Couples Research & Therapy *Newsletter*

The Newsletter of Couples Research & Therapy AABT–SIG Spring/Summer '04

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Counsel from the Co-Presidents

Disseminating Couple Interventions Derived from Research

Hello from your new SIG co-presidents! In case you were unable to attend the SIG meeting in November, we thought we'd take a moment to re-introduce ourselves and to invite you to contact either of us if you have any suggestions or questions:

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As you know, the Couples Research and Therapy SIG web site is currently under construction. A call has gone out to our membership requesting seminal articles in the marital literature. Undoubtedly, some of these contributions will come from Couples SIG members who have developed marital and premarital interventions. Our members have devoted tireless efforts to documenting the efficacy of their interventions and investigating the key mechanisms of action. Thus, we thought it would be worthwhile to use our first column to discuss the importance of disseminating this knowledge beyond the borders of academia. Such discussion within the SIG has been increasing over the last few years, and a stimulating panel discussion relevant to these issues was moderated by Bob Weiss in the Spring/Summer 2000 SIG newsletter. The purpose of this column is to trigger discussion about the direction that couples research in general, and its potential impact on social policy and clinical work specifically, might take over the next decade.

In our professional lives, we wear many hats. Generally speaking, our jobs involve some combination of teaching, research, administration, and clinical work. We often receive more positive reinforcement for these activities than we do for service in our communities. As researchers, we are highly skilled in the acquisition of knowledge and the advancement of science but may be less skilled and/or interested in public relations and self promotion. However, such efforts may be precisely where our energies should increase. Specifically, we are encouraged by the recent efforts of some of our SIG members to disseminate couples intervention programs into the public domain and to teach community service providers how to implement our interventions.

There are many examples of research-supported interventions developed by the Couples SIG membership. Couple researchers in our group have developed tertiary interventions for marital dysfunction (*e.g., Jacobson & Margolin's (1979) and R.B. Stuart's (1980) Behavioral Marital Therapies; Epstein &*

TREASURER UPDATE

It was great seeing so many of you in Boston. Our SIG continues to grow in membership and visibility. We've added several new members since the convention. We now have 106 nonstudent members and 93 student/postdoc members, for a total of 199 SIG members.

Our treasury currently contains approximately $1035, 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.

As usual, dues are $20 for faculty members/professionals and $5 for students/1st year postdocs. If you were unable to pay dues back in November, 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.
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If you recently made a transition, or are planning for upcoming transitions in your work or life, please be sure to email me with new contact information, keldridg@pepperdine.edu.

I'm looking forward to seeing you in New Orleans!

-Kathleen

Don't Forget to Pay Your Dues! Our SIG Needs Your Support!!

Baucom's (2002) Cognitive Behavioral Couple Therapy; Snyder, Wills, & Grady-Fletcher's (1991) Insight Oriented Marital Therapy; Jacobson & Christensen's Integrated Behavioral Couple Therapy (1996; Jacobson, Christensen, Prince, Cordova, & Eldridge, (2000); Halford's (2001) Self-Regulatory Couple Therapy), tertiary interventions targeting specific problems associated with marital dysfunction (*e.g., O'Leary, Heyman, & Neidig's (1999) Conjoint Violence Treatment; Gordon, Baucom, & Snyder's (2000) Integrated Forgiveness Treatment; Beach's (2001) Couples and Family Therapy for Depression; O'Farrell & Fals-Stewart's (2000; in press) Behavioral Couples Therapy for Alcoholism and Drug Abuse*), and even primary and secondary prevention programs targeting marital dysfunction and dating violence (*e.g., Markman, Floyd, Stanley, & Storaasli's (1988) Prevention and Relationship Enhancement Program; Rogge, Cobb, Johnson, Lawrence & Bradbury's (2002) Compassionate and Accepting Relationships through Empathy Program; Avery-Leaf, Cascardi, O'Leary, & Cano's (1997) Dating Violence Prevention Program*). Naturally, there are differences in the amounts of evidence that have been gathered to support these treatments. Certainly, it makes sense to continue to collect data on our interventions and to extend our efficacy research into community settings to determine the effectiveness of our interventions in the less-controlled real world. Nonetheless, we need to ask ourselves how much supportive research evidence is necessary before we start exporting and disseminating our empirically supported treatments to the public. To what extent do we have a responsibility to disseminate the couple interventions that have strong empirical support? If indeed clinicians in the community want to learn these interventions, it would be in our best interest and in the best of interest of the couples being served to conduct training workshops and clinical supervision to teach community therapists these treatments with an emphasis on treatment adherence. Moreover, we would like to generate increased discussion of ways in which we as a SIG could improve upon our efforts to publicize those interventions with empirical support and even the notion of prioritizing research-driven and empirically supported interventions. Hopefully, we can continue to engage in such discussions and promote the widespread utility of empirically derived couple interventions.

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Editors' Note

We want you all to know that we are honored to co-edit the SIG newsletter. It has been a great deal of fun communicating with many of you, who have answered numerous questions regarding the family tree and have readily contributed your news (in the *Kudos* section), your work (in the *In Press* and *Measures* sections), and your expertise (the main articles by Alan Fruzzetti and Annmarie Cano and their labs) to this issue. Thank you for all your help. It has been a pleasure getting to know you better, and we look forward to co-editing the next three issues! As we work on these issues, we will be looking for more suggestions for improving this newsletter. If anyone has any suggestions for new topics or sections, please contact us. Your contributions make this newsletter what it is! We would love to hear from you!

Farrah & Eric

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Surf the Internet without guilt!

Go to the AABT Couples SIG website:
www.aabtcouples.org/home.htm

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What to do after getting your PhD: Advice for current graduate students

Sara J. Steinberg and Susan Stanton

Graduate school in clinical psychology can often seem like such an enduring process that sometimes actually receiving a PhD and planning a career can be quite daunting. Couples research is a new and exciting area of study that has many types of job opportunities in a variety of settings. The challenge for many graduate students is to figure out what type of job suits them best. While many students in PhD programs are on the academic path, others are more clinically focused. And then there are those who are somewhere in between. Because deciding on a career path and making the necessary choices to accomplish one's goals can be challenging, we turned to the experts- those who have recently started their careers. This article will discuss the factors that contribute to making career decisions, identify different career paths that couples researchers choose, and provide some resources to help graduate students make these decisions.

<u>Factors that contribute to career decisions post-graduation</u>:

- What kind of research you want to do (i.e., clinical trials research and research in primary care settings may be better suited for a medical school).
- Type of desired career:
  - If you definitely want a research career, a post-doc may be the best route to start. A post-doc allows you to focus on developing a research career and excuses you from many administrative responsibilities and teaching.
  - If you want to do some combination of research, teaching, and clinical work, then figure out what your priorities are (e.g., 80% research v. 80% clinical) and look for a post-doc or other type of job that suits your interests.
- Type of population you want to work with (e.g., military veterans, substance abusers, couples in which one partner is depressed).

- Location and family: Is it more important for you to live in a certain geographical area and/or to be near family, or for you to have a specific position?
- Salary
- Job availability
- Weather (this is not a joke; it is important to be honest with yourself about what factors will affect your life satisfaction and what you are willing to live with).

