we throw at them in therapy.

If this newsletter is any indication, couples will have even more to keep track of in future therapy sessions. This issue offers many new considerations for therapy with special populations of couples, from Doug Snyder and Mark Whisman's preview of their book to Karen Prager's book review of Susan Johnson's terrific new resource for working with couples coping with trauma to Gary Birchler's summary of major findings from his symposium on couples with substance abuse. We also revisit the 2002 AABT conference with two articles on relational diagnoses, as well as a summary of the Couples Research and Therapy SIG business meeting. As we remarked at AABT, our SIG celebrates more than 30 years of research on couples. Danielle Black and Lauren Papp bring us up to speed on major developments in the field with a list of seminal articles, especially useful for graduate students and young professionals who read all these articles when they were first published. Happy summer reading! After reading the classics, take a look at the many in press articles for the latest research.

Email sstanton@email.unc.edu to contribute to the next newsletter.

Seconds Minutes Hours

Your Guide to the 2002 Couples SIG Business Meeting

With a comfortably large room to fit our more than 100 members, we met during the 2002 AABT weekend to talk couples stuff. The first order of business involved various elections and committees. ***Brian Baucom*** (bbaucom@ucla.edu) took on the title of web guru from ***Ragnar Beer*** and ***Kathleen Eldridge*** (kathleen.eldridge@pepperdine.edu) picked up the purse strings as ***Erika Lawrence*** stepped down as treasurer. Please email them with any questions about the web page or dues. The new committee to choose the Robert. L. Weiss Student Poster Award winner consisted of ***Erika Lawrence*** (Chair), ***Mari Clements***, ***Carolyn Kohn***, and ***Lynn Rankin-Esquer***. They will email the listserv in the fall with more information about submissions for the 2003 award.

Speaking about the poster award, Norm Epstein and his committee presented ***Rene D. Sell*** the Weiss Award (complete with monetary gift!) for her poster with Elizabeth Epstein and Barbara S. McCrady entitled Do Female Partners of Drug Abusers Benefit from Conjoint Behavioral Treatment?, and gave ***Michael Lorber*** and Honorable Mention for his poster with K. Daniel O'Leary entitled Psychological Aggression at Engagement Predicts Increases in Male Physical Aggression in Early Marriage.

In other business, we paid close attention to our social gatherings, as one person noted that the SIG dinners were becoming "wedding-like" (by the way, thanks to Danielle Black and Lauren Papp for organizing an awesome dinner at Lavequia!). Suggestions for alternative events included a cocktail party or both a dinner and cocktail party. Send the student co-presidents your suggestions!

Talk turned to the preconference meeting, and after well-deserved praise for this year's discussions on the future of couples research and on couples research and public policy, we tossed around ideas for next year's event. Topics volunteered by members were public policy, online research and other technological tools, other methodological topics, sexuality, and a mentoring panel in which junior members of the SIG could hear advice on different career paths. Siggers also tossed around the idea of bringing in an outside speaker on whatever topic is chosen (sexuality seemed to be the most popular option) as well as the notion of keeping the meeting discussion-focused.

Given the recent discussions on the listserv about relational diagnoses as well as the presence of Division 43's (family) Terry Patterson, we looked at ways in which to increase communication with other groups within AABT who study similar topics to the couples SIG. The discussion focused on making connections with the new Parenting and Families SIG and other AABT members not in the Couples SIG who study violence or child maltreatment. Strategies included jointly putting together symposium for AABT, collaborating on articles for *Behavioral Therapy* (AABT's newsletter), hosting a combined preconference meeting on a topic of mutual interest, and socializing together during the conference.

Finally, our SIG co-presidents solicited names of leading couples researchers whom we would like to nominate for Invited Addresses at the next (and all future) AABT conference, as well as encouraged the submission of more panel discussions on couples topics since our SIG is one of the largest in AABT!

Compiled by Susan Stanton.

Announcement

The Coche Center and The Weekend Schools celebrates its 25th birthday this year as a Practice in Mental Health Service Delivery and Adult Relationship Education Center. ***Judith Coche***, Ph.D., a member of AABT, said that her vision, since 1978 has been to bring state of the art clinical intervention, behavioral research, and adult education to the public in a way families can use and afford. Now, one quarter of a century later, as a way to celebrate the growth of mental health service delivery in general, and the growth of The Coche Center in particular, clients and colleagues are being offered their first annual 30 minute "Mental Health Check Up" at no charge this fall.

Clinician's Corner: *Treating Difficult Couples*

Douglas K. Snyder, Texas A&M University, & Mark A. Whisman, University of Colorado

Rarely do couples come to us as therapists with simple, encapsulated complaints amenable to brief interventions that, after a few sessions, restore the couple to individual and relationship health. Too often, couples avoid seeking professional assistance until initial differences or disappointments fester over a protracted period into generalized disillusionment and deeply engrained patterns of negative interaction. By one account, couples wait an average of six years once they start having problems before seeking outside assistance. Moreover, relationship problems frequently interact with substantial emotional, behavioral, or health problems in one or both partners. Even among couples in the community, research suggests that relationship conflict both contributes to – and is exacerbated by – disorders of mood, anxiety, substance abuse, physical aggression, sexual dysfunctions, personality disorders, and physical illness. Among couples entering therapy, the comorbidity of relationship problems with individual emotional or behavioral deficits often seems the norm rather than the exception.

Even to the experienced couple therapist, the term "difficult couple" may appear redundant. What distinguishes "difficult" from "nondifficult" couples? Is it the intensity and disinhibition of hostility exchanged between partners within sessions, or the apparent immutability of dysfunctional patterns of interaction reenacted over many years? Is it the deep roots of maladaptive relationship patterns in partners' early developmental experiences, or their vulnerability to acute stressors beyond their control in their current personal or professional lives? Are couples more difficult to treat when individual and relationship dysfunctions interact recursively to reinforce and maintain each other? Each of these factors may distinguish more difficult from less difficult couples. And as experienced couple therapists know too well, often times several of these complicating factors coexist.

In this brief article, we first summarize findings regarding the comorbidity between relationship distress and a broad spectrum of emotional and behavioral disorders. We then describe a variety of approaches for helping clients with coexisting mental and relationship disorders. Finally, we articulate implications of recent findings regarding comorbid individual and relational difficulties for clinical training and research.

The Comorbidity of Relationship Distress and Mental and Physical Health Problems

There is a large and growing literature that links problems in intimate relationships with the onset, co-occurrence, and course of mental and physical health problems in adults. From a diathesis-stress model, poor relationship functioning increases the likelihood of already vulnerable individuals developing or maintaining mental health problems. Similarly, mental health problem in one partner can result in emotional and financial burdens for the other as well as the disruption of important family routines. Hence, relationship distress and individual emotional or behavioral difficulties likely mutually influence one another in a bidirectional and reciprocal fashion.

Whisman (1999) evaluated the association between marital distress and 12-month prevalence rates of 13 psychiatric disorders using data from the National Comorbidity Survey based on 2,538 married persons across the United States. His findings confirmed that maritally distressed people were more likely to have psychiatric disorders than nondistressed people. For example, in comparison to nondistressed individuals, distressed individuals are 3 times more likely to have a mood disorder, 2.5 times more likely to have an anxiety disorder, and 2 times more likely to have a substance use disorder. In addition, marital distress was associated with each class of disorder and with each specific disorder that was evaluated, with the exception of bipolar disorder; that is, the association between marital distress and psychiatric disorders was not limited to a select group of disorders. Moreover, the magnitudes of the associations between marital distress and disorders were generally quite large. In a subsequent study, Whisman, Sheldon, and Goering (2000) evaluated the association between psychiatric disorders and marital distress while controlling for distress with relationships with relatives and close friends. Their findings confirmed that mental health problems are associated with greater marital distress, above and beyond general distress in other close relationships.

