Couples Research & Therapy *NEWSLETTER*

The Newsletter of the Couples Research & Therapy ABCT–SIG, Spring/Summer 2007

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Couples SIG *Newsletter* Editors:

William A. Aldridge II, M.A.
238 Davie Hall
Psychology Dept. UNC-CH
Chapel Hill, NC 27599-3270
will_aldridge@unc.edu

Diana L. Brown, M.S.
Philadelphia College of Osteopathic Medicine
Philadelphia, PA
dianabr@pcom.edu

Couples and Health: An Exciting Opportunity to Marry the Fields.

Tina Gremore[1], Nicole Pukay-Martin[1], Don Baucom[1], Laura Porter[2], Jennifer Kirby[1], Frank Keefe[2], and Jasmine Hudepohl[1]

[1]*University of North Carolina at Chapel Hill*
[2]*Duke University Medical Center*

If you are reading this article, there's a good chance you are interested in conducting research with or are treating couples. You may be thinking, "What does a health article have to do with me? I'm a couple researcher!" Good, keep reading and we'll tell you! We'd like to introduce you to the couples and health area, if you are not already acquainted with it. We'll tell you about our latest venture into the health arena with our couples and breast cancer intervention, why couple researchers are so important in working with couples with health issues, and how you might break into this area if you find your curiosity sufficiently piqued.

For most of us, our core training in the relationship domain is based on the fundamentals of relationship functioning, enhancing adaptive relationships, and alleviating discord among the maritally dissatisfied. In Cognitive Behavioral Couple Therapy (CBCT), our focus has been primarily on assessment and intervention of important behaviors, cognitions, and affect while couples develop and change over the course of a relationship.

If we look at couples from a developmental perspective, they will undoubtedly confront a variety of stressors and challenges. As couple therapists, we strive to understand adaptive and healthy ways to confront normal developmental stressors such as relating to in-laws, having and raising children, dealing with finances, balancing demands of careers, transitioning to retirement, as well as coping with end of life issues. In addition to these common stressors, some couples must also deal with atypical stressors that are a bit outside normal developmental milestones. Complicating life factors such as psychopathology (either with their spouse or with other family members), interpersonal traumas such as infidelity, childbearing difficulties or infertility, provision of care to an ailing relative, and health issues within the couple constitute more than just typical garden-variety distress and can create many challenging situations for couples and their families. As couple therapists, we must recognize these complicating factors and develop ways of conceptualizing these stressors and aiding couples with effective ways of coping with them.

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Letter from the Co-Presidents

There have been many SIG-related activities since the last newsletter, including newly elected SIG officers, award presentations, and several SIG-related events at the conference in Chicago. In this column, we will fill you in on each of them, as well as give you a hint of things to come.

First, at the 2006 conference, we elected a **new Treasurer/Membership Chair,** Lorelei Simpson. We are very grateful for Lorelei for stepping up for this important role in the SIG!! If you need to contact Lorelei, her email is lsimpson@smu.edu. We also want to express our appreciation for all the service that Shalonda Kelly provided in this role over the last two years. She did a great job with the various duties of the position. Tasks like tracking contact data and collecting dues from the busy members of our large SIG are probably a bit like herding cats, so kudos to Shalonda for her hard work.

Weiss Graduate Student Poster Awards were also presented at the 2006 SIG meeting. There were two first place winners, each awarded $125: (1) Janette L. Funk mentored by Ronald D. Rogge at the University of Rochester for the poster "Can we detect change over time? Assessing the sensitivity to change in marital satisfaction measures" and (2) Soonhee Lee, who presented "Moving beyond the limitations of self-report data: Validation of an implicit measure of relationship satisfaction" with Ronald D. Rogge and Harry Reis. Third place (and $50 award) went to Lindsey A. Einhorn, mentored by Howard J. Markman and Scott M. Stanley of the University of Denver, for the poster "The impact of economic strain on marital satisfaction." Thanks to all the committee members for their review of the candidates and congratulations to the students for their excellent work!

There were also several excellent **SIG-sponsored events at the 2006 conference**. We want to thank Matt Sanders for the excellent preconference event "The Dissemination of Evidence-Based Family Interventions: Lessons Learned," Brian Doss and Erika Lawrence for moderating the panel discussion on incorporating couple and family processes into the DSM-V, and Kristi Coop Gordon and Amy Holtzworth-Munroe for moderating the panel discussion on empirically supported treatments in couple and family therapy. These events were very stimulating and generated much productive dialogue among members of the SIG and others.

The Couples SIG was also represented by four excellent posters at the **SIG Exhibition and Cocktail Hour**. We would like to thank Keith Sanford, Laura Watkins and colleagues, Kathryn Carhart & Felicia Pratto, and Michelle Leonard and co-authors for presenting their work in this forum.

We are already looking forward to next fall's conference in Philadelphia! SIG members weighed in on topics of interest for this year's preconference event both at the November meeting and through subsequent emails. Out of all the suggestions, sex proved to be most popular (surprising?). We are very fortunate to announce **this year's preconference event: "Integrating Psychobiosocial Sex Therapy Techniques into Couple Therapy"** by **Barry McCarthy, Ph.D.** Dr. McCarthy is a clinical psychologist, a professor of psychology at American University, a certified sex and marital therapist, and the author of 71 professional articles, 19 book chapters, and 11 lay public books about relationships and sexuality including Metz and McCarthy's "Coping with Erectile Dysfunction" (which won the Society for Sex Therapy and Research consumer book of the year) and the 2007 book "Men's Sexual Health" by McCarthy and Metz. Please be sure to come to this seminar on the evening of Thursday November 15th in the conference hotel (exact location and times TBD).

Several ABCT-wide changes and future happenings were announced at the SIG Leaders meeting that we want to pass on to you. First, the ABCT board will be meeting in June 2007 to discuss the organization's 3 year strategic plan. If you have input on ABCT that you would like considered at this meeting, please let Sarah and Beth know, and we will pass this along through the SIG liaison. Second, David Reitman, the Behavior Therapist editor, encouraged SIG members to submit articles to be published in tBT. tBT is abstracted on PsycInfo and peer reviewed. Finally, to keep you abreast of what ABCT governance is working on, they have announced 4 ABCT mission points: 1. Providing a professional home to our members (SIGs like ours are playing a key role in meeting this goal). 2. Spread the voice of CBT more broadly. 3. Improve our governance structure. 4. Improving technology (e.g., the listserv, the ABCT and SIG websites). In response to the fourth mission point, the SIG leaders put forth a general plea that SIGs receive some help with our websites from ABCT; right now that doesn't look like it will happen but the request was loud and clear.