Job options:

- Post-doctoral position- either in a research or clinical setting, or some combination of the two.
- Assistant professor positions at state schools, private schools, VA hospitals, and psychiatry departments.
- Non-profit think tanks. These positions might include program development, grant writing, developing research fidelity measures, writing papers, or supervising social workers.
- Staff psychologist in a hospital setting (sometimes these positions are a combination of clinicalwork, research, and teaching).
- Part-time (60%) assistant professor combined with part-time private practice (while this job combination may not be common, some universities are flexible and this is one way of raising kids and also being an active researcher/clinician).
- Conducting research in a large government funded company to evaluate government policies, programs, impacts, etc.

Advice:

- Find out about licensing requirements in your state before finishing graduate school.
- Do not immediately go into solo private practice because of the following disadvantages: financial difficulties, risk of intellectual staleness, risk of not remaining current with research, and the risk of doing the same skill repeatedly.
- Get well-rounded clinical experience in inpatient, emergency, and community areas before beginning independent clinical work.
- If you decide on a primarily clinical career, be sure to remain current in the research in your areas of interest.
- If you decide on a primarily research career, be open to different environments of conducting research (i.e., government agencies, medical schools), rather than being limited to an academic position.
- Do not allow the subculture of your graduate school to limit career choices (i.e., even if your program suggests that a tenure track research and teaching career is the ideal option, working at a medical school may be a viable alternative). There are opportunities on internship or on a post-doc to find your own niche.

Resources:

U.S. Department of Labor page on psychologists: This site provides statistics on the types of careers psychologists tend to have, median salaries, and information about sub-specialties.
http://stats.bls.gov/oco/ocos056.htm

American Association of Marital and Therapy: This organization is primarily for people getting a master's degree as a marital and family therapist, but it also has a number of links that could be of interest to clinical Ph.D.s interested in clinical work. They also have a research and education foundation for people who might be interested in more applied, organizational research.
http://www.aamft.org/index_nm.asp

APA: The APA has a section for early career psychologists that is applicable for people with a new doctorate in clinical psychology. Links such as early careers and where psychologists are getting jobs show a variety of career options. They also list a book about careers in psychology that applies to the undergraduate through doctoral levels.
http://www.apa.org/earlycareer/

Psyc Careers: A search engine for jobs requiring an advanced degree in psychology as well as a number of articles about psychology careers.
http://www.psyccareers.com/

Professional associations: The following link is a compilation of various associations in the field of psychology. If you are interested in a particular niche, these associations often have information on getting started in a career in that area.
http://www.psychology.org/links/Organizations/Associations/

About careers in psychology: Although this is mostly for undergraduate psychology majors, the last chapter talks about different aspects of clinical psychology and salary information.
http://www.gsu.edu/~wwwpug/appleby.htm#Section%2012

Himelin's guide to the helping professions: This site also is primarily for undergraduates, but it has a lot of different career suggestions in the clinical and counseling chapter.
http://www.lemoyne.edu/OTRP/otrpresources/helping-online.html

Association of State and Provincial Psychology Board: This website provides information about licensing and has links to other helpful resources.
http://www.asppb.org/

An Integrative Approach to Understanding Pain in the Interpersonal Context

Michelle T. Roos, Annmarie Cano, Ph.D., Jennifer D. Hanawalt, and Ayna B. Johansen

Chronic pain is just one of many chronic health conditions that affect individuals and families. The costs attributed to chronic pain (e.g., treatment, lost work days) are estimated at $215 billion per year in the United States (American Academy of Orthopaedic Surgeons, 1999). Unfortunately, chronic pain often co-occurs with psychiatric disorders including depression. Estimates based on standardized diagnostic interviews have produced comorbidity rates between 30% and 54% (Romano & Turner, 1985), whereas estimates based on self-report measures of depressive symptoms have produced comorbidity rates of up to 100% (see Romano & Turner, 1985 for a review). The prevalence rate of depression appears to be higher in chronic pain samples than in other samples with a chronic medical illness (Banks & Kerns, 1996). Given that chronic pain in and of itself is troublesome and that it is associated with elevated psychological distress, the importance of identifying modifiable targets of intervention for chronic pain is clear. Indeed, funding agencies have made chronic pain research a priority in recognition of its high financial and human cost (e.g., NIH PA-03-152 Biobehavioral Pain Research).

While there are substantial financial and psychological costs associated with chronic pain, there are also interpersonal costs. Pain researchers have explored these interpersonal costs in the context of marriage. It is understandable that the couple would be studied in the context of chronic pain as individuals with chronic pain (ICPs) often have the most contact with their significant others. Moreover, some research has shown that romantic relationships often suffer after the onset of a chronic pain condition (Romano, Turner, & Clancy, 1989).

Fordyce (1976) was the first to directly spell out the reinforcing role of significant others in the pain process. He argued that partners may provide more attention to ICPs when the former express pain or engage in pain behaviors (e.g., grimacing, limping, rubbing). Reinforcement of pain behaviors may lead to less activity and increased disability. Conversely, partners may ignore pain behaviors leading to the extinction of these behaviors and reinforce well behaviors (e.g., physical exercise). Turk, Meichenbaum, and Genest (1983) took this operant model one step further and suggested that cognitions and perceptions about the pain and one's social environment may also exert an influence on pain and disability. Specifically, appraisals of pain as disabling and untreatable may influence pain severity and behaviors. Maladaptive cognitions (e.g., catastrophizing, maladaptive coping) may also increase the risk of depression in individuals who face stressors that may or may not be related directly to the pain (e.g., relationship stressors; Banks & Kerns, 1996).

These existing models are helpful in conceptualizing the role of couples' relationships in pain, disability, and distress. There are, however, several issues concerning interpersonal processes that are not adequately addressed by these models. First, there is an overreliance on operant mechanisms explaining the relationship between couples' interactions and pain. It is likely that other aspects of the relationship including affective expression and social support may also play a role in health outcomes. Indeed, other models of health with a focus on couples' relationships have suggested that this might be the case (Burman & Margolin, 1992; Kiecolt-Glaser & Newton, 2001). Of course, models of couples' functioning such as the Marital Discord Model of Depression (Beach, Sandeen, & O'Leary, 1990), Interactional Models of Depression (Joiner & Coyne, 1999), and Integrative Behavioral Couples Therapy approaches (Jacobson et al., 2000) all suggest that while cognitive-behavioral approaches explain much in couples' relationships, other variables (e.g., social support, empathy, stressors) are also useful.

Second, models that include some attention to the role of close relationships to pain outcomes tend to be "one sided" in that the focus is on the ICPs and not the couple. The dynamic nature of couples' cognitions, behaviors, and affect are often overlooked and these couple variables are not often examined in relation to pain. The idea of viewing a condition or illness as "ours" instead of "yours/mine" is a position that other researchers have taken in the past (Lyons, Sullivan, & Ritvo, 1995), but not all pain researchers take this "couples" perspective. In fact, in our research we have found that many couples do not take a couples perspective of their pain!

In our view, the literature seems to be lacking a truly comprehensive model to explain the inter-relationships between couples functioning, distress, and pain in couples. Our research group has therefore formulated a working model of chronic pain in an interpersonal context. It has been our experience that the members of a couple are not often aware of the effect that their mood or health has on the other spouse. Couple members have been truly moved by their experience of participating in our projects and often find that they are able to gain some insight into their spouse's perspective. We first used a cross-sectional approach to gain an initial glimpse into the world of these couples (N = 110 pain clinic couples; N = 139 community-based pain couples), and are beginning a

larger longitudinal study in May 2004 to learn more about how couples change over time.