Research linking relationship distress to personality disorders is surprisingly sparse, given that personality disorders are often conceptualized as disorders of interpersonal behaviors. However, there is some evidence that individuals with personality disorders – including those with a comorbid Axis I disorder – have greater relationship distress than individuals with only Axis I disorders. Not only do relationship distress and individual emotional and behavioral problems covary, but research has also confirmed the impact of relationship distress on the outcome to treatments for such problems. For example, marital distress predicts slower recovery and a greater likelihood of relapse for depression, increased likelihood of relapse and time to relapse for alcoholic patients in treatment, and poorer outcome to individual treatment for married or cohabiting people with generalized anxiety disorder.

Approaches to Treating Coexisting Mental and Relationship Disorders

A number of couple interventions have been evaluated for their efficacy for treating selected emotional and behavioral disorders of individual partners (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998). In general, these interventions generally fall into one of three classes:

(1) disorder-specific interventions, in which relationship issues are addressed to the extent that they impact, or are impacted by, the partner's disorder

(2) partner-assisted interventions, in which the partner acts as a surrogate therapist, coaching the individual to complete homework assignments and providing support

(3) general couple therapy addressing specific domains of relationship functioning that contribute to or exacerbate the emotional or behavioral problems exhibited by one or both partners.

To date, research has generally supported the efficacy of both disorder-specific and partner-assisted interventions for the treatment of anxiety disorders, major depression, alcohol- and related substance-abuse, partner aggression, and specific sexual dysfunctions. Less frequently encountered, and more challenging both for couples and their therapists, are occasions when one partner develops a major mental illness that significantly disrupts cognitive processes or results in psychotic symptoms. Recent couple-based treatments have been developed for individuals suffering from bipolar disorders or schizophrenia-spectrum disorders, building on previous advances in assisting families of individuals with major mental illness from a behavioral approach. Each of these treatments espouses a broad-based approach not only for assisting the individual suffering the disorder, but also for minimizing the deleterious effects and mobilizing the support of their partner and other family members.

More recently, several investigators have emphasized adaptations of existing couple approaches for additional individual difficulties for which specific couple-based interventions have not yet been developed or as extensively empirically validated. Examples include application of emotionally focused couple therapy to treatment of posttraumatic stress disorder, translation of dialectical behavioral therapy to couples in which one partner exhibits a borderline personality disorder, and interdisciplinary approaches to couples suffering problems of aging or other physical illness. Snyder and colleagues (e.g., Snyder & Schneider, 2002) have argued that when working with difficult couples, no single treatment modality or theoretical approach will likely fully address the full spectrum of individual and relationship dysfunction that difficult couples frequently present. Hence, they advocate technical integration within a theoretically pluralistic approach for selecting, sequencing, and pacing couple interventions. Specifically, their model proposes using initial structural and strategic interventions to contain crises and strengthen the couple's relationship, followed with behavioral techniques for promoting essential relationship skills, and then incorporating cognitive and insight-oriented approaches as appropriate to address intrapersonal factors linked to relationship functioning.

Implications for Clinical Practice and Training

In a newly released edited book on Treating Difficult Couples (Guilford Press, 2003), Snyder and Whisman articulate key implications of recent conceptual and empirical developments regarding comorbid relationship distress and emotional and behavioral disorders for clinical practice and training. Among these are the following:

- Effective treatment of individuals and couples requires comprehensive assessment of intrapersonal and interpersonal functioning throughout affective, behavioral, and cognitive domains across multiple levels of the family and socio-ecological system. This includes the onset, course, and previous treatment of partners' individual difficulties and the manner in which these contribute to, result from, or interact with relationship problems. Assessment of individual and relationship functioning essential to effective treatment requires recognizing heterogeneity both in the patterns of characteristics defining individual and relationship problems and in their levels of intensity. Subdromal expressions of individual or relationship disorders may warrant consideration of treatment approaches similar to those developed for their more intensive clinical counterparts.

- Therapy will be most effective when individuals and couples are matched to treatments for which they possess prerequisite attributes and are excluded from treatments for which they are particularly ill-suited. For assessment to influence treatment, individual differences in intrapersonal and interpersonal functioning need to be linked to alternative models and modalities of intervention. Although the development and evaluation of disorder-specific and partner-assisted couple treatments for individual problems comprise a relatively recent phenomenon, continued advances along these lines promise to alter substantially the practice of couple therapy. No longer will generic relationship-enhancement techniques suffice as more effective approaches to working with difficult couples are articulated.

- Empirical findings regarding the efficacy of couple- and family-based interventions for individual emotional, behavioral, and health problems should influence practice guidelines at the corporate level. At the simplest level, this implies collaboration among practitioners varying in discipline and level of expertise. A higher order of corporate response involves institutional policies formalizing multidisciplinary interventions across individual and couple or family levels. For example, within medical settings this involves systematic attention to relationship phenomena on primary care units and inclusion of couple interventions to treat individual health problems or contain their secondary effects. Finally, corporate response among health maintenance organizations and third-party payers requires eliminating clinical service and reimbursement

policies that discourage couple- and family-based treatments.

• Differences in urgency of individual and relationship issues and their progression during therapy require an organizational conceptual framework for selecting, sequencing, and pacing interventions. Although virtually all approaches to couple therapy possess an implicit progression of individual treatment components, difficult couples demand special attention to the selection, sequencing, and pacing of specific interventions. For some couples this consideration is mandated by individual or relationship issues that impede an initial working alliance between partners or with the therapist – as in severely antagonistic relationships or with narcissistic or paranoid clients. For other couples the modal sequencing of interventions must be modified to contend with such crises as suicidality, alcohol or drug dependence, major psychopathology, infidelity, violence, or other trauma including recent diagnosis of a terminal illness. Because such crises may emerge at any point during couple therapy, practitioners need an organizational framework for integrating concurrent individual and relationship interventions, and linking immediate responses to crisis to therapeutic strategies that both preceded and follow these events.

• Effective treatment of difficult couples often requires therapists to conceptualize and practice integratively across diverse theoretical orientations. Difficult couples often require thinking outside the parameters of any one theoretical orientation – in part because theoretical approaches to both individual and couple therapy vary in their attention to cognitive, affective, and behavioral components of intrapersonal and interpersonal functioning. The more difficult the couple, the greater the need may be to draw on increasingly diverse intervention strategies to address multiple individual and relationship problems. Integrative practice may be pursued in two ways. One path involves training in, and use of, theoretically integrative models described in the literature. An alternative to adopting an existing integrative approach is to practice pluralistically across multiple theoretical modalities, but to pursue technical integration by incorporating a conceptual organizational framework tailored to couple differences in individual and relationship functioning.

Conclusions

Effective treatment of both individuals and couples requires assessment and intervention strategies targeting both intrapersonal as well as interpersonal components of functioning. All therapists need to be competent in recognizing the recursive influences of individual and couple difficulties. To achieve this objective, additional research needs to delineate the impact of relationship functioning on the treatment of mental and physical disorders, and the impact of individual functioning on the treatment of couple distress – including therapeutic processes, mechanisms of change, and both intermediate and long-term outcomes. Empirical findings from such research need to be incorporated both by individual practitioners and the broader healthcare system to ensure the utilization of couple-based interventions that have been demonstrated to be equally or more effective than traditional individual treatment modalities in treating or preventing clients' emotional and behavioral disorders.

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KUDOS! KUDOS! KUDOS! KUDOS!

Joanne Davila was awarded an NIMH R01 to study stability and change in attachment security within dating couples and across dating partners over time.

Miriam Ehrensaft received a grant from Columbia Center for Youth Violence Prevention for "Service Needs of Pediatric Psychiatry Outpatients Exposed to Domestic Violence."

Annette Mahoney is happy to announce the birth of her son, Anthony Jeremy Mahoney, on Feb. 1, 2003 weighing in at 7 lb., 11 oz.

Terry Patterson was promoted to full professor at the University of San Francisco, and re-appointed as Chair of the Institutional Review Board for the Protection of Human Subjects for a three-year term.