Again, feel free to contact us with any feedback or comments that you may have. Have a great summer!

- Sarah Whitton and Beth Allen

Editors' Note

Break out your kites and bikes but watch out for mosquito bites! Spring has sprung and with it comes the birth of a new edition of the Couples SIG Newsletter.

A collection of prominent leaders in our field have contributed to this inspiring edition of the SIG Newsletter. Tina Gremore and her colleagues at UNC and Duke and Sara Bauer and Tammy Sher at IIT have contributed wonderful articles on health-related intervention research in the couple field. In addition, Rise VanFleet, a leader in the Filial Therapy field, has contributed an inspirational article highlighting this unique form of family intervention. We owe thanks to our contributors who have donated their time, effort, and commitment to the SIG. We'd also like to thank all who responded to the call for "Kudos" and "In Press" information!

With open arms, but saddened hearts, we are approaching our fourth and final newsletter with the SIG. With Will and Diana both burning midnight oil to work on their dissertation projects and Diana giving birth to her first child (Fiona Laurenn Brown) on April 30, we welcome a shift to neutral gear as we wind down the mountain but will surely miss our semiannual contribution to the SIG!

For our final newsletter we will focus on the 2007 ABCT Convention and hope to gather articles pertaining to sexual issues in couple research and therapy, which is the topic of our SIG preconference event. Please feel free to pass on your ideas for the fall edition of the newsletter!

- Diana Brown
and Will Aldridge

Comments? Criticisms? Suggestions? Crazy ideas? Send them to the editors!

Contact Will at
will_aldridge@unc.edu
and Diana at
dianabr@pcom.edu

"COUPLES AND HEALTH"

FROM PAGE 1

Broadly speaking, couple researchers have given less attention to how to work with couples around health and medical issues than they have with other age appropriate developmental stressors. Health problems can be very difficult for couples to address; they often engender emotional reactions such as fear, guilt, and/or worry for themselves as individuals as well as concerns about their relationship. Health problems also may necessitate adjustments in the couple's lifestyle. For example, health declines may cause functional impairment resulting in inability to work and creating financial stress for the couple. Severe functional impairment may require one partner to move into a caregiving role, significantly shifting the couple's relationship.

Additional distress and challenge occurs for couples when the health stressor is not age appropriate. For example, when a woman in her early 30s develops breast cancer, the diagnosis of cancer at this young age is not only psychologically traumatic, but it also often involves aggressive medical treatment. Current medical treatments are very effective in lengthening survival; however, they can have deleterious psychosocial consequences. Couples may be faced with issues such as infertility, early menopause, concerns about body image, difficulty with sexual intimacy, and fears of recurrence, not to mention the ways the partners' quality of life are affected by these issues. How do we help couples deal with these disruptive health stressors that have vast implications for the physical and psychological health of the patient, her partner, and her family?

In this article, we focus on how relationships can be complicated by medical problems, and we ask the question: do you have to be a full-fledged health psychologist and medical expert to help these couples coping with medical issues? We think the answer is NO (whew!). Furthermore, couple therapists bring an expertise to the table that we believe is helpful in the medical psychology/health arena, specifically to couples coping with medical difficulties. What we also find promising is that there appears to be an increased awareness of the need to include couples experts in the care of patients with medical illness, both within the medical field as well as with funding agencies such as the National Institute of Health. In fact, we are currently in Year 4 of a 5-year study funded by the National Cancer Institute to examine the effects of a couple-based intervention for women with breast cancer and their partners. Thus, many of the examples in this article come from our understanding of breast cancer; although we believe that our work with cancer patients illustrates only one area of health that can benefit from the contribution of couple researchers. Moreover, the general principles we will discuss have applications to any health issue.

Why intervene on the couple level for health problems?

It may not be immediately clear how a couple-based intervention can benefit individuals with a medical disorder. A common response we might hear from couples approached for such an intervention is, "If I'm sick with a medical problem, why would I need a psychological intervention with my partner?" Additionally, someone in the medical world might wonder why a couple intervention would be indicated when an individual has a medical problem. Well, there are several reasons. Broadly speaking, a medical disorder occurs within the context of the couple's relationship, and the couple's dynamics influence how the couple copes with physical illness. Singing to the choir, we all know that the environment influences behavior, in both positive and negative ways. Intervening with the couple gives us a chance to affect the environment in helpful ways and to use both individual and couple level strengths to optimize the physical and psychological health of the individuals in addition to enhancing

the couple's relationship. We have an opportunity to teach couples how they can enhance their efforts together as a team and use their relationships as a resource to address medical problems. We can help them conceptualize the challenges they will likely encounter, and address the disease as a couple rather than viewing it as an individual problem.

Intervening at the couple level for medical issues may be important because couples may not understand the centrality of the relationship to effective coping. Specifically, the partner may not appreciate that this is a "couple level issue" and that working as a team can contribute to optimal recovery. Medical diagnoses such as heart disease and diabetes provide good examples of how the relationship context could be detrimental if both spouses do not engage in couple-level coping. For example, imagine that the male partner of a dyad is diagnosed with heart disease, and his physician recommends lifestyle changes. His wife, although concerned about his health, views this diagnosis as her partner's medical problem; she may think, "If he cares about his health, he had better change his lifestyle." She does not have the genetic pre-disposition for heart disease, so she has been able to eat a high fat diet without obvious negative health consequences. Subsequently, she sees no need to alter her eating behavior or exercise. Since she does most of the grocery shopping, she purchases the foods they have always eaten which are high in fat and contraindicated in her husband's "heart healthy" diet. Thus, he will be apt to consume the unhealthy choices that are habitual for him as they are easily accessible in their home and served for dinner most nights. On the other hand, if both partners were to view his medical condition as a couple's issue, they may think of a lifestyle change as important for their well-being as a couple. Perhaps she would be more motivated to work together to increase her health behaviors by decreasing her fat intake and increasing exercise, thus creating support for him around initiating these changes which may in turn be more helpful in building and maintaining his motivation. At a very practical level, aiming at the same health and lifestyle goals might influence the foods they choose to keep in their home, making it less likely that either would have easy access to choices that are not heart healthy. Although making some lifestyle changes are extremely difficult, couples working as a team may enhance their capacity to make meaningful adjustments to promote and sustain their individual health as well as their health as a couple (Sher & Baucom, 2001).