In our lab, we collect self-report and observational data on cognitions, behaviors, and affect from both members of the couple, thereby addressing the need for multi-modal/multi-construct assessment in both partners. Interestingly, in some of our preliminary analyses, we have found that an assessment of both partners leads to intriguing new findings. For example, while most researchers might guess that the spouse of an ICP might be relatively healthy, we have found that almost half of the spouses struggled with a chronic pain condition themselves (Roos & Cano, 2003). Without requesting this information from spouses, we would not have learned that the presence of chronic pain in the spouse also affects how they think and what they do in response to the identified ICP. Furthermore, we found that there are important differences in how ICPs and their spouses perceive the pain problem especially when the ICP was a woman or was depressed (Cano, Johansen, & Geisser, in press).

Our group has identified several sets of variables from the literature and from our work that are central to an interpersonal view of chronic pain. One set of variables is centered on the pain condition itself. These variables include pain diagnosis, duration, sites, severity, pain related disability, and pain behaviors. The importance of pain variables has been well documented in the literature in relation to mood (e.g., Banks & Kerns, 1996). Some evidence suggests that pain variables are also related to marital functioning (e.g., marital satisfaction; spouse responses to pain; Romano et al., 1995; Flor, Turk, & Scholz, 1987; Saarijärvi, Rytökoski, & Karppi, 1990; Schwartz, Slater, & Birchler, 1994). We are also interested in both spouses' pain coping strategies and cognitions. Sullivan et al. (2001) suggested that pain catastrophizing (e.g., an exaggerated negative focus on pain) is one cognitive strategy that ICPs may use to gain intimacy and support from others. In our research we found support that catastrophizing and perceptions of spousal support were positively related at shorter pain durations whereas no relationship was found at longer pain durations (Cano, in press). It appears that we must examine not only the characteristics of the pain but also the thought processes and behaviors that both spouses engage in when confronted with pain.

We also collect data on couples functioning. Couples functioning is an important correlate of psychological distress independent of pain severity and disability (Cano, Gillis, Heinz, Geisser, & Foran, 2004). Furthermore, including each spouse's perspective of the couples' marital functioning constitutes an important step toward developing a comprehensive view of the potentially bi-directional relationship between marital factors and chronic pain and distress. We believe that it is important to consider the ways in which the spouses' perception of the marriage may influence their behavior towards the ICP. For example, spouses who feel more invested in the relationship may also be more supportive toward the ICP. We also gather data on other couples-oriented perceptions and have also collected observational data from our couples in order to examine their expressed affect and interaction styles toward one another. We are not taking an operant view of these interactions as some pain researchers have done but we are trying to understand the context in which spouses talk about the pain: is it a context of empathy and understanding or a context of disagreement and misunderstanding (or disbelief) about the pain?

In addition to these variables, our group collects information on mood variables from each member of the couple. As noted earlier, depression and pain are highly comorbid with one another. Further, the longitudinal impact of comorbid chronic pain and depression on the couple is something that has not yet been taken into consideration. Learning about the longitudinal associations between marital functioning, pain factors, and depression in both spouses will be especially useful in developing marital interventions for this population.

Finally, for our longitudinal investigation, we will collect information on life events and chronic stressors faced by these couples. Life events are related to health outcomes, such as pain, and distress (e.g., Sarason, Sarason, Potter, & Antoni, 1985). For many of our couples, the pain itself is a chronic stressor, and having to deal with other significant life events may add to their difficulties in coping with the pain and with problems in their marriages.

The data collected from each couple provides our group with a more comprehensive view of the complex associations between marriage, mood, and pain so that we will be able to formulate an integrative model that incorporates cognitive-behavioral-affective principles. We believe that learning more about the interpersonal environment is key to understanding chronic illnesses and to developing strategies for helping couples build a stronger relationship despite (or even as a result of) chronic health problems. The need for treatments that account for interpersonal relationships has been well established. For example, negative marital environments may lead to poorer health (Robles & Kiecolt-Glaser, 2003) and having a stable and satisfying relationship can provide some protective benefits from the incidence of physical illnesses (Kowall, Johnson, & Lee, 2003). However, chronic pain treatments often focus solely on the ICP and when they do include partners, often focus on an operant conceptualization. We hope that our research and others' research efforts will offer more comprehensive views of pain that account for both partners' cognitions, behaviors, affective expressions, and other variables of importance.

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Comments? Criticism? Suggestions? Notes of affection? Crazy ideas? Send them to the editors!

Contact Eric at gadol@unc.edu and Farrah at fhughes@utk.edu

***Kudos** to the following people…*

- **Steve Beach** received the Owens Award on March 31, 2004, from the University of Georgia. This competitive, university-wide award is given for an outstanding body of research in the social sciences. Congratulations!
- **Bill Fals-Stewart** has been elected a Fellow of Div 43 of APA!
- Julie and **Greg Stuart** became the proud parents of Nathan James Stuart on Friday, April 16. He weighed 6 pounds, 8 ounces and was 19.5 inches long. Best wishes to the new parents!

Couples Dialectical Behavior Therapy: An Approach to Both Individual and Relational Distress

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Two of the biggest problems facing couple therapists are: 1) one partner's emotional reactivity toward the other; and 2) partner general distress and psychopathology. Although traditional cognitive-behavioral couples therapy has made some significant inroads toward solving both of these problems (cf. Beach et al., 1990; Jacobson, et al., 1991, 1993; O'Leary et al., 1990; Snyder & Whisman, 2003), they often befuddle clinicians and impede good outcomes. One way to tie these two problems together is to consider the role of *emotion dysregulation* in both individual and couple distress. In fact, a significant proportion of partners who seek couples therapy may have problems with emotion regulation within the context of their relationship specifically or more broadly in life (Fruzzetti & Iverson, in press). Distressed partners tend to be more sensitive to negative relationship events, they are more negatively reactive (and less positively reactive), and often exhibit a slow return to baseline following negative interactions (Fruzzetti & Fruzzetti, 2003; Gottman, 1980). In fact, many distressed relationships might be characterized colloquially as "borderline" due to these factors. The Dialectical Behavior Therapy (DBT) model for emotion regulation may offer some opportunities to synthesize individual and relationship skills in to improve outcomes, particularly in couples with distressed or dysregulated partners, with additional opportunities to address both conflict and intimacy patterns simultaneously (Fruzzetti, 1996).

In this paper we will describe the model on which Couples DBT is based, and briefly describe targets and skills employed in this treatment in order to give an overview of its scope and flexibility. This therapy is still in development, but some recent data support the approach, which we will summarize.

Transactional Model of Individual and Relationship Distress

Couples processes and individual problems tend to influence each other in a reciprocal manner. The theoretical importance of validating and invalidating behaviors is described as a key tenet of the overall transactional model (also may be called biosocial, contextual behavioral, or systemic) of emotion dysregulation for individuals (Linehan, 1993a) and for relationships (Fruzzetti & Fruzzetti, 2003; Fruzzetti & Iverson, in press). In particular, pervasive *invalidating* responses to a partner's private experiences (e.g., emotions, thoughts, wants) is hypothesized to mediate the development and maintenance of individual emotion regulation problems as well as relationship distress. Specifically, this model suggests that particular partner/family "invalidating" responses and a lack of "validating" ones, are part of the partner/family transactions (along with the individual emotional vulnerability) that lead to emotion reactivity, emotion dysregulation and dysfunction. Specifically, when accurate self-descriptions or self-disclosures are met with invalidating responses, a sequence of problematic learning is initiated or maintained (cf. Fruzzetti & Boulanger, 2004; Fruzzetti & Iverson, in press). Over time, this learning may further deteriorate into many of the problematic behaviors we see in distressed and reactive couples and families.