Kieran Sullivan was granted tenure and promotion to associate professor a couple months ago here at Santa Clara University in California.

The (De)Merits of Relational Diagnoses

By Steven Beach, University of Georgia

I would like to propose that we debate whether there are categories of relationship difficulty that are sufficiently troubling and sufficiently unlikely to remit spontaneously that they merit being included in the next edition of the Diagnostic and Statistical Manual (DSM) as part of a new category of "relational diagnoses." One of the exciting things about this proposal is that it raises a number of basic conceptual issues about the nature of dyadic problems and draws our attention to scientific issues that need to be addressed. The resulting discussion is therefore likely to be multifaceted with many possible twists and turns. Regardless of the ultimate outcome of the debate I suspect we, as a field, will be well served by engaging in the discussion. Accordingly, I hope this issue is of sufficient interest that it will lead to considerable debate. In this column I will provide an opening argument for the development of "relational diagnoses." But I hope others will continue the debate both pro and con.

What are some of the arguments in favor of including a category of "relational diagnoses" in the next DSM?

1. Relationship difficulties are known to carry significant and unacceptable risks of morbidity and mortality in a variety of contexts (e.g. Coyne, et al., 2002), and are sufficiently common to merit regular attention in both inpatient and outpatient settings. I suspect this is not a very controversial point, but it is one that requires additional empirical support.
2. It is widely believed that relational difficulties are related to the ongoing epidemic of divorce in this country (e.g. Markman, Stanley, & Blumberg, 1994) and relational diagnoses might clarify which types of relationship problems confer risk of divorce and so galvanize greater prevention efforts. This may be a slightly more controversial assertion, but is in keeping with a long tradition of work in Divorce Prevention.
3. Inclusion of well-validated relational diagnoses in the next DSM has the potential to help practitioners distinguish between relationship problems that require intervention and those that may improve on their own. This could lead to more efficient use of scarce clinical resources. This argument may be controversial, but if current approaches to marital therapy cannot meet current or project future demand for services, some rational basis for allocating services is important, or new methods of service delivery are necessary (for an example of this type of concern see Fincham & Beach, 2001).

What are some of the arguments against including a category of relational diagnoses in the next DSM?

Although a number of potential arguments can be posed, I will suggest two basic conceptual issues.

1. The first and potentially strongest argument against including a "relational disorders" category in DSM-V is the view that dyadic systems are unlikely to have pathologies that are independent of the individuals who comprise them. Some classic work in the marital area suggests that system pathology is relatively independent of individual pathology. However, the nature of the contribution of individuals to dyadic dysfunction is an important point of ongoing research and discussion. Accordingly, one important issue is whether dyadic "systems" can display pathology and whether such pathology can (and sometimes does) maintain itself regardless of changes in individual functioning. There are, of course, strong and weak versions of the view that system pathology can be independent of individual pathology and it may not be necessary to demonstrate complete independence before it becomes sensible to diagnose system pathology in its own right.

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Couple Research & Family Psychology: How Are Those Bridges Doing?

By Terry Patterson

During 2002 bridges were built between the APA Division of Family Psychology and the AABT Couples SIG. The impetus for this effort came from discussions between Division 43 and SIG members about the re-emergence of the potential for a relational diagnosis category to be included in *DSM-V*. Granted, many AABT members (particularly researchers) and some 43 members have long abandoned the notion of formal diagnosis as being irrelevant to empirical investigation or intervention science, but the notion of joining forces in a functional manner in order to prioritize the significance of relationships appeared to merit further discussion. The idea of "joining forces with the enemy" appealed to some as a means of advancing the causes of research funding and third-party reimbursement, if not of bridging the epistemological divide.

To this end Steve Beach wrote a column in his role as Science Editor of *the Family Psychologist (Beach, 2002*) [See Beach's article on this topic on this page], and a reply followed by Florence Kaslow and Terry Patterson (2002). The latter article detailed the history of an interdisciplinary coalition of mental health organizations on relational diagnosis in the early '90s, which culminated in an optional category to code relationships on Axis IV of *DSM-IV (see Yingling et al, 1998).* The conclusion of the overall effort was that additional independent research would be needed for inclusion as a major category in the next *DSM*.

I was then invited to be part of a panel on family research at the AABT convention in Reno last year, during which some interesting

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2. A second argument against including "relational diagnoses" in DSM-V is the possibility that relationship dissatisfaction is inherently continuous and so does not lend itself to being characterized in terms of categories. It is quite possible that this is the dominant view among marital researchers at the present time. Supporting this view, the most commonly used dependent variables in outcome research in the family and marital areas are satisfaction measures that strongly suggest continuity. However, if we cannot demonstrate discontinuity it will be hard to argue that relationship problems are amenable to being parsed into diagnostic categories. It is true, of course, that this same criticism can be leveled against many of the diagnostic categories already in the DSM. But there would seem to be little intellectual merit in compounding this problem by proposing a system of relational diagnoses that is "also" misleading. Accordingly, a second major issue that must be resolved if we are to make a case for relational disorders is whether some types of relationship dysfunction can be characterized as being discontinuous with normal functioning. Of course, one could suggest that some important dimensions of relationship functioning are continuous and others are not. In that case one might create useful descriptive dimensions out of the former and create useful diagnostic categories out of the latter.

What types of research might be helpful in moving the debate forward?

There are many types of research that have the potential to help clarify the potential value of relational diagnoses. Among others, these include research to refine brief assessment modules adapted for different dyadic relationships, research that establishes the potential reliability of specific relational diagnoses, and research that suggests the added value of relational diagnoses for effective clinical practice (for more detail see discussion in First, et al., 2002). However, I would like to suggest that computer simulations and taxometrics deserve greater attention given the useful information they can provide on the central conceptual problems posed by the debate over relational diagnoses.

Computer Simulations. Although they are not new, due to recent developments in mathematics, computer simulations of mathematical models have made dramatic contributions recently in a number of areas of scientific inquiry. They are particularly popular in the study of cellular automata, neural nets, and dynamical systems (see Gottman, Swanson, & Swanson, 2002 for a nice historical overview in the marital area). The recent upsurge in the use of computer simulations of dynamical systems should be of particular use to those of us in the marital area. As was noted by Weiss (2002), dynamical systems modeling has a great deal of potential for helping us better understand dyadic systems. In particular, computer simulations of dynamical systems can demonstrate:

1) that dyadic systems can have emergent properties

2) that distinct sub-populations can diverge starkly despite similarity in initial starting points

3) that some problematic relationship dynamics can become self-perpetuating

4) that dyadic systems can be "disordered" in the absence of disorder at the individual level.

Linked to empirical examination of particular dyadic systems, mathematical models have the potential to be quite persuasive (again, see Gottman et al., 2002 for an example).

For interested parties, I would recommend the book by Nowak and Vallacher (1998) on "Dynamical Social Psychology." Nowak and Vallacher (1998) demonstrate that two individual logistic equations (self-influencing systems), tied together by a parameter that represents the degree of influence between the members of the dyad, can demonstrate emergent systemic properties. The logistic equations were chosen to reflect self-influencing systems that are extremely complex in their behavior (i.e. individuals demonstrating non-repeating patterns of

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is a remarkable and interesting result. At a certain point of mutual influence, there during which some interesting dialogue took place. Highlights are as follows:

- There was no expressed opposition to pursuing this matter, although there was significant variance in the breadth and depth of interest
- SIG has primarily a research agenda, and the establishment of relational diagnoses could lead to a common terminology and criteria for designation of key variables
- SIG is not particularly interested in the reimbursement issue, although many practitioners and clients are
- SIG members stressed that although efforts leading toward inclusion in DSM may further a research agenda, it need not be driven by DSM
- Although NIMH has allegedly indicated no interest in funding DSM research, individual researchers might apply using research agendas that include a DSM focus.
- ApA (Psychiatry) has not yet determined whether to include relational diagnosis work groups in the task forces it has established for DSM-V
- The APA Practice Directorate has signaled an interest in supporting Division 43's explorations of this issue
- Additional conceptual delineation and field trials to discriminate between individual and relational disorders are needed regarding duration, severity, and co morbidity
- Although DSM will continue to be a manual of individual disorders, sufficient evidence exists for relational disturbances that affect personal functioning
- Allied mental health and consumer organizations will have to be included in the effort; massed political strength may influence funding priorities and political decisions.