As clearly illustrated in the example above, the directives for behavior change do not occur in a vacuum, but rather in a social context of which the partner is a huge part. Partners can help facilitate change or create barriers; even when partners recognize that the illness is a couple level issue, their impact can be inadvertently negative when they are trying to be helpful. For instance, in satisfied relationships in which one person has osteoarthritis, research has shown that very well-meaning partners can inadvertently interfere with pain management. Especially when they are happy in their relationship, partners do not like seeing their sweeties in pain and want to help their partner with tasks that might cause pain. There is a tendency, therefore, for healthy partners to take on many of the daily tasks that require physical activity. Although in the short term these caring partners decrease their partner's pain from movement, in the long run, they can upset the delicate balance between activity and rest by doing too much for their partners. These concerned partners can inadvertently decrease the activity of an arthritis patient to the point that it creates more pain for them in the end (Keefe, Caldwell, Baucom, Salley, Robinson, Timmons, Beaupre, Weisberg, & Helms, 1996; 1999).

Furthermore, if we think about the importance of spousal social support in coping with difficulties and distress, we have another reason to intervene on the couple level. Of the relationships one has in his or her lifetime, the marital relationship is one of the most significant. Research shows that spousal support may play a unique role in adjustment; people often describe their partner as the first person they go to when things are tough, and other sources of support do not seem to be able to compensate for deficits in spousal support (Julien & Markman, 1991). When women are diagnosed with and treated for breast cancer, they often comment that emotional support from their spouse is a key component of their well-being during and after the breast cancer. Conversely, women with breast cancer experience distress if they perceive that support is not forthcoming from their partners (Manne, Ostroff & Winkel, 2005). Additionally, not only do women with breast cancer need support, but their partners often need support as well. Interestingly, men often engage in protective buffering and inhibit expressing their thoughts and feelings related to the breast cancer, presumably so they will not "burden" their wives. However, research shows that the opposite behaviors seem to be more helpful. Increased levels of expression from males is associated with positive outcomes; women feel more supported when their husbands are sharing their own emotions with the women, specifically around the breast cancer (Manne, Sherman, & Ross, 2004). Thus, communicating openly about the impact of breast cancer seems to be more beneficial than trying to protect each other from negative feelings. These findings point out what we often experience clinically; partners want to be of help and be supportive, but they do not know what is helpful. As relationship experts, we can help them understand how to be of assistance to their loved one.

What do we know as couple therapists that we can bring into the health arena?

Part of the unique perspective we bring is our understanding of how couples can cope as a team with medical stressors. Couples may not have all of the necessary resources to figure out how to optimize their coping during this time, especially if they are dealing with life-threatening, physically-demanding, and time-

consuming medical interventions. That's where we come in! We can tailor our clinical intervention to the challenges couples are facing, educate them with regard to what to expect, and teach them how to optimize their adjustment and maintain a positive quality of life in the face of this medical difficulty. We guide them through conversations to elucidate the issues and conceptualize the problems they encounter. We normalize and validate their experience and promote understanding of the ways in which they can support and care for each other. We aid in providing a psychological and relational understanding to their medical diagnosis and treatment. We can encourage them to use positive and adaptive ways to cope with very challenging medical stressors, reinforce the positive ways they are currently coping, and teach them skills that promote optimal functioning.

As couple therapists, we understand the system within which the couple operates and can use this understanding to bolster the resources of the couple and to help them to optimize their adaptation to a health stressor. Often, each partner is the other's biggest advocate; we have the opportunity to affect the closest person and, therefore, the context within which the medical disorder operates. We understand the importance of support behaviors and can assist couples in determining what would be most helpful for each partner while dealing with the medical stressor. We can educate the partner with regard to specific ways to help the patient. We also understand when ineffective communication may interfere with optimal functioning; thus, we can identify barriers and intervene to decrease unproductive interaction patterns.

Principles of adaptive and healthy relationship functioning continue to hold when one person in the dyad must face life with a medical illness. As couple therapists and researchers, we have a great deal of knowledge about how people should love, support, and communicate with each other; nothing about having a health problem changes that! Having a medical problem accentuates the need to use good relationship skills to best adapt in a psychologically healthy way that will promote the physical and emotional health of both partners. Our general couple's principles provide a course of action regarding how to help couples use their best resource, their relationship, to adapt to the demands of the health stressor.

One of our goals as couple therapists, and this applies to health issues, is to decrease behaviors that we know are maladaptive and unhelpful. In all contexts, criticism, disdain, contempt, chronic avoidance/withdrawal, and inappropriate emotional over-involvement are negative predictors of relationship satisfaction. These behaviors continue to limit and deter couples from joining together when medical problems are present. General principles of couple's therapy may be needed to teach more adaptive communication skills centered on how the couple regulates negative affect, shares thoughts and feelings, and makes decisions around the medical concern.

On the positive end of the spectrum, we know that when couples use open and constructive communication skills, each partner feels: (a) safe to express his/her thoughts and feelings; (b) heard and understood while communicating; (c) safe to talk about what they need and to problem solve about how to meet those needs in healthy ways; and (d) intimate and connected emotionally. Ideally, when couples are functioning at an optimal level, each individual feels supported, validated, accepted and respected for his/her individuality and unique contribution to the relationship. Healthy couples have a collaborative rather than a competitive style. Happy couples share positive and enjoyable recreational activities that promote closeness and connection as a couple. Also among psychological healthy couples, balance and equality is valued, and the relationship creates a context that fosters both individuals' growth. Roles are somewhat flexible, such that during times of stress, partners can shift responsibilities to take care of a partner in need. For instance, if a medical problem produces functional impairment and there is a persistent imbalance in role responsibilities, the healthy couple approaches this shift mindfully and intentionally. They may negotiate new ways to contribute to the relationship so that they each feel valued and respected. Decreasing negative and enhancing positive ways of relating may be important in helping the couple utilize all of their individual and relationship resources to address the demands of the medical illness.

Ok, you've convinced me that this is important and needed; how do I develop a couple-based treatment for a medical problem?

Within the couples and health arena, you have the opportunity to develop creative interventions as another way of helping equip couples for the wide variety of challenges they will face in navigating life. To begin this creative process, your first task will be to conceptualize how you want to intervene with the medical disorder.

Baucom, Shoham, Mueser, Daiuto, and Stickle (1998) outline the ways in which couple- and family-based interventions can be applied in different ways, depending on the presenting difficulties and issues confronted by the couple or family. These authors describe three different categories of couples based treatments: general couple therapy, disorder- specific couple intervention and partner-assisted couple intervention. If a couple is not satisfied with their relationship, the explicit focus of treatment is to intervene on the distressed relationship. In this case, general couple therapy is indicated and various forms have been deemed efficacious or possibly efficacious for treating relationship distress (e.g., BMT, EFT, Insight-oriented). However, for couples presenting with medical difficulties, disorder-specific and partner-assisted interventions will be helpful regardless of couple distress.