Emotion Dysregulation

The development of emotion dysregulation problems is predicated on a combination of 1) emotion vulnerability (sensitivity to emotional stimuli, high reactivity to emotional stimuli, and a slow return to baseline following high arousal; presumably, vulnerability may be a result of temperament factors and/or shaped over time developmentally); 2) a lack of skills to modulate arousal (e.g., social skills to generate social support, attention control, impulse control skills, distress tolerance, self-soothing, effective self-talk, contact with long-term

goals); and 3) regular or pervasive invalidation from partners, family and the social environment (Linehan, 1993a). Borderline personality disorder may be considered a prototype for emotions dysregulation, but other disorders include these factors as well (Fruzzetti, 2002).

Invalidating Responses

Emotion regulation difficulties are a function of individual emotional vulnerability and are maintained in an ongoing transaction with a spouse/partner (and family members and others). These transactions are characterized by "invalidating" responses to the partner's self-disclosures. In DBT, invalidation refers to criticizing, de-legitimizing, missing/not noticing, disregarding or otherwise rejecting the other's experiences (especially private ones such as thoughts, feelings, wants, etc.). Invalidating responses suppress the discrimination, identification and expression of these private experiences in general, and create and exacerbate individual distress in the moment. When a partner or family member communicates invalidation, this communication tends to result in increased partner arousal and vulnerability (Sayrs & Fruzzetti, 2004; Swan, 1997). Over time, an individual may develop pervasive patterns of behavior that reflect both her or his own increased vulnerabilities and the normative consequences of pervasive invalidation. Thus, invalidation retards accurate expression, which increases invalidation, and so on.

Dialectics in Couples Therapy

There are several core dialectics that need to be resolved in successful treatment with couples and families (Fruzzetti & Fruzzetti, 2003): 1) closeness versus conflict; 2) partner acceptance versus partner change; 3) one partner's needs and desires versus the other's; and 4) intimacy versus autonomy. By assuming a dialectical approach, these apparent polarities can be effectively targeted for synthesis. In other words, neither partner is "wrong" or "right," but rather the therapist helps the clients define and achieve what is effective for both individuals, as well as the relationship. For example, the target vis-à-vis intimacy/autonomy conflict would not be compromise. Rather, the target would be to use intimacy to foster autonomy (intimate support for individual activities and achievement), and use autonomy to enhance intimacy (individual partners can bring richness back to the relationship to share).

Development of Couples DBT

Applications of DBT have been developed for families (e.g., Fruzzetti, Hoffman, & Santisteban, 2004; Fruzzetti, 2004; Hoffman, Fruzzetti & Swenson, 1999), as well as for couples (e.g., Fruzzetti & Fruzzetti, 2003). Couples DBT has its roots in both individual DBT, initially developed to treat problems of severe emotion dysregulation in borderline clients (Linehan, 1993a. 1993b), and Behavior Marital Therapy (BMT; Jacobson & Margolin, 1979), which emphasizes applying learning principles to the problems of distressed relationships. BMT has been effective in both improving relationship satisfaction and reducing individual distress and depression (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998; Jacobson, Dobson, Fruzzetti, Schmaling & Salusky, 1991). However, studies utilizing BMT have revealed specific clinical significance and improvement durability limitations. For example, at least one third of the couples studied in randomized clinical trials of BMT do not respond at all, and although another 25-30% improve, they are still distressed at the termination of therapy (Halford, Sanders, & Behrens, 1993; Jacobson, 1989; Jacobson et al., 1984). There are two important limitations of BMT in the context of difficult cases with severely problematic individual behaviors (e.g., domestic violence, suicidality, substance abuse): 1) many couples with these problems have been excluded from BMT treatment trials; and 2) the treatment is not based on a specific model of individual/familial distress and consequently does not specifically integrate partner psychopathology into its model. In addition, in part because it is based primarily a relational model, BMT fails to address thoroughly the role of emotional processes in relationships. This is a significant limitation, given that an important component of relationship conflict and intimacy is the emotional arousal that partners experience while communicating (Fruzzetti & Jacobson, 1990), and that emotion awareness and emotion regulation skills are central to promoting healthy individual and familial functioning (Fruzzetti & Fruzzetti, 2003; Katz, Wilson, & Gottman, 1999).

Couples DBT has some overlap with other treatments as well. For example, Greenberg and Johnson (1988) developed Emotionally Focused Therapy (EFT) in order to help couples identify unexpressed, underlying emotions and to redefine couples' interactions in terms of these newly experienced emotions. A key principle in EFT is then to enhance emotional awareness. However, clients do not learn specific emotion regulation skills, and relatively high levels of individual functioning are recommended for this treatment. Similarly, Christensen and colleagues developed Integrative Behavioral Couple Therapy (IBCT; Christensen, Jacobson, & Babcock, 1995; Christensen et al., 2004), which is a variation BMT. In IBCT, an emphasis is placed on acceptance strategies and self-directed change, with a specific emphasis on the expression of "soft" emotions, as opposed to "hard" emotions. Although IBCT emphasizes the expression of emotions, and emphasizes acceptance (similar to DBT), the treatment does not focus on increasing emotion regulation skills per se, nor on integrating individual distress targets with relationship targets.

Modes of Treatment Delivery

DBT with Couples can be delivered in a variety of modes. Like most types of couple therapy, it can be administered with one couple at a time meeting on a regular (e.g., weekly) basis. In this mode couples that prefer structure can follow an established skill-based curriculum, whereas couples that prefer a more flexible agenda can do this, and the therapist can simply bring in whatever skills are needed as targets are encountered (within the treatment target hierarchy).

Because there is a skill focus in this treatment, DBT with Couples may also be delivered to multiple couples in a semi-structured group format. In this mode time is divided roughly equally between 1) homework review, 2) new skill teaching, and 3) practice.

Treatment Targets, Skills, and Strategies by Stage of Treatment

Couples DBT is organized around four stages of disorder that range from most severe (Stage 1) to least severe (Stage 4). When couples enter treatment their initial assessment determines their level of disorder and skillfulness, and they begin treatment in the appropriate stage. Of course, progression from one stage to the next is not always linear; sometimes couples backslide and temporarily return to targets and skills of a previous stage.

Skills utilized in this treatment include those individual DBT skills developed by Linehan (1993b) as well as complementary relationship-oriented couple and family skills developed more recently (e.g., Fruzzetti & Fruzzetti, 2003; Hoffman, Fruzzetti & Swenson, 1999).

Assessment

Both relationship factors and individual functioning must be assessed when assessing complex couples and families. DBT for couples utilizes traditional assessment measures of relationship and individual distress, as well as assessment tools specific to the treatment. For example, diary cards are self-monitoring tools by which individual behaviors (e.g., aggression, drinking, mood ratings, mindfulness practice, etc.) and relationship behaviors (e.g., feelings of closeness, time spent together, accurate self-disclosures, validating responses) can be assessed and monitored throughout treatment (providing both immediate treatment targets and longer-term outcome assessment). Chain (behavioral) analyses of target behaviors are used throughout treatment to better understand antecedents and consequences of particular individual and relational behaviors (including overt and private behaviors, such as thoughts, wants, and emotions) that inhibit the use of healthy/functional behaviors. Samples of couple/familial communication (videotaped assessments) are essential to the assessment of initial functioning and treatment progress with couples and families. The Validating and Invalidating Behavior Coding Scale (Fruzzetti, 2001; Fruzzetti et al., 2004) was developed specifically to assess these core behaviors.