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behavior). Yet, when they are linked in a single system by mutual influence, there is a dramatic transition from uncoordinated dyadic interaction (with each individual's behavior relatively independent of the other) to highly coordinated interaction. That is, as we move from a less to a more interdependent dyadic system, the behavior of the system has emergent properties that do not depend on the specific characteristics of the individual members (see page 196). Thus, even relatively simple mathematical models can illustrate the emergent properties of dyadic systems.

Similarly, Nowak and Vallacher (1998) demonstrate the tendency of some systems to converge toward a particular stable "attractor" (see page 58-60). That is, despite their inherent potential for dynamic change and the complex behavior of their constituent elements, some systems tend to perpetuate a particular outcome once they fall close enough to the system attractor. In the framework of Relational Diagnoses, this suggests that some dyadic systems may find themselves unable to break free of a particular problematic pattern unless there is an outside influence that allows the system to escape the pull of the system attractor. Combined with empirical observation of persons in troubled dyadic relationships, it should be possible to gauge the degree of fit between the simulation and the actual dyads. A good fit between simulation and observation provides strong evidence for the essential correctness of the mathematical model (see Gottman, Swanson, & Swanson, 2002).

Of course, even if we ultimately decide that systems can have pathology that is independent of the elements comprising the system, and that this provides an adequate description of some of the dyadic problems we confront in marital therapy, we will still confront the hurdle of demonstrating discontinuity. That is, we will need to show that proposed relationship diagnostic categories are categorical and not just extreme points on an underlying continuum of relationship distress. How can we decide if some types of relationship difficulties represent a qualitatively "different state" deserving a diagnostic label whereas other difficulties are better captured by continuous dimensions?

Taxometrics (Waller & Meehl, 1998) is an approach that may help make the case that any "relational disorders" we ultimately propose represent valid diagnostic "entities" and are not merely extreme forms of normal difficulties faced in all dyadic relationships. Taxometric investigation is designed to see whether a particular dimension changes gradually and continuously, or alternatively if it has a non-arbitrary boundary at which point it becomes qualitatively different. If we believe that some relational disorders represent qualitatively different states, as we must if we are to propose diagnostic categories rather than descriptive dimensions, taxometrics provides a critical test of our expectations. Accordingly, taxometrics has the potential to validate categories of relational diagnosis. It can also provide evidence that such categories are not arbitrary and do not merely capture outliers from the normal population. When there are two distinct groups in a population and a valid set of indicators is available, taxometrics produces estimates of the base rate of the two "types." This is a great advance over traditional approaches to diagnostic validation in which cut-points for distinguishing between clinical and sub-clinical forms of the disorder are necessarily somewhat arbitrary. Accordingly, taxometrics can provide persuasive evidence of diagnostic validity. The taxometric approach has been developed by Waller and Meehl (1998) and is very nicely explicated in their book "Multivariate Taxometric Procedures."

How can marital researchers play a role in influencing the DSM?

As we debate the potential utility of "Relational Diagnoses" marital researchers have a pivotal role to play. If there are any valid relational disorders, one might expect to find evidence of them in the marital area. Direct demonstration of the independence of dyadic processes from individual characteristics via dynamical systems models, along with convincing demonstrations of the correspondence between the simulations and the behavior of

(see RELATIONAL DIAGNOSIS, continued on next page)

(BRIDGES, continued from page 8)
The current president of Division 43, Scotty Hargrove, had planned a conference at the Bowen Center at Georgetown University this Spring with Michael Kerr, a *DSM* committee member as the speaker. Although this conference was postponed, the issue remains alive in the Division. The need for additional independent research is paramount for future progress on this issue, just as it was ten years ago. For a full portrayal of the relational diagnosis issue, see the chapter on this topic in DSM-IV-TR (APA, 2002), and the excellent volume by Kaslow (1996).

Beyond relational diagnosis, the current Division 43 President-elect, Jay Lebow is a researcher and clinician at the Family Institute at Northwestern University and has significant ties to practitioners at all levels. Jay has indicated that his priority as president will be to accentuate the link between family research and the practice of family psychology, which can lead to a greater rapprochement between practitioners and researchers in the field. Related to this is an interest in bringing scientists and practitioners together in working toward a scientifically grounded system of relational diagnosis for the next DSM. In addition, he intends to help generate a research agenda by assessing the empirical status of the field, and by becoming more vocal in disseminating the strong empirical base of support for many couple and family approaches.

Picking up on Jay's theme, I would like to emphasize that I believe that family psychologists and SIG members have many common areas of interest. I detailed the foundations and misconceptions regarding these at the Reno conference as follows:

- Do not assume that "family" refers only to psychotherapy with families. It is used as a generic term for consultation, prevention, research, teaching, and intervention with couples, parents and children, and other systems.

(see BRIDGES, continued on next page)

(RELATIONAL DIAGNOSIS, continued from page 9)
real dyads could be very helpful in determining whether any valid relational diagnostic categories exist in the marital area. Likewise, convincing demonstrations of the existence of discrete categories of relationship dysfunction along with demonstrations of the importance of these categories for understanding morbidity and mortality may be quite persuasive as well. Accordingly, it may be that marital researchers are especially well positioned to sort out the merits (or lack of merit) in any proposals for relational diagnoses.

As may be clear, I do not think the debate over the creation of a category of "relational diagnoses" should be pursued as if the issue were already decided. Nor do I think the issue should be debated as if it could be decided through armchair analysis alone. In conjunction with debate regarding conceptual issues there will need to be innovative and creative research to better document and define the underlying structure of marital problems. It is my hope that we, as a group, will play a central role in providing the needed research. Hopefully, we are up to the challenge.

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Want to be a Couples SIG member?

Send dues to Kathleen Eldridge ($5 for students; $20 for others; see contact information on page 3).

Note: You must be a member of AABT (see www.aabt.org for information).

Not on the Couples SIG listserv?

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(BRIDGES, continued from page 9)

- Do not assume that all Division 43 members are strong adherents of diagnosis. A traditional emphasis on intervention has created some strange bedfellows between medical-model clinicians and others who deal with diagnosis mainly (although increasingly less) for reimbursement.
- Do not assume that a "systems approach" is homogeneous. General Systems Theory (GST-VonBertalanffy, 1968) is the basic referent, and many family psychologists adhere to a behavioral or cognitive model.
- Assume that we also have a lot in common with other relational scientists and clinicians from other disciplines and organizations in social work, family therapy, psychiatry, and nursing, including AAMFT, NCFR, NASW, NAMI, etc.
- As the field moves increasingly toward a greater emphasis on an empirical basis for assessment and treatment, adhering to traditional divisions will impede our ability to pursue an agenda that has many elements of mutual interest. Current political realities, examined closely, may give further support to an emphasis on empirical findings regarding marriage, child development, and broad family issues in public policy, research funding, and accessibility to treatments.

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"Is There a Need to Update Traditional Behavioral Couple Therapy for Special Populations?"

By Gary R. Birchler

This was the title of a symposium at the 2002 AABT Convention in Reno. The presenters included Bill Fals-Stewart, Dan O'Leary, and Andy Christensen. Unfortunately, there was a schedule conflict and many Siggers had to choose between two competing (and both worthy) symposia. It has been suggested that a brief recapitulation of the basic issue here might be of interest to those who could not attend. In this brief article, I seek to alert the readers to the powerful and impressive research findings based on the application of BCT to two hardcore special populations: alcohol and drug abusers and their significant others. In this particular article, space does not allow for an exposition of the impressive treatment programs described at the symposium by Dan and Andy. Of course, for those of you who would like to hear all the speakers' verbatim presentations, there is an AABT audiotape available of the same name. I take full responsibility for the tone and bias of this article ---and in the spirit of my mentor Bob Weiss, I say that I do not intend to offend anyone, but I wouldn't mind provoking everyone.