A disorder-specific intervention for health focuses on the ways in which a couple interacts or addresses situations related to the individual's medical diagnosis. This type of intervention explicitly targets relationship issues that might contribute to positive coping, or the maintenance or exacerbation of the medical problem as well as psychological and relationship issues secondary to the medical problem. Especially among couples who are not distressed, disorder-specific interventions can help couples increase awareness of some of the challenges they will encounter and provide a supportive context within which couples can discuss how to address these issues together. These interventions can also help couples to enhance and build on their current relationship tools to optimize positive communication and support. From our couples and breast cancer research, we know that how the couple deals with the diagnosis and treatment of breast cancer as a couple has implications for each partner's individual psychological and emotional functioning as well as the quality of their relationship (Baucom, Heinrichs, Scott, Gremore, Kirby, & Zimmermann, et al., 2005; Scott, Halford, & Ward, 2004). Initial findings from our breast cancer study indicate that global relationship quality does not predict adjustment to breast cancer; however, the quality of communication and partner responses to breast cancer does predict women's adjustment (Porter, Baucom, Kirby, Gremore, & Keefe, 2007). These findings clearly indicate that a strong relationship is simply not enough to get a couple through this challenging time! The couple must react in specific and appropriate ways to foster their effective coping. Clearly, this responsibility highlights the importance of a targeted intervention that guides couples through the challenges of coping with medical illness.

As an example of what a disorder-specific health intervention might look like, our breast cancer intervention targets how the couple can share thoughts and feelings about breast cancer to increase instrumental and emotional support, as well as how the partners can use good decision-making skills to navigate the life changes associated with having breast cancer. Because sexuality and body image are common concerns among patients with breast cancer and their spouses, we emphasize the ways couples can use support and decision-making skills to understand and adjust to the changes they may experience in these domains. Depending on the needs of the couple, the intervention may involve teaching patients to relate differently around issues of sexuality and/or may involve providing psycho-education regarding the effects of chemotherapy and hormone-inhibiting drugs on sexual desire.

Although the experience of breast cancer involves numerous challenges, many couples also report "post-traumatic growth" or that their values and their priorities in life have changed as a result of having cancer. In our couples-based program for breast cancer, we specifically target trying to maximize growth by having couples reevaluate their priorities and make behavioral changes to live consistently within those values whether they are to work less, spend more time with family, etc. In essence, from a cognitive-behavioral perspective people are developing different standards in life with the attendant need to translate those into specific behaviors. As cognitive behavioral therapists we know a great deal about how to help couples through this process to create meaningful change out of their experience with illness.

In addition to disorder-specific interventions for non-distressed couples, partner-assisted interventions can be beneficial when working with an individual with health issues. In this type of intervention, the individual with the medical illness is the identified patient, while the partner plays the role of surrogate therapist or coach in assisting the patient. The partner is instructed on how to best support the person with the medical illness as he/she attempts to make the necessary health behavior changes. In this way the marital relationship helps to support the treatment plan by providing an in-home "coach" to help the patient follow the medical plan; the marital relationship is not the target of the intervention per se. For instance, when a person has severe type 2 diabetes, he/she must check insulin levels and administer insulin shots if oral medications have been ineffective. Using a partner-assisted intervention model with a spouse with diabetes, the partner is taught to encourage the patient to monitor his/her blood sugar and take prescribed medication. The partner serves as a coach to encourage the patient to follow-through with his/her treatment plan. With this type of intervention, the partner reinforces the individual's appropriate health behaviors, but the intervention does not target or significantly alter how the couple interacts around the disease beyond the partner being a coach or cheerleader.

Using disorder-specific and partner-assisted interventions assumes that the medical problem occurs in the context of a satisfied, well-functioning relationship. But, you might ask, what do I do if the couple is distressed? Well, if you are following a research protocol that does not directly address relationship distress, you do your best to stay within protocol guidelines and refer the patients to couple therapy. If you are in clinical practice or have the freedom to be more creative, then you will want to do general couples therapy, often first, with the goal of addressing the marital problems and increasing the ability of the couple to work together effectively around the disorder. However, the extent to which you intervene on the relationship distress will depend on the level and impact of the distress within the couple. Is the distress directly contributing to the health problems or interfering with optimal management of the disease? If so, treat the relational distress. Can the couple work together to face the disease despite their difficulties? If yes, target the disease first; in fact, learning to work together as a team to approach a medical problem often may be very beneficial to a martially distressed couple. As a general rule of thumb, treat the distress to the extent that it interferes with the disorder-specific or partner-assisted intervention.

How do I enter into the medical world - do I need to become an expert in a disease to treat a couple with a medical disorder?

We think it is important to expand and develop some new areas of expertise if you work with couples experiencing health concerns. However, the medical knowledge you will need is not insurmountable. You certainly do not need to obtain a biology or medical degree in your spare time to move into the couples and health arena! Venturing into the medical world can be daunting, but if you find people to collaborate with (who presumably know what they are doing!), a voyage into the health arena will take you into a new world. We are confident that you will discover that you have a huge knowledge base of psychological and couple principles with a great deal to offer in the couple and health area! This is not to say that you will not have to learn anything about the medical disorder. You will need to have a basic understanding of the health stressor and the context within which it is operating; specifically, you need to know enough information to develop and carry out appropriate interventions tailored to the specific disorder. You need to understand the physical and psychological consequences of the disorder on the individual and couple level.

Good couple-based health interventions will undoubtedly incorporate an educational component, so you need to know enough about the disease to educate patients and their partners about the medical aspects of the disease and treatment, what they can reasonably expect in the coming weeks, months, and years, and how they can approach this illness as a couple. You need to be well versed enough in the disease and its effects to be able to choose relevant couple principles and incorporate them into treatment. Thus, you do not have to be an expert, but you must possess enough basic knowledge that you can effectively apply your sophisticated couple therapist skills in an appropriate intervention.

In addition to learning about the medical disorder, another challenge you will face is determining the experts with whom you need to collaborate. Depending on the disease you focus on, you may need experts from the medical field, health psychology, and other disciplines to create a team of professionals who have the collective knowledge base to develop and carry out a clinical intervention. You are going to need experts from the environment in which you will do your recruitment. This is essential, especially if you are making a move from a psychology department to recruit in a hospital setting. You will have to learn how to operate in the medical culture, and a person who "lives" in this world can be your guide for figuring out how to navigate this environment. Recruitment is often the most difficult aspect of clinical research, and optimizing your efforts by forming collaborative relationships with the medical team is essential to getting your couples and health research off the ground. In short, find someone who knows and understands the disease you want to work with, as well as the medical environment. You understand relationships, he/she understands the disease, and you can form a strong partnership to take on a new area of couples and health together.