Stage 1

Targets In Stage 1 of treatment, partners focus on achieving individual self-control over significantly dysfunctional behaviors. Life threatening and other "out of control" behaviors are addressed hierarchically according to how severely they interfere with the couple's/family's quality of life. These behaviors include (in order): 1) reducing/eliminating life-threatening behaviors (suicidality, aggression and violence, child neglect, etc.; NB: when active suicidality is present, concurrent individual treatment is recommended; see Fruzzetti & Fruzzetti, 2003 for a fuller description of this protocol); 2) reducing/eliminating treatment interfering behaviors (not coming to treatment, not collaborating, not completing diary cards or doing homework, etc.); and 3) reducing/eliminating severe quality-of-life behaviors (affairs, severe alcohol or drug use, severe depression, criminal behavior, etc.). It is important to stress that Stage 1 behaviors are targeted as *individual* behaviors regardless of their relational context, with an exclusive emphasis on individual partner responsibility and commitment to manage (control) her or his own behavior.

There are specific protocols for aggression and domestic violence for both perpetrators (Fruzzetti & Levensky, 2000) and for victims (Iverson, Shenk, & Fruzzetti, 2004). The dialectical tension between doing couple therapy for domestic violence versus individual treatment is at least partially resolved by seeing the elimination of aggression as an individual target (safety is not predicated on the partner changing her behavior), but in the context of couple therapy (i.e., it is the 1st stage in couple treatment).

The treatment of anger is particularly important in this stage. In this model, anything more than modest anger is viewed as problematic, regardless of whether anger is normative or justified per se (Fruzzetti & Iverson, in press). Partners are taught to observe escalating anger as a problematic, often self-invalidating response, and to focus attention on describing the situation and their reactions to it (i.e., primary emotions) without judgments. This allows partners to stay centered regarding their own experience while de-escalating.

Skills *Individual mindfulness* skills facilitate attention control, increase self-awareness, including emotional awareness and experiencing, and self-management skills. First, partners learn how to discriminate, label, and "accept" their own experiences, and how to let go of judgments by focusing on description. Mindfulness is essential for the development of all other skills (Fruzzetti, et al., 2003; Linehan, 1993b). *Distress tolerance skills* may be utilized, particularly in Stage 1 of treatment, to interrupt negative emotion escalation, endure crises without engaging in dysfunctional behavior (e.g., aggression towards partner, verbal abuse, substance use) and to "accept" things in life that are undesirable, but unchangeable in that moment (Linehan, 1993b). *Emotion regulation* skills help reduce emotional vulnerability, reactivity, and misery and facilitate emotion modulation. Such skills include awareness of one's own rising reactivity (how to recognize when his or her emotional arousal is increasing); understanding what has caused the reactivity (linking reactivity to whatever the other person's behavior or expression) in a *non-judgmental* (e.g., descriptive) way; identifying the accurate primary emotion; and self-validation of one's own experience (cf. Fruzzetti & Iverson, in press; Fruzzetti & Iverson, 2004). These individual skills are employed primarily to reduce invalidation, negative escalation, and out of control individual behaviors. They also help set the stage for accurate self-expression and validation, which are central to treatment in Stage 2.

Stage 2

Targets In Stage 2, emphasis is placed on improving communication and understanding through expression and validation skills and on reconditioning time together through relationship activation. As noted earlier, the core healthy transaction is one in which one partner is able to identify what he or she is thinking, feeling, wanting, etc., and communicating that accurately (*self-disclosure*), followed by the other partner understanding that experience and communicating that understanding back (*validation*). This two-step process precludes many dysfunctional alternatives. Because couples who are distressed (and individuals who are distressed) often have withdrawn and stopped engaging in meaningful activities, *relationship activation* is also an important goal in Stage 2.

Skills In Stage 2 of treatment, partners learn specific mindfulness and emotion regulation skills in order to discriminate and label private experiences effectively and to express them accurately (*accurate expression* skills). Partners learn *relationship mindfulness* skills to increase understanding of the other and *validation* skills to communicate that understanding to their partner. Relationship mindfulness skills include teaching clients how to be aware of their own emotional reactivity; how to connect the emotional reaction to its stimulus (e.g., partner's expression, behavior, events) in a non-judgmental manner. Partners learn how to notice and accurately label the emotions that are associated with the rising reactivity, and how to distinguish primary emotional responses (accurate or authentic emotions, such as sadness, shame, worry, etc.) from secondary emotional responses (reactions to primary emotion, such as anger). Partners also learn how to self-validate and mindfully describe situations, which further reduces emotional reactivity, and how to stay aware of longer term goals (e.g., "this is my partner, my love"). Finally, partners learn at least 8 ways to validate (communicate understanding, acceptance, and legitimacy) the other's experience verbally and non-verbally, and how to recover from invalidation.

Woven throughout Stage 2 are stimulus control and relationship activation exercises, which provide both an opportunity to practice skills and important "reconditioning" for each other. Partners practice different levels of intensity of being together (e.g., passively together, actively together, interactively together) with the idea that some of the negative reactivity that has been learned during long periods of relationship distressed can be "unlearned" (Fruzzetti & Iverson, 2004; in press).

Stage 3

Targets The main targets in Stage 3 are reducing destructive conflict by resolving or managing relationship problems and altering problematic interaction patterns. This stage typically includes problem-solving or problem-management skills employed to resolve individual life problems and thematic relationship problems. By this point in treatment, safety has been achieved, partners are both more in control of their relationship behaviors, and effective communication has become possible. In this stage the couple will refine their change strategies and problem management skills, and try to disengage from chronic, problematic interaction styles.

Skills *Problem/conflict management* are based on BMT problem-solving skills (Jacobson & Margolin, 1979), albeit with some important differences. For example, Couples DBT incorporates individual mindfulness so that partners can sort through what they want, accurately express their wants (e.g., wanting more acknowledgement of role as homemaker or bread-winner, requesting more help around the house, asking for more autonomy, etc.), give and receive validation, and effectively negotiate differences. In addition, effective resolution in Couples DBT may involve *accepting* the problem *or* solving it. *Observing* skills allow partners to notice problematic interactions patterns (e.g., engage-distance) or conflict themes (e.g., closeness vs. independence). Once observed, couples can return to the basic "two-step" dance of accurate disclosure/validation, and then negotiate, rather than simply recapitulating the problematic pattern.

Stage 4

Targets The target in Stage 4 is simply enhanced relationship closeness and intimacy. This is targeted in two ways. First, left over conflict is targeted for transformation into closeness. Second, relationship mindfulness is extended (and titrated) to as many couple interactions as desired by each partner so that he or she experiences the level of closeness desired.