The Issue

Ever since Behavioral Couple Therapy (BCT), formerly called Behavioral Marital Therapy (BMT), emerged as a viable treatment for distressed couples in the late 1960s, there have been attempts to enhance the effects of the basic intervention components. More recently referred to as Traditional Behavioral Couple Therapy, this 30-year old social learning approach consists primarily of the application of behavioral exchange and communication/ problem solving training to address couple relationship problems. I am going to refer to this classic approach as BCT.

Deriving from BCT, currently there are three well developed, though still evolving alternative approaches to traditional BCT. There is Cognitive-Behavioral Couple Therapy, which emerged in the late 1980s; Don Baucom and Norm Epstein have continued to be the major proponents of CBCT. More recently, Integrative Behavioral Couple Therapy emerged in the mid 1990s; Andy Christensen and Neil Jacobson have been the senior proponents. And most recently, there is Self-Regulatory Couple Therapy, with the treatment manual by Kim Halford published in 2001.

…At least one group of clinical researchers has relied rather exclusively on traditional BCT as the approach to employ when treating substance-abusing patients and their partners.

Despite the fact that over the years BCT has been shown repeatedly to be an empirically valid treatment approach for couple distress, it seems that each of these newer renditions of BCT has been developed because, in part, the clinical outcomes have fallen short of optimum results, the positive results obtained have not been sustained at long-term follow-up, or some additional intervention component was deemed necessary for the adequate treatment of certain couple types or problems.

Interestingly and highly germane to this issue, in the context of the historical effectiveness of BCT and the constant revisions over 30 years by many innovative investigators, at least one group of clinical researchers has relied rather exclusively on traditional BCT as the approach to employ when treating substance-abusing patients and their partners. These proponents have included Tim O'Farrell, Bill Fals-Stewart, myself, and others. Moreover, to varying degrees, these same traditional and fundamental BCT intervention components have been retained and featured by other groups working with special couple populations. On one end of the couple distress continuum I think of Howard Markman, Scott Stanley, and Susan Blumberg working preventatively with engaged or newlywed couples; on the other end I think of Dan O'Leary, Rick Heyman, and Robert Neidig who have employed conjoint therapy to treat couples experiencing physical aggression.

So, we have contemporary clinical practitioners and significantly funded research investigators who have relied almost exclusively on traditional BCT to treat highly distressed, substance-abusing adults and their partners, other investigators who feature BCT interventions as important treatment components in working with special couple populations, and still others who, while they have retained certain features of BCT, have nevertheless determined the need to add cognitive, affective, and integrated treatment components in order to improve the chances of getting the desired outcomes.

Accordingly, the original AABT symposium was designed to consider this issue in the context of hearing more about the details and empirical outcomes of specific programs, clinical applications, and, indeed, to take into account, when available,

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the hard data about outcomes using BCT and/or its derivative approaches.

The Challenge

In my view, this is a fascinating area for exploration, debate, and even potential concern. For example, some directions being promoted and proposed by the various investigators would appear contradictory…and if the future directions are not contradictory, we seek to understand why not? Put simply, the proponents of CBCT, IBCT, and SRCT, for that matter, all maintain that traditional BCT does not allow sufficiently for the specific context in which a given distressed couple operates. These approaches seek to individualize the treatment components for a given couple, depending on the nature of their conflict themes and/or the relative importance of individual, cognitive, behavioral, and affective variables in the determination of the couple's problems. In stark contrast, traditional BCT as applied to substance-abusing couples, offers the same basic treatment for every couple. Most of these studies have offered standardized conjoint treatments for 12 weeks. Moreover, given managed care and other community-based constraints, there has been pressure to develop 6-session treatments…or 3-session treatments…and to develop group vs. individual couple treatment programs. As required, this direction of (funded) treatment development would seem to virtually eliminate the time required and the clinician's ability to adequately assess and offer individualized treatment components to specific couples. In this regard, considering the treatment of substance-abusing couples, the question changes from *Is traditional BCT good enough?* to *Can BCT be further simplified and offered successfully in 6 sessions or in a group format?*

I would like you all to consider this point: Because psychosocial treatments almost always fall short of some optimal outcome for some subset of patients, there is continually a push to modify, improve, change, and enhance what we have. That process is the hallmark of any growing science. But when a treatment is changed, the improvements must be viewed as relative. As seductive as it may be to ignore, whenever a treatment such as BCT is undergoing the transformation that is now clearly underway, we must keep in mind the age-old, but critical question: *For whom, and under what circumstances, does this treatment work?* In many clinical settings, substance-abusing partners are discouraged from participating in couples therapy. Indeed, substance abuse is considered such a difficult (and potentially intractable) problem that couples that include an alcohol- or drug-abusing partner are routinely excluded from couple treatment experimental designs. Accordingly, one might expect, given the challenges associated with substance-abusing couples, that BCT alone, without the more individualized and innovative treatment components being proposed these days, would be totally ineffective.

The Outcomes

Primary and secondary outcomes, based on the integration of plain vanilla BCT with individualized or group treatment for the alcohol- and drug-abusing partners (where the male or the female partner is substance dependent), are impressive. The BCT package includes (*all together now*): communication and problem solving training, dyadic behavior change: increasing positive caring behaviors and decreasing negative, conflict behaviors, and contingency contracting regarding maintaining sobriety, recovery planning, and relapse prevention. The treatment programs are completely manualized and every couple, essentially, gets run through the same sheep dip! Here is a simple outline of the findings derived from more than a decade of funded clinical research (specific references are included in the Fals-Stewart, et al, article referenced below).

Primary outcomes refer to the effects on substance use and dyadic adjustment. BCT, in combination with individual-based or group treatment for alcoholism or drug abuse (IBT), results in a highly significant pattern of less frequent substance use, happier relationships, and lower risk of marital separation and divorce compared to results for IBT and/or couple psychoeducation, without BCT. Moreover, drug-abusing partners also have been shown to have fewer positive urine drug screens, fewer drug-related arrests and hospitalizations, and a longer time to relapse after the completion of treatment.

…Whenever a treatment is undergoing the transformation that is now clearly underway, we must keep in mind the age-old, but critical question:
For whom, and under what circumstances, does this treatment work?

Secondary outcomes refer to effects not primarily targeted by BCT, but deemed to be of considerable importance, such as intimate partner violence, children's emotional and behavioral functioning, cost outcomes, and most recently HIV risk exposure. First, BCT for both alcohol- and drug-abusing males and their partners results in decreased partner violence after BCT, compared to when BCT is not included in the treatment program. Second, for children of both alcohol- and drug-abusing fathers, only BCT improved children's functioning to below clinical levels of psychosocial impairment, compared to IBT or couple psychoeducation. Third, relative to IBT, BCT has been shown to have a far greater cost-benefit ratio than IBT (e.g., 50% more reduction in post-treatment costs after one year) and be far more cost-effective (i.e., significantly greater clinical improvements, such as fewer days of substance use) than is the case for IBT. Fourth, compared to IBT and attention-control treatment, BCT was significantly more

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effective in reducing drug-abusing partners' HIV risk behaviors. Compared to an overall pretreatment baseline of 40% drug-abusers who engaged in HIV risk behaviors (i.e., needle practices and unprotected sex), after treatment the engagement rates for BCT were 19%, for IBT 33%, and for attention control 34%.

Clearly, given these significant and consistent findings in several studies of male and female alcohol- and drug-abusers and their nonsubstance-abusing partners, BCT does appear to have impressive effects. In fact, although it is indeed an empirical question that awaits future research, it may be that rather than looking for more sophisticated and innovative treatment component augmentations to get desired effects, the very simplicity and focused nature of BCT is what makes this approach effective with these particular substance-abusing populations.