Okay, so have we convinced you yet? Are you running to find the nearest medical expert with whom you can collaborate? Well, we are confident that, as couple researchers, we have a great deal to offer the medical field. We believe that our field's knowledge and application of couple principles can greatly improve quality of life for individuals and couples as they deal with a medical illness. In fact, we think that keeping our knowledge to ourselves is doing a disservice to those who eventually must face a medical diagnosis. We hope that someday we will have as many psychological and couple-based interventions as there are types of medical illnesses, thus enhancing many people's quality of life- let's help everyone thrive! With your couple-based training, you have the skills to help us in this endeavor. After reading this article, you know the basic ideas involved in moving to the health arena. So, if you are interested and your curiosity is piqued, come join us in this exciting new extension of couple research and intervention!

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TREASURER'S UPDATE

Dear SIGers,

First, I'd like to thank Shalonda Kelly for her two years of service as the SIG Treasurer. She did a great job keeping up with our finances and membership. Thanks Shalonda!

Second, I'd like to introduce myself as your new SIG Treasurer. Please email me at lsimpson@smu.edu if you have any comments or recommendations or have updates on title/affiliation changes or contact information for our membership list.

It was great to see so many people in Chicago this past year – we now have 118 members, of whom 62 are professionals and 56 are students. In the past year we gained 23 new student members and 2 new professional members. Welcome!

Dues remain at $20 for professional members and $5 for students, post-docs, and retired members. If you didn't get a chance to pay your dues at the last conference, please mail a check made out to Lorelei Simpson, with ABCT Couples SIG in the memo line, to the address below and I'll send you a receipt by email.

Prior to the 2006 conference, our SIG balance was $1339.98. In 2006 we deposited $2212 into our account. At the conference we paid out $1211.13 for our cocktail party, $300 for student awards, and $550 for the pre-conference speaker, leaving our current SIG balance at $1490.85. Thanks to everyone for supporting our SIG!

And finally, if you're not already on it, remember to join the SIG listserv at the www.couplessig.net.

See you in November!

Lorelei Simpson, Ph.D.
Assistant Professor and ABCT Couples SIG Treasurer
Southern Methodist University
Department of Psychology
P.O. Box 750442
Dallas, TX 75275-0442
Phone: 214-768-2395
Email: lsimpson@smu.edu

Don't Forget to Pay Your Dues!

Our SIG Needs Your Support!

The Use of Filial Therapy to Help Families Experiencing Traumatic Events

Risë VanFleet
Family Enhancement & Play Therapy Center
Boiling Springs, PA

Five-year-old Cassie was playing with her mother during a special playtime in their home. She placed several of the dark green soldiers behind a mountain she had created from several blocks. She then lined up some toy military jeeps and trucks, pretending that they were under attack by the invisible "bad guys." Imaginary bombs fell from the sky and the jeeps and trucks were overturned. As she played, her mother watched carefully and commented, "Those soldiers are hiding… the trucks are under attack! The soldiers are fighting the bad guys! They're getting hurt!" Cassie looked at her mom and smiled, "Yeah! They can't see the bad guys—they're very sneaky." Her mom replied, "The bad guys are trying to trick those soldiers." Cassie's play continued, and eventually the soldiers emerged from behind the mountain, shot their guns all around the area, and then put the jeeps and trucks back on their wheels. Cassie said, "They're strong soldiers." Her mother replied, "They're strong and know how to fight the bad guys. They are keeping everyone safe."

This excerpt describes a special Filial Therapy play session held in Cassie's home with her mother. Her father was serving in the military in Iraq at the time. Cassie was using the natural developmental process of play to communicate and comprehend something that was happening to her family. Her play seemed to show her awareness and anxieties about the war in which her father was engaged as well as giving her an opportunity to master her fears. Her mother was providing this opportunity by her acceptance and empathy. She permitted the play and showed that she understood it. These weekly play sessions had reduced Cassie's night terrors and daytime tantrums, all of which seemed to be related to her father's deployment. Her mother reported feeling less anxious herself, as she was able to do something that helped Cassie with her feelings and reactions.

The approach that Cassie's mother used is called Filial Therapy. This family therapy approach uses special parent-child play sessions to help children with a wide range of problems and to help parents understand and respond to their children in more beneficial ways. Cassie's difficult behaviors began to subside after just four such play sessions, and she began to resemble the happy-go-lucky five-year-old she had been prior to her father's deployment after just eight play sessions. When her father returned after a year in Iraq, he held special play sessions with her as a way of getting reacquainted.

With 45 years of clinical use and research behind it, Filial Therapy is rapidly gaining recognition and respect as a powerful tool for helping families with a wide range of child-related and parenting problems. The numbers of clinicians who are using it and researchers who are studying it have been growing at a faster rate than ever before. It is particularly well-suited for use with families who must cope with trauma, including single-event traumas as well as chronic trauma, such as child maltreatment. Filial Therapy has been used for families who have suffered from car accidents, home fires, natural disasters, terrorism and other forms of school and community violence, chronic medical illness, and many other stressful events (VanFleet & Sniscak, 2003a). It has also served as a core intervention for individuals involved in foster care, adoption, and family reunification (VanFleet, 2006a; VanFleet & Sniscak, 2003b). This contribution provides an overview of Filial Therapy for readers who might be unfamiliar with it, and then discusses its unique place among family interventions that are useful in helping children and parents cope with traumatic events, with an emphasis on single-event traumas such as family tragedies and disasters.

Filial Therapy (FT) was developed in the early 1960s by Drs. Bernard and Louise Guerney and their colleagues as a means of resolving a wide range of child and family problems (Guerney, 1964; Guerney, 1983; Guerney, 2003a; Guerney, 2003b; Ginsberg, 2003; VanFleet, 2005, 2006b). Filial Therapy is a relatively short-term, theoretically integrative model of family therapy with a primary focus on strengthening parent-child relationships. Working within a psychoeducational framework, the therapist trains and supervises parents as they conduct special nondirective (or child-centered) play sessions with their children. After parents have mastered basic play session skills, the therapist helps them recognize and understand their children's play themes. The therapist also encourages parents to discuss their own reactions to the play sessions and to make adjustments that can help the entire family system become more adaptive. Great emphasis is placed on the creation of emotional safety for children and parents alike. The play sessions eventually move to the home setting, and the therapist continues to

meet with the parents to monitor progress and help parents generalize and maintain the skills they have learned in the play sessions to daily life. Filial Therapy typically involves 10 to 20 one-hour sessions, although more time is sometimes needed for exceptionally difficult problems or when working with multiproblem families or groups.