Skills *Acceptance* skills involve using relationship mindfulness to recontextualize a "problem behavior" that is detracting from closeness and intimacy in the relationship. Partners learn how to "let go" of unnecessary suffering in the service of their relationship. These skills are influenced by the "radical acceptance" skills (e.g., turning the mind) taught in individual DBT (Linehan 1993b). Such skills are aimed at helping clients "let go" of unnecessary suffering (e.g., negative reactivity to the lack of change by the partner). The steps involved include: 1) *Individual mindfulness*: awareness that the tactics he or she has tried in order to get the partner to change is now maintaining the problem and is causing both partners to suffer. This includes a willingness to stop putting energy into trying to change the partner, and an acknowledgment that giving up the struggle for change likely means that the person will not get the specific behavior he or she was wanting, but may benefit from increased closeness (balancing short-term goals with long-term goals). 2) *Behavioral tolerance*: the partner decides to tolerate the behavior in question as opposed to continuing to react negatively to it or trying to get the partner to change. This includes tolerating and self-validating one's own disappointment about the lack of change (similar to grieving), as well as "letting go" of anger and judgments about the partner. 3) *Pattern awareness:* This step involves recognizing the consequences (emotional distance, reactivity, conflict,

less intimacy) of ongoing disappointment and anger that has resulted from an "extreme" focus on changing the partner's behavior. The consequences of trying to get the other person to change may be far more negative than the "problem" itself. 4) *True Acceptance and Synthesis of Conflict into Closeness:* In this final step, the partner recontextualizes the original problem behavior in manner that does not have the same negative valence. Of course, not all 4 steps must be completed to achieve significant improvements in closeness. Simply engaging in the process collaboratively may result in an important shift in interaction patterns vis-à-vis closeness in the relationship.

Research

Although individual DBT has been shown to be a highly effective treatment in more than 30 studies, applications to couples and families are very recent. Regardless, several studies suggest this is a promising approach: One recent study showed that DBT family interventions significantly augmented outcomes in individual DBT (Fruzzetti, 2004). In a study (just wrapping up) of couples with mixed individual and relationship distress, a couples group format was utilized. Partners reported significant improvements in individual distress and depression as well as significant improvements in relationship satisfaction, with improvements maintained at 3 month follow-up. Moreover, observational data showed significant improvements in validating responses (and decreased invalidating ones) from pre to post (Mosco & Fruzzetti, 2003), which mediated outcomes, supporting the model and its putative mechanism of change. In a community sample of families with a member with borderline personality disorder (or at least significant features of BPD) a family skill group demonstrated significant reductions in individual distress and burden, and increased empowerment (Hoffman, Fruzzetti, Buteau, et al., 2004). Other studies are underway. Clearly, much more research needs to be done, including direct comparisons with more established approaches. However, these initial results are promising.

Conclusion

Couples with partners with significant distress and psychopathology pose particular problems for most couple therapists. Couples DBT provides a coherent, integrated model, based on emotion regulation principles, relevant to both individual and relationship distress. The treatment is organized into 4 stages of disorder (or, severity), and includes relevant skills for each stage. Preliminary research suggests this may be a promising approach to treating multi-problem couples and families.

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Book Review *Treating Difficult Couples*

Edited by Douglas K. Snyder and Mark A. Whisman
Publication Date: May 2003 ISBN: 1572308826
448Pages List Price: $45.00
Review by Miriam Ehrensaft, Ph.D.

As the field of couples therapy has matured, our conceptualization of the interplay between dyadic and individual problems, such as physical illness or mental disorders, has become more sophisticated. Increasingly, the field is recognizing the recursive nature of individual and relational problems.

Certainly, *Treating Difficult Couples* is not the first book to address the role of special issues, such as depression or anxiety, in couples therapy (e.g., O'Leary and Beach's texts on depression and marriage). However, what distinguishes this book from others is its conceptual integration of a wide range of mental and physical health problems and their association with dyadic problems. Couples therapists seeking a conceptual framework on integrating dyadic and individual problems will be hard pressed to find a better reference book. From the point of view of research, the book makes a strong case for viewing the course of mental disorders in the context of interpersonal relationships. Given the current emphasis of NIH on mental disorders, it is an invaluable resource for anyone seeking to convince granting agencies that the search for novel approaches to improving mental and physical health should be placed squarely in the context of intimate relationships.

The editors, Snyder and Whisman, have done a superb job of selecting contributors who are experts in both research and clinical practice relevant to their particular area. The book takes a 'Boulder Model' approach to the problem of comorbid individual and dyadic problems, and the chapters present an excellent balance of research findings and practical suggestions. The book is divided into four parts. Part I is an overview of empirical and conceptual issues in managing emotional, behavioral and health concerns in couples therapy. Part II reviews couple-based treatments for emotional and behavioral disorders, including anxiety and depressive disorders, schizophrenia-spectrum disorders, substance abuse, sexual dysfunction, and partner abuse. Part III offers specific examples of adaptations to couples therapy for specific individual problems, including various personality disorders, Post Traumatic Stress Disorder, physical illness and aging and cognitive issues. The fourth and final section offers an insightful integration of the preceding chapters and highlights the bi-directional influence of individual problems and dyadic difficulties.

The book makes a truly substantive contribution to both to the fields of couples therapy and psychopathology. From a clinical perspective, the text offers hands-on techniques and case illustrations on ways to educate patients about the extent to which individual problems play a role in exacerbating their relational problems, as well as ways that relationship dysfunction impacts the course of individual psychological problems (e.g., substance abuse). All of this information is backed by state-of-the-art research and references for further reading. From the point of view of individual psychopathology, the book reviews findings that establish intimate relationships as having critical implications for the course and outcome of psychological disorders. Furthermore, the book highlights advances in the approaches to using the intimate relationship as a

tool for assessing and treating psychopathology. Thus, readers are guided to use the dyadic relationship to engineer lasting environmental change, and in so doing, to maximize the impact of therapeutic approaches for mental health disorders.

I would have liked a chapter addressing child behavior problems and parenting issues in the context of couples therapy, given the association of marital dissatisfaction with child internalizing and externalizing problems (e.g., Davies & Cummings, 1994). Also missing was a discussion of cross-cultural issues, such as differences in values and traditions that may arise in relationships of partners from different cultural or religious backgrounds. As a whole, though, the book represents one of the most important contributions to our field in the last decade. I recommend this book to both therapists in formation and more senior therapists. Moreover, the chapters on the integration of individual problems and relationship distress would be excellent conceptual reading for a graduate course on couples research.

This book will undoubtedly find its way to the bookshelves of couples therapists seeking up-to-the-moment information on helping couples struggling with special needs. Even more useful for the field of clinical psychology as a whole would be for the book to find its way to therapists conducting primarily individual therapy, so that their patients might also benefit from a couples based approach to their mental and physical health problems.

As such, my only significant criticism is of the book's title. I would have liked to see the book market itself more directly to researchers and therapists outside the field of couples therapy, perhaps by labeling the book as a powerful tool for challenging individual problems. It is this strength that will make me continue to reach for it for both individual and couples cases.

Book Review

Attachment Processes in Couple and Family Therapy

Edited by Susan M. Johnson and Valerie E. Whiffen
Publication Date: May 2003 ISBN: 1572308737
422 Pages List Price: $42.00
Review by: Nate Tomcik, M.A.

As a graduate student and novice couple therapist I've found that there are many books available to broaden my theoretical understanding of marital distress and strengthen my technical skill. *Attachment Processes in Couple and Family Therapy* was one of those rare books that took this process a step further and dramatically changed the way I think about couple therapy. A variety of disciplines are represented by the contributing authors of this book, who draw from the fields of developmental, clinical, and social psychology. The result is an interesting blend of complementary perspectives that emphasize the importance of understanding attachment style as an organizing theme by which individuals structure their relationships. For those not well steeped in the attachment style literature, a brief summary of the history of attachment research is presented as an introduction preceding the rest of the book's content.