Future Directions

Despite some impressive research conducted over the past several years, primarily by Bill Fals-Stewart and Tim O'Farrell as Principal Investigators, there are some significant gaps in BCT research with these populations. We need more progress in at least the following four areas:

1) *dissemination* of BCT to community-based treatment programs (BCT is totally under-utilized given its cost structure and relative empirical support)

2) expand BCT research to *additional types of substance-abusing populations* (e.g., nobody knows what to do when both partners use; we need to learn more about couples where female partners are the only substance abusers)

3) examine the *mechanisms* of action underlying the effects of BCT

4) the addition of *other intervention components* to standard BCT specifically targeted to enhance important secondary outcomes, particularly decreases in intimate partner violence, reductions in HIV risk behaviors, and improvements in children's psychosocial adjustment

In conclusion, to date, this body of research suggests that there may not yet be a mandate to discard traditional BCT as an effective treatment approach. Indeed, BCT may have certain attributes that allow for simple, focused, manualized, cost-effective, and therefore relatively easy implementation across several types of providers and substance-abusing couple populations.

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Notes From Danielle and Lauren

Couples SIG Graduate Students' Co-Presidents' Column

We are grateful to Dr. Birchler and Susan Stanton for suggesting that we collect SIG members' recommendations for important articles. We also thank the SIG members who contributed their ideas. The suggestions we received fell into categories of Correlates of Marital Quality, Therapy Process, Treatment Outcome Studies, and Statistical and Methodological Approaches. Below are articles and books suggested to you for your summer reading pleasure. Enjoy!!

Correlates of Marital Quality

Bradbury, T. N., Fincham, F. D., & Beach, S. R. H. (2000). Research on the nature and determinants of marital satisfaction: A decade in review. *Journal of Marriage and the Family, 62,* 964-980.

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Therapy Process

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Book Review

Emotionally Focused Couple Therapy with Trauma Survivors: Strengthening the Attachment Bonds

By: Susan M. Johnson. (2002) New York: Guilford Press.

Review by: Karen J. Prager, University of Texas at Dallas

As I read Susan M. Johnson's new book, *Emotionally Focused Couple Therapy with Trauma Survivors*, I found myself reflecting back on recalcitrant couples I have worked with, in which one of the partners met criteria for borderline disorder. Such couples are always memorable to me because they often need extended treatment, and because they are more likely than most couples in therapy to fall back on old habits while still in therapy. Johnson's book reminded me of these couples because the behavior of these individuals matched her description of trauma survivors. I then remembered that recent research indicates that many individuals who meet criteria for borderline disorder experienced multiple traumas during childhood, especially sexual abuse. Johnson's book gave me a new perspective on these patients, some of whom acknowledged no traumas and yet behaved in their marital relationships as though the spouse were traumatizing them on a weekly basis.

The purpose of Johnson's book, stated in Chapter 1, is to serve "as a guide for the therapist working with couples who are struggling with the impact of trauma on their relationships, seeking to create secure bonds that promote healing for the survivor" (p. 10). Drawing on attachment theory, Johnson conceptualizes the couple relationship as a potentially safe haven for a traumatized individual who is confronting a trauma and its emotional impact. Research has reliably demonstrated that a secure attachment provides children with a secure base from which to venture out and explore the unknown. Applying these findings to adults, Johnson argues that a secure attachment in the couple relationship can promote healing in the trauma survivor. So central is the couple relationship, in her view, that she says, if "a person's connection with significant others is not part of the coping and healing process, then, inevitably, it becomes part of the problem and even a source of retraumatization" (p. 7). The couple relationship can either augment the coping resources that the individual has at hand, or it can unwittingly confirm long-held negative expectations of close relationships.

In chapter 2, Johnson argues, and later illustrates convincingly with case examples, that the disproportionately intense and erratic behaviors, thinking patterns, and emotions that are so distressing in the couple relationship are meaningful and reasonable when viewed as reactions to the overwhelming terror of trauma. Residual effects of trauma can account for feelings of terror and helplessness in the face of interpersonal stress, and for a narrowness and constriction of focus in an individual's life. The rigidity and repetitiveness of these emotional reactions may reflect (as much as cause) an absent healing process and the subsequent re-traumatizing effects of an insecure couple relationship.

Johnson begins Chapter 3 by pairing each symptom of PTSD with the corresponding healing resources offered by secure attachments. For example, when a traumatic experience "colors the world as dangerous/unpredictable," the secure attachment can provide "a safe haven" (p. 37). Working models (or expectations of self, other, and relationship) learned and rehearsed in early relationships can be altered through healing communication in the couple relationship. This is because "working models are formed, elaborated, [and] maintained" in attachment relationships, and are in turn "changed through emotional communication" within those same relationships (p. 41). In other words, couple therapists can alter partners' expectations of felt security by helping them to communicate differently. Once the couple's communication is no longer confirming negative, anxiety-provoking working models learned from earlier relationships, the individual will have less need to resort to outmoded and dysfunctional strategies for coping with the emotional aftermath of the trauma. A more secure attachment results from, and generates, more nurturing, soothing communication, which in turn helps a traumatized partner to heal.

Assessment requires both conjoint and individual sessions with partners, with the latter serving several functions; in particular, they provide an opportunity to explore trauma-related issues without the added stress of disclosing them simultaneously to the partner. The first goal of the assessment process is to ascertain how fully the traumatized partner has confronted the emotional effects of the trauma and thereby reduced its unintended impact on the relationship. The extensiveness of the work involved in confronting the trauma will depend, in part, upon the level of trauma: the most difficult ones to sort out are those that were "chronic and central in a partner's past relationships" (p. 66). The second goal is to determine whether the partners' relationship has exacerbated the emotional residue of the trauma by re-confirming "worst fears" about close relationships. Third, the therapist must determine the traumatized partner's level of self-awareness, i.e., of the impact of the trauma on his/her behavior. Finally, the therapist must assess the couple's history of talking about and attempting to address the effects of the trauma together.

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The therapist's role with a trauma survivor and his/her partner is primarily as healer (as opposed to deliberately stirring up the system, for example). More than anything, the couple will need the therapist to "provide a secure and responsive connection;" the therapist must enter, with the client, the "struggle to grasp and make sense out of that [traumatic] experience" (p. 70-71). The length of treatment and the extent to which other mental health professionals are brought in (e.g., for simultaneous individual therapy) will depend upon the severity of the trauma and the extent to which the traumatized individual has confronted and coped with the effects of the trauma. In all cases, the therapist educates the couple about the long-term effects of trauma, which helps them begin "to formulate the dragon, that is, the terror and helplessness elicited by the trauma, and the negative cycle of interactions" (p. 82). Education is a kind of cognitive restructuring, in which partners learn to attribute at least some of their relationship difficulties to a "third force," or the post-traumatic symptoms themselves, which then become a "dragon" that the two can fight together, in mutual cooperation rather than in mutual blame.

Chapter 5 provides an overview of emotionally focused therapy as it is used to heal couples in which trauma aftermath is part of the picture. Johnson recommends that therapy begin with the establishment of a strong alliance between therapist and couple, which is "explicitly collaborative" (p. 83). The therapist also must be prepared to help the partners cope with "trauma experiences that emerge in the therapy sessions," including intense emotion and bizarre responses (p. 83.) Emotion-focused therapy rests on the assumptions that "therapists must help clients create a *working distance* from emotion…being in touch with, but not overwhelmed by, an emotion" (p. 85).

The first stage of therapy, called "stabilization," involves two tasks: creating a safe context and clarifying the couple's interactional patterns" (p. 87). Therapeutic techniques are vividly described, including reflection, validation, empathic inference, and collaborative efforts to achieve psychological safety. Tracking and summarizing interactions, with a particular focus on identifying and naming emotional responses allows the therapist to clarify the couple's interaction pattern.