Filial Therapy has been researched since its earliest days and now has over 40 years of solid empirical history (VanFleet, Ryan, & Smith, 2005). Outcome studies have consistently demonstrated its value in improving (a) children's presenting problems, (b) parental empathy, (c) parents' skill levels, (d) parents' stress levels, and (e) the quality of parent-child relationships within the family. Most parents report greater satisfaction with their children and their coparenting experiences. Gains have been maintained in 3- and 5-year follow up studies. Research has also demonstrated its multicultural adaptability and its effectiveness with a wide range of populations (VanFleet, Ryan, & Smith, 2005; Guerney, 2003b; VanFleet & Guerney, 2003).

At its core, FT is a family therapy approach that uses special play interactions as its primary mode of communication, relationship-building, and problem resolution. All family members are involved, including parents or caregivers and siblings. Because play is one of the principal ways that children develop affective, cognitive, behavioral, social, neurobiological and physical capacities, it is perhaps the most developmentally-relevant and effective modality for use with children, including adolescents. (Filial Therapy was developed for children 3 to 12 years old, but traumatized adolescents often engage readily in imaginative play, and other forms of play therapy and family therapy that derive from FT are useful for that age group as well.)

It is not uncommon to hear families interviewed on television following traumatic events say that they wish to put the incident behind them and move forward, almost as if the trauma had not occurred. While the "pull yourself up by the bootstraps" approach might work for some adults, it has not been shown to be effective for most children and families. And while some families have significant post-trauma resilience, they typically do not deny the traumatic experience that they had. Trauma nearly always has an impact on the entire family, and families who acknowledge the trauma, join together in coping with it, communicate openly and patiently with each other about it, and flexibly and wisely use resources at their disposal seem to adapt more readily and completely afterwards (McCubbin & Figley, 1983).

Studies suggest that family cohesiveness can moderate the impact of trauma on children (Figley, 1989; Garbarino, Kostelny, & Dubrow, 1991; Garbarino, Dubrow, Kostelny, & Pardo, 1992). When parents can manage their own reactions and then focus their attention on helping their children cope, children seem to do better. This focus on the children's needs can be quite difficult, however, as parents must also deal with their own reactions to the traumatic event.

Filial Therapy offers a unique way for professionals to assist families as they build or rebuild their cohesiveness and support all members of their families following a disaster. Filial Therapy simultaneously offers considerable emotional support to parents. This relatively short-term intervention strengthens the family system so that it can overcome the shock and pain of trauma and loss. It can be employed as a preventive tool following trauma or to assist families with significant post-trauma distress (VanFleet & Sniscak, 2003a).

One of the hallmarks of traumatic experience is a sense of helplessness. Many parents seem eager to do something that helps their families cope. The Filial Therapy play sessions provide a developmentally-sensitive means for children to regain a sense of control and mastery while providing parents with tools that help them help their own family members. The therapist assists this process by teaching the parents to conduct the special play sessions as well as by providing empathy and support to the parents as they discuss their own reactions to the trauma and to their children's play themes, which often reflect their own trauma and loss reactions. In essence, the therapist helps the parents by supporting them emotionally and showing them how to help their own children through the use of therapeutically-beneficial play sessions. Children can overcome serious trauma when given the opportunity to play about it and have their feelings and confusions accepted by their parents. Parents can overcome their sense of helplessness by doing something constructive that helps their children while providing them with empathy and acceptance of their own feelings and dilemmas.

Filial Therapy offers a unique, systemic approach to strengthen family cohesiveness and resilience. Filial Therapy has been used successfully following countless family, community, and national tragedies, such as parental murder-suicides, devastating car accidents or house fires, the Oklahoma City Bombing, September 11th, hurricanes, tornadoes, and floods, the July 7th Underground bombings in London, serious medical trauma, school shootings, racial and ethnic violence, and many others. A major project is currently underway offering Filial Therapy to indigent families displaced by Hurricane Katrina in New Orleans (McCann, personal communication).

During his initial Filial Therapy play sessions with his grandmother, eleven-year-old Tyrone played with a plastic alligator that swam through water he had poured into a shallow bowl. The alligator then "ate" the small human figures he had placed on a small floating plastic raft. This play seemed reminiscent of his experiences and fears during Hurricane Katrina when he and his family

were stranded in the top floor of their building while the water rose closer to them. In his later play sessions, he asked his grandmother to pretend she was standing on a roof, about to fall into the water. Wearing a makeshift police helmet and using a rope, he became the "hero" of a rescue team that then saved her from danger. In these play sessions, he became animated and laughed with joy when his grandmother grabbed one end of the rope as he instructed her, and pretended to jump from her "roof" over to where he was standing. They embraced as his grandmother smiled and said, "Tyrone, you just saved your old granny! Just in time. I'm so lucky you were here to save me." She was effectively engaging in the imaginary play that he had created.

Tyrone's play helped him master his Katrina-related fears, and his grandmother effectively used the play session skills she had learned in Filial Therapy to help facilitate that process. The therapist provided much emotional support to the grandmother as she did so, because she was experiencing post-trauma reactions as well. The grandmother later told a researcher, "It was so good to see him laughing again. I learned ways to help my boy move from dark back to light. And it helped me, too, but it wasn't always easy. When we played, I could see how he was thinking about what we went through, and it reminded me of it, too. But then when he 'saved' me, I knew we both were going to be okay. We're still dealing with having no home, no place to go back to, and missing our old friends and neighbors, but we're together and enjoying each other. And that's what family is for."

More information about the practice of Filial Therapy, research on the approach, and training opportunities, please contact the author at the Family Enhancement & Play Therapy Center, Inc., PO Box 613, Boiling Springs, PA 17007, 717-249-4707, www.play-therapy.com, or at Risevanfleet@aol.com.

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Surf the Internet without guilt!	Visit the ABCT Couples SIG website: www.couplessig.net	Thanks to Nikki Frousakis for serving as our webmaster!