The first section of the book is dedicated to providing a detailed argument for the clinical utility of attachment styles. A thorough review of attachment literature is presented, including the stability of attachment styles from infancy to adulthood and the role of adult attachment styles as a means to access support and regulate autonomy and relatedness in current romantic relationships. Central to the authors' point is the idea that dependency is the natural state of human relationships, which is oftentimes discouraged and even pathologized in individualistic cultures, such as ours, which place a high premium on self-reliance. Furthermore, the characteristic styles that humans develop to manage their dependency needs may either be adaptive or maladaptive, which paradoxically encourages or stifles effective autonomy. The second section of the book focuses on current interventions that utilize attachment theory in their approaches. Susan Johnson presents the role of attachment in EFT and Joanne Davila discusses effective ways to incorporate adult attachment styles in behavioral models of couple therapy. There are also a few chapters on family based interventions in adoptive families and for families with depressed adolescents. The third section of the book takes a look at the application of attachment based interventions for particular populations, including repairing disrupted infant-mother attachments, same sex couples, and the role of attachment in older adults. The final section of the book demonstrates the applicability of attachment based interventions with specific types of problems. I found the chapter on the effects of child sexual abuse on current couple relationships from an attachment perspective to be particularly useful.

In general I was impressed with the extensive array of perspectives and clinical applications of attachment theory presented in this book. I quite literally found every chapter of this book useful in expanding my knowledge of attachment theory in the context of couple and family therapy. I think this book should be required reading for both graduate students and practitioners looking to expand the depth of their interventions and gain a better understanding of attachment style as an organizing theme behind human relationships.

HOT OFF THE PRESS

In Press and Recently Published Literature

Clements, M. L., Stanley, S. M., & Markman, H. J. (in press). Before they said "I do": Discriminating among marital outcomes over 13 years. *Journal of Marriage and Family*.

One hundred couples were followed for 13 years from the premarital period well through the primary risk period for divorce. Results of discriminant analysis indicated that couples who remain satisfied, become distressed, and divorce can be reliably classified on the basis of premarital data. Furthermore, both previously identified demographic risk factors and couple interaction variables contributed to classification accuracy, suggesting that both types of variables play important roles in relationship outcomes. The method employed here addresses weakness in previous studies by (a) following couples for an extended period after marriage, (b) utilizing multiple validated self-report and observational measures, and (c) making predictions simultaneously for divorced, distressed, and satisfied couples.

Fals-Stewart, W., Kelley, M. L., Fincham, F. D., Golden, J., & Logsdon, T. (in press). The emotional and behavioral problems of children living with drug-abusing fathers: Comparisons with children living with alcoholic fathers and nonsubstance-abusing fathers. *Journal of Family Psychology*.

The emotional and behavioral problems of 8-12 year-old children living in two-parent families with drug-abusing fathers (N = 40) were compared to those of children living in families with fathers who abused alcohol (N = 40) and children living with fathers who did not abuse drugs or alcohol (N = 40). Mothers in all of these family types did not abuse drugs or alcohol. Children living with fathers who abuse drugs experienced more internalizing and externalizing symptoms than children living with fathers who abused alcohol or children whose fathers did not abuse drugs or alcohol. Interparental conflict and parenting behavior partially mediated the relationship between family type and children's adjustment.

Fortunata, B., & Kohn, C. S. (2003). Psychosocial and Personality Characteristics of Lesbian Batterers. *Violence & Victims, 18,* 557-568.

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 Nonbatterers). 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 Nonbatterers. 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.

Hall, J.H. & Fincham, F.D. (in press). Self-forgiveness: The stepchild of forgiveness research. *Journal of Social and Clinical Psychology*.

Although research on interpersonal forgiveness is burgeoning there is little conceptual or empirical scholarship on self-forgiveness. To stimulate research on this topic a conceptual analysis of self-forgiveness is offered, in which self-forgiveness is defined and distinguished from interpersonal forgiveness and pseudo self-forgiveness. The conditions under which self-forgiveness is appropriate are also identified. A theoretical model describing the processes involved in self-forgiveness following the perpetration of an interpersonal transgression is outlined and the proposed emotional, social-cognitive, and offense-related determinants of self-forgiveness are described. The limitations of the model and its implications for future research are explored.

Kachadourian, L.K., Fincham, F.D., & Davila, J. (in press). The tendency to forgive in dating and married couples: Association

with attachment and relationship satisfaction. *Personal Relationships*.

Given the positive benefits associated with interpersonal forgiveness, the current investigation examined the tendency to forgive in romantic relationships. Two studies tested the hypothesis that the tendency to forgive mediates the association between attachment models of self and other and relationship satisfaction in dating (n = 184) and marital relationships (n = 96). In addition, the extent to which the tendency to forgive predicts forgiveness of an actual transgression was examined among married couples. The tendency to forgive partially mediated the relation between model of other (relationship partner) and satisfaction for those in dating relationships and for husbands. In addition, for those in marital relationships, the tendency to forgive partially mediated the relation between model of self and satisfaction. In addition, for wives, endorsing a greater tendency to forgive was related to forgiveness of an actual transgression, regardless of the severity of that transgression. For husbands, endorsing a greater tendency to forgive was related to forgiveness of an actual transgression, but only for more severe transgressions. Results are discussed in terms of who is more likely to forgive and the role that the tendency to forgive plays in romantic relationships.

Leone, J., Johnson, M., Cohan, C.L., & Lloyd, S. (in press). Consequences of domestic violence for low-income, ethnic women: A control-based typology of male-partner violence. *Journal of Marriage and Family*.

The current study used a random sample of 563 low-income women to test Johnson's (1995) theory that there are two major forms of male-partner violence, situational couple violence and intimate terrorism, which are distinguished in terms of their embeddedness in a general pattern of control. The study examined the associations between type of violence experienced and respondents' physical health, psychological distress, and economic well-being. Analyses revealed three distinct patterns of partner violence: Intimate Terrorism, Control/No Threat, and Situational Couple Violence. Compared to victims of control/no threat and situational couple violence, victims of intimate terrorism reported more injuries from physical violence and more work/activity time lost due to injuries. Compared to women who experienced no violence in the previous year, victims of intimate terrorism reported a greater likelihood of visiting a doctor, poorer health, more psychological distress, and a greater likelihood of receiving government assistance.

Sanford, K. (in press). Attributions and anger in early marriage: Wives are event-dependent and husbands are schematic. *Journal of Family Psychology*.

Two types of attributions believed to predict anger in married couples were investigated. Wives' anger was expected to be predicted by event-dependent attributions, appraisals based on the unique aspects of one's current situation. Husbands' anger was expected to be predicted by schematic attributions, appraisals based on one's global sentiment in the relationship. Seventy-seven recently married couples attended two assessment sessions, and each couple identified four incidents pertaining to unresolved relationship issues. Participants rated their event-dependent attributions and their anger prior to a discussion for each incident. They also completed questionnaires regarding schematic attributions and relationship sentiment. Hierarchical linear modeling was used to distinguish between the two types of attributions. Strong support was found for the expected gender differences. Results suggest that wives are particularly attentive to the details of interpersonal interaction.

Sanford, K. & Rowatt, W. C. (in press). Emotion and attachment in marriage and roommate relationships: When is negative emotion positive for relationships? *Personal Relationships*.