The second stage of therapy is "restructuring the bond between the partners" which involves three tasks. The first is "expanding and restructuring emotional experience" (p. 100) which helps partners to "claim and congruently express…avoided…unformulated experience…integrating it into that partner's sense of self" (p. 100). The grounding of this therapy in Carl Rogers' humanistic personality theory was especially clear to me at this point, when the intermediate goal of therapy is to use guided self-exploration to help clients establish congruence between their felt experiences and their concept of self. The second task Johnson calls "expanding self with other" (p. 102), which allows each partner to expand their definition of self to include previously marginalized or denied emotional reactions, sometimes including positive aspects of the self. Finally, the third task is "restructuring interactions toward accessibility and responsiveness" (p. 102). This is the stage of therapy in which the therapist teaches the couple how to create a secure attachment bond with their communication: partners learn how to reach out to one another for help and how to nurture and validate one another in the process. Therapy concludes with a third stage in which the therapist helps the couple to reflect on their change process in a positive and empowering way, creating a story that heightens their bond and reinforces a more positive self-image for each.

In the remaining chapters, Johnson addresses different types and manifestations of trauma in the survivor and in the couple. She begins, in Chapter 6, by analyzing a couple coming in at a "frequent referral point," that is, when the survivor's individual therapy has reached an impasse and the need for couple therapy had become clear. Chapter 7 documents a case in which the husband suffered with PTSD as a result of a history of child abuse. Chapter 8 illustrates treatment issues raised when a couple is dealing with the physical illness of one or the other, and Chapter 9 examines a case of PTSD in a combat veteran. Each of these chapters presents a case study which allows the principles of assessment and treatment to be vividly illustrated and explained.

In her final chapter, Johnson reminds practitioners that they should update their conceptualizations of trauma recovery to include the couple relationship and the quality of attachment between the partners. Traditionally understood as an individual problem requiring individual treatments, the treatment of post-traumatic symptoms and behaviors neglects a salient and distressing source of dysfunction by neglecting the couple relationship. Emotionally-focused couple therapy (along with cognitive-behavioral couple therapy) already has demonstrated effectiveness for healing relationship problems and associated depression. Indications in ongoing research are that it will also make a significant contribution to the treatment of PTSD.

I highly recommend this beautifully written, informative book to couple therapists and researchers. AABT members will find Johnson's book to offer a rich and compelling description of trauma, attachment, and therapeutic change. I found that it expanded my understanding of the erratic and volatile behavior I confronted in some of my most difficult cases. Understanding these reactions as adaptations to the terror of trauma, and recognizing the re-traumatizing effects of distressed couple relationships, will help therapists work more effectively with the specific needs of survivors and their relationship partners.

What's In Press?

Cano, A., O'Leary, K.D., & Heinz, W. (in press). Short-term consequences of severe marital stressors. *Journal of Social and Personal Relationships.*

This longitudinal study was conducted to examine the short-term impact of severe marital stressors and marital discord on psychological distress and marital dissolution in two groups of women. One group consisted of women reporting a recent severe marital stressor (e.g., infidelity, threat of separation) whereas the maritally discordant group consisted of women denying a recent marital stressor but reporting similar levels of marital discord. Results indicated that baseline marital discord was related to later depressive and anxiety symptoms for the control group only. In addition, women experiencing a marital stressor reported reductions in depressive and anxiety symptoms within several months after the event, after which their symptoms leveled off. In contrast, the control group's symptoms remained stable over all three assessments. The marital stressor group was significantly more likely to separate or divorce than the control group. These results are discussed in light of models of marital and psychological distress.

Cano, A. & Vivian, D. (in press). Are life stressors associated with marital violence? *Journal of Family Psychology.*

The current study examined the link between different conceptualizations of life stressors and physical violence against spouses. Life stressors were measured in several different ways to test whether stressor frequencies and perceived impacts, life domains of stressors (i.e., loss, threat), and the nature of stressors (i.e., occupational, interpersonal) are correlates of men's and women's moderate and severe violence. We also explored potential mediators and moderators of the stress-violence relationship. Community and clinic couples participated in this study. Results indicated that occupational and loss stressors were associated with men's violence whereas a wider array of stressors was associated with women's violence. In addition, stressors only discriminated between violent and nonviolent men whereas some stressors also discriminated between moderately and severely violent women. Depressive symptoms moderated the stressor impact-violence association such that impact and women's violence were significantly correlated for women with elevated depressive symptoms. Results are discussed in light of theoretical and clinical implications.

Davila, J., & Sargent, E. (in press). The meaning of life (events) predicts change in attachment security. *Personality and Social Psychology Bulletin.*

Building on prior research, which has failed to find consistent effects of life events on change in self-reported adult attachment security over time (Baldwin & Fehr, 1994; Davila et al., 1997; Scharfe & Bartholomew, 1995), the present study tested the hypothesis that it is the meaning people assign to events, rather than the objective features of events, that is associated with changing levels of security. Participants (n = 154) engaged in an 8-week daily diary study, during which they completed daily self-report measures of attachment security, negative life events, perceptions of loss associated with events, and mood. Hierarchical linear modeling revealed that perceptions of greater interpersonal (but not achievement) loss associated with life events were significantly associated with greater insecurity on a day-to-day basis, even controlling for objective features of events and for mood. Trait levels of security did not moderate this association. Results are discussed with regard to social-cognitive models of attachment security and the utility of understanding the meaning of life events in order to understand how attachment models may be confirmed or disconfirmed.

Dush, C.M.K., Cohan, C.L., & Amato, P.R. (in press). The relationship between cohabitation and marital quality and stability: Change across cohorts? *Journal of Marriage and Family.*

The relationship between premarital cohabitation and marital dysfunction was examined with a total sample of 1,425 spouses in two U.S. marriage cohorts: those married between 1964 and 1980 (when cohabitation was less common) and those married between 1981 and 1997 (when cohabitation was more common). Spouses in both cohorts who cohabited prior to marriage reported poorer marital quality and greater marital instability. When selection factors for cohabitation and subsequent marital instability were included in the statistical model, cohabitors in both cohorts continued to exhibit poorer marital quality and greater marital instability. These findings lend stronger support to an "experience of cohabitation" perspective than to a "selection" perspective as an explanation for why couples who cohabit before marriage tend to have more troubled relationships.

Fortunata, B., & Kohn, C. S. (Manuscript accepted pending revisions). Psychosocial and personality characteristics of lesbian batterers, *Violence & Victims.*

Prevalence of domestic violence (DV) in lesbian and heterosexual relationships appears to be similar. Despite this, few studies have examined factors associated with DV in lesbian relationships, and even fewer have examined characteristics of lesbian batterers. Demographic and psychosocial characteristics and personality traits were examined in 100 lesbians in current relationships

(33 Batterers and 67 Non-Batterers). Results indicated that Batterers were more likely to report childhood physical and sexual abuse and higher rates of alcohol problems. Results from the MCMI-III indicated that, after controlling for Debasement and Desirability indices, Batterers were more likely to report aggressive, antisocial, borderline, and paranoid personality traits, and higher alcohol-dependent, drug-dependent, and delusional clinical symptoms compared to Non-Batterers. These results provide support for social learning and psychopathology theoretical models of DV and clinical observations of lesbian batterers, and expand our current DV paradigms to include information about same-sex DV.

Guay, S., Boisvert, J.-M., & Freeston, M.H. (in press). Validity of three measures of communication for predicting relationship adjustment and stability among a sample of young couples, *Psychological Assessment.*

The goal of this study was to examine if data from three different measures of communication (i.e. self-report, quasi-observational and observational) can predict relationship adjustment and stability one year later when used conjointly. Sixty-two young couples participated in this study. The three measures of communication tested were: (1) the Communication Skills Test-Revised (CST-R), (2) the Communication Box (CB), and (3) the Demand/ Withdraw Pattern Questionnaire (DWPQ). Using hierarchical multiple regression analyses, results revealed that the CST-R and the DWPQ predict both genders' relationship adjustment one year later when used conjointly. Using logistic regression analyses, none of the measures of communication significantly predicted relationship stability. In conclusion, the combination of CST-R and the DWPQ appears to be useful for predicting relationship adjustment longitudinally.