Letter from the Student Co-Presidents

Dear Couple SIGer's,

The Couples Therapy and Research SIG has always excelled in fulfilling the functions that its name implies, i.e., fostering therapists and researchers as they work with couples and investigate clinical issues related to close relationships. From our SIG's active participation on the Program Committee and our annual student research awards to our annual preconference seminars on clinical topics, we have worked hard to support both facets of our field. At last year's conference, however, we had the opportunity to discuss an area that our field has largely neglected despite its importance. As a group, the Couples Therapy and Research SIG has not been active in influencing public policy that impacts our field.

This lack of active participation in the politics and development of policy relevant to couples therapy and research has resulted in some serious consequences over the years. Since 1986, the National Institute of Mental Health no longer funds research that focuses on relationship processes, requiring instead that any couples-related research be focused on treatment of diagnosable disorders. Today, the studies that receive funding are those that examine how to treat depression, OCD, or the traumatic effects of breast cancer in the couples context, to name a few examples. A study focusing on interventions to improve relationship functioning will receive no such funds. Similarly, relationship distress has no formal diagnosis in the DSM-IV, and healthcare plans generally do not cover therapy for relationship distress.

Other changes in public policy have had less serious, though still important, implications for our field. Consider the decision by some states and many religious organizations to reward or require premarital counseling for those married within their province. While there is certainly recognition of the positive effects our field can have on young couples, these decisions have generally not been made with input from experts in the SIG. As a result, couples may be required to seek out counseling without knowledge of which interventions are supported by the efficacy and effectiveness research that members of the SIG have conducted.

Someone in our SIG described this trend as policy guiding research, rather than research guiding policy. Rather than the experts in our field serving as advisors to those making policy, policy-makers have generally made decisions that impact our field without consulting those in our field. When we consider what has drawn us to this area of study, it is not surprising that few of us have stepped forward to serve as advisors to policy-makers. The excitement of exploring relationship processes in research and having a positive impact on a couple's relationship in therapy have little overlap with becoming involved with the bureaucratic process of developing policy. I should mention that a number of people within our SIG have become involved on their own. The University of Denver research group has been involved with the Oklahoma Marriage Initiative (www.OKmarriage.org), and other members of the SIG have developed relationships with local judicial systems to be involved in the treatment of those convicted of domestic abuse and other relationship-related offenses. However, such involvement is not the norm in our SIG. Since this is not an area with which our SIG is familiar, I (Eric) spoke with a professor of public policy at the University of North Carolina at Chapel Hill, Daniel Gitterman.

My conversation with Dr. Gitterman began with some confusion. When I explained that I am a member of a special interest group, he immediately assumed that the purpose of the group was to lobby policy-makers on issues related to couples therapy and research. I had to explain that we focus on the therapy and research itself, not on the policy, but the initial confusion highlighted our lack of activity in this area.

As we spoke, Dr. Gitterman offered a few suggestions that would help our SIG move toward being more involved with and influential in public policy. The first and most basic recommendation that he offered was that the SIG needs to be aware of what public policy is being established at a national level. Any policy that is under consideration or has been passed at a state or federal level should be shared with the other members of the SIG across the nation. Of course, this information is necessary to enable us to become involved in the decisions about these policies.

Second, Dr. Gitterman suggested that the SIG begin collecting money specifically for active lobbying on important policy issues. Any group that has been successful in lobbying for the interests of its members has required money to fund the campaign.

Third, Dr. Gitterman recommended that some members of our field step out of our comfort zone and begin more active involvement in policy-making through contact with legislators. Some members of our SIG have already gained experience with this, as mentioned above. We believe that the SIG would benefit from stronger and more organized involvement in legislation, and we can draw on the expertise of these more experienced members of the SIG.

As an initial response to Dr. Gitterman's recommendations, we are proposing an addition to this newsletter: a "Policy Watch" section. Under this proposal, the newsletter editors will solicit information from the SIG about active public policy issues across the nation. We hope this process will gain support and begin in time for the fall edition of the SIG Newsletter. As the SIG begins to monitor policy-making more closely, we hope that the SIG will find new motivation to become involved in influencing the public policy relevant to our field.

- Eric Gadol and Brian Baucom

Research to Real World: A Student's Perspective

Sarah Levinson Bauer and Tamara Sher
Illinois Institute of Technology

Dr. Tamara Sher's lab at the Illinois Institute of Technology focuses on couples issues and health psychology. For years our students have worked on various research projects in these fields, while attempting to delineate our own specific research interests. For all the current students, we were fortunate enough to have a chance to work on one of these great studies: Partners for Life (PFL; see Sher et al., 2002, for a more complete description).

Partners for Life investigated the effects of partner involvement in making and maintaining behavior change within a cardiac risk population. The study was funded by the National Institute of Health as part of the Behavioral Change Consortium (BCC). In addition to the main grant, PFL researchers earned a supplemental grant to examine nutrition as it relates to cardiac health.

Eligibility Criteria

Participants for PFL were recruited from clinics at two large teaching hospitals and one community hospital in and around the city of Chicago. Participants were eligible for inclusion in the larger study if they (a) had a history of heart disease (heart attack, bypass surgery, angioplasty/stent, treatment of angina); (b) had a spouse or live-in intimate partner; (c) had abnormal cholesterol levels that required treatment with lipid-lowering medication; (d) were able to participate in regular exercise as defined by the ability to walk for 10 minutes at a time without resting; and (e) needed to lose weight or implement a low fat diet. Exclusionary criteria included (a) contraindications to cholesterol lowering medication therapy; (b) evidence of other uncontrolled or concurrent conditions, such as hypertension, congestive heart failure, diabetes or thyroid disease; (c) inability to read or speak English at a sixth grade level; (d) psychiatric hospitalization in the last 12 months; (e) maintenance on anti-psychotic or bipolar medications; and/or (f) diagnosable DSM-IV substance abuse with concurrent treatment.

Procedure

Participants were randomized into two groups: one in which patients with Coronary Artery Disease (CAD) received a 6 month lifestyle intervention (individuals group) and one in which patients with CAD and their partners received the 6 month intervention with the addition of a relationship skills component (couples group). Both groups received health education regarding diet, exercise, and medication adherence.

Participants remained under the care of their own physician throughout the study, but the study cardiologist managed cholesterol levels and communicated any medication changes with referring physicians. Participants met with our study's Nurse Coordinator at the following time points: Baseline, 3 weeks, 12 weeks, 6 months, 12 months and 18 months. During these visits, participants were asked about amount of physical activity, nutrition intake, and medication adherence. At two points throughout the study, we videotaped a short conversation between participants and their partners.