Three types of negative emotion (hard, soft, and fear-based) were believed to be integral to functioning in close interpersonal relationships. Hard emotion includes feeling angry, soft emotion includes feeling sad or hurt, and fear-based emotion includes feeling anxious or threatened. Married persons (Studies 1 and 3) and college roommates (Study 2) rated the extent to which they would feel different emotions in response to a variety of negative partner behaviors. Confirmatory factor analysis supported the distinction between the three types of emotion. Although hard and soft negative emotions were highly positively correlated, they had opposite effects when used to predict relationship functioning. After controlling for shared variance between the emotions, soft emotion was associated with positive relationship functioning (high satisfaction, low conflict, and low avoidance) and hard emotion was associated with negative relationship functioning (low satisfaction, high conflict, and high avoidance). In contrast, fear-based emotion was strongly, positively, and uniquely associated with relationship anxiety.

List of Newly Developed Measures for Assessing Couples/Families:

We are beginning to compile a list of measures that SIG members have recently developed, as well as those that they find most useful (in both practice and research). Here are the measures we've collected so far. We hope to develop this list on the SIG website, in conjunction with Brian Baucom, so that it will be easily accessible to all.

Also, we would like to thank Scott Stanley (Sstanley82@aol.com) for his input on this list of measures. Last fall, he wrote a paper for an NICHD measurement conference on couples; thus he has thoroughly reviewed constructs and measures relevant to couple functioning. His paper has a substantial appendix containing couples constructs and measures, and in the paper he also describes an overall context for where the field is heading. To read the paper, access the following URL: http://www.popcenter.umd.edu/conferences/mifd/papers/stanley.pdf

Please e-mail any newly developed measures to Eric Gadol (gadol@unc.edu) for inclusion in the fall SIG newsletter.

Developed by SIG members:

- Matthew Johnson (mjohnson@binghamton.edu) has developed and published a rating system for observing affect in dyadic interactions. It is called the Behavioral Affective Rating System (BARS).
    - Johnson, M. D. (2002). The observation of specific affect in marital interactions: Psychometric properties of a coding system and a rating system. *Psychological Assessment, 14,* 423-438.
- Jennifer Langhinrichsen-Rohling (jlr@usouthal.edu) has developed a measure called the Unwanted Pursuit Behavior Inventory (Palarea & Langhinrichsen-Rohling, 1998) that assesses the occurrence, frequency and impact/ degree of fear associated with experiencing a variety of unwanted pursuit behaviors (including those that would constitute stalking) that can occur during times of relationship separation and/or break-ups.
    - Langhinrichsen-Rohling, J., Palarea, R. E., Cohen, J., & Rohling, M. L. (2000). Breaking up is hard to do: Unwanted pursuit behaviors following the dissolution of a romantic relationship. *Violence and Victims, 15,* 1-17.
- Gary Birchler and Bill Fals-Stewart (Gary.Birchler@med.va.gov) have developed a very brief measure that assesses a couple's maladaptive responses to conflict. It is still used in ongoing BCT and shown to track a mechanism of change over the course of treatment.
    - Birchler, G. R., & Fals-Stewart, W. (1994). The Response to Conflict scale: Psychometric properties. *Assessment, 1,* 335-344.

Most Useful to SIG members:

Commitment measures:

- Johnson, M. P., Caughlin, J. P., & Huston, T. L. (1999). The tripartite nature of marital commitment: Personal, moral, and structural reasons to stay married. *Journal of Marriage and the Family, 61,* 160-177.
- Stanley, S. M. & Markman, H. J. (1992). Assessing commitment in personal relationships. *Journal of Marriage and the Family, 54,* 595-608.

Communications Pattern Questionnaire

- Heavey, C. L., Larson, B., Christensen, A., & Zumtobel, D. C. (1996). The communication patterns questionnaires: The reliability and validity of a constructive communication subscale. *Journal of Marriage and the Family, 58,* 796-800.

Willingness to Sacrifice

- Van Lange, P. A. M., Rusbult, C. E., Drigotas, S. M., Arriaga, X. B., Witcher, B. S. & Cox, C. L. (1997). Willingness to sacrifice in close relationships. *Journal of Personality and Social Psychology, 72,* 1373-1395.

Marital Satisfaction Inventory – Revised

- Snyder, D. K. (1997). *Manual for the Marital Satisfaction Inventory - Revised*. Los Angeles, CA: Western Psychological Services.
- Means-Christensen, A. J., Snyder, D. K., Negy, C. (2003). Assessing nontraditional couples: Validity of the Marital Satisfaction Inventory-Revised with gay, lesbian, and cohabiting heterosexual couples. *Journal of Marital and Family Therapy, 29,* 69 – 83.

Conflict Tactics Scale – Revised

- Straus, M. A., Hamby, S. L., Boney-McCoy, S., Sugarman, D. B., Finkelhor, D., Moore, D. W., & Runyun, D. K. (2003). *Conflict Tactics Scales Handbook and Revised Forms*. Los Angeles, CA: Western Psychological Services.

Dyadic Adjustment Scale

- Spanier, G. B. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and the Family, 38,* 15-28.

Areas of Change Questionnaire

- Margolin, G., Talovic, S., & Weinstein, C. D. (1983). Areas of Change Questionnaire: A practical approach to marital assessment. *Journal of Consulting and Clinical Psychology, 51,* 944 – 955.

ANNOUNCEMENTS

♦ Barry Ginsberg's (Bginzer@aol.com) book, **Relationship Enhancement Family Therapy,** was originally published in 1997 by John Wiley & Sons (at $100.00 +). It is now being self-published by The Relationship Enhancement Press in a paperback edition for $14.95 plus $3.50 postage & handling. It has a comprehensive chapter on Relationship Enhancement Couples Therapy. Anyone who would like to purchase a copy can send a check for $14.95 plus $3.50 postage & handling to:

Barry G. Ginsberg, Ph.D.
The Center of Relationship Enhancement
P.O. Box 5268
Doylestown, PA 18901

♦ Bill Fals-Stewart and Gary Birchler are offering an all day Institute and a 90-minute Workshop on "Learning Sobriety Together" at the 8th Annual Smart Marriages Conference in Dallas, June 8-11. This unique conference attracts over 1500 people interested in marriage education; several other SIG members are prominently and regularly involved in the program. Please contact Bill or Gary for additional information.

SIG Family Tree

At our SIG dinner at the 2003 AABT conference in Boston, we began tracing our academic genealogy. I attempted to decipher the names, lines, scratch marks, and arrows (I even discovered a few nonrecursive models), and the Family Tree appears on the next page, as best as I could reconstruct it. If you would like to make changes or additions, please send an e-mail to me at fhughes@utk.edu. This is a work in progress, so there are many branches that still need to be completed; the information on which this initial family tree is based includes the information provided by members at the last SIG dinner and information I have gleaned from e-mails sent to me by SIG members.

On a personal note, I have had to reconstruct my own academic genealogy for a graduate course this semester. Because of that project, I have come to better understand the development of our field as a whole, and I am extremely proud of my academic heritage. I also am proud to part of a group that strives to preserve its legacy, as we have done with the creation of this Family Tree.

A couple of notes: SIG members received their own "boxes" if they had "descendants" listed on the original family tree. Parentheses indicate a student who trained, but did not earn their Ph.D., under a particular adviser. Also, the listing of names is rather arbitrary, determined only by space limitations (i.e., the order of names is not chronological or based on importance).

~FMH

Our "Roots" (in alphabetical order):

Don Baucom	Norman Epstein
Frank Fincham	John Gottman
Kurt Hahlweg	Kim Halford
Neil Jacobson	Dan O'Leary
Matt Sanders	Doug Snyder
Bob Weiss	

Pictures of the "family tree dinner" are located on our SIG website at http://www.aabtcouples.org/home.htm, as is a graphical version. Many thanks to Farrah for her hard work on transcribing the original to this version!