Holtzworth-Munroe, A., Meehan, J.C., Herron, K., Rehman, U., & Stuart, G.L. (in press). Do subtypes of maritally violent men continue to differ over time? *Journal of Consulting and Clinical Psychology.*

Among over 20 published batterer typology studies, only one (Gottman et al., 1995) gathered longitudinal data, and in that study, only relationship stability was examined longitudinally. Thus, virtually no data exist regarding the question of whether subtypes of martially violent men continue to differ from one another over time. The present study was designed to address this issue. We predicted that, at 1.5 and 3 year follow-up assessments, the subtypes identified, at Time 1, in Holtzworth-Munroe et al. (2000; i.e., Family Only, Low Level Antisocial, Borderline/ Dysphoric, and Generally Violent/Antisocial) would continue to differ in their levels of husband violence and on variables theoretically related to their use of violence (e.g., generality of violence, psychopathology, jealousy, impulsivity, attitudes toward violence and women; Holtzworth-Munroe & Stuart, 1994). Many group differences emerged in the predicted direction; however, perhaps due to relatively small sample sizes at follow-ups, not all reached statistical significance. The implications of these findings for understanding husband violence (e.g., not all violent men escalate their marital violence; possible overlap of the Borderline/Dysphoric and Generally Violent/Antisocial subgroups) are discussed, as are methodological issues in this type of research (e.g., the need for more assessments over time, the instability of violent relationships, sampling concerns).

Johnson, S., & Whiffen, V. (Eds.) (in press). *Attachment Processes in Couple & Family Therapy.* Guilford.

This unique volume shows how attachment theory can inform, enhance and guide interventions for a wide range of relationship problems and clinical issues. Chapters include evocative clinical material and a focus on problems such as depression and PTSD in couples and families, as well as innovative chapters on topics that are often not addressed, such as interventions for same sex couples.

Moore, T.M., Strauss, J.L, Herman, S., & Donatucci, D.F. (in press). Erectile dysfunction in early, middle, and late adulthood: Symptom patterns and psychosocial correlates. *Journal of Sex and Marital Therapy.*

The prevalence of erectile dysfunction (ED) increases with age. However, it may emerge at any time during the adult years, and may bear a close relationship to ongoing psychosocial issues affecting the patient and his partner. The present study examined ED symptomatology and its associated psychosocial context in 560 men aged 19-87 attending a urology clinic for erectile difficulties. Participants were divided into three age groups: Early Adulthood (age 19-39); Middle Adulthood (40-59); and Late Adulthood (60+). They completed a self-report assessment battery evaluating medical, psychological, and lifestyle factors empirically or theoretically related to ED. Results showed that while younger men reported more positive overall ratings of their sex life and better overall erectile functioning relative to older men, they also reported comparatively less relationship satisfaction, greater depressive symptomatology, more negative reactions from partners, and less job satisfaction. Results suggest that older men experience less difficulty than younger men adjusting to life in the face of ED.

Moore, T.M., & Stuart, G.L. (in press). Effects of masculine gender role stress on men's cognitive, affective, physiological, and aggressive responses to intimate conflict situations. *Psychology of Men and Masculinity.*

This study aimed to replicate past research examining the relationship between masculine gender role stress (MGRS) and attributions of negative intent, anger, negative affect and verbal aggression in response to masculine gender

relevant, and masculine gender irrelevant intimate conflict situations, and extend this line of research by examining the impact of masculine gender role stress on men's physiological reactivity to intimate conflict situations that challenge masculinity. In general, it was expected that high MGRS men would be more likely to appraise intimate conflict situations as threatening than low MGRS men, resulting in elevated reports of negative attributions, negative affect, anger, verbal aggression, and physiological reactivity (as indexed by heart rate and skin conductance). Eighty college men who scored high or low on the MGRS scale listened to audiotaped vignettes of hypothetical intimate conflict situations involving either masculine gender relevant or irrelevant contexts. Skin conductance level (SCL) and heart rate (HR) were obtained before, during, and after exposure to each vignette, and attributions of negative intent, state anger, negative affect, and verbal conflict tactics were obtained in response to each vignette. Results showed that high MGRS men reported more state anger, negative intent attributions, and verbal aggression tactics than did low MGRS men. Relative to high MGRS men, low MGRS men evidenced greater SCL in response to masculine gender relevant and irrelevant vignettes. Results did not support an expected relationship between masculine gender role stress and physiological responses to gender relevant threats, but did suggest that under arousal may be a potential contributor to a relationship between masculinity and partner violence. Implications of these results for future research were discussed.

Schumacher, J. A., Fals-Stewart, W., Leonard, K. E. (in press). Domestic violence treatment referrals for men seeking alcohol treatment. *Journal of Substance Abuse Treatment.*

The annual prevalence of intimate partner violence (IPV) in samples of men seeking alcohol treatment has been estimated at 50% or higher. One proposed approach to these co-occurring problems is the provision of IPV screening and treatment referrals within alcohol treatment programs. The current study found that alcohol treatment providers infrequently referred men with a pretreatment year history of IPV to domestic violence treatment programs, and that men receiving such referrals rarely followed the recommendation and sought additional treatment. These findings suggest future research is necessary to identify factors that may act as barriers to IPV assessment or referral in alcohol treatment settings, factors that may limit client follow-through on such referrals, and new strategies for addressing IPV in substance abusing populations.

Stuart, G.L. & Holtzworth-Munroe, A. (in press). Testing a theoretical model of the relationship between impulsivity, mediating variables, and marital violence. *Journal of Family Violence.*

The present study involved a multimethod assessment of impulsivity among 86 men. Using two questionnaires and four performance-based measures of impulsivity, the factor structure of the impulsivity data was examined. Four constructs that theoretically mediate the relationship between impulsivity and husband violence (i.e., substance abuse, anger/hostility, marital dissatisfaction, and psychological abuse) were assessed to examine a mediational model predictive of husband violence. Substance abuse and marital dissatisfaction mediated the relationship between impulsivity and psychological abuse. Psychological abuse mediated the relationship between substance abuse and marital dissatisfaction and husband violence. Although anger/hostility was not a mediator, there were bivariate associations between anger/hostility and impulsivity, psychological abuse, and husband violence. The results of the regression analyses were virtually identical when controlling for the effect of intelligence on the model variables. The implications of the findings for the assessment of impulsivity and for future husband violence research are discussed.

Sullivan, K.T., Pasch, L.A., Cornelius, T., & Cirigliano, E. (in press). Predicting participation in premarital prevention programs: The health belief model and social norms. *Family Process.*

The development of effective programs to prevent marital distress and divorce has been a recent focus for marital researchers, but the effective dissemination of these programs to engaged couples has received relatively little attention. The purpose of this study is to determine which factors predict couples' participation in premarital counseling. Predictive factors were derived from the health prevention literature, with a particular focus on the health belief model (HBM). The HBM states that people are motivated to participate in prevention programs when they perceive they are at risk for a serious problem and perceive that the prevention program will be easily attainable and helpful. Couples' beliefs and attitudes about premarital counseling were assessed at least six months before their wedding at Time 1. At Time 2, one month following the wedding, couples were interviewed by telephone to determine whether or not they had actually participated in premarital counseling. Results indicate that the HBM predicts couples' participation in premarital counseling programs, especially for women. The strongest predictors of couples' participation were couples' perceptions of barriers to counseling and whether or not they had counseling recommended to them. These variables predicted participation even after controlling for important demographic variables. Recommendations for recruiting engaged couples for premarital counseling are made based on the findings.

End of Newsletter.

Please contact Susan at sstanton@email.unc.edu for submissions to the fall newsletter.