In accordance with our supplement grant, participants also had their blood drawn at Baseline, 6 months, 12 months and 18 months. In addition to providing a typical blood profile and cholesterol work-up, the blood samples were spun in a centrifuge, serum was collected, and the samples were analyzed at the University of Illinois-Chicago for folate and carotenoid levels. This data was then sent to the BCC for multi-site level analyses (see http://www1.od.nih.gov/behaviorchange/ for a more complete description).

Measures

Patients and their partners were mailed a packet of questionnaires at several time points: Baseline, post-intervention (6 months post-baseline), follow up (12 months post-baseline) and maintenance (18 months post-baseline).

The packet of questionnaires addressed several variables of interest: fat intake, fruit and vegetable intake, physical activity, physical activity staging, smoking history, smoking status, marital satisfaction, perceived health status, depression, decisional balance for exercise, decisional balance for weight loss and health care climate, and select personality traits (i.e., optimism and perceived criticism).

We measured fat intake using the Kristal Food Habits Questionnaire (Kristal, Shattuck, Henry & Fowler, 1990). Fruit and vegetable intake was measured by the NCI Fruit and Vegetable Screener (Thompson et al., in press). Physical activity was measured by the Yale Physical Activity Survey (YPAS; Dipietro et al., 1993), which is a self-report questionnaire measuring frequency and duration of exercise. Stage of change for exercise was measured by the Physical Activity Stage questionnaire (Nigg & Riebe, 2002). Smoking history was assessed at baseline only; however, smoking status was assessed at each of the time points. Marital Satisfaction was measured by the Dyadic Adjustment

Scale (DAS; Spanier, 1976). Health status was measured by the Medical Outcomes Study 36-item short form health survey (SF-36; Ware & Sherbourne, 1992). Depressive symptoms were measured by the Center for Epidemiological Studies – Depression Scale (CES-D; Radloff, 1977). Optimism, which was only assessed at baseline, was measured by the Life Orientation Test (LOT; Scheier & Carver, 1985), which is a 12-item self-report measure of global optimism, with higher scores indicating greater optimism.

In addition to the above mentioned measures, participants reported their food intake for 3 days in a row at each of the time points to the study's nutritionist. She noted their levels of certain nutrients and these values were calculated into averages, which were then used in data analysis.

We measured medication adherence through the use of track caps (MEMS), which are medicine bottles that monitor medication intake through bottle openings. We were able to use this data to determine the rates of adherence for the cholesterol medications.

In addition to the self-report scales, exercise was monitored through the use of polar monitors. These are heart monitors that are to be worn while exercising. This data was used to help us verify the exercise levels reported on the home exercise logs and the self-report physical activity scales.

Results

It was originally predicted that there would be no group differences (individuals versus couples) at the end of treatment. Instead, it was hypothesized that group differences would emerge at the 12 month and 18 month follow-ups in favor of those in the couple group due to the emphasis on environmental support for change. Results were not as anticipated and could no have been predicted by the literature. Data were analyzed using hierarchical linear models (HLM) primarily because this allows for more sensitive evaluation of change than general linear models (e.g. repeated measures analysis of variance). Additionally, HLM allows for the assessment of two elements of change, long-term change (linear change) and treatment reactivity (quadratic change).

Most importantly, results suggested that relationship satisfaction was a treatment moderator. That is, when relationship satisfaction (DAS) at baseline was taken into account, there was a clear benefit to being in the couples group. Specifically, for those who began the intervention satisfied in their relationships, improvement was evident in both the individuals and couples groups. However, if patients began the intervention distressed in their relationships, improvement was only evident if there were in the couples group; if they were in the individuals group, they actually got worse over time. The full results are available upon request and are being submitted for publication.

PFL from a Graduate Student's Perspective

As could be imagined, this thorough study required a lot of "behind the scenes" work. Tammy's graduate students were very fortunate to be able to work on this extensive study. As research assistants and project coordinators, we wore many hats. We entered data, organized databases, had "data checking parties" (and we use the word party very loosely), spun the blood samples and retrieved the serum, sent packets of measures (and queries for missing data) to our participants, and monitored the videotaped communication sessions. Additionally, we were able to collaborate with other members of the BCC for several papers and projects, which are still in the works. Some of the best experiences we had, however, came from analyzing data. Besides getting an inside understanding of study operations, Tammy gave us the opportunity to analyze her data in ways that we found interesting, and present this data in journals or at professional meetings. I think I can speak for my entire lab when I say that we have found this experience invaluable.

Taking PFL on the Road

The original goal of PFL was to compare a couples approach to cardiac rehabilitation with a more traditional patient focused approach to cardiac rehabilitation. Of particular interest was which approach is better at maintaining change across time. With all PFL's strengths, there were certainly weaknesses. The intervention required a lot of patients in terms of scope, time, and convenience. Additionally, we still are not sure how participants maintain the changes that they have made across time. This got us thinking: What happens when researchers take their toys and go home?

Keeping this in mind, it was the goal of our next study to reach more participants by making the intervention more convenient without compromising the quality of the services. In accordance with this goal, PFL is now partnering with *InterventUSA,* an internet based, commercial venture built around scientific and comprehensive programs for lifestyle management and cardiac disease risk reduction. While the "Partners for Life" program only reached a limited number of participants, the *Intervent* Lifestyle Management programs have been utilized by over 50,000 individuals and have been shown to be effective in randomized clinical trials published in over 70 scientific manuscripts/abstracts.

We are currently adapting our PFL couples manual to be a couples online training course and health program for a cardiac risk population. Our hope is to merge these two endeavors and reach a maximum number of participants, while taking something that works in a controlled setting and applying it to the real world. We trust that this merge will benefit more patients, in broader

settings, and will be more consistent with the goals of busy cardiac clinics.

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KUDOS

Kudos to the following people...

Brian Doss and his wife Amanda Jensen Doss are expecting their first child at the end of June. In addition, and perhaps ironically, Brian got an R03 from NICHD earlier this year to do interventions over the transition to parenthood.

Tara M. Neavins received the "2006 Employee of the Year" Award for River Valley Services. She is currently the Day Supervisor of the Mobile Crisis Team.

Deborah Rhatigan has been hired as a psychology tenure-track assistant professor at the University of Tennessee-Knoxville starting fall 2007.

Our SIG Newsletter Co-Editor, Diana Brown, gave birth to a new daughter, Fiona Laurenn Brown, on April 30th! She was 7lbs, 12oz and 19 ½ inches long. Both mother and daughter are doing very well.

KUDOS

HOT OFF THE PRESS

In Press and Recently Published Literature

Barry, R., Lakey, B., & Oreheck, E. (2007). Links among attachment dimensions, affect and the self for attachment styles and bonds. *Personality and Social Psychology Bulletin.*

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